INTERPROFESSIONAL PRIMARY HEALTH CARE (IPC) COLLABORATION, FAMILY HEALTH TEAMS (FHTS) IN ONTARIO

INTERPROFESSIONAL PRIMARY HEALTH CARE (IPC) COLLABORATION, FAMILY HEALTH TEAMS (FHTS) IN ONTARIO

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**ABSTRACT**

**Background:** Interprofessional team-based approaches to primary health care (PHC) delivery have gained support in the literature. Interprofessional primary health care (IPC) models of service delivery allow for different professionals to work together to address patients’ needs. Family Health Teams (FHTs) are a newly introduced model of IPC delivery in Ontario. A variety of factors can influence collaboration between professionals in IPC teams.

**Purpose/Research Objectives:** The purpose of this study was to examine stakeholders’ perspectives about policy factors that influence IPC team collaboration, using the example of FHTs in Ontario.

**Methods:** This descriptive study employs semi-structured interviews with key informants from select Ontario FHTs. Directed content analysis was used to examine the Mulvale and Bourgeault (2007) framework. Interviews were conducted with FHT professionals to describe their perspectives on the influence of policy factors in shaping collaboration within their teams and whether identified policy factors acted to enhance or hinder collaboration.

**Findings:** Key informants cited, with highest agreement, economic and regulatory factors as influencing collaboration. Factors agreed upon unanimously by all key informants included funding, provider payment/remuneration, and practice scope. Key informants identified a range of policy factors that hinder collaboration. These included provider payment/remuneration, legal accountability, and the existence of multiple governing bodies.

**Implications/Conclusion:** A number of policy factors were reported to influence collaboration in FHTs in Ontario. Although the findings suggest that incremental reform is possible, widespread policy reform of physician incentives, a key barrier to collaboration, is unlikely. Prospects for reform of this factor may be more promising at an organizational level.

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**LIST OF ABBREVIATIONS**

3-I- 3 I Framework referring to institutions, ideas, and interests

AFHTO- Association of Family Health Teams of Ontario

CHA- Canada Health Act

CHC- Community Health Centre

CLSCs- *centre local de services communautaires*

FFS- fee-for-service

FHG- Family Health Group

FHN- Family Health Network

FHT- Family Health Team

HSO- Health Services Organization

IPC- Interprofessional Primary Health Care

MOHLTC- Ministry of Health and Long-Term Care

OHIP- Ontario Health Insurance Plan

OMA- Ontario Medical Association

PC- Primary Care

PCN- Primary Care Network

PHC- Primary Health Care

PHCT- Primary Health Care Team

RNAO- Registered Nurses’ Association of Ontario

WHO- World Health Organization

**DECLARATION OF ACADEMIC ACHIEVEMENT**

The following is a declaration that the content of the research in this document has been completed by Shaghayegh Donya Razavi and recognizes the contributions of Dr. Gillian Mulvale, Dr. Sandy Isaacs, and Dr. Andrea Baumann in both the research process and the completion of the thesis.

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**CHAPTER 1: INTRODUCTION**

Primary health care (PHC) emerged as a major interest of the international health community following the Declaration of Alma-Ata in 1978. An important message that developed from Alma-Ata and the Conference on Primary Health Care, USSR, 6-12 September, was the urgent need for action by international governments to protect, promote, and ultimately achieve the goal of “health for all”. The mantra of “health for all” reflected the social justice environment of the era. The Declaration of Alma-Ata stressed the importance of identifying global inequalities in health status. A key determinant of health in many high performing countries is a well-functioning PHC system.

The health systems literature draws an important distinction between primary care (PC) and PHC. Primary care can be considered the medical model of response to illness (Mable & Marriott, 2002). It often serves as the first point of contact that an individual has with or entry into the health care system (Dinh, 2012a; Starfield, 1998). Generally, PC describes a narrow concept focused on doctor-patient interactions and relationships. It is largely, but not exclusively, focused on acute care that is traditionally delivered by solo practice physicians (Muldoon, Hogg, & Levitt, 2006; Hutchison, Abelson, & Lavis, 2001).

On the other hand, PHC is a broader term with an emphasis on population and public health and represents an approach to health policy and service delivery (Muldoon et al., 2006). Additionally, PHC is referred to as “coordinated function for other specialized health care sectors as well as community services” (Dinh, 2012a, p. 2). This definition of PHC emphasizes interconnections between various health-related services. This perspective expands the role of PHC to include health advocacy and promotion, disease prevention, diagnostic services, access to treatments, and palliative, rehabilitative, and curative care (Ontario Health Services Restructuring Commission, 1999). Furthermore, the World Health Organization (WHO) recognizes PHC as a system-wide strategy. As a result, team-based approaches are used to address PHC whereas PC has been largely focused on acute care delivered by solo practice physicians.

The literature suggests that interprofessional team-based approaches can lead to improved health outcomes and performance in PHC (Dinh & Bounajm, 2013; Scott & Lagendyk, 2012; Virani, 2012; Mitchell, Parker & Giles, 2011; Interprofessional Care Strategic Implementation Committee, 2010; Oandason & Robinson, 2009; Zwarenstein, Goldman, & Reeves, 2009; Hutchison et al., 2001). The literature also suggests that many countries have PHC systems that include interprofessional models of service delivery. Examples include the United Kingdom, Sweden, Spain, Cuba, and Brazil (Glenngård, 2012; Keck & Reed, 2012; Reeves, Lewin, Espin, & Zwarenstein, 2010; Gene-Badia et al., 2007; Glenngård, Hjalte, Svensson, Anell, & Bankauskaite, 2005; McLean et al., 2005; Spiegel &Yassi, 2004; Goni, 1999; Poulton & West, 1999; Novás & Sacasas, 1989). In Canada, as elsewhere, PC has traditionally been offered by family physicians working in solo practice, with limited progress made towards interprofessional primary health care (IPC). In this study, IPC refers to the delivery of PHC services in an interprofessional model of care. Professionals from various background including medicine, nursing, mental health, pharmacy, and nutrition work together in a team-based setting, to meet the PHC needs of the general population. In order to advance health system performance in countries around the world, it is important to understand how policy factors may influence the ability to advance interprofessional models of PHC delivery.

The concept of team-based approaches allows for IPC to support PHC delivery, as opposed to traditional PC. IPC models of care delivery allow for different professionals to work together to address patient needs. It allows for a holistic approach to care (Gocan et al., 2014), which addresses both medical concerns and social determinants of health (Hutchison, Levesque, Strumpf, & Coyle, 2011). Interprofessional models facilitate the linking of various health services delivered to patients in one location. Health promotion initiatives are prominent in IPC teams, such as Community Health Centers (Hutchison et al., 2011). Our definition of PHC is consistent with Alma-Ata and supports a holistic approach to population health emphasizing disease prevention and health promotion efforts in addition to chronic disease management in addition to acute care.

Within Canada, PHC appeared on the governmental agenda via the *First Ministers' Accord on Healthcare* (2000) and the *First Ministers' Accord on Healthcare Renewal* (2003). These federal reports cite their chief motivation as changes in PHC reform. The reports advocated for the following: 24/7 access to health providers, timely access to diagnostic procedures and treatments (i.e. reduced wait times), information sharing and uniformity among health care providers with respect to health histories or medical tests, access to quality home and community care services, access to drugs without extreme financial burden, and access to quality care regardless of location of residence. By an Order in Council issued by the Canadian Parliament, Roy Romanow (a former Saskatchewan Premier) was commissioned to examine the current health care system in Canada and engage in a dialogue about the future of the public health care system. Romanow and the Commission on the Future of Health Care in Canada developed a report commonly referred to as the Romanow Report of 2002. This report, entitled *Building on Values: The Future of Health Care in Canada*, was based on a review of the national health care system. It highlighted the need to transform Canadian health care from a disconnected, treatment-focused system to one of comprehensive health care delivery. In his review of Medicare, Romanow addressed key components of the Canadian health care system, including PC service delivery and prevention, investment in health human resources and health care providers, and improving access and quality of care. Rosser, Colwill, Kasperski, and Wilson (2011) emphasized that Canada and the United States have faced a crisis in PHC. Human resources in health care, specifically physician shortages, have led to the emergence of PHC on the policy agenda in Canada.

Primary health care reform can mean different things in different contexts (Hutchison et al., 2001). In the Canadian context, meanings have included 24/7 access to a health provider, access to quality care regardless of region of residence, and access to essential medication without enduring financial hardship, to name a few. The focus of the current study was on IPC and the need for a collaborative approach to population health, as emphasized in the *Building on Values* report (2002). In the report, it is noted that "Teamwork and interdisciplinary collaboration are expected from health care providers either working in primary health care organizations or participating in networks of providers" (p. 117) and "more interdisciplinary teams with enhanced roles for nurses, pharmacists and other providers" should be created (p. 120). One of the primary goals of the *Accord on Healthcare Renewal* (2003) was to ensure that patients always had access to the appropriate health care provider. The report stressed the need for interprofessional and collaborative practice to meet patient needs and multidisciplinary approaches to PHC.

Consequently, in the mid to late 2000s, multiple reports on the benefits of and potential challenges to interprofessional team-based approaches to primary health care were written (Virani 2012; Interprofessional Care Strategic Implementation Committee, 2010; Oandason & Robinson, 2009; Deber & Baumann, 2005). Virani (2012) gives an encompassing definition of interprofessional team models that is essential to understanding collaboration in IPC settings in Canada:

Interprofessional team models are teams with different health care disciplines working together towards common goals to meet the needs of a patient population. Team members divide the work based on their scope of practice; they share information to support one another's work and coordinate processes and interventions to provide a number of services and programs. (p. 3)

Interprofessional primary health care delivery models are widespread across the country, and include but are not limited to Quebec's *Centres locaux de services communautaires* (local community health centres), integrated health networks in British Columbia, Primary Care Networks in Alberta, and family health teams (FHTs) in Ontario (Johnston, Green, Thille, Savage, Roberts, Russell, & Hogg, 2011; Sicotte, D’Amour, & Moreault, 2002).

**Statement of the Problem**

In light of looming physician shortages and deteriorating access to care in the late 1990s and early 2000s, PHC reform came to dominate the health policy agenda in Ontario (Kralj & Kantarevic, 2012; Rosser et al., 2011). The Canadian political environment and global push for PHC reform created a policy window in which FHTs appeared as one model of IPC delivery. In the next chapter, the policy context that led to the introduction of FHTs is explored through a review of the literature on the history of PHC reform in Ontario.

While the introduction of FHTs is a significant policy event in Ontario, the literature to date suggests that in practice there is considerable variation in the extent of interprofessional collaboration within individual teams. Various contextual factors have been suggested as influencing the effectiveness of interprofessional collaboration in PHC settings (Mulvale, Danner, & Pasic, 2008). While these factors are explored in more depth in Chapter 2, a brief summary is presented here. Pertinent factors can be better understood by dividing them into internal and external factor categories. Internal factors include characteristics of individuals and teams that affect their interaction, and are usually within the control of the team. Such factors include team vision, leadership, professional maturity, flexibility, openness, and team communication.

External factors can be contrasted with internal factors. Typically, these factors are not within the control of any individual team member. These factors and their impact are often determined by governmental decision making, as well as policy development and implementation. Examples include funding, remuneration, financing, practice scope, accountability, regulation, and education and training. Although such policy factors are beyond the individual and team control, they may strongly influence team collaboration. A large number of studies in the academic and policy literature have examined the influence of individual and organizational factors on collaboration. In comparison, relatively few studies have examined the influence of policy factors on interprofessional collaboration in PHC teams.

Policy factors that may influence collaboration are identified in Chapter 4. It is important for those interested in improving collaboration in IPC to understand the prospects for reform of the identified factors in order to enhance facilitators and overcome barriers. The latter are explored in the discussion chapter 5.

**Purpose**

The overall purpose of this study was to examine the relevance of policy factors identified by Mulvale and Bourgeault (2007) on interprofessional collaboration in PHC, by soliciting stakeholders’ perspectives.

**Study Objective**

1. To describe the impact of the identified policy factors on interprofessional collaboration in PHC.
2. To describe key informants’ perceptions of the identified factors which enhance or hinder collaboration, specifically in FHTs.

**Research questions**

1. From the perspective of health care providers, team leaders, and administrators in FHTs in Ontario, which policy factors identified by Mulvale and Bourgeault (2007), if any, influence interprofessional collaboration?
	1. What factors are described as facilitating interprofessional collaboration in FHTs?
	2. What factors are described as barriers to interprofessional collaboration in FHTs teams?

In the following chapter, a review of the literature is conducted (1) to understand the role of interests, institutions, and ideas in the development of PHC reform in Ontario using the 3-I policy analytic framework, and (2) to explore what is known to date about factors that influence the effectiveness of collaboration in IPC teams.

**CHAPTER 2: LITERATURE REVIEW**

**SECTION II: HISTORICAL BACKGROUND AND PRIMARY HEALTH CARE POLICY**

This study examined factors that influence interprofessional collaboration in the domain of PHC in Canada. The role of interprofessional collaboration has its own set of challenges and historical legacies that influence policy reform. The ability of FHTs to serve as a suitable model to address access and care delivery concerns was context dependant and largely influenced by the historical background of PHC development in Canada. The following section focuses on the historical policy context that led to the development of FHTs as an IPC in Ontario.

**National Perspective: Emergence of Primary Health Care in Canada**

The Canada Health Act (CHA) is federal legislation introduced and adopted in 1985 (Hutchison et al., 2011; Maioni, 2010; CHA, 1985). It built on earlier federal legislation that introduced the notion of public funding for medical services, including the Hospital Insurance and Diagnostic Services Act of 1957 and the Medical Services Act (1966). The CHA promotes a publically funded health insurance scheme by laying out the conditions that all Canadian provinces and territories must adhere to in their respective insurance programs in order to maintain federal funding contributions insured health services and extended health care. According to the CHA preamble, the Parliament of Canada recognizes the following:

That Canadians can achieve further improvements in their well-being through combining individual lifestyles that emphasize fitness, prevention of disease and health promotion with collective action against the social, environmental and occupational causes of disease, and that they desire a system of health services that will promote physical and mental health and protection against disease. (CHA, 1985, p. 1)

Furthermore, the Parliament "wishes to encourage the development of health services throughout Canada by assisting the provinces in meeting the costs thereof" (CHA, 1985, p. 2). Because of these foundational goals, which emphasize holistic approaches to health and public/governmental coverage of health care expenses, the CHA has come to define Canadian health care and universal coverage (Maioni, 2010). This legislation led to reform and the development PHC policies.

Hutchison et al. (2011) note, "Beginning in the late 1990s, Canada's improved fiscal climate and higher federal health care funding (some earmarked for PHC) made investments in PHC easier for provincial governments to contemplate" (p. 261). Furthermore, in 2000, the First Ministers (prime minister and provincial and territorial premiers) developed their *Accord on Healthcare*, which established the Primary Health Care Transition Fund, allocating $800 million dollars to PHC reform. Both the *First Ministers' Accord on Healthcare* (2000)and the *First Ministers' Accord on Health Care Renewal* (2003) influenced the policy environment to encourage integrative and community-based practices in health care (Health Canada, 2003). The goal was to address access to, quality of, and sustainability of the Canadian health care system for all (Health Canada, 2003). Furthermore, publically funded health insurance under the CHA was meant to guarantee universal access to health care for all Canadians.

**Conceptual Framework**

Review of the literature demonstrates that historical context and policy context are relevant in the differential development of PHC among countries. To understand the factors that led to the emergence of policy to support the introduction of FHTs as a model of interprofessional PHC delivery in Ontario, the 3-I policy analytic framework is used. As explained in a briefing commissioned by the National Collaborating Centre for Healthy Public Policy, the 3-I framework brings together common components of the political science literature to explain policy development processes (Gauvin, 2014).

 This framework emphasizes a policy triad between institutions, ideas, and interests. Walt et al. (2008) have observed that the relationship between the triad components drives health policy analysis. According to Gauvin (2014),

 By bringing different schools of thought together, the "3-i" framework constitutes a relevant theoretical instrument for public health practitioners' toolboxes. Such a framework can help to explore how interests, ideas, and institutions interact to influence, and ultimately, form policy developments and choices. (p. 4).

In the sections that follow, the elements of the framework are described and used to frame the literature review on policy development, which led to the introduction of FHTs in Ontario. In Chapter 5, the framework is again applied to an analysis of prospects for policy reform to set the stage for enhanced interprofessional collaboration in FHTs in Ontario based on the findings of Chapter 4.

***Institutions***

Institutionalism and the concept of institutions appear in political-economic discourse (Greener, 2005; Pierson & Skocpol, 2002; Hall & Taylor, 1996; Mearsheimer, 1994; Keohane, 1989). Institutions refer to overarching structures within which decision making of all types occurs. Robert Keohane (1989), a political scientist and international relations theorist, defines an institution as anything that constrains action, acts to guide behaviour, and sets out a certain set of rules that may or may not be issue specific. Similarly, institutions in policymaking focus on rules or procedural guidelines that shape the problem representation (Bacchi, 2009) and determine the course of action.

Institutions may be comprised of formal decision-making structures such as state structures and policy legacies. A policy legacy is the way past decisions influence the policy environment and create lasting changes to the context in which future policy decisions are made (Howlett, Ramesh & Perl, 2009; Mulvale, Abelson, & Goering, 2007; Greener, 2005). Institutions may consist of larger social and economic systems such as capitalism, socialism, and democracy (Howlett et al., 2009). These institutions shape emerging norms and reinforce existing norms. By nature, such institutions resist change and strongly influence the policy environment in which PHC reform develops.

***Interests***

Interests involve the actorswho may be affected by decision-making processes in either their development or their outcome. Policy actors are individuals or groups that are involved in any given policy issue. Actors may include elected officials, the public, political parties, bureaucracy, interest or pressure groups, think tanks and research organizations, the mass media, and other experts and consultants (Howett et al., 2009). An interest can be considered as the "stake" actors have in various policy issues. When actors have an interest they may or may not mobilize to pursue this interest depending on relative strength and ability.

***Ideas***

A third element of the policy triad focuses on ideas. The impact of ideas is twofold: ideas can hold both a knowledge component and a value component. Openness to new ideas and the interplay of these ideas with institutions and interests that affect policy are key to determining the acceptability of proposed policies. Sinha's (2004) definition adopts the premise that ideas and the meaning actors give them are interrelated. Building upon this concept, there is a distinction between knowledge and values. Knowledge reflects a current, evidence-based reality, whereas values are tightly intertwined with moral notions and ideologies. Evidence, as fact, primarily influences beliefs and is less likely to sway values, while values are deeply rooted beliefs that are not easily changed. Consequently, the interplay between evidence and values influences policymaking. Ideas can be as unchanging and powerful as the institutions from which they emerge, particularly when rooted in deeply held values.

