Principles and Framework Literature Review

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To: EICP Steering Committee

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Acronyms

AGIP	Advisory Group Interprofessional Practitioners
CAOT	Canadian Association of Occupational Therapists
CASLPA	Canadian Association of Speech-Language Pathologists and Audiologists
CASW	Canadian Association of Social Workers
CCARH	Canadian Centre for Analysis of Regionalization and Health
CEPHP	Canadian Coalition on Enhancing Preventative Practices of Health Professionals
CFPC	College of Family Physicians of Canada
CHCC	Community Health Care Centres
CHSRF	Canadian Health Services Research Foundation
CIHI	Canadian Institute for Health Information
CIHR	Canadian Institute of Health Research
CMA	Canadian Medical Association
CNA	Canadian Nurses Association
CPA (Physiotherapy)	Canadian Physiotherapy Association
CPA (Psychology)	Canadian Psychological Association
CPhA	Canadian Pharmacists Association
DC	Dietitians of Canada
EICP	Enhancing Interdisciplinary Collaboration in Primary Health Care
IECPCP	Interdisciplinary Education for Collaborative, Patient-Centred Practice
IHHRD	Integrated Health Human Resources Development
IPCA	Interdisciplinary Primary Care Agency
P&F	Principles & Framework
PHC	Primary Health Care
SC	Steering Committee

1.0 Introduction

The purpose of the Enhancing Interdisciplinary Collaboration in Primary Health Care (EICP) initiative is to enhance the quality, effectiveness and efficiency of the delivery of Primary Health Care (PHC) in Canada. The objective in this first phase is to develop a set of guiding principles and a framework that will better define the relationship between the client/patient and the practitioners who comprise the PHC system. This phase will also look at how PHC interacts with other elements in the broader health system.

The goal is not to develop a single model of PHC, but rather to create a more comprehensive knowledge base for future action. We begin by reviewing the extensive literature related to models of interdisciplinary collaboration in multiple settings. Using this information as a base will enable the Steering Committee to engage in an informed dialogue. This paper highlights pertinent findings, with respect to the concepts of principles and frameworks, published in major PHC system reports. Although the literature review is in an early stage of development, some interesting findings from research into interdisciplinary collaboration at an organizational level are also discussed. We begin by reiterating basic definitions of principles, framework and interdisciplinary collaboration, as they apply to this initiative.

2.0 Definitions

Principles are the shared values that all parties agree are critical to PHC. These principles are intended to guide the development of the PHC.

The ***Framework*** is composed of the structural pieces that frame PHC. The framework describes the characteristics of a systemic approach to PHC and the elements required to support the operation of such a system.

The principles and framework are relevant to a broad range of practice settings across Canada, from community health centres to private practitioners, and provide a *vision* for how the PHC system should develop.

One definition of ***Interdisciplinary Collaboration*** in health care[1] finds that collaboration has the following attributes:

- Development of a common purpose or care outcome;
- Acceptance and recognition of complementary skills and expertise among different providers;
- Effective co-ordination and communication among providers; and
- Collaboration as a framework for strengthening inter-professional communication and increasing the efficient use of health care resources.

For the most part, experts agree that teamwork and interdisciplinary collaboration are critical to an integrated health system, and especially to the PHC system.

3.0 Research Related to Principles

Much of the literature reviewed to date discusses the generic principles that drive effective teamwork in a variety of settings. Many of these principles are relevant for the purposes of the steering committee's work. The following section summarizes some of the key documents for consideration.

3.1 Document: Working Together: A Joint CNA/CMA Collaborative Practice Project, HIV/AIDS Example (March 1996)[2]

This paper outlines the broad principles for collaborative practice, when delivering health care and support services to individuals with HIV/AIDS. The principles are described as "general" in nature and are applicable to the development of collaborative practice models. They state that services should share the following traits:

- Patient-centred;
- A shared or common vision, values and philosophy focused on meeting care needs;
- A clear definition and understanding by all stakeholders of team members' roles and responsibilities;
- A climate of respect, trust, mutual support and shared decision-making;
- Effective communication;
- Empowerment of all team members;
- Respect for autonomous professional judgment; and
- Respect for autonomous choices and decisions of the care recipient.

