Introduction

Today's healthcare labor force is being asked to work in collaborative, integrated teams to achieve the goal of delivering patient-centered, safe and effective care that meets the growing and complex needs of an aging population. A vision for collaborative practice fueled by interprofessional education has emerged on a national level, and momentum is building in academic and practice settings in support of this vision. In order to sustain this momentum and make interprofessional collaborative practice a reality, healthcare leaders and educators must critically evaluate the cultures, systems and infrastructures currently in place.

Healthcare organizations also must understand that collaboration is more than just working together and working well with others outside the traditional care circle. It is also a commitment to a new operational framework and an acknowledgment that an integrated healthcare workforce will need innovative tools, resources and technology that can stand up to and promote the demands of team-based care delivery today.

Driving Forces and Guiding Principles

As defined by the World Health Organization, collaborative practice occurs when multiple health workers from different professional backgrounds provide comprehensive services by working with patients, their families, caregivers and communities to deliver the highest quality of care across settings.

This effort is supported by a growing body of evidence that demonstrates that the incorporation of patient preferences contributes to higher-value healthcare. Value also is enhanced when patients, families and communities assume increased responsibility for factors influencing health.

Inextricably linked to this care delivery model is interprofessional education, which takes place when students of two or more professions learn about, from and with each other to enable effective collaboration and improve health outcomes.

Summary

The Affordable Care Act, which ushered in unprecedented change for healthcare, also put impetus behind a concept that had been gaining momentum over decades: interprofessional, collaborative education and practice. While proponents see this team approach to medicine as the most direct path to patient-centered care, there are numerous roadblocks to be overcome before the journey is the complete.
The call for an interprofessional approach to education has been building since the 1970s in a series of landmark conference, national and Institute of Medicine (IOM) reports. The premise behind this team-based approach to medical education and practice is that healthcare delivered by well-functioning coordinated teams leads to better patient and family outcomes, more efficient healthcare services and higher levels of satisfaction among healthcare providers.

While not new itself, the concept of interprofessional collaborative practice was given new impetus by the charge of the Affordable Care Act to develop more responsive healthcare organizations and structures, such as accountable care organizations (ACOs), integrated clinical networks, patient-centered medical homes and transitional care models.

It is, admittedly, a sea of change for historically siloed healthcare organizations, as the individual-expert model gives way to collaborative problem solving and decision making across the patient-care team.

Coordinating Center and Interprofessional Competencies

Coordination and recommendations for meeting these new challenges in a holistic way continue to emerge.

In an effort to ensure that collaborative practice and interprofessional education remain linked, for instance, the U. S. Health Resources and Services Administration (HRSA) on September 14, 2012, selected the University of Minnesota Academic Health Center to lead a new coordinating center aimed at providing national leadership for this endeavor.

The Coordinating Center for Interprofessional Education and Collaborative Practice (CC-IPECP) will receive $8.1 million over five years in grants from HRSA and four foundations to promote expertise in these joined pursuits, particularly in medically underserved areas. Nationally recognized leaders in the field will lead the coordinating center, which will include partnerships with other training and health delivery sites around the country.

The work of the CC-IPECP will support the Interprofessional Collaborative Practice Core Competencies established by the Interprofessional Education Collaborative in May of 2011. The Core Competencies are based on the IOM competencies and are organized within four domains:

**Competency Domain 1: Values/Ethics for the Interprofessional Practice**

Work with individuals of other professions to maintain a climate of mutual respect and shared values.

**Competency Domain 2: Roles/Responsibilities**

Use the knowledge of one’s own role and those of other professions to appropriately assess and address the healthcare needs of the patients and populations served.

“Evidence suggests that interprofessional teams achieve better outcomes and that team-based care should become the normative clinical practice.”

Interprofessional Education Collaboration Expert Panel

While collaboration is important throughout the health system, it is especially important at the patient interface.
Competency Domain 3: Interprofessional Communication

Communicate with patients, families, communities and other health professionals in a responsive and responsible manner that supports a team approach to the maintenance of health and the treatment of disease.

Competency Domain 4: Teams and Teamwork

Apply relationship-building values and the principles of team dynamics to perform effectively in different team roles to plan and deliver patient/population-centered care that is safe, timely, efficient, effective and equitable.

Interprofessional Communication is especially important, as the exchange of information is a critical factor in all phases of collaborative patient care, and the impact of this exchange – or lack of exchange – can be profound.

For instance, the Joint Commission reported that failures in communication accounted for more than 60 percent of the root causes of sentinel events that occurred between 1995 and 2004. Research also has demonstrated that 70 percent of all medical errors can be attributed to poor healthcare team interactions. In addition, it has been reported that, when surgical teams less frequently shared information during intraoperative and handoff phases, results included increased odds of major complications or death.

These established foci and competencies align with another related effort – the Institute for Healthcare Improvement (IHI) Triple Aim approach to health-system performance, which encourages that new designs be developed to simultaneously pursue – and share accountability for – three dimensions:

- Improving the patient experience of care (including quality and satisfaction)
- Improving the health of populations
- Reducing the per capita cost of healthcare

Having developed a proposed concept design, IHI maintains that many areas of healthcare reform can be furthered and strengthened by Triple Aim thinking, including ACOs; bundled payments and other innovative financing approaches; new models of primary care, such as patient-centered medical homes; sanctions for avoidable events, such as hospital readmissions or infections; and the integration of information technology.