Policy-making involves competing interests pursued by various actors based on ideas (values and evidence), within institutional constraints and opportunities. The interplay of institutions, ideas, and interests shapes policy development and will influence policy outcomes.

**Application of the 3-I Framework: Emergence of Primary Health Care in Canada**

Consideration of the historical influences of institutions, ideas, and interests helps to explain the evolving policy context that set the stage for the introduction of FHTs in Ontario, with a particular focus on policy legacies arising, most recently, from the CHA*.*

***Institutions***

The British North America Act of 1867 assigns jurisdiction of health care services to provinces and territories (Hutchison et al., 2001; Lewis, Donaldson, Mitton, & Currie, 2001). This is the first manifestation of federalism in Canadian health care. It was followed by the Health Insurance and Diagnostic Services Act in 1957 and the Medical Care Act in 1966, which introduced the idea of publically funded medical services (Hutchison et al., 2001) as well as conditions of universality, public administration, comprehensiveness and portability. The CHA is a hallmark of the role of Canadian federalism in national health care. Under Canadian federalism, each level of government has formal legal powers and a certain degree of political autonomy (Cameron & Simeon, 2002). Canadian federalism is an overarching structure that guides virtually all government behaviour and decision making, including health care.

The federal role in Canadian health care resides primarily in providing funding contributions to provincial health care budgets and influencing the direction of health care spending through leveraging revenue transfers (Hutchison et al., 2001). The CHA made federal funding of provincial health care budgets conditional on adherence to five key principles related to health care access and consolidated the standard of the publically funded health insurance system in Canada known as Medicare (Lewis et al., 2001). The stated purpose of the CHA (1985) is "to establish criteria and conditions in respect of insured health services and extended health care services provided under provincial law that must be met before a full cash contribution may be made" (p. 5).

The CHA strongly reinforced the principle of public funding for medical services in its creation of a publically funded insurance program, specifically strengthening FFS models of remuneration for solo practice physicians. The CHA emphasizes the role of hospitals, medical practitioners, and dentists in health services delivery According to the CHA (1985), "'insured health services' means hospital services (including surgical-dental care) and physician services provided to insured persons, but does not include any health services that a person is entitled to and eligible for under any other Act of Parliament" (p. 3), which privileges physicians relative to many other health care providers whose services are not covered by public insurance. The concepts of user charges (direct charges to patients for insured services) and extra-billing (charging a patient beyond what is covered by the health insurance plan) were disallowed by the CHA. If provinces failed to comply with the restrictions on extra-billing and users’ charges, the billing would be deducted from the federal cash contribution to the provincial or territorial insurance plan (CHA, 1985). This further supported FFS remuneration models as physicians were to bill the provincial insurance plan, known in Ontario as OHIP (Ontario Health Insurance Plan), for each insured service that they provided to their patients (CHA, 1985). OHIP, in and of itself becomes an enduring institutional structure, responsible for physician remuneration based primarily on FFS billing as implied by the CHA.

The legacies of the CHA reinforce physician dominance in health care. They strengthen practice autonomy, power, and control over practice structure (Hutchison et al., 2011; Hutchison et al., 2001). The CHA maintain FFS remuneration for physicians while other health care providers work on a salaried model (Hutchison et al., 2011). Any type of IPC model can be viewed as a threat to physicians because of the need to share the funding pool. Consequently, the institutional legacies of the CHA mutually reinforce and influence the ability for innovative models of care to emerge within the Canadian policy context.

 Pierson (1993) noted that institutional legacies can be strong and enduring and can be highly resistant to change once they are adopted. Consequently, such legacies guide and constrain the behaviour of "rational actors" (Pierson, 1993, p. 606). Pierson (2000) introduced the concept of path dependence, citing Margaret Levi's (1997, p. 28) definition:

Path dependence has to mean, if it is to mean anything, that once a country or region has started down a track, the costs of reversal are very high. There will be other choice points, but the entrenchments of certain institutional arrangements obstruct an easy reversal of the initial choice. (p. 252)

This definition is applicable to health care in Canada. Institutional legacies of federalism, the CHA, and the OHIP structure are strong. Moreover, they present challenges to changes in PHC delivery. Institutional legacies reinforce solo physician practice on a FFS basis and make it difficult to introduce interprofessional models of PHC practice.

###### **Ideas**

According to the CHA (1985), provincial insurance programs adhere to the following principal standards:

* Public administration: Provincial health care insurance plans must be administered and operated publically, on a non-profit basis;
* Comprehensiveness: The provincial insurance plan must guarantee that all insured health services are provided by hospitals, medical practitioners or dentists;
* Universality: Entitles all eligible persons of a province to insured services on uniform terms and conditions; and
* Accessibility and portability: Coverage of provincial residents while out-of-province, thus extending coverage to all jurisdictions in Canada.

These five standards shape Canadian policy development and are the foundation of PHC nationwide.

 Funding for health services and universal access are regarded as core values of health care in Canada. The CHA emphasizes that patients should not pay out-of-pocket for any insured services and user charges and extra-billing will be penalized by deductions from the federal cash contributions to the provincial and territorial insurance programs (CHA, 1985). However, Hutchinson et al. (2001) note that the CHA "had the important effect of reinforcing hospital- and physician-centered health care, limiting the potential for innovations in health care delivery based on alternative settings and providers, even in situations where they might be more appropriate or efficient" (p. 119).

Taken together, these core values can be interpreted to mean solo physician practice, with physicians retaining clinical autonomy and guaranteed payment on a fee-for-service basis through the public insurance plan (Lavis, 2004). Any threats to that value, including the introduction of IPC models, can be expected to raise public concern. Consequently, the CHA reinforces the privileging of the medical profession, specifically physicians and limits policymakers' abilities to engage in PHC reform, particularly via interprofessional models of service delivery.

As previously stated, PC reform emerged on the policy agenda in the early 2000s with the *First Ministers' Accord on Health Care* and the *First Ministers' Accord on Healthcare Renewal*. Federal commissions highlighted the shortage of health human resources across the country and the fragmented, uncoordinated health care system (Romanow, 2002; Kirby, 2003). The Kirby Commission authorized the Standing Senate Committee on Social Affairs, Science and Technology to "examine and report on the infrastructure and governance of the public health system in Canada" (Kirby, 2003, p. 1).

The First Ministers’ reports influenced the policy environment to encourage integrative and community-based practices in health care. The action plan for reform included 24/7 access to health providers; timely access to diagnostic procedures and treatments; information sharing and uniformity among health care providers with respect to health histories or medical tests; access to quality home and community care services; access to drugs without extreme financial burden; and access to quality care regardless of location of residence. Although more explicitly stated, the ideas inherent in the Accord’s action plan were reminiscent of the core values highlighted in the Canada Health Act. The notions of universality and accessibility permeate the action plan outline in the First Ministers’ Accord on Health Care Renewal. This speaks to the enduring nature of the ideas of the CHA and demonstrates that these ideas have become core values of the Canadian health care system. These values are an integral part of health care across the country and are deeply held by many Canadians and as such can be strongly resistant to change.

While not explicitly calling for IPC models, recommendations from the reports set the stage for the entry of these models in Canada. Furthermore, the reports and the resulting policy environment embraced the values integral to the WHO Declaration of Alma-Ata (1978) discussed in chapter 1. Values of universality and accessibility were at the core both of the CHA and the Declaration of Alma-Ata. Consequently, not only were these values locally and nationally popular, but had also gained wide spread global support.

***Interests***

Hutchison et al. (2001) have asserted that PC systems can be characterized in three major ways: organization and governance, funding and remuneration, and delivery. Each can be associated with one or a few of the following interest groups: federal and provincial governments, physicians and other health care practitioners, and the general public. These groups are composed of actors who hold interests that are important in the Canadian health care landscape when it comes to PC reform. Patient interests include coverage by a PC physician and obtaining necessary health services in a timely manner with assurance of quality in delivery. The most obvious way patients, the primary public interest group in health care, influence policy is through exercising their right to vote in governmental elections (Howlett, Ramesh, & Perl, 2009).

Health and allied care professionals’ interests include providing health care or health services to the public and fair remuneration. In interprofessional models of service delivery, these professionals include physicians, nursing staff, pharmacists, mental health workers, and dietitians. The interests of each group are primarily supported by their regulatory bodies and professional associations. For example, nursing interests and concerns are brought to the attention the Registered Nurses Association of Ontario (RNAO). Physician interests are advocated by the Ontario Medical Association (OMA).

The strength of these associations influences the actors’ abilities to mobilize. In the case of interprofessional mobilization in Ontario, exploration of the institutions and ideas that have shaped the policy environment in which FHTs emerged demonstrated that physician dominance and the primacy of the medical field is of utmost significance in PHC reform in Ontario (Hutchison et al, 2001). Since physicians have remained dominant through historical legacies of PHC in Canada, any reform that threatens their interest has been unlikely to succeed. Public interests usually align with physicians as long as they do not threaten their deeply held values, including the core values of the CHA like universality. Interprofessional models of care may be resisted for these reasons. However, the government acts as another powerful interest group that is likely to mobilize around IPC models of care. This is a result of the governmental need to use financial resources most effectively and focus on cost-cutting while delivering PHC to the general public (Howlett, Ramesh, & Perl, 2009).

Governmental interests emphasize the creation of polices to balance the provision of patient care with funding, in other words effective use of available resources (Howlett et al., 2009). In Ontario, the 2003 election led to a change of administration from a conservative government under Harris (Premier of Ontario from 1995–2002) to a liberal government under McGuinty (Premier of Ontario from 2002–2013) and a subsequent shift in the health policy environment. This political interest group not only had the ability to mobilize, but also the means through which to affect PHC reform in the province. The guarantee of universal PHC coverage, meaning a family doctor for every Ontario resident was a campaign promise of the Liberals (Rosser et al., 2011).

The role of the federal government is not as explicit as that of the provincial government. As per the British North America (Constitution) Act of 1867, health care design, management, and service delivery fall under the jurisdiction of provincial governments (Hutchison et al., 2001). However, the federal government occupies an important position with respect to universal access. It has a strong financial presence with specific interests and influence in health-related matters across the country (Maioni, 2010). When McGuinty was elected in Ontario, the federal and provincial parties were aligned (Maioni, 2010).

The 3-I framework highlights the institutions, ideas, and interests (actors) that influence the development of health care policy in Canada. Considering federalism as an institution, it is apparent that there are specific actors involved in constructing pertinent guidelines. These overarching guidelines are set by the federal government. Provincial governments act within the guidelines to address patient needs. Health care providers serve patient populations. They also conform to and execute provincial and federal health mandates. Patient populations are impacted by the decisions of governmental bodies and the implementation of health care policies that influence their care. Consequently, patient populations are an integral interest group. It is clear that the federal government, provincial governments, health care providers, and patients are all actors, with their own interests. Each actor is bound by certain institutions, guidelines, ideas and values.

**SECTION II: INTERPROFESSIONAL PRIMARY HEALTH CARE AND COLLABORATION**

**Disciplinarity in Health Care**

Various terminologies appear in the discourse on collaborative models of care and disciplinarity in healthcare. The terminology includes but is not limited to the following: cross-disciplinary, multidisciplinary, interdisciplinary, and transdisciplinary. The concept of disciplinarity can be applied in heath research; however, it is also important in approaches to health care in practice and PHC reform policy. Although there is some disagreement in the academic community on the exact nuances between each approach, the terms can be conceptualized as a gradient of collaboration (D’Amour, Ferrada-Videla, San Martin Rodriguez, & Beaulieu, 2005).

Choi and Pak (2003) conducted a detailed comparison and analysis of a range of definitions and objectives of multidisciplinarity, interdisciplinarity and transdisciplinarity in health research, services, and education and policy, which appear in the literature. Along with other disciplinary literature this scoping review has led to numerous conceptualizations. Cross-disciplinary is usually explained as an approach in which problems concerning one discipline are viewed from the perspective of another discipline (Stember, 1991).

Multidisciplinary refers to the study of a single subject or problem from different disciplinary perspectives that are functioning separately (Choi & Pak, 2006; D’Amour et al., 2005; Dyer, 2003; Opie, 1997; Stember, 1991). In health care delivery this means that a single aliment may be diagnosed and treated using the expertise of professionals from separate and distinct disciplines. They would apply the education and training of their specific professional background in patient care (D’Amour et al., 2005). However, the perspectives, findings, conclusions, and subsequent modes of action that arise from the various disciplines are not necessarily integrated. There may be a multiplicity of discipline-specific solutions. Neither the cross-disciplinary nor multi-disciplinary approach requires professionals from the various disciplines to interact in a regular manner and influence one another or participate in shared decision-making. The professionals do not act collectively and this results in low levels of collaboration.

Conversely, the interdisciplinary approach creates unique models by integrating a range of disciplinary approaches. Although the distinctive contributions of each discipline remain intact, interdisciplinary models foster collaboration and the integration of several pieces into a whole. Collaboration can lead to the development of unified and multifaceted solutions to a patient problem in practice or research question for study (D’Amour et al., 2005). Examination of the literature suggests that the transdisciplinary approach goes a step further and involves the use of a common theoretical model by different disciplines (Choi & Pak, 2006; D’Amour et al., 2005; Van den Besselaar & Heimeriks, 2001; Stember, 1991). There is a certain degree of boundary blurring between disciplines to establish a standardized theoretical model, which is uniformly applied to a problem or research question (D’Amour et al., 2005; Dyer, 2003; Stepans, Thompson, & Buchanan, 2002; Paul & Peterson, 2001; Opie, 1997). This approach requires a rigorous team approach and a great deal of communication and knowledge sharing (Choi & Pak, 2006; Van den Besselaar & Heimeriks, 2001). Addressing patient concerns and problems, and overall health can involve a substantial amount of interaction and boundary blurring between professionals of various disciplinary backgrounds in order to provide the highest quality of patient-centered care possible.

Commonly, most of the aforementioned terms are used interchangeably with ‘interprofessional’. However, a distinction is made to be made in the literature. The main difference is that disciplinarity in health care is used to characterize the interactions of different academic disciplines and their approaches to a health problem. Conversely, as noted by Angelini (2011, p. 176), "interprofessional implies professions working together in collaboration by integrating services and utilizing teamwork concepts." This notion is supported by Mu and Royeen (2004) in their examination of collaborative practice occupational therapy. Based on their review, they contend that interprofessional is the preferred term most commonly used in the fields of "allied health (Hawyard et al., 2000), counselling (Shoffner and Briggs, 2001), nursing (National League of Nursing, 1998), and social work (Reese and Sontag, 2001)" (p. 246). The key distinction is that the term discipline is used when discussing collaboration in academic settings, while interprofessional is used to describe collaboration between health care providers in practice (Mu & Royeen, 2004). Angelini (2011) observed, "Interprofessional collaboration in health settings specifically, is defined as health disciplines coming together around patient care issues, allowing decision making to occur within the group and allowing for transformation to occur" (p. 176). This statement demonstrates that although the contributions the educational discipline is important, it is the purposeful interactions occurring between professionals in any given team that defines collaboration as interprofessional.

**Family Health Teams: An Interprofessional Model of PHC Delivery in Ontario**

The focus of the PHC model in the current study was on Ontario's Family Health Teams (FHTs). In FHTs, team processes and patient care can involve numerous health professions. These professionals engage in collaboration and integration of the various unique skills, expertise and knowledge each has to offer as required to meet individual patient needs (Baldwin & DeWitt, 1996). These characteristics may be discipline-specific but are meant to complement each other in patient diagnostics and service delivery. The FHT is an example of a model of health care delivery that occurs within the PHC setting and commonly involves multiple professionals from different disciplinary backgrounds. Collaboration between professionals in the FHT setting is hereafter referred to as IPC collaboration.

Family Health Teams are an example of physician-led PHC organizations that provide PHC services to meet patients’ needs in an interprofessional model (Dinh, 2012). Patient health needs are addressed by a team of health professionals, including family physicians, nurse practitioners, registered nurses, social workers, dietitians, pharmacists, and administrators (Gocan et al., 2014; Dinh, 2012). These professionals work together to provide comprehensive care and health services to meet the needs of their communities and their patient roster (MOHLTC, 2014). According to the Ministry of Health and Long-Term Care (MOHLTC) (2014), there are currently over 3 million Ontarians rostered to FHTs across the province. There are presently 200 operational FHTs in Ontario, all have been implemented since 2005(Gocan et al., 2014).

Historically, the Canadian model for PC was organized around solo and small-practice family doctors and general practitioners who, in large majority, received remuneration on a fee-for-service (FFS) schema, with physician-centered primary care delivery (Hutchison et al., 2001). Hutchison et al. (2001) noted that by 2001, “Fewer than 10% of PC physicians work[ed] in multidisciplinary team practices” (p. 117). Family Health Teams emerged in the context of PC reform and developed from earlier models of PC in Ontario. These models included Community Health Centres (CHCs), which first appeared in 1980 and were interprofessional in nature, followed by Family Health Networks (FHNs) in 2001, and Family Health Groups (FHGs) in 2003. The latter two are physician-only practices. In Quebec, CHCs are referred to as *centre local de services communautaires* (CLSCs). The FHT is another model of health care delivery that supplies PHC facilities with health care providers from a plethora of disciplinary backgrounds in order to expand the scope of coverage (Rosser et al., 2011).

Family health teams are the latest model of PC delivery which aim to ensure that each patient is seen by the right healthcare professional and to deliver patient-centered care (MOHLTC, 2014). One of the key differences between previous models, such as the FHNs or FHGs, and FHTs was the issue of physician remuneration. FHTs payment reform meant that there would be a proposed blended remuneration strategy combining capitation, fee-for-service and bonuses (Rosser et al., 2011). In addition to FHNs, FHGs and CHCs, earlier models of care delivery across Ontario included the Health Services Organization (HSO) Program, which was established in 1973, followed by the Primary Care Network (PCN) Program in 1999. Key components of the programs included rostered patients and a capitated payment model (Hutchison et al., 2001). According to Hutchison et al. (2001), these physician-led group practices were meant to provide an alternative to the traditional "private, fee-for-service, and solo . . . practice" (p. 116) model for PHC service delivery in Ontario. The existing HSO in Hamilton became the root organization for the development of the Hamilton FHT, which is one of the largest FHTs in Ontario and was examined in this study.

**Interprofessional Primary Health Care: Factors that Influence Collaboration**

Interprofessional primary health care and collaborative care are discussed in both the academic and grey literature. Based on the academic literature, numerous factors influence interdisciplinary team collaboration. Individual-level characteristics or within team factors such as role specification and clarity, and trust and respect have been highlighted (Dinh, 2012b; D’Amour et al., 2005; Dieleman, Farris, Feeney, Johnson, Tsuyuki, & Brilliant, 2004; Zillich, McDonough, Carter, & Doucette, 2004). Zillich et al. (2004) conducted a random survey examining collaborative physician-pharmacist relationships in the State of Iowa. Role specification and perceptions of trustworthiness among team members (within team factors), were the most significant drivers of collaboration among respondents (Zillich et al, 2004).