The paper suggests that collaborative approaches are more successful when there are shared values such as mutual respect, trust (i.e., confidence in and reliance on the expertise of teammates) and belief in the effects of synergy (i.e., that group efforts are more effective than independent work).

3.2 Document: A Joint Statement on Scopes of Practice (February 2003): CMA, CNA and CPhA

This statement delineates principles and criteria that are used to determine scopes of practice. It is based on the premise that policy decisions must put patients first. These principles focus on:

- Safe, ethical, high-quality, timely care that is responsive to the needs of patients, affordable and provided by competent care providers;

- A flexible approach that enables providers to practice to the full extent of their education, skill, competence and judgment;
- A responsive approach to the needs of the public;
- Excellent communication;
- An evidence-based approach;
- The belief that individual care should be delivered in a co-ordinated fashion by qualified health care providers;
- Quality assurance and improvement; and
- The premise that patient choices must be taken into account.

3.3 Document: Integrated Health Human Resources Development; An Inventory of Activity in Canada

(February 1996): CAOT, DC, CNA and CPA (Physiotherapy)[3]

This document outlines the development of an Integrated Health Human Resources Development framework (*The National Framework* - IHHRD), which profiles an interdisciplinary, intersectoral approach to human resources management. This work was meant to complement integrated health human resources projects and efforts to create a more flexible health workforce that is able to respond to the health needs of the Canadian population.[4] The initiatives related to the IHHRD project championed an interdisciplinary approach and focused on the relationships among various service providers. This report suggests that there are nine key principles guiding integrated health human resource development:

- A shared vision;
- A goal-driven and needs-based approach;
- Consumer-focused action;
- Collaborative action for change;
- Adequate resources;
- Unique and shared competencies;
- Evidence-based decision-making;
- A leadership that is accountable for outcomes; and
- Accountability by providers.

3.4 Document: Choices for Change: The Path for Restructuring Primary Healthcare Services in Canada

(November 2003): CHSRF[5]

This document examines various models of PHC delivery and provides a synthesis of the benefits and drawbacks of these models. Recommendations from the report focus on making PHC services effective, relevant and reliable in the Canadian context. The report recommends two models of PHC, both of which are based (to varying degrees) on multidisciplinary teams. The report finds that professional co-operation is based on:

- A common vision;
- Trust;
- Mutual respect among professionals; and
- Recognition of particular areas of competence.

The report suggests that these skills, attitudes and behaviours are developed over time through a lengthy learning process, beginning with training and extending to practice settings.[6] However, the authors stress that these skills are easily lost by new trainees when the environment is not receptive to the expression of their values and attitudes.

3.5 Document: Primary Care and Family Medicine in Canada: A Prescription for Renewal

(October 2000): CFPC[7]

This document presents a model of delivery of primary care services by family doctors, nurses and other health care providers. Some of the principles of primary care highlighted in this document are:

- Comprehensive and continuing care;
- Teamwork involving a broad spectrum of health care professionals, as being essential to the delivery of high-quality care;
- Mutually supportive roles for doctors and nurses;
- Working relationships that fully utilize and respect the contributions of all providers; and
- Clear role delineation.

3.6 Document: Interdisciplinary collaboration within Quebec community health centres

(2002): Claude Sicotte, Danielle D'Amour and Marie-Pierre Moreault.[8]

This research paper provides some very important insights based on the study of interdisciplinary collaboration among Quebec Community Health Care Centres (CHCCs). The Quebec model of PHC is among the oldest in Canada. For this study, the entire population of CHCCs was surveyed to investigate:

- The intensity of inter-professional collaboration among CHCCs; and
- The organizational and professional factors that foster or limit interdisciplinary collaboration.

Overall, the study found that the CHCCs have reached only *modest* results in interdisciplinary collaboration. There is still an overriding tension between traditional professional models and the innovative ideas engendered in the interdisciplinary collaborative service delivery model. The results of this study have implications for both the principles and framework of the EICP initiative.

