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A demonstration study of collaboration in primary care: Insights from physicians and psychologists

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ABSTRACT

Background: Increasing recognition of the complex interplay of biopsychosocial factors influencing health and of the inefficiencies in the delivery of mental health services in primary care emphasize the need for different health professions to work together and enhance patient-centred care.
Methods: Two psychologists were integrated into two family medicine practices in Eastern Ontario, Canada, for 12 months. Researchers observed the development of collaboration but did not facilitate it.
Findings: The type and level of collaboration that developed fits the definition of basic collaboration of on-site or co-located care models. Although physicians and psychologists had differing perspectives about collaboration, both identified two-way communication, access to and comfort in working with each other, confidence in each other's competence and mutual respect as essential for collaboration. Development of collaboration requires supportive structures and continuous facilitation.
Conclusions: The physicians and psychologists identified referral/informal consultation as an optimal model of collaboration between mental health professionals and physicians in primary care settings.

1. Introduction

Increasing recognition of the complex interplay of biopsychosocial factors influencing health and healthcare emphasizes the necessity for different health professions to work together for the greater benefit of the patient.[1–3] Collaborative mental healthcare is a concept and also a model in which healthcare providers from primary care and mental health work together to provide coordinated and effective services for patients with mental health needs. Within the context of Canadian healthcare and mental health, primary care physicians play a crucial role. Historical organization of healthcare delivery,[4–6] existing funding models for psychological care[5–8] and a multitude of other factors account for the fact that most primary mental healthcare services are provided by primary care physicians. As «gatekeepers» to healthcare for many Canadians,[9] they are often the sole providers of mental health treatments in primary healthcare.[3] However, the delivery of primary mental healthcare has not been optimal and inefficiencies have been reported.[10–16]

Patients, families, healthcare providers and researchers have long identified the need for integrating mental health and primary care services.[17] Indeed, the provision and quality of primary mental healthcare could be improved if care was provided by qualified mental health professionals working in close collaboration with primary care physicians.[2,18–20] Psychologists in particular have been identified as experts trained in assessment, diagnosis and treatment of mental illnesses and addictions, whereas physicians and other primary care providers do not always have such expertise.[13,19–21]

Psychologists have the training and skills required to work in a coordinated manner within an interdisciplinary team. Interdisciplinary teams, which include psychologists, can enable people to reduce their risk of developing a chronic illness, receive effective treatment, and lower health care costs.[22] Providing mental and behavioral health services in primary care greatly increases access for underserved people, helps eliminate stigma and increases awareness of the psychosocial aspects of health.[23–25] Despite the

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mounting evidence supporting the value of integration of psychologists in primary healthcare, psychologists have not been front and center in this integrative and interprofessional care movement to date.[24]

Interprofessional collaboration described as "an active and ongoing partnership often between people from diverse backgrounds with distinctive professional cultures … who work together to solve problems or provide services",[26] is intrinsic to collaborative care and provides an opportunity to improve access to services. Regarded as an underpinning tenet of primary healthcare it is, however, a variably understood concept, hard to implement, and is typically difficult to demonstrate in primary care settings.[27] Increasing support for interprofessional care creates a momentum for healthcare delivery organizations and academic institutions to find optimal ways for implementing interprofessional collaborative practice. While various aspects of interprofessional collaboration in primary care including impact of time, physical space and design, organisational boundaries, health professional roles, collective learning in teams, and new knowledge have received some attention in literature,[28] fewer studies have focused on mental health as a particular area of care. There has been limited feedback about which mental health care providers fit best the context of primary care and how well those providers can be integrated into the overall functioning of the primary care team.[29,30] The demonstration project described in this article makes contribution to fill these particular gaps in knowledge.

We examined the development of collaboration between primary care physicians and psychologists integrated in two community-based primary care practices. Results of this project provide unique insights into the extent and scope of collaboration that developed naturally between family physicians and psychologists in busy primary care settings, their perspectives on collaborative processes, and its perceived success.