Perea, Cardenas and Hernandez (2009) examined the role of leadership, participation, motivation and reciprocity in the work environment of *policlínicos universitarios* (teaching polyclinics). The descriptive study provided a cross-sectional analysis and sampled 420 professionals from 21 polyclinics in Havana, Cuba. The authors found that skilled professionals who were learning how to work in the polyclinic setting benefited from a strong leadership presence. Indeed, leadership was found to correlate most positively with workplace environment.

Team-centered factors further impact collaborative care. Multiple studies cite the importance of team feedback and evaluation in team performance and effective collaboration in IPC settings (Johnston et al., 2011; Gené-Badia et al., 2007; McLean, Atkins, & McLean, 2005). McLean et al. (2005) examined the impact of a standardized national quality accreditation process for Primary Health Care Teams (PHCTs), in the United Kingdom (UK). They focused on perceptions of team effectiveness and performance. Postal questionnaires were used as the method of survey data collection. Results demonstrated that completing the Quality Practice Award (QPA) was highly significant in improved perceptions of teamwork within the PHCT. The QPA is a quality accreditation process for PHCTs and is the gold standard of quality in PC practice in the UK. Relevant criteria covered by the QPA include practice organization and clinical care provided (McLean et al., 2005).

Another UK study demonstrated that practice structure predicts team process and together they predict outcomes (Bower, Campbell, Bojke, & Sibbald, 2003). The study was conducted using a stratified random sample. Methods included self-report measures and survey data collection. The authors demonstrated that team climate—as characterized by participation, support for innovation, reflexivity, task orientation, and clarity of objectives and teamwork—influences team effectiveness (Bower et al, 2003). D’Amour et al.’s (2005) review further supports the notion that teamwork is an essential factor that influences collaboration, specifically in health-related contexts. Shortell, Marsteller, and Lin’s (2004) study of chronic illness care team in the United States adds to the literature by providing empirical support for the relationship between participation and openness to innovation and collaboration in PHC teams.

A Spanish study of PHCTs demonstrated that team effectiveness is positively influenced by team composition variables including goals, empowerment, relationship and communication, flexibility, and recognition and appreciation (Goni, 1999). Data were collected through a questionnaire that was sent to each member of the PHCTs and through information provided by the central health authority. Several studies have noted that team collaboration is facilitated by regular team meetings (Hern, Talen, Babiuch, & Durazo-Arvizu, 2009; Dobson, Henry, Taylor, Zello, Lachaine, Forbes, & Keegan, 2006; D’Amour et al., 2005; Dieleman et al., 2004; Bower et al., 2003; Goni, 1999).

D'Amour et al. (2005) argue that partnership in an interprofessional setting implies pursuit of common goals. Poulton and West (1999) noted a positive correlation between team effectiveness and having shared objectives in their study of interprofessional PHC practice in the UK. This implies that there is empirical support that shared objectives or common goals influence collaboration in interprofessional PHC setting (Poulton & West, 1999).

Although research into larger systemic or policy factors has been limited, factors such as remuneration have been found to be associated with IPC team collaboration (Alberta Health Services, 2013; Dinh, 2012b; Mulvale & Bourgeault, 2007; Bourgeault & Mulvale, 2006). Perea et al. (2009) stress the importance of quality health human resource training to address PHC needs. Furthermore, they highlighted meso level factors such as the role of the workplace environment in strengthening or weakening existing organizational structures and the need for the workplace environment to be included as a critical element of planning and development. They also noted that systemic components of IPC are policy factors that can directly affect team collaboration or interact with individual or within team factors to influence collaboration.

The grey literature supports findings from the academic literature and facilitates examination of IPC collaboration in a Canadian context that is pertinent to this study. Five major Canadian literature reviews provide relevant discussions of IPC and collaborative practice: Carter (2012), Dinh (2012a, 2012b), Davies (2012), and Virani (2012). The studies identified the following characteristics as definitive of interprofessional practice: shared responsibility for outcomes, multiple workers from various professional backgrounds, regular and purposeful communications, and collaboration and coordinated care. Dinh (2012a, 2012b) concluded that formal arrangements were an important characteristic of interprofessional collaborative practice and included formalized offices or practices, electronic health records, and structured team meetings. Dinh (2012b) also emphasized team responsibility for patient populations, not simply the welfare of individual patients.

Virani (2012) emphasized the importance of leadership regardless of the model of care used to delivery PHC. Virani's review focused on prospects for collaboration in interprofessional team models, nurse-led models, case management models, patient navigation models, and shared care models and highlighted the success or failure of these models as dependent upon context. In examining CHCs as an interprofessional team model of care delivery, Virani noted that they emerged in a holistic context in the early 1970s when no other such models existed across Canada. In light of the "quiet revolution" in Quebec in the 1960s, the need to modernize the social system was recognized by the provincial government and CLSCs were subsequently established to provide community care from a group of health service providers in a single location based (Virani, 2012, p. 105).

Additionally, Carter (2012) and Davies (2012) identified factors relevant to the current study and the development of a thorough definition of IPC collaboration. Carter's (2012) definition of collaborative practice includes interdependency of the relationship and the need to deliver the highest quality of care. Davies (2012) notes the involvement of shared decision making, complementary skills and equal value of team members and their contributions.

**Conceptual Framework: Mulvale and Bourgeault (2007)**

The literature demonstrates that numerous factors can influence collaboration in health care. Many researchers address the notion of collaboration in interprofessional PHC delivery settings and maintain that various factors affect collaboration in IPC settings (Carter, 2012; Davies; 2012; Dinh, 2012a, Dinh, 2012b, Virani, 2012; Zwarenstein et al., 2009; Lemieux-Charles & McGuire, 2006; D'Amour, Ferrada-Videla, San Martin Rodriguez, & Beaulieu, 2005). To better understand the influence of these factors on IPC collaboration, theoretical models and conceptual frameworks have been developed (D'Amour, Ferrada-Videla, San Martin Rodriguez, & Beaulieu, 2005).

The literature review uncovered a few relevant frameworks for examination of factors that influence collaboration in health care. Two frameworks were identified that place primary emphasis on factors within the team, albeit set within a broader context. The first is Lemieux-Charles and McGuire’s (2006) used an integrated (health care) team effectiveness model (ITEM) to determine the efficacy of interprofessional health care teams across acute, long-term and PHC settings. The framework investigates the interactions between task design factors, team process factors, organizational context, and team psychosocial traits and their influence on team effectiveness. Sicotte et al. (2002) developed an analytical framework of interdisciplinary collaboration from their study of Community Health Care Centres in Quebec. This framework emphasizes intragroup processes and factors that influence the intensity of collaboration. Although both frameworks provide a guide to examining the influence of contextual factors on interprofessional collaboration, they are focused on within team processes. In contrast, the aim of the current study was to discern the relationship between policy factors, which are external to the team, on collaboration in an IPC setting.

A third framework was identified that provides more detail across three levels: policy, within team, and personal. The Mulvale and Bourgeault conceptual framework was initially developed in 2007 in a study of contextual factors and collaborative mental health care in Ontario. In their study, Mulvale and Bourgeault (2007, p. 50) observed, "Collaborative mental health care is a concept that emphasizes opportunities to strengthen the accessibility and delivery of mental health services in PC settings through interdisciplinary collaboration." The framework is dynamic as it captures interactions between the levels and factors that influence collaboration. It has been adapted and used in subsequent studies of collaborative mental health care and FHTs in Canada (Mulvale & Bourgeault, 2014; Mulvale et al., 2008; Mulvale & Bourgeault, 2007). Given that the objective of this study is to examine policy factors, it adopts the Mulvale and Bourgeault framework with a particular emphasis on policy factors.

A modified version of the framework was used in the current study to focus on and explore the policy factors that influence team collaboration (see Figure 1).



*Figure 1.* Factors that influence collaboration in interprofessional primary health care teams. Adapted and modified from "Finding the right mix: How do contextual factors affect collaborative mental health in Ontario?" by G. Mulvale and I. L. Bourgeault, 2007, *Canadian Public Policy, 33* (Supplement), p. S53. Reprinted with permission from Mulvale and Bourgeault.

The model was originally developed from a study assessing contextual factors that affect collaborative mental health care in Ontario (Mulvale & Bourgeault, 2007).

Collaborative mental health care is a concept that emphasizes opportunities to strengthen the accessibility and delivery of mental health services in primary care settings through interdisciplinary collaboration. (p. 50)

This definition and the concept of collaborative mental health care is particularly relevant in the studies of collaboration in interprofessional team in PHC since the model incorporates multiple professionals from various disciplinary backgrounds and each individual uses their expertise to address patients’ mental health needs in a holistic manner in primary health care settings. Mulvale, Danner, & Pasic (2008) have further applied the framework to a study of FHTs. It is therefore an appropriate framework to use in this study.

In their study, Mulvale and Bourgeault (2007) adopted a multi-method approach, collecting qualitative data through key informant interviews. Participants reported on the various factors that affected interprofessional collaboration in mental health service delivery in the PC setting. The authors found that most factors could be grouped into one of three categories: global level (program characteristics), local level (local community characteristics) and within team (team characteristics) factors. These factors and the interactions between them were described as influencing quality of collaboration. Over time, the conceptual framework was further developed and modified to encompass factors that influence collaboration in IPC teams (Mulvale et al., 2008).

The global level of factors applies to the policy factors that the current study explored: economic, regulatory, education and training, governance, and political. It is suggested in the related literature that team collaboration is influenced by remuneration and payment schemes (Dinh, 2012b; Mulvale et al., 2008; Mulvale & Bourgeault, 2007; Craven & Bland, 2002; Dewa, Hoch & Goering, 2001), formal education (Perea et al., 2009; Mulvale et al., 2008; Craven & Bland, 2002; Hall & Weaver, 2001) and decision making and organizational structures (Perea et al., 2009; Mulvale & Bourgeault, 2007; Hall, 2005). However, while within team and personal factors have been explored in depth in the literature, policy factors and their influences on team collaboration is an area where fewer studies have been conducted and the studies that do exist less in-depth. This study looked policy factors and collaboration in a focused way. The Mulvale and Bourgeault framework provides a model of factors that will be used to examine this relationship.

The literature review demonstrates that the influence of contextual factors on interprofessional collaboration in a PHC setting is an intensely studied area of health systems and health policy research. Both the academic and the grey literature highlight the role of within team factors on collaborative practice. However, there is a clear knowledge gap when it comes to the specific influence of policy factors on IPC collaboration. Although there have been attempts to develop conceptual and analytic frameworks to guide the analysis on such relationships, many of the frameworks emphasize team process and intragroup dynamics. The Mulvale and Bourgeault framework addresses the influences of systemic factors outside of the team's control on collaborative practice. The policy factor categories outlined in the framework were used to guide the current study, which examined the influence of specific policy factors on collaboration among FHT professionals in Hamilton.

**SECTION III: SUMMATION**

The 3-I assessment of the literature and the policy context in which FHTs emerged demonstrate that prospects for reform are highly dependent on powers beyond the control of any given IPC team. The literature demonstrates that a range of factors influence interprofessional collaboration in the PHC setting, which would be expected to apply in the Ontario context, the focus of this paper. The study adopts the Mulvale and Bourgeault (2007) framework because of its emphasis on policy factors. Policy factors such as governance, politics and economics, also shape policy development and implementation. This further suggests that macro level assessment of policy factors and their influence on team collaboration in the IPC setting is a fruitful area of research to be explored.

Complex interactions may shape the influence of policy factors on IPC collaboration. This study aims to identify policy factors that act to enhance or hinder collaboration among health providers in FHTs, these factors are termed facilitators and barriers respectively. Chapter 4 will examine the findings of the study to identify the relevant policy factors that affected IPC collaboration in FHTs, drawing specific attention to factors that facilitated or impeded collaboration in the team.

**CHAPTER 3: METHODOLOGY**

**Study Design**

This study aimed to describe how the identified policy factors influence interprofessional collaboration in PHC. The research used directed content analysis to explore an existing framework about the contextual factors that influence interprofessional collaboration. The study uses Ontario Family Health Teams (FHTs) as an example of a model of IPC service delivery. In order to answer the research questions and meet the objectives outlined in chapter 1, a descriptive approach was taken. Primary data collection was conducted through semi-structured interviews with FHT professionals. The interview guide was developed using the Mulvale and Bourgeault (2007) framework to reflect the directed content analysis method used to analyze the data.

The data was analyzed using a directed content analysis approach discussed in the literature (Hsieh & Shannon, 2005; Kondracki et al., 2002) for both prevailing themes from the framework and newly emerging themes. Kondracki et al. (2002) explain content analysis (CA) and its use as the following: “Content analysis is used to develop objective inferences about a subject of interest in any type of communication. The process of CA codes raw material (i.e., textual material, visual images, illustrations) according to a classification scheme.” (p. 224). Direct content analysis is an example of a qualitative data analysis technique. Hsieh and Shannon (2005) explain that there are areas in research where a theory or model exists however it is either incomplete or could benefit from additional research and elaboration. “The goal of a directed approach to content analysis is to validate or extend conceptually a theoretical framework or theory.” (Hsieh & Shannon, 2005, p. 1281).

Directed content analysis uses both inductive and deductive approaches, with a focus on the latter. With the deductive approach the researcher begins with predetermined categories based on literature or other sources and sorts the data into these categories, on the other hand, with the inductive approach the researcher examines the data without preconceived notions or categories and allows themes to emerge on their own (Hsieh & Shannon, 2005; Kondracki et al., 2002). In qualitative research it is understood that the two approaches (deductive and inductive reasoning) are not mutually exclusive and although one technique may be relied upon more heavily, using a blended approach can prove beneficial (Kondracki et al., 2002). The use of the Mulvale and Bourgeault (2007) framework presents exactly this opportunity to use an existing framework which includes policy factors as a category of factors in a larger model and to also build and elaborate on the policy category that has not been researched in depth.

In order to avoid simple traditional doctor-nurse partnerships, the current study adopts the definition that IPC teams must include three or more providers of different disciplines working to their scope of practice. Furthermore, team members engage in coordination and shared decision making regarding the delivery of comprehensive health services to patients. Members have integrated knowledge of the roles of other members and have a shared responsibility for both patient and team-based outcomes. They communicate and interact interdependently and in a formal arrangement to solve or explore common issues and use the range of expertise afforded by the interprofessional nature of the team. In the context of this study, Ontario's FHTs are reflective of the definition of IPC collaboration as outlined. The relevance of the FHT model with respect to this definition makes FHTs ideal for examining the factors that influence IPC team collaboration.

**Research Tradition**

This qualitative study was conducted using a descriptive approach (Neergaard, Oleson, Andersen & Sondergaard, 2009; Sandelowski, 2000) and directed content analysis (Hsieh & Shannon, 2005) was used in order to address the aforementioned research questions.

Qualitative approaches have been found to be an appropriate methodology to address distinct research objectives such as programs and attitudes, behaviours, motivations, and factors associated with changing processes (Shi, 2008). Kondracki et al. (2002) explain that “qualitative analysis is often used to examine latent or inferred meanings of the communication under study, which may lead to the development of constructs of theories based on the researchers’ knowledge and evidence drawn from the study” (p. 224). Furthermore, according to Shi (2008) qualitative research serves as a multipurpose approach to research that can be used to improve understanding, establish findings, while confirming what has been previously identified (Shi, 2008). What’s more, this form of research can be used to explore phenomena, and to develop concepts and further questions (Shi, 2008; Green & Thorogood, 2004; Pope, Ziebland, & Mays, 2000; Sandelowski, 2000), while permitting collection of descriptive data.

This type of descriptive approach lends itself to small sample sizes, and is suitable to a small-scale M.Sc. level study (Sandelowski, 2000; Shi, 2008; Pope et al., 2000). Direct content analysis was well suited for the current study. Hsieh and & Shannon argue that, “the main strength of a direct approach of content analysis is that existing theory can be supported and extended.” (p. 1283). This methodology was chosen to add insight into the relationship between policy factors and IPC, to elaborate and build upon the Mulvavle and Bourgeault (2007) framework.

**Analysis of Policy Factors that affect IPC Collaboration**

Policy processes are a dynamic and continually changing aspect of health systems research. In the policy analysis tradition (Harrison, 2001), an existing conceptual framework is often used to guide the analysis in order to promote rigour. This study primarily uses a deductive approach, building upon the Mulvale and Bourgeault (2007) conceptual framework to describe and elaborate upon policy factors that influence collaboration.

Conceptual Framework

The Mulvale and Bourgeault (2007) framework was a highly relevant model for analysis identified in the initial literature review. This framework outlines multiple levels of factors that affect collaboration in IPC teams. The framework also highlights interactions between factors levels that can influence collaboration. The relationship between these factor levels is dynamic and bi-directional in nature. The framework captures a broad range of individual, micro (team), meso (organizational/regional) and macro (policy) factors that influence collaboration in IPC and service delivery (Mulvale & Bourgeault, 2007). This study focuses in on the policy category of factors, in the Mulvale and Bourgeault framework, such as funding and professional regulation. Using deductive reasoning, the Mulvale and Bourgeault framework serves as a preliminary guide for development of the study and initial data coding. The framework is expanded upon and refined here by analyzing themes drawn from inductive analysis of the findings.

The Mulvale and Bourgeault (2007) framework was used to guide the selection of data sources to be included in the literature review, the questions included in the semi-structured interview guide, and was used as a starting point for the analysis by acting as a framework for initial data coding.

Data Source

The primary data source was information collected through semi-structured key informant interviews using open ended questions with key informants in Family Health Teams in Ontario.

Data Collection Procedures

Key informant interviews were conducted using a semi-structured interview guide (see Appendix A) with FHT professionals which described key informants’ perspectives on the influence of policy factors in shaping collaboration within their teams. The interview guides asked key informants about the policy factors suggested in the Mulvale and Bourgeault framework and other policy factors that they considered important that were not captured in the framework. In addition to identifying the factors that influence IPC collaboration, participants were also asked to speak to how the factors they identified influence collaboration in their specific teams.

The conceptual framework and a consent form/information sheet were provided as a reference for participants prior to their scheduled interviews (see Appendix B). Categories of policy factors appeared instead of specific policy factors in the conceptual framework provided to participants. Policy factor categories include economic, regulatory, education, governance, and political. Specific policy factors include funding, remuneration, practice scope, education, and accountability. Participants were asked to elaborate on the categories they identified in the framework and highlight any emerging factors that did not appear in it.