Since their creation in the 1970s, the Quebec CHCCs have been based on a model that outlines the following principles for CHCC organizations:

- Responsive to social and health care needs within their territory;
- Fosters close collaboration among professionals (i.e., mainly physicians, nurses and social workers, and eventually physiotherapists, occupational therapists and psychologists);
- Collaboration through a global, integrated approach to patient care delivery; and
- Interdisciplinary collaboration linked to work group internal dynamics and shared group beliefs and understanding.

3.7 Document: Canadian Association of Social Workers: Social Policy Principles

(March 2003).[9]

This document highlights the key social policy principles favoured by most social workers. The following principles are used by the Canadian Association of Social Workers to guide the evaluation of federal social policy initiatives:

- Dignity for the individual, including a commitment to the values of acceptance, self-determination and respect;
- Equality and an affirmation of the importance of equal opportunity policies;
- Equal treatment for individuals and families in like circumstances;
- Comprehensive services;
- Services based on best practices;
- Constitutional integrity;

- A *grassroots* approach in which decisions and delivery of social services are as closely connected as possible to the client; and
- Recognition of the right/obligation of social workers to participate in social dialogue and the development of social policies and programs.

3.8 Document: Strengthening Primary Care

(2000). CPA (Psychology)[10]

In this document the role of psychological care in a PHC system is discussed. Working from the World Health Organization's definition of health as *complete physical, mental and social well-being* this document suggests that an effective primary care delivery system must address the broad-based indicators of health including biological, psychological, social and cultural components. The document refers to extensive literature highlighting the benefits to clients and society of an expanded primary care system that includes psychological care. Some of the key beliefs highlighted in the document are:

- Interdisciplinary community-based primary care is the most cost-effective and efficacious means of delivering health care services.
- Offering the proper form of care, for example through appropriate referral of primary care patients to psychological treatment, results in decreased-suffering, cost-savings and increased satisfaction for consumers and care-givers.
- Accessibility to quality psychological health care remains a concern in Canada.
- Primary care restructuring must recognize the need to integrate physical and psychological health through viable interdisciplinary delivery models.

3.9 Document: Pharmacists and Primary Health Care

(May 2004). CPhA[11]

This document highlights the role of pharmacists in the current evolution of PHC in Canada. Based on the work of the World Health Organization, CIHI and the Romanow Commission, the CPhA concurs that the following principles are key to PHC:

- A system that is accessible, accountable and cost-effective with methods that are evidence-based, practical and socially acceptable;
- An approach that ensures comprehensive quality programs that provide basic, around the clock care;
- A system that empowers patients and communities to use resources effectively and fully;
- A system based on the needs and characteristics of the population it is serving;
- An approach that promotes inter- and multidisciplinary care; and
- An approach that values seamless care between the levels of primary, secondary and tertiary care.

3.10 Document: Interdisciplinary Primary Care Models

(April 30, 1997). The Working Group on Interdisciplinary Primary Care Models on behalf of the Advisory Group Interprofessional Practitioners (AGIP).[12]

This document provides a very clear, stepwise outline of the elements involved in building an Interdisciplinary Primary Care Agency (IPCA). The authors clarify from the outset that interdisciplinary primary care is an *approach* to care, distinguished by first contact, continuous, comprehensive and coordinated care for a defined population. The group identified the following key principles underlying the interdisciplinary model:

- Coordination, quality and continuity of care is improved through collaborative teamwork;
- Improved access to a broad range/choice of services is viewed as important;
- Patient satisfaction is improved through access to the appropriate provider (respecting both clinical need and patient choice);
- Provider satisfaction is seen as both important and as improved through enhanced collaboration; and
- PHC services should be provided at the right time by the most appropriate provider

3.11 Document: The Role of the Registered Dietitian in Primary Health Care

(May 2001): DC[13]

In this document the Dietitians of Canada endorse the following principles for primary care reform:

- The application of a *population health approach* that addresses all determinants of health (for example income, social supports, education, employment etc) and links PHC with other relevant sectors (for example schools, housing, volunteer organizations etc).
- Access to a comprehensive scope of PHC services through the most appropriate provider of those services.
- Coordination and continuity between providers (with an emphasis on the importance of information technology as a facilitating factor)
- Interdisciplinary group practices comprised of a mix of service providers based on community needs.
- An integrated, responsive and cost-effective system with a focus on population-based funding.