2. Methods

This was a one-year demonstration project exploring the integration of full-time psychologists into two family medicine practices (one psychologist per practice) in Eastern Ontario, Canada. One practice (Francophone with 4 family physicians) was in a rural area and the other (Anglophone with 10 family physicians) was in an urban area. Neither physicians nor psychologists had any previous experience with interprofessional collaborative primary care practice prior to this project.

In this project, researchers only observed the development of collaboration between physicians and psychologists and did not facilitate the process. Physicians could refer patients to the psychologist in a usual manner, filling out a referral note or the patient could self-refer. Intentionally, no instructions or guidelines for the collaboration were provided; researchers delivered a brief presentation of the project to participating physicians and psychologists. The psychologists were requested to keep open hours once a week to encourage physicians to stop by and discuss care plans and other aspects of patient care and collaboration. The physicians were requested to participate in four 90-minute knowledge transfer sessions (accredited by the Canadian College of Family Physicians) delivered by psychologists every three months.

Mixed (quantitative and qualitative) methods were used in this demonstration project and are described elsewhere.[15] This article reports on the qualitative results only. Four focus groups were held separately with the psychologists and the physicians to assess the collaborative process (barriers, challenges, etc.) throughout the project. Meetings took place approximately every three to four months. The psychologists (N = 2) and the physicians from both clinics (N = 14) met separately with a group facilitator (not a research team member) to explore the dynamics and experiences associated with collaboration in their respective clinics. Individual telephone interviews were conducted with those physicians who could not join group meetings. These interviews averaged 30 min in length and were conducted by the facilitator. The interviews and focus groups were recorded and transcribed verbatim.

A content analysis was applied to data from the focus groups to identify and summarize themes and prominent aspects of content. To guide the analysis, elements of interprofessional collaboration (e.g., communication, responsibility, accountability, coordination, cooperation, autonomy, mutual trust and respect among the providers)[31] and characteristics of team effectiveness that are known to influence success of collaborative care (e.g., members seeing their roles as important to the team, open communication, and the existence of autonomy)[32] were used to develop initial codes. The focus group facilitator developed initial codes and a senior researcher (not a research team member) verified the codes. Categories and themes were then developed based on the coded segments and validated by the research team which included a family physician and a psychologist (both in active primary care practices). Discrepancies were resolved in meetings by gaining consensus. Reflective analysis conducted by the researchers followed the content analysis and was used to evaluate the trustworthiness of findings.

3. Findings

For ease of presentation of results, we have drawn on general life-cycle models[33] to identify stages of development in the collaboration between the psychologists and primary care physicians. Findings described below are thus organized according to three stages of development: inception, maturation, and return to "care as usual".

3.1. Inception phase (month 0 to month 6)

The first two focus groups took place in the inception phase of collaboration (at month 3 and 6). During this time, both physicians and psychologists reported that collaboration remained most often unstructured. This phase is characterized by concerns and preoccupations that both physicians and psychologists had about the development and the imminent end of the project. Physicians were concerned of the short duration of the study and even early in the study, apprehended the departure of the psychologists. This was likely attributed to the perceived importance of this study as an opportunity to increase access to psychological care for patients who could not afford it otherwise. Some physicians described psychologists as potential 'caregivers' not only to their patients but also to themselves and were concerned that their departure would have a negative effect on their practice (e.g., increased stress from having to handle the mental health conditions).

The psychologists described the pace of work in primary care clinics as quicker than what they were used to, and acknowledged how busy the physicians were. They reported having a higher caseload than psychologists usually have in a private practice. At the same time, they were concerned that physicians might be taking on cases that could be referred to them. They also perceived that they were intruding on the physicians' time when they desired to discuss cases with them. However, the latter concern dissipated by the end of the inception phase when they reported feeling well integrated and at ease in their work environments.

The open hours that psychologists were requested to keep at the start of the project were removed by the end of the inception phase because physicians did not take advantage of them. Physician preferred brief and casual hallway consultations instead.