Key informants were recruited from the Hamilton area of Ontario via email. Semi-structured interviews were conducted face-to-face at each participant's FHT site with those who agreed to be involved in the study. The interviews were audio recorded and transcribed verbatim. Transcripts were supplemented by field notes taken by the researcher throughout the interview. Field notes were taken throughout the interview as a backup in case the tape failed.

The interviews were transcribed post-interview. In accordance with directed content analysis (Hsieh & Shannon, 2005), the prior framework was used to determine the initial coding scheme for the interview transcripts. Although coding of the transcripts was an ongoing process, interview questions were not modified or refined during the data collection process. An anonymous code was recorded on notes, transcripts, and audio recordings to protect the identity of participants. Data was stored in a locked filing cabinet in the researcher's home. Electronic data, including audio-recordings, was stored on a password-protected computer on a secure network. The study data will be kept for a period of up to three years to allow for publishing and dissemination of findings in the peer-review process. Following this three-year period, data will be deleted and audio recordings will be erased.

**Study Sample**

The populations of interest for the study were health care and allied health professionals working in an IPC delivery model. Family Health Teams, a recently introduced model of IPC delivery in Ontario, were selected to understand the role of policy factors in IPC teams. In order to describe the role of policy factors as fully as possible, both academic and non-academic FHTs in Ontario were considered part of the sample. Originally, it was anticipated that this relationship would be assessed by gathering data from the team leads because they were expected to have more in depth knowledge about the influence of policy factors in FHTs in comparison to frontline health workers. As a result of their specialized knowledge, team leads were considered to be one key interest group in IPC delivery through FHTs. Other key interest groups include policymakers, service providers, patients, patient families, and governmental bodies. However, following the insight gained from the first two interviews conducted with a physician lead and an executive director of one of the FHTs, it was discovered there were other FHT professionals who might have unique insight into the role of policy factors on IPC delivery.

Due to the scope of this study, the study sample was limited to team leads and health care providers working within urban Family Health Teams in the Hamilton area of Ontario. The Hamilton area was selected due to accessibility for the researcher. Note that rural FHTs were not considered although it was expected that many of the same policy factors would apply to both rural and urban FHTs. As outlined by Gocan et al. (2014), "There are a number of common challenges to interprofessional collaboration within FHTs despite their clear mandate for team-based practice and Ontario Ministry of Health guidelines for establishing collaborative care" (p. 14).

Team leads of FHTs in Hamilton were originally recruited via email based on response rate, team leads were sent multiple (up to three) follow-up emails reminding them of the opportunity to participate in the study.

**Sampling Design**

Aconvenience sampling approach was adopted as the primary sampling method. Urban Family Health Teams currently operating in Hamilton, Ontario, served as the sampling frame. However, following the preliminary interviews and because of difficulties with recruitment, a snowball sampling technique was adopted to select study participants, wherein current study participants assisted in the recruitment of future participants from their pool of FHT colleagues. The primary consideration in convenience sampling is ease of availability of participants (Given, 2008; Shi, 2008; Green & Thorogood, 2004). Snowball sampling is often used when populations of interests are considered ‘hidden’ due to low number of participants or difficulties with access to potential participants (Browne, 2007). Both convenience and snowball sampling are dependent on readiness and willingness to participate (Given, 2008; Shi, 2008; Browne, 2007). Both sampling techniques are inexpensive methods to accumulate participants (Given, 2008). Additionally, convenience and snowball sampling are efficient since they allow for recruitment in time sensitive studies.

One of the problematic elements of convenience sampling is a potential lack of transferability (Shi, 2008). Shi (2008) argues that small sample sizes are adequate for relatively homogenous populations. In this case, the study methodology was descriptive and the sample was homogenous to the extent that participants are typical figures in urban FHTs. Since there is little existing research in this area, I aimed to conduct an examination of how the identified policy factors are perceived by PHC professionals working in the context of FHTs. Snowball sampling was used to recruit individuals who work closely together, and who could contribute different perspectives on a similar workplace context. Snowball sampling is critiqued for exclusion of those who are not within the social network of the participant doing the recruiting (Browne, 2007). Offsetting this limitation to some degree is the fact that the researcher has relied on the specific expertise of a select few study key informants to identify others who have the relevant knowledge of policy factors and collaboration in order to answer the research questions.

The researcher initially anticipated conducting a single interview with the team lead of 8 to 10 FHTs across Toronto and Hamilton. However, following the first two interviews, the decision was made to limit the number of FHTs included in the sample and expand the number of interviews at each FHT. The intent was to gather insight into the perspectives of a wider range of interests with regard to policy factors affecting academic and non-academic FHT settings. One academic and one non-academic FHT were selected and 10 interviews were conducted. Participant categories included physician lead, physician co-lead, executive director, nurse co-lead, nursing manager, mental health manager, pharmacy manager, unit manager, and clinical manager.

A sample size of 10 individuals was considered appropriate to capture a diversity of perspectives while seeking theoretical saturation across key policy factors being considered (Shi, 2008; Pope & Mays, 2000). Saturation is understood as the point at which no further new information of themes emerge from the data or key informant interviews (Giacomini & Cook, 2008; Francis et al., 2010; Shi, 2008; Guest, Bunce, & Johnson, 2006). For the purposes of this study saturation was achieved across the key policy factors being considered.

**Data analysis/coding**

The researcher transcribed all interview data. In accordance with direct content analysis the transcripts were initially coded into key themes using the categories of the Mulvale and Bourgeault framework (2007) that related to policy factors. QSR NVivo10 qualitative data analysis software was used to manage the data. Within each of the initial themes (policy factor category), there were sub-categories identifying more specific factors. For example, economics was a larger theme (from the Mulvale & Bourgeault framework) but was further described with sub-categories, e.g. funding. Following the initial coding, the researcher returned to the data and identified a number of emergent themes. The findings classified in each of the initial themes and the emergent themes were discussed with Dr. Gillian Mulvale, one of the co-developers of the conceptual framework on which this study is based. This is illustrative of a deductive approach to data analysis.

Although the initial deductive coding of the data into the factors identified in the Mulvale & Bourgeault (2007) framework, an inductive analysis was also integrated into the analysis as a few new, relevant themes were identified throughout the coding process. The inductive analysis accomplished the identification of sub-categories of policy factors that key informants indicated affected collaboration in the FHT. This is in line with the directed content analysis method using a prior framework (Hsieh and Shannon, 2005; Lacey & Luff, 2001; Richie & Spencer, 1994).

**Quality Criteria and Qualitative Rigour**

When conducting qualitative research there are certain quality criteria that need to be considered in order to increase the rigour of the study. The two most relevant quality criteria for this study were credibility and dependability of findings. Qualitative researchers commonly use the words credibility or trustworthiness interchangeably (Giacomini & Cook, 2008). The credibility of study findings is participant-oriented and dependant on the perceptions of the key informants included in the study and includes the researcher perspective(s) and judgment (Giacomini & Cook, 2008). The concept of credibility is highly context dependant and cannot be defined by the researcher (Krefting, 1991). In qualitative research the researcher is commonly considered a part of the research itself (Rodgers & Cowles, 1993). Consequently, self-awareness of the researcher, referred to as reflexivity, and conforming to methodological procedures are necessary in order to promote credibility of study findings.

Dependability and consistency are often used interchangeably in qualitative research to refer to the range of variability found in study findings (Krefting, 1991). Consistency of interviewing technique can improve dependability of study findings (Krefting, 1991). As a characteristic of the descriptive approach, open-ended questions were asked so as to not presuppose the key informants’ responses. The questions were not modified post-interviews and the same semi-structured interview guide was used across all interviews as opposed to an evolving interview guide supported by other qualitative methodologies (Shi, 2008). In this study, the researcher was cognizant of the manner in which the open-ended questions were worded in the interview guide and made a conscious effort to conduct the interviews with as much consistency as possible.

The researcher accounts for both dependability and credibility as quality criteria that were addressed in this study by highlighting consistency between the multiple key informants in their responses to questions. There was a high degree of consensus among study participants. Two additional ways that dependability and credibility of study findings can be accounted for is through member checking and triangulation (Krefting, 1991). Member checking occurs when study transcripts, codes, and/or findings are presented to study participants in order to confirm or comment on accuracy. Although member checking would have been a useful way to improve the rigour of this study, it was not feasible considering the nature of key informants’ employment. As health care providers with significant constraints on their time, member checking was deemed not feasible for the purposes of this study. Triangulation is another technique used to improve the rigour of research studies (Giacomini & Cook, 2008; Krefting, 1991). At its very basic level, triangulation involves cross-checking data to ensure agreement among sources (Giacomini & Cook, 2008). For the purposes of this study, through the technique of triangulation, study data and findings were cross-referenced with the literature and with multiple key informants. The literature supported the findings of the study as discussed in chapter 5 and agreement between key informants about a wide range of the policy factors addressed in the study acted to strengthen dependability and credibility of the study.

**Ethical considerations**

The study was approved by the Hamilton Integrated Research Ethics Board (HiREB) Study Research Committee before data collection began. There were no known risks to participation in the study. Participants were free to choose whether they would participate in the study. Participants were informed that they were able to withdraw from the study during the period in which interviews were being conducted. If participants felt uncomfortable with any questions, they were able to raise their concerns with the investigator or withdraw from the study without explanation. As noted, informed consent was obtained from the participants prior to the interview or at the time of interview. Before the interviews commenced, participants were reminded of their consent and freedom to withdraw from the study at any point.

**CHAPTER 4: FINDINGS PART I**

The focus of this chapter is on the findings of the study. What was learned from the key informant interviews regarding policy factors that affect collaboration in the Hamilton and McMaster FHTs is discussed here.

**Key Informant Demographics**

Ten key informants from varying professional backgrounds participated in the study (see Table 1). Eight out of nine interviews were conducted one-on-one with the researcher and the participant. The ninth interview was conducted in a focus group manner with two key informants being interviewed by the researcher simultaneously. The interviews were conducted with professionals from two separate FHTs, the Hamilton FHT and the McMaster FHT. Of the 10 key informants, four were members of the McMaster FHT, whereas six worked for the Hamilton FHT.

Key informants’ characteristics included a 60% female, 40% male split. In terms of education background, 8 out of 10 key informants had a post-graduate degree or higher, these degrees included Master’s of Social Work, medical degrees (MD), or a PhD in pharmacy. Two out of 10 key informants had an undergraduate degree or less, for example a Bachelor’s degree in Nursing (BScN). Seven out of 10 key informants had been employed at the FHT for five years or longer.

**Breakdown of Analysis**

The key informant interviews were based on a later version of the Mulvale and Bourgeault Conceptual Framework (2007) that focused on factors that influence collaboration in IPC teams. The model is broken down into three major levels: within team, personal, and policy level. In this study, interprofessional collaboration in PHC was examined and the effects of policy factors on this interprofessional collaboration were the focus of analysis. The policy level is broken down into five main categories: economic, regulatory, education and training, governance, and political. Under each of these categories, multiple specific policy factors were found to influence collaboration in IPC teams. The author examined the interview transcripts and coding. The initial coding scheme was developed based on the conceptual framework. The frequency with which factors from the conceptual framework were identified by key informants was reported. These factors were then classified as barriers, facilitators, or both with respect to their influence on collaboration, based on whether key informants described these factors as acting to enhance or impede collaboration within the FHT.

**Results**

Based on the conceptual framework, Table 2 provides definitions of each specific factor and Table 3 lists the policy factors identified by key informants as influencing collaboration and identifies which interviews they were identified in and then tallies the frequency of interviews in which they were mentioned. Considering the overlap between the factors identified by key informants as influencing collaboration and those found in the Mulvale and Bourgeault framework, the findings demonstrated that the framework continues to be relevant in the study of factors that affect team collaboration.

The frequency of reporting is significant because it highlights the level of consensus between the two FHTs and among the different professionals who were interviewed. The findings showed that factors grouped under economic and regulatory categories were reported with the highest frequency. The specific policy factors reported with the highest frequency were funding and provider payment/remuneration (economic) and practice scope (regulatory), reported by all 10 key informants. In addition, legal accountability and professional regulation (regulatory) reported by nine and seven key informants respectively, whether IPC was built into training (education) reported by seven key informants, and leverage and political influence to affect policy (political), reported by nine out of 10 key informants, were other most commonly reported factors that influence collaboration in the FHT. As a result of the high frequency of reporting of these factors, the author concluded that these factors were particularly important and relevant to collaboration in the FHTs.

Interestingly, regardless of their professional backgrounds, all key informants spoke to the impact of economic factors on collaboration in the team. However, there were certain areas where key informants’ with specific professional backgrounds spoke to the influence of policy factors on collaboration in the FHT more in detail. Specifically, physician leads, professional co-leads, and the executive director spoke more directly about the governance and political categories when compared with other health care providers.

Each of the specific policy factors can be identified either as a facilitator of collaboration, acting to enhance team functioning in the FHT, or as a barrier to collaboration, making it more difficult for the various professionals to work together in providing collaborative care. Many of these factors can act as both facilitators of and barriers to collaboration depending on the context. This is demonstrated in Table 3. For example, a provider-based governance model can be a barrier to collaboration by making other health care providers in the team feel underappreciated and reinforce the medical dominance and hierarchy of physicians in the team. On the other hand, key informant 008 said,

When we are talking about our power dynamics and our historical elevation of the medical profession, when we started, we had an all physician board, I think that absolutely affected our development, but in some ways I think it was the right decision… who could bring together 150 docs and have them develop that kind of trust and openness to change and to outsiders… It was very physician dominant. But I think that there has been good awareness of moving into more openness and sharing of power as time allows, as trust is built… I think had we gone with a community board from the get go given our size, it would have been a disaster. I think with a small group of physicians you could develop trust more easily with each other…

This view demonstrates that in the historical context of the Hamilton FHT’s development, a provider based governance model was necessary to get the FHT up and running. In this scenario, whether the governance structure acts as a barrier or facilitator is temporal bound. A provider based governance structure may alienate allied care providers and community members. However, here we see that at the inception of the FHT, development of trust was contingent on a provider based governance structure. Over time the governance of the FHT has moved to a mixed model of both physician providers and community members. Incremental change can and does occur over time to facilitate collaboration among all care providers.

Economic

Funding for the FHT comes primarily from the Ontario Ministry of Health and Long-Term Care (MOHLTC). Ministry funding for the Hamilton and McMaster FHTs is based on roster size using a blended capitation model. As per the MOHLTC’s (2009) guide to physician remuneration in FHTs, “Blended Capitation Models provide a base payment per patient for the provision of comprehensive care plus incentives, premiums and special payments for the provision of specific primary health care services” (p. 5). Physician incentives are components of the blended model and include New Patient Fees and Cumulative Preventive Care Payments and bonuses. Physicians are eligible to receive bonuses for up to 60 patients per year, who were otherwise without a family physician, if they are able to roster them to the FHT (MOHLTC, 2012). Preventative care bonuses are provided for “informing eligible enrolled patients about the value of preventive care interventions and to encourage them to receive applicable services” (MOHLTC, 2012, p. 21). Key informant 003, a physician member of the Hamilton FHT, explained the breakdown of physician’s income in the blended capitation model,

The majority of the payment, about 70% comes from capitation, but there is a volume modifier, so physicians get 15% of the schedule of benefits, also [there is] FFS funding for services delivered that aren’t in the basket [of care] that make up the capitation. There are a number of patients who aren’t rostered and physicians would just bill the schedule of benefits for those patients. Then there are activities outside of the office, hospital work, nursing home work, and that’s FFS. There are also various bonuses…

All other FHT allied health professionals are remunerated by salary meaning they receive a certain amount of money per year and are not eligible for additional incentive and bonuses. Without fail, every key informant pointed to specific economic factors as influencing collaboration in the FHT. However, key informant 003 further explained one way in which remunerating physicians on a blended capitation model helps facilitate collaboration,

So the importance of that [the physician remuneration breakdown] is because the majority of physician’s income comes from capitation, it removes the barrier to working with other professionals… in a traditional FFS model physicians are paid, in general, the same fee no matter how complex the patient is, and if there’s an interprofessional team in place, if another team member sees one of the lower acuity patients, it alters the physician’s case mass, and that would have a negative impact on their income. So if you are only seeing very complicated patients, your volumes will go down, so that puts up a barrier. So having a blended payment model that’s capitation based takes away the barriers to working with other professionals.

Consequently, other allied care providers are able to treat patients as their skills and expertise allow without a significant negative influence on physicians’ income.

In the economic category, key informants identified that funding and provider payment/remuneration could act as both barriers and facilitators. Funding emerged as one of the most significant policy factors affecting collaboration between professionals in the FHT model of IPC delivery. The primary source of funding for the Hamilton FHT is from the MOHLTC. Funding for the McMaster Academic FHT comes from multiple different sources including the MOHLTC, McMaster University and Hamilton Health Sciences (a hospital group of 7 hospitals, a cancer centre and an urgent care centre that together serve the needs of residents across Hamilton and south central Ontario). Across both FHTs, all allied health professionals are paid by salary and they are funded through the FHT. All physicians’ remuneration is based on a model of capitation, both at the Hamilton FHT and at the McMaster FHT. The Ontario Medical Association (OMA) negotiates physician remuneration with the MOHLTC on behalf of physicians. At the McMaster FHT most full-time physicians are also academic physicians and hold faculty positions at the university. These physicians are paid through McMaster University, specifically by the Department of Family Medicine.

One of the concerns echoed by the key informants with respect to funding and provider payment is that Ministry funding is not adequate to cover allied health professionals’ salaries. Key informant 004 explained,

The salaries for the IHPs [interdisciplinary health professionals] are not up to the level in the community, compared to other sectors. So as a result, it’s a negative incentive towards retention. We’ve been lucky we’ve been able to work around that by offering other positive benefits to working at a FHT, but it does challenge retention, which impacts collaboration. If you have a revolving door of staff, it’s hard to build teams and hard to build collaboration.

This sentiment was echoed by key informant 008:

Government funding does not cover enough… The government is not on par with paying what the going rate is; you never get enough money, so you need other funding sources to ensure that if you want a full-time therapist, that you are able to create that position, and in creating that position, then at least you can define what that collaboration looks like...

Certain key informants identified that the inability to hire the professionals that you want or need in the practice as a result Ministry funding restrictions. The inability to hire necessary professionals can lead to strained relationships between collaborating professionals who may then be required to perform additional tasks placing extra strain on their time. Furthermore, when the FHT is unable to hire the most appropriate professional this affects the quality of patient care as well as efficiency of practice.

Key informant 002 commented,

Arguably what you want, you want the cheapest person with adequate competence to do the job... Why would I want, taxpayers to pay a doctor to provide nutritional counseling to an obese teenager. They are making 350 Gs a year, do I really want them spending half an hour counseling an obese teenager. Why wouldn’t I want a young… dietician, who is making 60 grand and who has the training and expertise specifically in this area to provide it.