4.0 Research Related to Frameworks

4.1 Document: Integrated Health Human Resources Development; An Inventory of Activity in Canada

(February 1996): CAOT, DC, CNA and CPA (Physiotherapy).

This framework provides a profile of an interdisciplinary, intersectoral approach to human resources management. The framework identifies complex relationships among five major elements of the health system:

1) The environment:
- System design and organization;
- Regulation and legislation;
- Social and demographic projections;
- Society expectations/public policy;
- Health research and technology advances;
- Economic forecasts/fiscal policy; and
- Funding policy.

2) Health needs:
- Consumer expectations and attitudes;
- Outcome based health goals;
- Health status and function; and
- Alternative service delivery approaches.

3) Health human resources planning:
- Human Resources role analysis;
- Resource supply and requirements;
- Funding mechanisms;
- Health information and technology use; and
- Integrated Human Resource models.

4) Education and training:
- Interdisciplinary health curricula;
- Retraining;
- Collaborative professional/technical programs;
- Outcome-based accreditation;
- Evidence-based practice and lifelong learning;
- Provider expectations/attitudes; and
- Outcome-based provider curricula.

5) Management:
- Needs-based services and programs;
- Outcome-based accreditation;

- Organizational practices and development;
- Integrated Human Resources policies;
- Integrated information systems;
- Provider reimbursement and collective agreements; and
- Integrated service delivery models.

4.2 Document: Choices for Change: The Path for Restructuring Primary Healthcare Services in Canada

(November 2003): CHSRF

The CHSRF document builds on the principles and effects of PHC highlighted earlier by suggesting that "PHC can be viewed as systems for organized action where players in a given social field (primary health care) and in a defined environment (Canada and its provinces) interact for mobilizing and using resources to generate activities, goods, or services required to achieve their objectives and joint projects."[14]
The document outlines six aspects of PHC, as a system for organized action:

- Vision: the beliefs, values and objectives by which players communicate and justify their actions;
- Resources: the quantity and variety of resources available;
- Organizational structure: the legislation, regulations, agreements and other arrangements that govern and guide the behaviour of players, their relations with each other, and the authorities that define them;
- Practices: the processes behind production of activities and services;
- Effects: the desired change in results of PHC over time; and
- Environment: the context in which players operate and the other systems with which they interact.

4.3 Document: Primary Care and Family Medicine in Canada: A Prescription for Renewal

(October 2000): CFPC

In this document, the proposed primary care model (The Family Practice Network) suggests that a commitment to the following areas is required to ensure success:

- The human resources needed to provide services;
- The training of future providers;
- The research required to evaluate outcomes;
- Remuneration and funding strategies to support all parts of the system; and
- Collaboration and communication among all key players.

4.4 Document: Opportunities and Potential: A Review of International Literature on Primary Health Care Reform and Models

(August 2000): Marriott and Mable.[15]

This document reviews the literature related to PHC and reform in six countries, from the 1980s to the end of March 2000. The experiences and lessons learned from these countries is examined in order to advance Canada's efforts to reform PHC. The authors describe several key organizational and policy elements that consistently appeared in most countries:

- A trend toward greater citizen participation in governance, management and planning;
- Citizen choice of organization and provider;
- The presence of "rostering";
- Movement toward physicians working in groups, with gatekeeping in all settings;
- Multidisciplinary efforts in most jurisdictions;
- Capitation;
- Priority given to health information systems; and
- Quality as a key policy objective.

4.5 Document: Increasing access to occupational therapy in primary health care

(January 2004): Donna Klaiman, CAOT[16]

PHC and occupational therapy both support a holistic approach to health. This document discusses developments in primary care and initiatives undertaken by the Canadian Association of Occupational Therapists (CAOT) to increase access to occupational therapy services in PHC in Canada. The author indicates that the CIHI model of PHC ("Bringing Together Health and Health Care") is consistent with the CAOT model of occupational performance. Both models focus on the dynamic relationship between clients and PHC providers, in which activities focus on health promotion, injury and disease prevention, as well as maximizing the client's ability to perform their given occupation. In an integrated framework, the client is at the centre and is connected to the physical, institutional, cultural and social environment. Clients are seen as active participants within the therapeutic relationship and indeed have a personal responsibility regarding their own health. PHC must recognize the close relationship between a person's sense of health and his or her social and physical environment. CAOT views the following systemic elements as important to the evolving role of occupational therapy in PHC:

- The effectiveness of teamwork;
- The importance of continuity (the SIPA model is given as an example);
- The financing and infrastructure of PHC;

- The roles and relationships among PHC providers; and
- Health human resource planning.