“We all share the vision of a U.S. healthcare system that engages patients, families, and communities in collaborative, team-based care. This coordinating center will help us move forward to achieve that goal.”

– Mary K. Wakefield, Ph.D., R.N. HRSA Administrator

Outcomes of an interprofessional project to improve outcomes related to sepsis included decreased mortality in patients admitted to a medical ICU from 25 percent in 2008 to 18 percent in 2012, and decreased average hospital length of stay of 2.35 days over the same time period.
Boundaries and Barriers

Proponents of collaborative practice see the model not only as a way to meet the objectives and requirements of healthcare reform and patient-centric care, but also embrace the concept as a way to promote efficient and effective operations, optimized reimbursements and reduced costs. Thus, there is a lot at stake for everyone involved at all levels of healthcare organizations.

There also are more than a few hurdles standing in the way of progress.

In addition to the seemingly immovable boundaries that separate departments and disciplines, there is the culture shock concomitant with changing “the way it has always been done” and the necessity of shifting the mind set from individual problem solving to team-based care planning and treatment.

There is also the fact that this mammoth change is not occurring in a vacuum, but is taking its place among all the many new healthcare reform initiatives, rules and regulations crowding the complex “to do list” for care delivery today.

And, as noted by the Center for Creative Leadership (CCL), hospitals and health systems already are managing a transitioning workforce. The physician’s role is evolving from independent practitioner to hospital-employed collaborator. The roles of executive leaders are expanding and the responsibilities being elevated. As new staffing models emerge, hospitals still face an ongoing nursing shortage and an aging nurse and physician workforce.

As the talent pool shrinks and demands increase, hospital, outpatient and clinical workforces are stretched thin. Thus it will be very tempting to keep one’s head down and forge ahead on the most familiar path. Add all the layers of operational hierarchy and personal work preferences, and the focus can narrow even more.

Further complicating the situation, the CCL pointed out, are the many and varied hospital/physician relationships. Hospital-owned physician practices and physicians in private practice who contract with the hospital (and may even partner with hospital competitors) all have demands and circumstances that make collaboration a significant challenge.

In such a fragmented system, the CCL report continues, boundaries (any form of “us versus them”) are prevalent and powerful. While these boundaries may have been frustrating or challenging in the past, today they are serious liabilities that lead to arduous and slow processes and watered-down policies.

Thus, healthcare organizations have their work cut out for them in managing the dynamics of change, actually leveraging the differences and different skills among team members to meet the shared goals of superlative care.

This is why the right clinical decision support solutions also must be in place to ease workloads and empower individuals while building teams.

Healthcare leaders must develop the ability to bridge departmental, cultural, organizational and industry divides. They must learn to break down barriers and silos and lead across traditional boundaries. Boundary-spanning leaders draw on networks and relationships as they work systemwide to meet the mission of healthcare.

Center for Creative Leadership

“Competencies can be operationalized and assessed by linking them with professional activities.”

– Ten Cate, O.

Entrustability of professional activities and competency-based training
Nuts and Bolts

When looking for tools and technology that support collaborative practice, it is important that healthcare leaders seek out broad-based and cohesive solutions that are patient-centered, align with clinical workflow, support interprofessional teams and span the continuum of care.

In a global sense, this transition will bring even more importance to the quality of an organization’s:

- Evidence-based solutions
- Clinical decision support
- Integrated interprofessional documentation
- Knowledge solutions
- Patient education and engagement solutions
- Professional development and continuing education resources
- Dialogue forums
- Technology solutions
- Ability to manage change

Primary goals providers named for implementing care plans included aiding clinical/financial improvements and improving interprofessional care coordination between caregivers. As one described: “Before, our nurses were going into a patient’s progress note. Now, we have them going to the patient’s care plan to add guidelines, which then gets the right information to document on our flow sheets when assessing the patient. It is all tied together, and that brings a lot more value.”

Clinical Decision Support 2012 Order Sets, Care Plans, Drug Databases

Conclusion

Patient-centric and team-focused, interprofessional collaborative practice represents a new playing field for today’s healthcare plans and hospitals. Boundaries have been removed, lines have been erased and rulebooks rewritten. Some things, however, remain unchanged: Leadership is integral to creating a motivated team, the ultimate goal is still the highest pursuit of the healthcare mission and the workforce must be equipped with tools and resources to handle the challenges of the healthcare environment.
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By streamlining workflows, practice and culture, we can promote safety and improve patient outcomes. Elsevier Care Planning is the only EHR-based care planning solution on the market that seamlessly integrates interprofessional care plans, evidence-based clinical practice guidelines and automated clinical documentation to drive collaborative, patient-centered care. Care Planning reduces practice variability, standardizes and improves the quality of documentation and promotes interprofessional collaboration across the continuum of care.

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