This quote demonstrates that working to scope and within a professional’s area of expertise is vital to successful functioning of the FHT and in maintaining collaboration in an efficient manner. Not only does this relate to funding but also addresses practice scope, an important regulatory factor that will be discussed next.

Regulatory

Legal accountability and practice scope were identified as the most highly relevant regulatory factors and were reported nearly unanimously by all key informants. Key informants explained that legal accountability and the concept of most responsible care provider influence the willingness of physicians to delegate tasks. The findings demonstrate that understanding professionals’ scopes of practice as well as professional regulation and responsibility create an environment where trust among professionals is strengthened and delegating tasks is done with ease and comfort.

The ability to work to optimal scope of practice while working within legal scope is also emphasized. It is important for the FHT to make sure that all staff are up-to-date on college requirements and have paid their fees to their regulatory body so that they are legally able to practice. Key informant 004 explained the difference between traditional nurses’ roles in clinical practice versus working at optimal scope of practice. Working at optimal scope enhances the strength of the relationship between physicians and nurses and influences collaboration in a positive way:

There’s what I call optimum scope, which is where I am pushing our nurses to achieve… the traditional role of a nurse in primary care, it is typically as supporting the physician throughout the course of the day. So bring the patients into the room, doing subjective assessments getting them set up for their visit with the physician, figuring out what’s going on. Then the physician would see them and then the nurse might come back and do wound care or immunizations or that kind of stuff, as well as telephone triage. Where optimum scope is, where many of our nurses have achieved and many are on the trajectory, the nurse has her own day. She delivers care autonomously, she does full well-baby visits, full well woman visits including medical breast exams and paps, sees patients for diabetic visits, follow-ups to cholesterol, high blood pressure, hypertension, sky’s the limit. We’ve developed about 20 medical directives to support that autonomous role… The only limitation on what the nurses can do is what the physicians delegate to them, so that is built on trust and it takes time to get there. But once that is achieved, it’s quite efficient and quite productive.

 Medical directives, mentioned in the above quote, are role-specific indirect physician orders intended to accelerate patient care (The Hospital for Sick Children, 2014). They allow health care professionals who are not physicians to perform tasks that are within their body of knowledge and skill but are traditionally carried out by a physician. Although this speaks to the enduring dominancy of physicians and potential hierarchy that continue to exist in the FHT model, at a policy level, ensuring that professionals are able to work within their optimal scope of practice can significantly enhance collaboration.

All FHT professionals are covered by liability insurance. The FHTs included in this study have invested in insurance policies to cover all their staff. Furthermore, many professionals maintain their own insurance through their regulatory bodies. For example, many nurses who practice both in the FHT and in the community or in private practice have additional liability insurance through the Registered Nurses Association of Ontario (RNAO) and have coverage from the two different parties. Key informant 004 stated,

The Hamilton FHT provides liability insurance that covers all of the IHPs [interprofessional health providers] working in the practices. And in addition I always recommend they maintain membership in the RNAO, which has built in liability insurance, so that they have coverage from two different parties.

Professional regulation and practice scope can either enhance and/or hinder collaboration. When practice scope is clearly defined and understood by one’s colleagues, different professionals are able to work to optimal scope; this enhances team collaboration. At the FHTs when professionals are well trained, have the opportunity to interact regularly, and have opportunities to discuss and share their practice scope with other members of their team, collaboration is facilitated (i.e., during formal team meetings or FHT organized educational events). On the other hand, when practice scope is not clearly defined and professionals are not able to interact regularly and educate one another about their practice scope, issues of territoriality over patient care and stressors with respect to legal accountability and liability can emerge.

Among the regulatory factors, legal accountability has been seen as an impediment that reduces an interprofessional team’s ability to collaborate. Legal accountability influences physicians’ willingness to delegate tasks to other professionals. These professionals may at times be more skilled and better suited to provide the specific type of care required by patients. When asked about professional regulation vs. legal accountability, key informant 001 explained,

I think that’s one of the biggest obstacles that physicians hide behind. I hear it all the time, especially from older physicians, you know, the buck stops here… it’s taken me a few years to get past that because I realize that with true collaboration there has to be a level of trust. That the professional that’s working to their full scope has the capability to provide as good or better care in that sort of domain to the patient that they’re seeing. So I think that most of the time when people talk, and it’s not just physicians sometimes that happens with other professionals as well, it’s that I’m afraid to collaborate with this person or that person because there’s legal ramifications if they screw up or if something, or if the outcome isn’t the desired outcome. But I think in reality that’s more of a control issue and the fears that if they’re not in control of the situation that something bad is going to happen.

However, because of misunderstandings of risk management and liability, physicians can be reluctant to delegate these tasks. Family Health Team staff rely intensively on medical directives to enhance collaboration and work around the barriers created by liability concerns. Key informant 002 highlighted the concerns of physicians when it comes to delegating responsibilities to other care providers:

When you ask me the willingness of docs… it’s been very difficult for docs to delegate… by virtue of their training they’re risk averse, ‘am I going to trust you to do an ear examination or an eye examination’, not until my risks are managed, I’ve got insurance and not until I know there’s a medical directive that you and I agree on and that I’ve seen you do it half a dozen times so I’ve got confidence.

In this statement, it is clear that regulatory factors like legal accountability do not influence collaboration in a vacuum. The ability and strength of collaboration is influenced by multiple, complex factors. Key informant 002 highlighted that physicians can be risk averse because of their training. Not only do contextual factors influence collaboration based on the interactions between levels of factors (ie. Personal, within team, policy) but within the policy category itself, multiple economic, regulatory, governance, and education and training factors interact to shape collaboration.

Furthermore, when asked what would be the most important policy factor that affects collaboration in the team, key informant 005 responded,

I think it would be more related to scope of practice… so that if people know their role well then they’re more likely to reinforce what somebody else has done, or to refer somebody to address a particular aspect that they may be less familiar with... Let’s say you are not comfortable with something then you bring it to the right person, whether in the same visit and you do it together or separate visit.

This further demonstrates that clear understanding of scope of practice facilitates collaboration by increasing comfort with task delegation or increased awareness of who might be the best professional suited to address patients’ needs when the original care giver’s expertise or skills are not enough or not context appropriate.

The scope of practice for professionals in FHTs is defined by their regulatory bodies such as the College of Physicians and Surgeons, the College of Occupational Therapy, the College of Social Work, etc. These colleges create the guidelines that define the professionals' scope of practice and consequently influence how they are able to interact and collaborate with other professionals in an IPC delivery setting.

Key informant 003 made the following comment:

It’s to everyone’s benefit when we all act to our full scope of practice. Physicians, if they didn’t train in an interprofessional model, are not familiar with these concepts so I think there is some difficulty in letting go of some control. Newer physicians, nobody’s trained in the province for almost 10 years except in an interprofessional model, so they are much more familiar with it… if you are not familiar with what the other’s professional scope of practice is, I think traditionally the medical model has been very much a hierarchy.

This statement demonstrates how various regulatory factors like practice scope, prior IPC exposure, strength of professional education, and even whether IPC is built into FHT training all interact with one another to influence collaboration.

Education and Training

Education and training is a highly relevant policy category that influences collaboration in IPC teams. A few new education and training related policy factors emerged in the interviews that were not captured in the conceptual framework. Firstly, the findings demonstrate that interprofessional education and collaboration are built into regular FHT training sessions and daily interactions at the FHT. Key informant 001 stated, “We do have a meeting at least once a month where we try to bring the whole team together to talk about sort of broader initiatives.” The FHTs also have annual quarterly events and annuals meetings across the FHT. Key informant 002 emphasized that each professional group has its own set of meetings and training sessions:

The mental health counsellors do get together monthly, I think the nurses get together monthly, the pharmacists get together I think even more regularly… the dieticians, I know, get together regularly… I know that the administrators get together regularly, and I know that we do interdisciplinary training on some subjects, right, so they’re supported not only through meetings but also through training.

Whether IPC is built into training is the specific factor that appeared with highest frequency from the education and training category. The strength of professional training and exposure to IPC and/or PHC prior to joining the FHT also emerged as highly relevant factors affecting professionals’ abilities to collaborate effectively. Both FHTs also hosts FHT-wide educational events as well as formalized education and training sessions.

Professional education and training both prior to and upon joining the FHT can influence collaboration in significant ways. The strength of professional training and exposure to IPC and/or PHC are emerging factors that were reported to influence collaboration among FHT professionals. Upon discussion, key informants explained that for the most part specific formalized IPC training was not offered by the FHTs.

Conversely, IPC education and training was built into other aspects of professional training and other formalized training and education sessions and FHT organized education activities. When asked whether there were training opportunities specific to interprofessional collaboration and care, key informants 009 and 010 explained that the McMaster FHT used to have training specific to collaboration, however since teams were already engaging in highly collaborative care effectively, these sessions became obsolete. Key informant 009 remarked,

Interestingly enough we used to have a group that was the interprofessionals and a lot of that focus was on interdisciplinary, getting to know one another, interdisciplinary care, but it actually evolved to the point that we were working so well together as a team and we had so many other venues that were modeling this that it actually came to the point that we stopped that meeting about a year ago because we felt like it wasn’t a good use of time…Like we were intentionally trying to create a new one that was already there and meeting the needs.

Key informant 010 stated,

So our interdisciplinary group that was meeting once a month is on a hiatus right now because we did a survey and people felt it wasn’t of value because we are already doing it.

Another factor that was often identified as influencing collaboration was the strength of professional education. Strong professional education was clearly identified as a facilitator by key informants. Key informant 010 observed that the strength of professional training, particularly in recent years interacts with other specific policy factors in shaping and influencing collaboration:

I think in general most of the disciplines have increased their own entry to practice education. This has led to changes in regulation and I think they are intimately connected. Increases scope and then sort of evolving into skills set. I think they are all connected and education is a piece of it. So it does allow us to work together in a different way than before. Because when it was diploma entry to practice and NPs didn’t have full scope of ordering and prescribing you couldn’t work together in those ways. So once the education level becomes the master’s level, the same is occurring in the other fields, moving to a higher level of education and greater autonomy and greater scope. And it cannot not affect our team because when you come in with a higher level of education and a greater scope then you work together in different ways.

 On the other hand, when the professional education curriculum is not as strong or as tailored to PHC and/or IPC as FHTs would like, this can create challenges. Key informant 005 commented,

I don’t think in terms of nursing, the curriculum hasn’t kept up with what this role is about… when you are training as a nurse, it’s [training] still very focused on acute care and not very much at all on primary care, so there remains still no body of nurses with adequate nursing in primary care which results in us hiring what I call green nurses …that don’t have any primary care experience, and our role in primary care is very different than acute care. So they come into our environment and it’s quite literally a two year orientation phase to get them comfortable in our environment... So when I come back to collaboration, you’re doing all this work figuring out your scope and getting your skills in, the collaboration piece sort of takes a back burner until you get all of that down.

As demonstrated by this quote, lacking a strong professional background, specifically a background in PHC and/or IPC, can act as a barrier, reducing the ability to collaborate. On the other hand, strong professional education seems enhances collaboration in IPC teams.

Governance

In the governance category, the specific policy factors reported with highest frequency included the governance structure of the FHT (i.e., whether the governance board was a mixed model, community-based model or provider-based model) and the existence of multiple governing bodies.

 The Hamilton FHT is a community FHT with a mixed governance model. This means that the FHT board of directors is made up of both physician care providers and community members. Upon inception the governance model was provider (physician) centric however over the years community members have been integrated into the governance board with three out of 12 members coming from the community. In contrast, the McMaster FHT is an academic FHT, which results in a more complex governance structure. The FHT has its own governance board in addition to being governed and regulated through both McMaster University and Hamilton Health Sciences. Key informant 007 described the complex structure of governance by multiple governing bodies at the McMaster FHT and highlights how the different goals and priorities of the multiple governing bodies can be problematic:

The governance piece for us is a big one because in our model we have governance… at the FHT right now… Our ultimate governance rests with the department of Family Medicine, now they have a dual mandate in that they are all about education and they are all about good clinical care. The FHT is actually the allied team in the teaching units, our goal is good patient care, because we are academic we also have teaching but I would argue that our first goal as a FHT is to deliver good patient care and then to teach so its 55-45. So our governance structure then is that we have an interprofessional, we have a department of Family Medicine committee, we have a sort of board with the leadership of the FHT and the leadership of the department sits there and does kind of the high level decision-making for the FHT, and then it goes to the Priorities and Planning Committee representation of the whole team where we make decisions about what we actually will enact in the FHT.

Key informant 006 supported the explanation of this complexity and further explained that:

McMaster and HHS, they also maybe have their own governance and their own political goals or aims within what we are doing here and so again trying to bring those two views together and trying to keep it simple and trying to communicate that so it doesn’t become a barrier, so that may be challenging as well…as an example we are moving downtown to a new building which is owned by McMaster, this current site is owned by HHS that’s going to have a huge impact on how we run the clinic and ultimately collaboration… it does end up having an effect because your space and how you use your space changes. It changes collaboration. Where we get our supplies from and who does our autoclaving, all that is going to change because HHS isn’t going to send someone out to us at a site that is not theirs.

These statements demonstrate that when multiple governing bodies exist, their institutional goals and interests may clash, which becomes a challenge when applied to IPC collaboration at the FHT.

Furthermore, academic FHTs are unique since they have an educational mandate and need to meet certain requirements in order to secure the educational component of their funding. Key informant 007 suggested that consequence of being an academic FHT:

The education piece for us is a big one just because we are funded by the Ministry for all of our allied health to have education, so there’s professional development dollars and so we insist that they use them. We also have bigger projects that allow us to stretch a bit… The other piece is that what we do all day is educate; all of our allied are actually part time faculty in the department of family medicine, because they have residents in their purview all the time… [they have] incredible collaborative knowledge. It’s not one that gets tagged; we don’t get a certificate for being interprofessional… You have your part time faculty at the department of family medicine, which means that if you are working on the unit you are already collaborative. You have your own professional scope of practice and licenses. In many instances our staff are co-faculty with the school of nursing, or someplace else in the Health Sciences and so for instance NPs take NP students all the time, they are part time faculty for that department as well but they are primarily faculty for the department of Family Medicine.

The key message here is that as a result of one component of governance, being an academic FHT, collaboration is often enhanced as the academic nature of the FHT has created structures that facilitate interactions, understanding, and teamwork among FHT professionals.

 When asked about the level of government that sets the major policies that influence collaboration in the FHT, all key informants identified the provincial government as the major player. However, as key informant 006 explained there are often multiple governing bodies with various different mandates that affect FHT governance and influence IPC collaboration.

Some of the policies come through them (Ministry of Health) through the FHT mandate but we also have the governance of all the colleges. So we have different demands from the College of Physicians and Surgeons, the College of Occupational Therapy, the College of Social Work. So, anybody who has a regulatory body; that has to be taken into account as well and then of course we are regulated by HHS and McMaster University. They may have some specific employment type situations or directions that need to be considered or patient confidentiality, whatever it may be, they may have their own way that they are expecting us to deal with things because part of our umbrella is dealing with them.

 Consequently, the existence of multiple governing bodies can make collaboration in an IPC setting more complex and difficult. Each governing body has its own goals, political aims, and mandates that may conflict with what is going on at the practice level at the FHT.

Political

Additionally, two major political factors were found to influence collaboration. Leverage and political influence was reported with high frequency, identified as highly relevant by 9 out of 10 participants, whereas strength and influence of leadership was identified by 4 out of 10.

 Considering the size, strength, and influence of both the Hamilton and McMaster FHTs, it was evident throughout the interviews that politics played a significant role in collaboration. Key informant 003 explained that the OMA and the Ministry of Health decided to reform PHC and Hamilton was select as a pilot site for the FHT model because it was the centre of most physicians who were operating within a capitated model of payment at that time. This is reflective of the HSO policy legacy of PHC in Hamilton. The Hamilton FHT formed from the existing HSO and physicians in the HSO model were already working under a capitated model of remuneration.

 Consequently, FHTs in Hamilton (Hamilton FHT and McMaster FHT) have become influential on a provincial level for different reasons. Part of the Hamilton FHT’s strength and influence comes from its large size, with over 88 sites and 150 physicians. The two most salient political factors that influence collaboration are strength and influence of leadership as well as leverage and political influence.

Key informant 008 from the Hamilton FHT stated,

When you think about politics, I think we’ve done very well to have… as our executive director. He is very political, so that’s really helped us because he knows he can manage politics, he knows politics and demographically he has the power and authority… knows his way around and because we are so large, we are the largest one in the province so we have the ability to influence the development of FHTs in Ontario. And we might not have even been able to leverage that if we had not had a very strong political guy.

This demonstrates that a good leader is able to lobby for the FHT’s best interest and influence collaboration among professionals and across organization. Leverage and political influence can be a result of size, historical legacies of PHC in Hamilton and remuneration schemes rooted in capitation, and powerful individuals including associate physician leads that hold sway with the OMA. However, having a strong and influential leader thus facilitates collaboration in this setting. Such leaders are able to advocate on behalf of their FHT to ensure that members’ needs are met. As a result, this can act to facilitate collaboration. This sentiment is echoed by multiple key informants at the McMaster FHT who state that their physician lead holds high regard and political influence. They further explain that their political influence has allowed for the adoption of policies that significantly contributed to improved collaboration among allied health professionals and the overall success of the FHT model. The physician lead has been a big advocate not only for collaboration within teams but has encouraged collaboration and “cohesion” between the two major sites of the FHT.

**Relative Importance of Policy Factors**

It is also important to note that while the focus of this study was on policy factors, these are not the only factors that key informants found to be important. In fact, many key informants had a tendency to default to speaking about within team factors such as hierarchy, autonomy, and particularly communication.

In addition to the within team factors, one organizational factor was raised that had not been mentioned in the Mulvale and Bourgeault conceptual framework used in this study: the practice facilitator, who played an educational role, was unique to the Hamilton FHT. Key informant 001 at the Hamilton FHT explains:

This Family Health Team… is one of the few in the province that has created a specific role that’s called facilitators… they [the facilitators] each have a number of physician practices that they are responsible for… their mandate is to do exactly what their name suggests: to facilitate change within the practice, encourage team meetings, facilitate the meetings, teach some skills in terms of team building and they’ve also been instrumental in rolling out the quality improvement plan which is the overarching mandate of the Family Health Team… in a sense they have an educational role.

The findings suggest that the creation of this position at the organizational level has had an impact on collaboration. At the organizational level, the Hamilton FHT recognized the need for collaboration between professionals. This practice facilitator role has encouraged and facilitated collaboration between professionals through their responsibilities described in the above quote.