4.6 Document: Interdisciplinary Primary Care Models

(April 30, 1997). The Working Group on Interdisciplinary Primary Care Models on behalf of the Advisory Group Interprofessional Practitioners (AGIP)

As mentioned, this document provides an overview of the building blocks of an IPCA. The features of this agency are described as:

- Rostering;
- The agency coordinates care for the rostered clients through a *team liaison* person
- Common Patient Record that is available on computer;
- Access facilitated by extended hours service for routine care and 24/7 service for urgent PHC;
- Funding arrangements based on capitation;
- Governance: The agency would be a not-for-profit organization with a Board of Directors. Providers would dictate the management and administrative structure of the agency;
- Regulation remains with the professional colleges but a complaints process would be established for agency functions; and
- Evaluation with an interest in cost-effectiveness and satisfaction.

5.0 Additional Research

An initial review of individual studies reveals some consistent themes that may be considered as possible building blocks of a PHC framework.

1. Regulatory mechanisms—the linkage among professional associations within the system:
    - The Taber Integrated Primary Care Project (August 2003)[17] concludes that implementation of the changes in their integrated PHC system would have been easier, if there was a clear process for negotiation.
    - Professional expertise and responsibilities are formalized in specific codes of ethics and scopes of practice (provincial and territorial legislation and policy). In the study of Quebec CHCCs, Sicotte found that in PHC settings, the delimitation of professional jurisdictions remains a major issue. The division of labour in interdisciplinary practice is confounded by the tension between traditional professional logic and interdisciplinary logic (focused on care-sharing and professional substitution).[18]

2. Educational system—the training of interdisciplinary teams:
    - In a British evaluative study of two collaborative, community nursing schemes, King[19] found that it was vital for staff from differing professions to have an understanding of each other's professional practice, values and culture. The study's authors argue for interactive, shared learning modules at an early stage in professional training, where students are engaged in small multidisciplinary groups and have the opportunity to interact with other student practitioners.
    - In assessing the situation of CHCCs in Quebec, Sicotte states that professional training programs must be realigned in order to foster collaborative relationships. These new training models need to include interdisciplinary values within the traditional professional model.[20]
    - The *Working Together* document also recommends that educational curricula incorporate theory and clinical experience in collaborative practice.
    - The *Prescription for Renewal* document highlights support from the CFPC for integrated models of education and training for all health care professionals. Shared experiences in training will enhance collaboration and understanding.
    - In a study by Dieleman,[21] effective teamwork was possible when providers learned about the skills and abilities that the other providers could offer to the team. Trust developed only after this learning occurred.

3. Funding and Payment models:
    - Appropriate funding is important to support interdisciplinary teams.
    - Funding and payment models must account for the expanded role inherent in a comprehensive primary heath care model; flexibility and choice should also be considered (*CFPC Prescription for Renewal).*

4. Infrastructure—possible elements could include:
    - Organizational design;
    - Corporate structure;
    - Buildings;
    - Technology (computers, integrated information systems);
    - Human resources;
    - Scope of services; and
    - Rostering.

    Here are some examples:
    - In the Taber study, implementation of an integrated PHC system was made easier by having professionals work together at the same site.
    - The Sicotte research found that there was increased responsiveness of services to population needs and better service integration/co-ordination in PHC systems when a coherent organizational structure existed. Formalized administrative initiatives were important to fostering

collaboration—in essence, concrete rules that help align the work group model with interdisciplinary values. Formalized processes and functions were also found to be critical, although they must be carefully introduced because professionals don't like to be constrained in their autonomy.