 Somewhat surprisingly, who did the hiring was also an emerging factor from this study that was not outlined in the original conceptual framework. Hiring practice is an organizational level factor that was described as both a facilitator of and a barrier to collaboration. At the Hamilton FHT all allied health professionals including mental health workers, dieticians, and pharmacists are hired, fired, and paid through the FHT, however there is an exception. Nurses remain employees of the practice/physician. The Ministry allocates a certain amount of funding to the FHT for nursing staff. The nursing salary is then funneled from the FHT to the practice physicians, who in turn pay their nurses. Consequently, nurses remain an employee of the physician and maintain the traditionally close physician-nurse relationship. Key informant 002 argued that this aspect of governance facilitates collaboration in the team and specifically between physicians and nurses by supporting the close knit relationship between nursing staff, physicians, and their practice.

I think traditionally, more physicians have had a collaborative role with nursing. I mean there are physicians that had nurses in their office, myself included, long before the FHT and in a lot of instances those were long term relationships… the FHT felt that disrupting that relationship, having the nurse in a sense dismissed by the physician to be hired by the FHT, wasn’t the right way to go…

Key informant 005 further supported the notion that FHT hiring the allied health professionals acts as a facilitator of collaboration while discussing the role of pharmacists in the practice. He explained that because they are hired through the FHT, pharmacists are seen more as collaborators than employees and this strengthens the team and fosters a positive environment for collaboration:

The governance issue… we have pharmacists that are our staff [FHT staff] that work at a location that is run by a physician… we go in there and then the physicians themselves don’t have any hiring or firing authority on the pharmacist… They are hired and fired through the FHT… It maybe facilitates collaboration a little bit because they are not seen as an employee but as a collaborator… a resource. We don’t want them to have the idea that they are a consultant. We want them to have the idea that there are a team. Because at the beginning it was like this is my consulting pharmacist but we want to move away from that philosophy and have the idea that they are a team member.

In these two examples we see that how hiring is done at the FHT can enhance or impede collaboration, and that the manner in which this policy factor affects collaboration is context dependant. Additionally, academic physicians at the McMaster FHT are employees of the McMaster University, the academic institution affiliated with the FHT, and their payment, which is capitated, comes from the university. Hiring through the FHT has commonly acted to facilitate collaboration by supporting the collaborative relationship between allied health professionals.

This demonstrates that although policy factors shape collaboration in IPC teams, these factors are not necessarily at the forefront for professionals working in the FHT on a daily basis nor are they, by any means, the most important factors contributing to collaborative practice in this IPC setting. However considering that the focus of the study was on policy factors, when probed, there was consensus among FHT professionals that all policy factor categories (economic, regulatory, education & training, governance, and political) were relevant in their influence on interprofessional collaboration.

**CHAPTER 5: DISCUSSION AND IMPLICATIONS**

This research describes the policy factors that influence collaboration in FHTs. Input from key informants identified a variety of economic, regulatory, education & training, governance, and political factors that have been suggested to influence collaboration in IPC teams. This chapter discusses the extent to which the identified factors are consistent with the findings of the literature review conducted in chapter 2. Newly emerging factors that were not found in the literature review but were reported by key informants are then discussed. The chapter then uses the example of prospects for reform of physicians’ incentives, the most commonly reported barrier to collaboration identified by key informants, to highlight the implications of the study findings.

**Policy Factors Consistent with Literature**

Chapter 2 explained that although within team and personal factors have been explored in depth in the policy literature, there is a knowledge gap when it comes to policy factors that influence IPC collaboration. This study is consistent with and further contributes to this body of literature.

Consistent with assessments that have suggested policy factors may be important, economic factors, in particular provider payment/remuneration and funding, were discussed by all key informants as influencing collaboration. The importance of provider payment/remuneration to interprofessional collaboration has been discussed in the literature (Dinh, 2012b; Mulvale et al., 2008; Mulvale & Bourgeault, 2007; Craven & Bland, 2002; Dewa et al., 2001). Key informants explained that incentive structures paid only to physicians and not to the team hindered collaboration. This is consistent with the findings of Mulvale et al. (2008). Their study suggested that, in contrast to physicians working on a FFS or even a blended capitation model, salary benchmarks for all other health providers can make collaboration among team members a challenge (Mulvale et al., 2008). This finding is echoed here. In addition, the findings of this study suggest that funding is another economic factor that influences collaboration in the IPC setting, which is also consistent with the literature (Dinh, 2012a; Dinh, 2012b; Mulvale et al., 2008; Mulvale and Bourgeault, 2007; Hutchison et al., 2001).

Interestingly, financing was outlined as an important component of the Mulvale and Bourgeault framework and reflected by the key informants in their 2007 study and by Mulvale et al., (2008). They define financing as “public insurance coverage for non-physician providers in the private practice primary care setting” (p.61). However, key informants in this study did not speak to this factor in a way that provided robust insight into its effects on collaboration. This may be because the primary focus of the study by Mulvale et al. (2008) was on delivery of primary mental health care within FHTs, and lack of public coverage for psychologist services was a particular concern.

The regulatory factors were the next category of policy factors identified with high levels of agreement by key informants across the two FHTs and the different professionals working at the FHTs. Key informants identified legal accountability (nine out of 10 informants), professional regulation (seven out of 10 informants), and practice scope (ten out of 10 informants) as relevant in their influence on IPC collaboration. These findings are consistent with the Mulvale and Bourgeault framework as well as the literature (Gocan et al., 2014; Mulvale et al., 2008). A literature review conducted by Gocan et al. (2014) suggested that scope of practice influenced professionals’ satisfaction with their work in the FHT setting. Additionally, they described challenges faced when professional scopes of practice were not fully understood or were misunderstood by colleagues. The authors highlighted the need to educate health care professionals about each other’s roles. These sentiments are echoed by this study as demonstrated in the findings of chapter 4.

Both formalized training/education sessions and the strength of professional education were identified by half of the key informants as influential in IPC collaboration. Taken together these findings are supported by the literature that highlights the role of formal education as a policy factor affecting collaboration (Dinh, 2012b; Perea et al., 2009; Mulvale et al., 2008; Craven & Bland, 2002; Hall & Weaver, 2001). Buljac-Samardzic, Dekker-van Doorn, van Wijngaarden, and van Wijk (2010) also conducted a literature review exploring interventions that improve team effectiveness. At a policy level, they found that training, specifically team-based training in multidisciplinary settings, improved prospects for collaboration (Buljac-Samardzic et al., 2010).

**Emerging Policy Factors**

The notion of IPC built into training opportunities, identified by seven out of 10 key informants, or IPC training or exposure to the collaborative model prior to or upon joining the FHT, identified by three out of 10 key informants, were considerable facilitators of collaboration. Formalized exposure to IPC in training was an emerging policy factor highlighted by the findings of this study.

The governance category highlights a few emerging policy factors that influenced IPC collaboration in FHTs. Unique to this study is that interviews were conducted with professionals from both an Academic FHT and a Community FHT (see Table 2). Specifically, academic FHTs tend to be responsible to multiple governing bodies including their FHT governance structure, as well as their academic or university governing structures. Academic FHTs are unique since they have an educational mandate and need to meet certain requirements in order to secure the educational components of their funding. Throughout the course of this study key informant interviews suggested that although overall FHTs have similar mandates in terms of delivery of holistic, interprofessional and patient-centered care, in a PHC setting, academic and community FHTs can have varying mandates.

One of the implications with this governance structure is that each governing body may have contradictory institutional goals. This may make collaboration difficult when health providers are trying to meet the requirements of different governing bodies as well as adequately addressing patient needs. However, institutional mandates, such as the educational mandate of academic FHTs may also act to enhance collaboration as explained by key informant 007 in chapter 4. The educational mandate of academic FHTs means that health providers from varying backgrounds, both students and professionals, must work together and educate one another in order to understand each other’s roles and to function effectively in an IPC model.

Finally, selected political factors emerged as influencing collaborative practice at the FHT. In the past, the concept of leadership, as a factor that influences collaboration, has been framed as a within team factor. However, we learned in this study that the ability of leadership to be strong and influential at a policy level means that these influential leaders have the ability to interact with government and governance structure in order to push for policies that facilitate collaboration in the FHT. The notion that strong leadership that deals with both central and local leadership structures is identified in a literature review conducted by D’Amour et al. (2005). However, they explain that leadership is not well documented in frameworks on interprofessional collaborative practice and highlight the need for further research in this area (D’Amour et al., 2005). Consequently, the findings of this study highlight that the strength and influence of leadership and the ability to leverage political actors is a policy factor that can influence, and specifically enhance collaboration within the team.

**Implications: Incentive Structures for Physicians as a Barrier to Collaboration**

Incentive structures for physicians as a component of provider payment will be used as an illustrative example to highlight prospects for reform in order to facilitate collaborative practice in this IPC setting. Of the five policy categories examined in this study, each policy factor in the economics category was identified unanimously by all key informants as highly influential in IPC collaboration in the two FHTs examined here. When asked: what would be the one policy factor they would change in order to support collaboration in the FHT?, seven out 10 key informants identified the elimination or sharing of incentive structures and bonuses as the factor they would change.

Part of the concern with incentives provided uniquely to physicians is that physicians receive incentives for providing specialized care while others don’t. Different health care providers in additional to physicians are contributing time and expertise in patient care but are not receiving bonuses. Care may be provided by multiple different professionals; however physicians are the only group that receives the bonuses. This may create perceptions of inequity in remuneration among allied health and foster a strained working environment and/or relationships between professionals.

Incentive structures are an important component of remuneration in the blended capitated model seen at the FHTs examined in the study and in this sense; the FHTs are similar to others across the province. As a result of the passion with which key informants discussed incentive structures and the influence of remuneration schemes on collaborative practice, the 3-I framework from Chapter 2 will be used to guide the discussion of prospects for their reform.

***Institutions***

The literature review from chapter 2 identified that there has been a legacy of a different payment model for physicians, when compared to other healthcare professionals. To review, physicians traditionally are paid through a fee-for-service remuneration model. This is a legacy of the introduction of public insurance for hospital and physicians services over the course of the development of the Canadian health care system that was strongly reinforced by the CHA of 1985. The findings of this study suggest that collaboration can be influenced by different remuneration schemes for the different health professionals on a team. When examining the prospects for reforming incentive structures there are institutional factors that need to be considered.

Firstly, the legacies of the CHA and its predecessors continue to be strong since the ideas of these acts have become engrained and strongly held values of the Canadian public. FFS remains the dominant model for physician remuneration, while most other allied health professionals are paid on a salary basis (Hutchison et al., 2011). Complete elimination of incentives and/or remunerating physicians on the same model as other allied health professionals can be seen as a risk to physicians’ interests since an alternative payment model may limit their flexibility in quantity of services delivered and billed for and threaten their funding pool by sharing resources with other health professionals.

Although medical dominance continues to be strong the findings of this study demonstrate that, in the FHT setting, a large proportion of the physicians are beginning to reduce, if not completely let go of, the notion of hierarchy within the team which has been found to inhibit collaboration in earlier studies (Mulvale et al., 2008; Mulvale and Bourgeault, 2007). This may, in part, reflect increasing comfort with a blended capitation model and sharing work across the interprofessional team.

This shift to greater comfort with a blended capitation model does not mean the same compensation for physicians as the salaried approach used for other health professionals in FHTs, nor does it imply elimination of incentives and bonuses that are components of the blended capitation model. However, it does bring closer alignment in the sense of a greater proportion of prospective payment, which is more consistent with the salaried model. At the same time, physicians retain a volume based incentive structure that parallels retrospective FFS payment and in so doing, continues the policy legacy of physicians having some control in setting the total amount of their package of remuneration.

***Interests***

Patients’ interests lie primarily with their need for acceptable care delivery by a suitable health care professional. Furthermore, as a part of the taxpaying public, patients may have a particular interest in remuneration schemes that lower overall health spending and costs to them as taxpayers. Although the traditional alignment of patients’ interests with physicians’ interests generally persists in the health care environment in Ontario today, their primary interest is in access to needed care (Soroka, 2011).

Physicians are the dominant interest when discussing provider payment reform. As such they may be resistant to changes that allow others access to incentive care bonuses or the elimination of incentive structures all together. Removing incentive structures completely may be met with strong resistance from the medical community considering the historical legacies of physician practice autonomy, control over the size of their practice and voice in how they make money.

Traditionally, it is expected that physicians would support incentive structures and remuneration schemes that maintain their dominance in the health care field. However, the findings of this study suggest that physicians’ perspectives on their needs and their approach to IPC have been steadily changing over the past decade. Physicians, particularly the ones interviewed in this study, acknowledge that more equitable models of payment, such as blended capitation, can act to relieve barriers to their effective collaboration with different health care professionals in team-based patient care settings like the FHT.

 Government is another interest group that needs to balance concerns about its own fiscal budget, which may require cost reductions (Drummond, 2012), with the need to provide a system that provides timely and appropriate care for patients. Governments may support the elimination of incentive structures as a cost-cutting strategy; however, they are also aware of the need for acceptable payment structures for physicians and other health professionals in order to provide care to the patient population. This dual interest for governments was enshrined in the accessibility principle of the Canada Health Act. It states that along with providing reasonable access for insured persons that public health insurance plans “… must provide for reasonable compensation for all insured health services rendered by medical practitioners or dentists”(CHA, 1985, p.8)."

 Throughout the study, key informants also explained that allied health professionals were able to voice their concerns more effectively in the FHT model and that their professional organizations were gaining more influence in the health care environment of the day. Although this may be the case, physicians remain the most powerful interest group and the group best equipped to mobilize and affect change (Lavis, 2004).

Although this conversation does not include an exhaustive list of interests with respect to incentive reform, particularly pertinent groups in the context of this study are discussed. Other interest groups may include professional organizations such as the RNAO, PHC researchers, or particularly commonly alienated or isolated professionals and professional groups like psychologists (Mulvale et al., 2007).

***Ideas***

 As highlighted in chapter 1 and 2, IPC models of care have gained support in the academic and policy literature. The ability to have a wide range of health services available in one location is appealing to the public and there is an increased acceptance among the public of IPC models of care and remuneration. Changing ideas about the value and contribution of collaboration in health care delivery may have downstream effects, allowing for more openness to reforming factors to enhance collaboration, including payment reform. Collaboration in an IPC team allows for distribution of the workload once the various professionals working together in a team have come to respect and value the contribution other health professionals bring to the team.

An integral component of IPC care and specifically the FHT model in Ontario is that the model does not threaten the core values of the CHA (public administration, comprehensiveness, universality, portability, and accessibility), in fact, when implemented effectively IPC models of care like the FHT can improve comprehensiveness of care (by potentially including providers whose services are not otherwise publicly covered), and accessibility across a wide population without financial barriers. Provider payment models that facilitate this collaboration thus do not threaten public values and comfort with respect to the concept of IPC care.

Consequently, prospects for reforming incentive structures as a policy factor are highly dependent on shifting physicians’ values and beliefs surrounding remuneration and the effectiveness of IPC models of service delivery. The findings suggest that there has been a shift in thinking about the concept of a physician’s role from solo practice, where the physician was responsible for virtually every aspect of a patient’s care, to a team-based model that works together to address patient needs and delivery of care. There has also been growing support within the OMA, to place greater emphasis on PHC in Ontario as well as an openness to alternative payment models (OMA, 2013), like blended capitation for example, which the key informants explained help foster collaboration.

**Prospects for reform**

Although deeply rooted values, particularly the five core principles of the CHA, persevere in the Canadian health care system and among the public today, and physicians’ dominance is still important, the analysis of payment models and the totality of this study demonstrates that there are areas where reform can find a way to emerge. The policy environment for interprofessional collaboration is changing. The findings of the study demonstrate that although provider payment, specifically incentives for physicians, can be a barrier to collaboration, these can be overcome when an incremental approach is adopted in which strong interests groups, like physicians, are invited rather than directed to embrace innovative models of care. In this case of primary care reform in Ontario, prospects for more widespread adoption of interprofessional collaborative practice are also more promising than they might otherwise be because of the experience of early adopters of the model. Looking ahead, the prospects for policy reform of payment schemes for physicians across the board to encourage more widespread adoption of IPC, are less clear. It is likely that physicians across the province would strongly resist removal of incentives that were found here to be a barrier to collaboration as they remain the last opportunity for physicians to have control over the total amount of remuneration they receive. Instead, there may be greater opportunity for physicians within individual FHTs to choose to share the incentives they receive with their colleagues from other professions, as has been found to occur in some FHTs, as a way to enhance interprofessional collaboration.

**Study limitations**

The study has several limitations that should be acknowledged. Firstly, initial difficulty with recruitment led to a shift in recruitment approach as discussed in chapter 3. Instead of speaking with physician leads at many FHTs, the decision was made to focus in more depth on two FHTs, by conducting several interviews among key informants who play different roles within the FHTs and who have different professional backgrounds. While this may be seen as a limitation in terms of the number of FHTs included in the study, it can be seen as a strength in presenting a greater diversity of perspectives across roles and health professions. Overall the number of interviews, N=10, is viewed as adequate to represent these perspectives in an exploratory study of this nature. The strong agreement among participants about the importance of most policy factors is also indicative of consistency of key themes.

A second limitation is that the two FHTs that were included were located in the same city within the province of Ontario, and thus do not reflect the broad range of geographic, community size, cultural diversity, and other contexts across the province. Given that the focus of the study was on policy factors, which would be expected to be largely consistent across the province as a whole, the overall findings are expected to be relevant to FHTs located in most other communities and contexts in Ontario.

A third limitation is that the two FHTs in Hamilton may be less representative than many other FHTs in terms of their experience in changing to new models of physician payment upon becoming a FHT, in that both FHTs emerged from prior models of funding that included capitated physician remuneration. For example, the Hamilton FHT had a history of operating as the Hamilton Health Service Organization (HSO), which paid physicians by capitation, and the McMaster physicians were similarly paid by capitation prior to the formation of the McMaster FHT because of prior status within an academic setting. While these physicians would have adjusted to a blended remuneration model upon the creation of the FHTs, their experience may be different than the majority of physicians across the province. Nonetheless, the key finding that differences in remuneration between physicians and other health professionals in the FHTs, particularly in the incentives paid to physicians, would be expected to remain a key barrier to collaboration.

**CHAPTER 6: CONCLUSION**

The objective of the study was to describe the policy factors that influence collaboration in IPC teams. The Ontario FHT was used as a demonstrative model of IPC delivery. Key informant interviews were conducted with ten professionals from the two FHTs in Hamilton, Ontario. The findings of the study suggest that over the past decade, as FHTs have been developed and implemented across the province, there has been progress in collaboration in this patient-centered care and IPC delivery model. The ability of all professionals in an IPC to engage in collaborative practice is an essential component to allow the team to function effectively and thus provide quality care to its patient population.

In Gocan et al.’s (2014) review, the authors highlight that “It is not enough for policy makers to establish interprofessional primary care practices… Policy makers need to provide leadership in the prioritization and standardization of preventative care, mental health services, and chronic disease management as core elements of primary healthcare rather than allowing these essential services to be regarded as optional or “add-on” components of care” (p.17). This means that systemic change needs to take place under the direction of policy leadership in creating a context that will foster collaboration. This study identified the current incentive structure within physician remuneration in FHTs, to be one of several barriers to collaboration. The 3-I analysis in the literature (chapter 2) and subsequent discussion of the prospects for reform of incentive structures (chapter 5) demonstrate that although institutional legacies, deeply rooted values, and strong interests may foster resistance in the development of effective models of IPC delivery, there is an increasing openness by the different interest groups (physicians, allied health, government, and public) to the concept of IPC collaboration.

At the same time, although policy reform is possible, there is limited likelihood of widespread adoption of new physician payment models that exclude incentives in the near future. Instead, prospects for improving this aspect of collaboration may best be tackled at an organizational level rather than a policy level. The considerable degree of the power to instill change still lies with physicians and physicians’ interests. What is beginning to change is the way physicians view their role in primary health care in Ontario, which in itself is a major shift in light of longstanding policy legacies in how PHC is delivered.

Although the incentives structure discussed in this study may be unique to Ontario, the lessons learned may be applied across jurisdictions and in different contexts. The findings and discussion show that paying close attention to equity in payment of different professionals helps foster an environment within teams that can enhance collaboration, with implications at both the policy and organizational level. Furthermore, although identified most commonly by key informants, incentive structures were not the only barriers to collaboration described by the key informants. The study demonstrates that incremental change at the organizational level may be a more effective way at tackling reform, than wide-reaching, ‘big bang’ efforts, which may be resistant to change. Widespread reform is difficult to achieve; further study and analysis is necessary to determine an ideal way to tackle reform of these additional barriers to collaboration.

**REFERENCES**

Alberta Heatlh Services. (2003). An exploratory study of interprofessional team in Primary Care Networks in Alberta. Alberta, Canada.

Angelini, D. J. (2011). Interdisciplinary and Interprofessional Education: What are the Key Issues and Considerations for the Future? *The Journal of Perinatal and Neonatal Nursing*, 25(2), 175–179.

Bacchi, C. (2009). *Rethinking policy analysis: Theory and politics*. In Bacchi, C. *Analysing Policy: What’s the problem represented to be?* (pp. 25-53). Frenchs Forest: Pearson Australia.

Bourgeault I. L. & Mulvale G. (2006). Collaborative health care teams in Canada and the USA: Confronting the structural embeddedness of medical dominance. *Health and Sociololgy Review,* 15 (5), 481–95.

Bower, P., Campbell, S., Bojke, C., & Sibbald, B. (2003). Team structure, team climate and the quality of care in primary care: An observational study. *Quality and Safety in Health Care,* (12), 273-280.

Browne, K. (2005). Snowball sampling: using social networks to research non‐heterosexual women. *International Journal of Social Research Methodology*, 8 (1), 47-60.

Buljac-Samardizic, M., Dekker-van Doorn, C. M., van Wijngaarden, J. D. H., & Wijk, K. P. (2010). Interventions to improve team effectiveness: A systematic review. *Health Policy*, 94, 183-195.

Cameron, D. & Simeon, R. (2002). Intergovernmental Relations in Canada: The Emergence of Collaborative Federalism. *The Journal of Federalism*, 32(2), 49-71.

Carter, T. (2012). Team based health care: Identifying key terminology/criteria and supporting the development of key indicators. Ottawa, Ontario: A report prepared for Health Canada, Strategic Policy Branch.

Canada Health Act. (1985). Published by the Minister of Justice at: <http://laws-lois.justice.gc.ca/eng/acts/C-6/page-1.html>.

Choi, B. C. K. & Pak, A. W. P. (2006). Multidisciplinarity, interdisciplinarity and transdisciplinarity in health research, services, education and policy: 1. Definitions, objectives, and evidence of effectiveness. *Clinical & Investigative Medicine*, 29 (6), 351- 364.

Craven, M. & Bland, R. (2002). Shared Mental Health Care: A Bibliography and Overview. *The Canadian Journal of Psychiatry*, 47(2), 51-104.

Davies, J. (2012). Measuring the performance of interprofessional collaboration; Impacts for patients, providers and the health system. Ottawa, ON.: A Report Prepared for Health Canada, Janet Davies Group.

Deber, R. & Baumann, A. (2005). Barriers and facilitators to enhancing interdisciplinary collaboration in primary health care.

Dewa, C., Hoch, J. S., and Goering, P. (2001). Using Financial Incentives to Promote Shared Mental Health Care, *Canadian Journal of Psychiatry,* 46(6), 488-495.

Dinh, T. & Bounajm, F. (2013). Improving Primary Health Care Through Collaboration Briefing 3- Measuring the Missed Opportunity. Ottawa.

Dinh, T. (2012a). Improving primary health care through collaboration Briefing 1 – Current knowledge about interprofessional teams in Canada. Ottawa, Ontario: Conference Board of Canada.

Dinh, T. (2012b). Improving primary health care through collaboration. Briefing 2 – Barriers to Successful Interprofessional Teams. Ottawa, Ontario: Conference Board of Canada.

Dieleman, S., Farris, K., Feeney, D., Johnson, J., Tsuyuki, R., & Brilliant, S. (2004). Primary health care teams: team members' perceptions of the collaborative process. *Journal of Interprofessional Care,* 18(1), 75-78.

Dobson, R., Henry, C., Taylor, J., Zello, G., Lachaine, J., Forbes, D., & Keegan, D. (2006). Interprofessional health care teams: Attitudes and environmental factors asociated with participation by community pharmacists. *Journal of Interprofessional Care,* 20(2), 119- 132.

Drummond, D. (2012). Public Services for Ontarians: A Path to Sustainability and Excellence. Commission on the Reform of Ontario’s Public Services. Queen’s Printer for Ontario, Accessed at <http://www.fin.gov.on.ca/en/reformcommission/chapters/report.pdf>.

Dyer, J. A. (2003). Multidisciplinary, interdisciplinary, and transdisciplinary educational models and Nursing Education. *Nursing Education Perspective*,24(4), 186-188.

Francis , J. J., Johnston , M., Robertson , C., Glidewell, L., Entwistle, V., Eccles, M. P., & Grimshaw, J. M. (2010). What is an adequate sample size? Operationalising data saturation for theory-based interview studies. *Psychology & Health*, 25(10): 1229-1245.

Gauvin, F. P. (2014). *Understanding policy developments and choices through the “3-i” framework: Interests, Ideas and Institutions*. Montréal, Québec: National Collaborating Centre for Healthy Public Policy.

Gené-Badia, J., Ascaso, C., Escaramis-Babiano, G., Sampietro-Colom, L., Catalán-Ramos, A., Sans-Corrales, M., & & Pujol-Ribera, E. (2007). Personalised care, access, quality and team coordination are the main dimensions of family medicine output. *Family Practice,* 24 (1), 41-47.

Giacomini, M. & Cook, D.J. (2008). Ch. 11.5: Qualitative research. In, Guyatt GH, Rennie, D., Meade, MO, & Cook, DJ (Eds)., *User’ Guides to the Medical Literature. A Manual for Evidence-Based Clinical Practice* (2nd Edition). (pp. 341-360). US: McGraw Hill.

Given, L. M. (2008). Exploratory Research. In *The SAGE Encyclopedia of Qualitative Research Methods Volume 1*. (pp.327-329). Thousand Oaks, California: SAGE Publications Inc.

Glenngård, Anna H. (2012). *The Swedish Health Care System, 2012*. In Thomson, Sarah, Robin Osborn, David Squires, and Miraya Jun eds (2012). International Profiles of Health Care Systems, 2012. Commonwealth Fund.

Glenngård A. H, Hjalte F, Svensson M, Anell A, Bankauskaite V. (2005). *Health Systems in Transition: Sweden*. Copenhagen, WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies.

Gocan, S., Laplante, M. A., & Woodend, K. A. (2014). Interprofessional Collaboration in Ontario’s Family Health Teams: A Review of the Literature. *Journal of Research in Interprofessional Practice and Education*, 3(3), 1-19.

Green, J. & Thorogood, N. (2004). *Qualitative Methods for Health Research*. Thousand Oaks, CA: SAGE Publications Inc.

Greener, I. (2005). The Potential of Path Dependence in Political Studies. *Politics*, 25 (1), 62-72.

Goni, S. (1999). An analysis of the effectiveness of Spanish primary health care teams. *Health Policy,* 48, 117.

Guest, G., Bunce, A., & Johnson, L. (2006). How Many Interviews Are Enough?: An Experiment with Data Saturation and Variability. *Field Methods*, 18(1): 59-82.

Hall, P. (2005). Interprofessional Teamwork: Professional Cultures as Barriers. *Journal of Interprofessional Care,* 19, 188-196.

Hall P.A. & Taylor, R. C. R. (1996). Political science and the three new institutionalisms. *Political Studies*, 44, 936-957.

Hall, P. & Weaver, L. (2001). Interdisciplinary Education and Teamwork: A Long and Winding Road. *Medical Education*, 35(9), 867-875.

Harrison, S. (2001). Policy analysis. In N. Fulop, P. P. Allen, A. Clarke & N. Black (Eds), *Studying the organization and delivery of health services* (pp.90-106). London: Routledge.

Health Canada. (2003). 2003 First Minister’s Accord on Health Renewal. Date Modified: 2006- 05-08. Accessed at <http://www.hc-sc.gc.ca/hcs-sss/delivery-prestation/fptcollab/2003accord/index-eng.php>.

## Hern, T., Talen, M., Babiuch, C., & Durazo-Arvizu, R. (2009). Patient care management teams: improving continuity, office efficiency, and teamwork in a residency clinic. *The Journal of Graduate Medical Education*, 1(1), 67–72.

Hsieh, H., & Shannon, S. (2005). Three approaches to qualitative content analysis.  *Qualitative Health Research,* 15: 1277-1288.

Howett, M., Ramesh, M. & Perl, A. (2009). *The Policy Context*. In *Studying Public Policy: Policy Cycles & Policy Subsystems*. Ontario: Oxford University Press.

Hutchison, B., Levesque, J. F., Strumpf, E. & Coyle, N. (2011). Primary Health Care in Canada: Systems in Motion. *The Milbank Quarterly*, 89(2), 256–288.

Hutchison, B., Abelson, J. & Lavis, J. (2001). Primary Care In Canada: So Much Innovation, So Little Change. *Health Affairs*, 20(3), 116-131.

Interprofessional Care Strategic Implementation Committee. (2010). Implementing Interprofessional Care in Ontario: Final Report of the Interprofessional Care Strategic Implementation Committee.

Johnston, S., Green, M., Thille, P., Savage, C., Roberts, L., Russell, G. & Hogg, W. . (2011). Performance feedback: an exploratory study to examine the acceptability and impact for interdisciplinary primary care teams. *BMC Family Practice, 12*(14), 1-10.

Keck, C. W. & Reed, G. A. (2012). The Curious Case of Cuba. *American Journal of Public Health*, 102 (8): e13-e22.

Kirby, (2003). Reforming Health Protection and Promotion in Canada: Time to Act. Report of the Standing Senate Committee on Social Affairs, Science and Technology. Ottawa: Senate of Canada.

Kondracki, N., Wellman, N, & Amundson, D. (2002). Content analysis: Review of  methods and their application in nutrition education. *Journal of Nutrition* *Education and Behavior*, 34, 224-230.

Kracauer, S. (1993). The challenge to qualitative content analysis. *Public Opinion Quarterly*, 16, 631-642.

Kralj, B. & Kantarevic, J. (2012). Primary Care in Ontario: reforms, investments and achievements. *Ontario Medical Review*, 18-24.

### Krefting, L. (1991). Rigor in Qualitative Research: The Assessment of Trustworthiness. [*American Journal of Occupational Therapy*](http://www.aota.org/Publications-News/AmericanJournalOfOccupationalTherapy.aspx), 45(3), 214-222.

Lacey, A. & Luff, D. (2001). Trent Focus for Research and Development in Primary Health Care: An Introduction to Qualitative Analysis. Trent Focus.

Lavis, J. (2004). Political elites and their influence on health-care reform in Canada. In McIntosh, T. Forest, P-G., & Marchildon, G. P., *The Governance of Health Care in Canada Romanow Papers Volume 3*. Toronto, Canada: University of Toronto Press Incorporated.

Lemieux-Charles, L. & McGuire, W. L. (2006). What do we know about health care team effectiveness? A review of the literature. *Medical Care Research and Review*, 63(3), 263-300.

Lewis, S., Donaldson, C., Mitton, C., & Currie, G. (2001). The future of health care in Canada. *BMJ Education and Debate*, 323, 926-929.

Mable, A. l. & Marriott, J. (2002). *Sharing the Learning. The Health Transition Fund. Synthesis Series: Primary Health Care.* Ottawa: Health Canada.

Maioni, A. (2010). Citizenship and Health Care in Canada. *International Journal of Canadian Studies*, 42, 225-242.

Manning, P. K. & Cullum-Swan, B. (1994). Narrative, Content, and Semiotic Analysis. In *Handbook of Qualitative Research* (pp. 463- 477): Thousand Oaks, CA: SAGE Publications, Inc.

McLean, T., Atkins, E., & McLean, K. (2005). Quality Practice Award and teamworking: the perceptions of primary health care team members in Scotland. *Journal of Interprofessional Care,* 19(2), 149-155.

Mearsheimer, J.J. (1994). The False Promise of International Institutions. International Security, 19(3), 5-49.

Ministry of Health and Long-Term Care (MOHLTC). (2014). Family Health Teams. Accessed at <http://www.health.gov.on.ca/en/pro/programs/fht/>.

Ministry of Health and Long-Term Care (MOHLTC). (2012). Billing & Payment Guide for Blended Salary Model (BSM) Physicians. Family Health Teams, Primary Health Care. Accessed at <http://www.health.gov.on.ca/en/pro/programs/fht/docs/fht_bsm_physicians_en.pdf>.

Ministry of Health and Long-Term Care (MOHLTC). (2009). Family Health Teams Advancing Family Health Care Guide to Physician Compensation. Accessed at <http://www.health.gov.on.ca/en/pro/programs/fht/docs/fht_compensation.pdf>.

Mitchell, R. J., Parker, V. & Giles, M. (2011). When do interprofessional teams succeed? Investigating the moderating roles of team and professional identity in interprofessional effectiveness. *Human Relations*, 64(10), 1321-1343.

## Mu, K. & Royeen, C. B. (2004). Interprofessional vs. interdisciplinary services in school-based occupational therapy practice. *Occupational Therapy International*, 11(4), 244-247.

Muldoon, L. K., Hogg, W. E., & Levitt, M. (2006). Primary Care (PC) and Primary Health Care (PHC) What is the Difference?. Canadian Journal of Public Health, 97(5), 409-411.

Mulvale, G. & Bourgeault, I. L. (2014). How social, political and economic factors shape formation and integration of interprofessional primary healthcare teams: A case study of Family Health Teams in Ontario. Manuscript in preparation.

Mulvale, G., Danner, U., & Pasic, D. (2008). Advancing community-based collaborative mental health care though interdisciplinary family health teams in Ontario. *Canadian Journal of Community Mental Health*, 27(2), 55-73.

Mulvale, G. & Bourgeault, I. L. (2007). Finding the Right Mix: How do Contextual Factors Affect Collaborative Mental Health Care in Ontario?.*Canadian Public Policy,* 33, S49 S64.

Mulvale, G., Abelson, J. & Goering, P. (2007). Mental Health Service Delivery in Ontario Canada: How do Policy Legacies Shape Prospects for Reform?. Health Economics, Policy and Law, 2, 363-389.

Neergaard, M. A., Olesen, F., Andersen, R. S. & Sondergaard, J. (2009). *BMC Medical Research Methodology,* 9(52), N/A.

Novás, D. *J. &* Sacasas, F.  *J.* (1989). *Del Policlínico integral al médico de la familia. Revista Cubana de Medicina General Integral,* 5(4), 556-64.

Oandason, I. & Robinson, J. (2009). Final Report to the Interprofessional Care Strategic Implementation Committee (IPCSIC).

Ontario Health Services Restructuring Commission. Primary Health Care Strategy (1999). Advice and Recommendations to Hon Elizabeth Witmer, Minister of Health. Accessed at <http://www.med.uottawa.ca/sim/data/Primary_Care.htm>.

Ontario Medical Association. (2013). Priorities for Building an Integrated and Accessible Primary Care System in Ontario.

# Opie, A. (1997). Effective Team Work in Health Care: A Review of Issues Discussed in Recent Research Literature. *Health Care Analysis*, 5(1), 62-73.

Paul, S., & Peterson, C. Q. (2001). Interprofessional collaboration: Issues for practice and research. *Occupational Therapy in Health Care*, 15, 1-12.

Perea, L. P., Cardenas, S. F. S. & Hernandez, L. D. (2009). Ambiente laboral en los policlínicos universitarios [Work environment in university polyclinics]. *Educación Médica Superior*, 23(2), 1-18.

Pierson, P. (2000). Increasing Path Returns, Path Dependence, and the Study of Politics. *American Political Science Review*, 94 (2), 251-267.

Pierson, P. (1993). When Effect Becomes Cause: Policy Feedback and Political Change. *World Politics*, 45(4), 595-628.

Pierson, P. & Skocpol, T. (2002). Historical Institutionalism in contemporary political science. In I. Katznelson and H.V. Miller (eds.) *Political Science: State of the Discipline* (pp. 693-721). New York: Norton.

Poulton, V., & West, M. (1999). The determinants of effectiveness in primary health care teams. *Journal of Interprofessional Care*, 13(1), 7-18.

Primary Health Care: Report of the International Conference on Primary Health Care, Alma-Ata, U.S.S.R., 6-12 September, 1978. Geneva: W.H.O, 1978.

Reeves, S., Lewin, S., Espin, S. & Zwarenstein, M. (2010). *Interprofessional Teamwork for Health and Social Care*. Oxford: Wiley-Blackwell.

Richie, J. & Spencer, L. (1994). Qualitative data analysis for applied policy. In Bryman, A. & Burgess, R. G. (Eds.), *Analyzing qualitative data* (p.173-194). London; New York: Routledge.

Rodgers, B. L. & Cowles, K. V. (1993). The Qualitative Research Audit Trail: A Complex Collection of Documentation. *Research in Nursing & Health*. 16, 219-226.

Romanow, Roy J. (2002). “Building on Values: The Future of Health Care in Canada.” Commission on the Future of Health Care in Canada.

Rosser, W. W., Colwill, J. M., Kasperski, J. & Wilson, L. (2011). Progress of Ontario’s Family Health Team Model: A Patient Centered Medical Home. *Annals of Family Medicine*, 9(2), 165-171.