- Patient rostering/registration will work only if it is strongly endorsed by both patients and physicians. It should be optional (*CFPC Prescription for Renewal 2000*).
- The Halton-Peel research suggests that there is no clearly defined or agreed upon list of health care services that all primary care professionals should provide (even within the same profession). In addition, this report found the following mechanisms that facilitate shared care"
  - Centralized access points to information and providers;
  - Co-located staff for physician practices;
  - Collaborative networks with specialists; and
  - Hospital affiliation and information technology (critical for building an infrastructure of support).[22]
- At the March 2003 Canadian Centre for Analysis of Regionalization and Health (CCARH) conference, Marie Beaulieu,[23] a team member with CHSRF, suggested that PHC is not about a single "basket" of services. She said that it is an interdisciplinary collaboration, since no single discipline able to respond to all needs. PHC requires a clear distribution of roles, and explicit mechanisms of collaboration and interdisciplinary training.
- The paper *Towards a Canadian Model Integrated Healthcare*[24] describes an integrated health care system as one where patients have a wide choice of primary care providers, including non-medical clinicians. Services should be provided by the health professional that can best meet the individual's needs. In addition, co-ordination and quality care is dependent on a common clinical information infrastructure.

5. Legal/Liability frameworks/ collective agreements:
   - Providers in interdisciplinary teams should be accountable for their own professional practice and should be responsible for securing their own liability coverage (*CFPC Prescription for Renewal 2000*).
   - Marie Beaulieu argues that there is a provincial responsibility to adjust the legal, regulatory and professional frameworks, as required, and to ensure that adequate financial and human support is aligned with PHC objectives.[25]

6. Public Education/Involvement/Choice:
   - Canadians should be allowed to choose their family physician and have the right to change, if desired (*CFPC Prescription for Renewal 2000*).
   - Changes in services and the roles of service providers can create confusion in the public and perhaps, a subsequent lack of acceptance. Public education about the changing nature of primary care delivery systems is needed. (King)

- The *Working Together* document suggests that care recipients have the ultimate choice in determining preferences and priorities about their health—they must be central to the collaborative team process.
- Consumers expect providers to understand each other's role and to work collaboratively to address their given health needs. (IHHRD).
- Internationally, citizens have been engaged in some pilot projects of PHC reform. There is a movement to enhance and reinforce their participation in the governance of PHC organizations (Marriott and Mable).

6.0 Conclusion

This paper provides an initial review of some of the key literature on PHC with respect to the concepts of principles and framework. This review is intended to assist steering committee members, as they collectively endeavour to develop these concepts more fully. Clearly, the body of literature related to interdisciplinary collaboration in PHC is extensive and additional findings will be highlighted as the initiative progresses.

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[2] Ibid.

[3] CAOT, DC, CNA and CPA, *Integrated Health Human Resources Development; An inventory of Activity in Canada* (Ottawa: IHHRDP, February 1996).

[4] Ibid.

[5] CHSRF, *Choices for Change: The Path for Restructuring Primary Healthcare Services in Canada* (Ottawa: CHSRF, 2003), p.4. Available from CHSRF, <www.chsrf.ca/final_research/commissioned_research/policy_synthesis/pdf/choices_for_change_e.pdf>.

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[9] CASW, *Canadian Association of Social Workers: Social Policy Principles* (Ottawa: CASW, March 2003). Available from CASW <www.casw-acts.ca>.

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[14] CHSRF, *Choices for Change: The Path for Restructuring Primary Healthcare Services in Canada* (Ottawa: CHSRF, 2003), p.4.

[15] John Marriott and Ann Mable, *Opportunities and Potential: A Review of International Literature on Primary Health Care Reform and Models* (Ottawa: Health Canada, 2000). Available from Health Canada, < www.hc-sc.gc.ca/phctf-fassp/english/new.html>.

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[19] Nigel King and Angela Ross, "Professional Identities and Interprofessional Relations: Evaluation of Collaborative Community Schemes," *Social Work in Health Care*, 38(2) (2003), p. 69.

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[22] Halton-Peel District Health Council, *Building a Primary Health Care Infrastructure in Halton-Peel: Planning for the Future* (Mississauga: Halton-Peel District Health Council, April 2004), p. 23.

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[25] Ibid.