Sandelowski, M. (2000). Focus on Research Methods- Whatever Happened to Qualitative Description. *Research in Nursing & Health*, 23, 334-340.

Scott, C. & Lagendyk, L. (2012).Contexts and Models in Primary Healthcare and their Impact on Interprofessional Relationships. Ottawa.

Shi, L. (2008). Qualitative Research, In *Health Services Research Methods* (2nd edition) (pp. 142-163). Clifton Park, NY: Delmar Cengage Learning.

Shortell, S., Marsteller, J., & Lin, M. (2004). The role of perceived team effectiveness in improving chronic illness care. *Medical Care*, 42(11), 1040–1048.

Sicotte, C., D’Amour, D., & Moreault, M. (2002). Interdisciplinary collaboration within Quebec community health care centres. *Social Science & Medicine*, 55(6), 991-1003.

Sinha, Aseema. (2004). Ideas, Interests and Institutions in Policy Change in India: A Comparison of West Bengal and Gujarat. In Rob Jenkins ed*. Regional Reflections: Case Studies of Democracy in Practice*, Oxford University Press.

Soroka, S. N. (2011). Public Perceptions and Media Coverage of the Canadian Healthcare System: A Synthesis. Canadian Health Services Research Foundation, Ottawa, Ontario.

Spiegel, J. M., & Yassi, A. (2004). Lessons from the margins of globalization: Appreciating the Cuban health paradox. *Journal of Public Health Policy*, 25(1), 85-110.

Starfield, B. (1998). Primary Care: balancing health needs, services and technology. (@nd edition) (pp. 8-9). New York: Oxford University Press. Accessed at <http://www.med.uottawa.ca/sim/data/Primary_Care.htm>.

Stember, M. (1991). Advancing the Social Sciences Through the Interdisciplinary Enterprise. *The Social Science Journal*, 28 (1), 1-14.

Stepans, M. B., Thompson, C. L., & Buchanan, M. L. (2002). The role of the nurse on a transdisciplinary early intervention assessment team. *Public Health Nursing*, 19, 238- 245.

## The Hospital for Sick Children. (2014). *Definition of medical directives*. Accessed at <http://www.sickkids.ca/medicaldirectives/101/definition/>.

Van den Besselaar, P & Heimeriks, G. (2001, July). Disciplinary, Multidisciplinary, Interdisciplinary - Concepts and Indicators -. Paper for Paper for the 8th conference on Scientometrics and Informetrics, Sydney, Australia. Paper retrieved from hcs.science.uva.nl/usr/peter/publications/2002issi.pdf‎.

Virani, T. (2012). Interprofessional Collaborative Teams. Ottawa.

Zillich, A. J., McDonough, R. P., Carter, B. L. & Doucette, W. R. (2004). Influential Characteristics of Physician/Pharmacist Collaborative Relationships. *The Annals of Pharmacotherapy,* 38, 764-770.

Zwarenstein, M., Goldman, J. & Reeves, S. (2009). Interprofessional collaboration : effects of practice-based interventions on professional practice and healthcare outcomes (Review). *The Cochrane Library*, (3), 1-29.

**TABLES**

**Table 1- Participant Demographics**

|  |  |
| --- | --- |
|  | **Participant ID** |
| **Basic Demographics** | **001** | **002** | **003** | **004** | **005** | **006** | **007** | **008** | **009** | **010** |
| Gender, female |  |  |  | X |  | X | X | X | X | X |
| Undergraduate degree (ie. BScN) or less |  |  |  | X |  |  |  |  | X |  |
| Post-graduate degree (ie. MSW, PhD) or professional degree (ie. MD) | X | X | X |  | X | X | X | X |  | X |
| Years of employment at FHT <5 |  | X |  |  |  | X |  |  |  | X |
| Years of employment at FHT >5 | X |  | X | X | X |  | X | X | X |  |
| Hamilton FHT | X | X | X | X | X |  |  | X |  |  |
| McMaster Academic FHT |  |  |  |  |  | X | X |  | X | X |

**Table 2- Definitions of Policy Factors**

|  |  |  |
| --- | --- | --- |
| Factor Category | Specific Factor  | Definition |
|  |  |  |
| **Economic** | FundingProvider payment | * The economic resources used to sustain the FHT. Including source(s) of funding.
* How different professional within the team are remunerated/payment models.
* Ie. Salaried, capitation, blended models, etc.
 |
| **Regulatory** | Legal accountabilityProfessional regulationPractice scope | * The extent to which professional is legally responsible for their patients’ wellbeing.
* This concept goes hand in hand with the notion of most responsible provider.
* Speaks to concerns with liability and liability insurance.
* Practice requirements and mandates that have been laid out by each professions regulatory body.
* Ie. The influence of the OMA over physicians’ practice or the RNAO on nursing practice.
* Definition of the responsibilities of each professional. What each professional is licensed to do.
* Issues with overlapping scopes of practice, working within scope of practice, and working to optimal scope of practice.
 |
| **Education and Training** | Strength of professional educationPrior IPC and/or PHC training joining FHTOngoing formalized training opportunities at FHT IPC built into FHT training | * The extent to which educational curricula are able to train and educate new professional in order to be able to practice efficiently in the field.
* Whether FHT professionals have had prior experience either educational or practical with IPC and/or PHC.
* The existence of educational session, organized by the FHT, in order to enhance professionals learning and skills.
* Although training is usually skill or disease specific, whether interprofessional collaboration is a part of this skill specific training.
 |
| **Governance**  | Governance model/ structure (mixed or community or provider)Setting (Academic vs. Community FHT)Multiple governing bodiesConflicting goals | * The Board of Directors of a FHT is responsible for its governance. Governance model can be provider based (the board is made up of physicians), community based (the board is made up solely of community members and not physician providers), or mixed (the governance board includes both physician providers and community members).
* An academic FHT combines it’s responsibly of delivering PHC to patients in their community with maintaining affiliations with academic institutes. They receive education funding and have an educational mandate to train students from various professional backgrounds.
* A community FHT is a combination of professionals that work together to delivery PHC and service the needs of the patients in their community.
* Existence of more than one governing body that sets goals and guidelines for FHT functioning.
* The governing bodies, professional schools and the FHT may have differing or conflicting goals.
 |
| **Political**  | LeadershipLeverage and political influence | * Leadership structure of the FHT ie. Physician leadership models vs. collaborative leadership model that include the interprofessional health providers
* The power of those in leadership roles to affect change at a policy level. Leaderships sway and leverage with government and other powerful organizations (ie. OMA).
 |
|  |  |  |

**Table 3- Policy Factors Identified and Frequency of Reporting by Key Informants**

|  |  |  |
| --- | --- | --- |
|  | **Participant ID** |  |
| **Policy Factor Category** | **Specific Factor** | 001 | 002 | 003 | 004 | 005 | 006 | 007 | 008 | 009 | 010 | Total |
| **Economic** | Funding | X | X | X | X | X | X | X | X | X | X | 10 |
| Provider payment/remuneration/incentives | X | X | X | X | X | X | X | X | X | X | 10 |
| **Regulatory** | Legal accountability | X | X | X | X | X | X | X | X |  | X | 9 |
| Professional regulation |  | X | X | X | X | X | X | X |  |  | 7 |
| Practice scope | X | X | X | X | X | X | X | X | X | X | 10 |
| **Education & Training**  | Strength of professional education |  | X |  | X |  | X |  | X |  | X | 5 |
| Prior IPC and/or PHC training joining FHT |  |  | X |  |  |  |  |  | X | X | 3 |
| Ongoing formalized training opportunities at FHT  | X | X |  |  |  | X |  |  | X | X | 5 |
| IPC built into FHT training | X |  |  | X | X |  | X | X | X | X | 7 |
| **Governance**  | Governance model/ structure (mixed or provider or community) |  | X | X | X |  |  |  | X |  |  | 4 |
| Setting (Academic vs. Community FHT) |  |  |  |  |  | X | X |  |  |  | 2 |
| Multiple governing bodies |  |  |  |  |  | X | X |  | X | X | 4 |
| Conflicting goals  | X | X |  |  |  | X | X |  |  |  | 4 |
| **Political** | Leadership | X | X | X |  |  |  |  | X |  |  | 4 |
| Leverage and political influence | X | X | X |  | X | X | X | X | X | X | 9 |

**Table 4- Policy Factors That Act as Barriers to or Facilitators of IPC Collaboration**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Policy Factor Category** | **Specific Factor** | **Barrier** | **Facilitator** | **Both** |
| **Economic** | Funding |  |  | X |
| Provider payment/remuneration/incentives |  |  | X |
| **Regulatory** | Legal accountability | X |  |  |
| Professional regulation |  |  | X |
| Practice scope |  |  | X |
| **Education & Training**  | Strength of professional education |  | X |  |
| Prior IPC and/or PHC training joining FHT |  | X |  |
| Ongoing formalized training opportunities at FHT  |  | X |  |
| IPC built into FHT training |  | X |  |
| **Governance**  | Governance model/ structure (mixed or community or provider) |  |  | X |
| Setting (Academic vs. Community FHT) | X |  |  |
| Multiple governing bodies | X |  |  |
| Conflicting goals  | X |  |  |
| **Political** | Leadership  |  |  | X |
| Leverage and political influence |  | X |  |

**APPENDIX A**

**Semi-Structured Interview Guide**

***Policy Factors and Interdisciplinary Primary Health Care (IPC) Collaboration***

**Background**

Once again I would like to thank you for your willingness to participate. I would also like to remind you that if there are any questions that make you uncomfortable and you would prefer not to answer, you are free to decline answering. Also, as a reminder you are free to withdraw from the study at anytime up until April 11th, 2014, or stop the interview at any point. If you choose to do so, all you have to do is let me know that you no longer wish to continue. If you have any questions at any point throughout the interview please do not hesitate to ask for clarification.

The purpose of this study is to explore policy factors that influence interdisciplinary primary health care (IPC) team collaboration. As a recently introduced model of IPC delivery in Ontario, the Family Health Team (FHT) has been selected as a basis for the study. Thank you for speaking with me on behalf of you FHT.

Are you comfortable to proceed?

**Personal Role in FHT**

In order to provide some context, I will ask you a series of background/demographic related question.

* What is your educational background?
* How long (how many years) have you worked in your profession?
* How long have you served as an administrative/physician lead in this FHT?
* As an administrative/physician lead what are some of your major responsibilities?
* How is it that you became/was selected as team lead?
* Did you work at a different FHT prior to your current position? Where? In what capacity? For how long?

**Nature of the Role(s)**

* Please briefly describe the typical responsibilities of each of the health professions that are involved health care delivery in your Family Health Teams?

**Collaboration in the team**

Recognizing that different interprofessional teams have different approaches to collaboration, how would you characterize interdisciplinary collaboration in your team?

[Probes:]

1. Do professionals from different disciplines work well together?
2. How often do professionals interact with each other in patient care?
3. Are ‘hallway consults’ frequent in your team?
4. Do professionals ever meet with patients together?
5. How do professionals communicate with each other and how often?
6. Do you have frequent team meetings of the whole team?

**Conceptual Framework**

As we begin, I wanted to draw your attention to the conceptual framework that was sent to you along with the consent form to participate. As you can see there are 3 categories of factors that this framework suggests influence team collaboration:

* some are factors within the team, such as communication and hierarchy
* some are factors personal factors such as flexibility and openness that may be shaped by the local context and the individual’s lives
* and some are outside policy factors that affect many teams. (Some examples of policy factors include funding, financing, regulation, education and training)

I would like to focus on policy factors.

1. Do you have any initial reactions to the policy categories that are listed in the framework? (economic, regulatory, education, governance, political)

[Probes:]

* Does the list of categories make sense to you?
	+ If so, can you explain how each affects collaboration in your team?
	+ Which policy factors facilitate collaboration? Which policy factors inhibit collaboration?

Maybe we can go through them in turn:

* + **Funding**
		- Who/where does funding for the collaborative component of IPC delivery in the FHT come from? How does this influence the team? (positive/problematic)

[Please explain.]

* + **Financing**
		- Does the extent of public coverage for different services/professionals affect collaboration in the team and who does what?
		- Are there any professional services offered by your FHT that patients pay for out of pocket?

[Please explain.]

* + **Provider payment**
		- How are healthcare providers in your team paid? For example, fee-for-service, salary, sessional, other?

[Please explain.]

* + **Professional regulation**
		- Do issues of professional regulation influence the ability of FHT professionals to work together and collaborate in patient care? [Please explain].
		- Are there areas where scopes of practice affect collaboration? [Please explain].
		- Do issues of professional responsibility affect interprofessional collaboration and teamwork?
		- How does legal accountability affect collaboration in the team?
		- Are there **other regulatory or accountability concerns** that affect collaboration among team members?
	+ **Education and training**
		- How does professional education and training affect the ability of professionals to work together as a team?

[Please explain.]

* + - Are their training opportunities to educate FHT staff on interdisciplinary collaborative practice? If so, are these trainings mandatory? How often do such training take place?
* Are there any policy factors listed in the conceptual framework that you would drop from the list?

[Please explain.]

* Are there other important policy factors that affect collaboration in your team that aren’t included here?

[Please explain.]

1. To summarize, what would you say are the most important factors that influence collaboration in your team?

[Probe – if needed, for examples]

1. Has your team developed any ‘workarounds’ in order to collaborate despite the challenges posed by the policy environment?

[Please explain].

1. What level of government sets the policies that you feel affect your teams’ ability to collaborate?

[Probes:]

* Federal
* Provincial
* Municipal
* Local Health Integration Network (LHIN)
* Other?

Which of these most affects collaboration in your team?

* Do you have the opportunity to give input to those levels of government about these policies?

[Please explain.]

* **Leadership**
	+ - Who takes leadership in interfacing with policy-makers around these policy factors? [How does that play out in practice and affect collaboration in the team?]
* If there was one policy that you could change that you think would be most helpful to supporting collaboration in your team, what would it be?

[Please explain].

Thank you very much for your participation in this interview.

**APPENDIX B**

**LETTER OF INFORMATION / CONSENT**

Interdisciplinary Primary Health Care (IPC) Collaboration, Family Health Teams (Ontario, Canada)

**Investigators:**

**Local Principal Investigator:** **Student Investigator:**

Dr. Gillian Mulvale Shaghayegh Donya Razavi

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**Purpose of the Study**

Many factors influence team collaboration when different professionals work together in patient care. These factors can act to help or hinder collaboration. The purpose of this study is to explore policy factors that may influence collaboration in interdisciplinary primary health care (IPC) teams. This study will focus on collaboration among professions in Ontario's Family Health Teams (FHTs).

This research is being done as part of a Master’s thesis in the Department of Global Health at McMaster University. You are invited to take part in this study on the role of policy factors in shaping interdisciplinary collaboration in IPC care in FHTs. We hope that the study will provide further insight into successful team collaboration in the Canadian healthcare system.

**Procedures involved in the Research**

Prior to the interview you will be provided with a modified version a conceptual framework entitled “Factors that influence collaboration in interprofessional primary care teams” (Mulvale & Bourgeault, 2012). Three levels of factors are identified (policy, personal, and within team factors) however in the interview you will be asked to focus on the policy factors. This framework is provided in its entirety in order to help you understand of how policy factors fit within the whole array of factors that influence collaboration. On the day of the interview, I will contact you either in person or via telephone (as you prefer). I will ask you a series of questions addressing different aspects of IPC collaboration in your FHT. I will also ask you for some demographic/background information like your title and educational background. With your permission, the interview will be digitally recorded and I will also be taking hand-written notes. The interview is expected to last between 30-45 minutes. I may contact you after the interview for a few follow up questions for clarification.

Please see a few sample questions:

* As an administrative/physician lead what are some of your major responsibilities?
* Briefly describe a typical day in your FHT and identify and briefly describe the responsibilities of each of the health professions that are involved health care delivery in your Family Health Teams?
* Recognizing that different interdisciplinary teams have different approaches to collaboration, how would you characterize interdisciplinary collaboration in your team? (e.g. professionals are largely ‘working in parallel’, ‘consulting when required’, ‘collaborating frequently while maintaining independent care’, ‘highly collaborative’?]
* Do you have any initial reactions to the policy categories that are listed in the framework?

**Potential Harms, Risks or Discomforts**

There are no known risks to participation in this study, and you are free to choose whether you will participate. You are not required to answer questions that you do not want to answer or that make you feel uncomfortable. You can withdraw at any time without any adverse consequences up until April 11th, 2014.

**Potential Benefits**

You may benefit indirectly by knowing that your perspectives have been heard about how to improve policy to help FHT members work better together. What is learned from this study may allow us to better understand the role of policy factors in primary health care (PHC) delivery potentially influence the direction of PHC policy reform.

**Confidentiality**

Every effort will be made to guarantee your confidentiality and privacy. To ensure confidentiality, all data will be marked with a study ID number and no personal identifiers will be used in reporting results. No one besides the investigator will know whether you participated unless you choose to tell them. The direct information collected throughout this study will only be shared with my thesis supervisor. However, results of the study will be made available in the form of a thesis, and I may wish to publish these results in academic journals.

The information you provide will be kept in a locked desk/cabinet where only my supervisor and I will have access to it. Information kept on a computer will be protected by a password. Once the study has been completed, the data will be kept for a period of up to 3 years to allow for publishing and dissemination of findings. Following this 3 year period, data will be deleted and audio-recordings will be erased.

**Participation and Withdrawal**

Your participation in this study is voluntary. If you decide to be part of the study, you can withdraw, at any time up until April 11th, 2014. If you decide to withdraw, there will be no consequences to you.  If you do not feel comfortable answering any of the questions during the interview you are free not to answer.

**Questions about the Study**

If you have questions or need more information about the study itself, please contact me at:

(289) 684-9953 or razavisd@mcmaster.ca. You may also wish to contact my faculty advisor, Dr. Gillian Mulvale at **(905) 525-9140 ext. 24707** or mulvale@mcmaster.ca.

This study has been reviewed by the Hamilton Integrated Research Ethics Board (HIREB). The HIREB is responsible for ensuring that participants are informed of the risks associated with the research, and that participants are free to decide if participation is right for them. If you have any questions about your rights as a research participant, please call the Office of the Chair, HIREB at 905.521.2100 x 42013.

**I would like to thank you in advanced for your time and consideration.**

Sincerely,

Donya Razavi

**CONSENT**

I have read the information presented in the information letter about a study being conducted by (Shaghayegh) Donya Razavi, of McMaster University.

I have had the opportunity to ask questions about my involvement in this study and to receive additional details I requested.

I understand that if I agree to participate in this study, I may withdraw from the study at any time. I have been given a copy of this form.

1. I agree to participate in the study. Yes No
2. I agree that the interview can be audio recorded. Yes No

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Name of Participant (Printed) Signature Date

Consent form explained in person by:

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Name and Role (Printed) Signature Date