spectra 131

Interprofessionality and coordinated care

2 **Interprofessionality as part of the solution to the lack of skilled workers**

Between 2017 and 2020 the FOPH implemented a support programme to promote interprofessional education and cooperation. This issue of spectra looks at the findings and recommendations that have emerged from four years of research and practical implementation – and at the way forward.

3 **When pharmacists and general practitioners form a symbiosis**

Many family doctor practices in Chur have closed in recent years. Medi Porta has developed an interprofessional business model to counteract the impending shortage of primary care. Combining the resources of pharmacies and doctor's practices allows tasks to be allocated sensibly and generates a wide-ranging service offering for the population.

4 **"Our task areas aren't strictly separate"**

Five questions for Thomas Ihde, Chief Physician Psychiatry at Berner Oberländer Spitäler fmi AG. Different professions have been collaborating closely for more than ten years in the Department of Psychiatry in Interlaken. Tasks are allocated in accordance with the individual needs of the patients.

Schweizerische Eidgenossenschaft
Confédération suisse
Confederazione Svizzera
Confederaziun svizra

Swiss Confederation

Federal Department of Home Affairs FDHA
Federal Office of Public Health FOPH

Read issue online

Interprofessionality as part of the solution to the lack of skilled workers

Between 2017 and 2020 the FOPH implemented a support programme to promote interprofessional education and cooperation. This issue of spectra looks at the findings and recommendations that have emerged from four years of research and practical implementation – and at the way forward.

"Interprofessional education is a tool. It's a tool to accomplish linkages between the education system and the health care delivery system. It is a tool to achieve better patient care. It is a tool to achieve better health for the public. It is a tool to achieve a more efficient and affordable health care system."
George E. Thibault, Institute for Medicine of the National Academies (USA)

The support programme "Interprofessionality in healthcare 2017–2012" originated from the skilled workers initiative. The question then (as now) was: How can we maintain our healthcare system so that it continues to meet needs in the future in the face of the impending lack of skilled workers? The answer is as follows: What is needed is healthcare that focuses even more intently on patients. At the same time, better use must be made of the potential for increasing efficiency. Interprofessional collaboration (IPC) makes an important contribution on both counts. Studies indicate that IPC has a direct influence on the quality of care because it is aligned with patients' needs and optimises coordination between the different healthcare professionals. It also has an indirect impact on the quality of care as a result of greater job satisfaction among the professionals because interprofessional teams work more on an equal footing instead of operating within rigid hierarchies. This means that skilled workers stay in their profession for longer, which in turn has a positive effect on the continuity of care and thus on the quality of the services provided. But IPC also helps to increase efficiency within the healthcare system because, if professionals work in a coordinated manner and as one unit, it is easier to avoid duplication.

Support programme approved

The Federal Council approved a budget of CHF 3 million for a support programme implemented between 2017 and 2020 to enable the Swiss healthcare system to benefit from IPC. The programme focused not only on research (e.g. to improve the scientific basis of care) but also on practical aspects (e.g. the compilation of good-practice models) and generated a wide variety of results. A total of 18 research projects were funded. They included a cost-benefit analysis of interprofessional collaboration and a study of the potential of interprofessional education. Although the programme produced some fascinating findings, it is difficult to derive definitive answers because a patient's well-being or successful teamwork in a hospital depends on a large number of other factors in addition to good IPC. So, for example, there is no final answer to the question of whether IPC is less expensive overall. While costs do not appear to be an obstacle – at least in the inpatient setting – the results do show that the rate of staff fluctuation is lower in interprofessional teams.

In the second area, practical implementation, the main aim of the support programme was to increase the visibility of good-practice models and networking between the different players. At the start of the programme, the FOPH called on interested professionals to present models exemplifying the successful implementation of interprofessional education (IPE) and IPC in the everyday medical setting. Interest was so great that a directory providing profiles of the models, activities and tools was created on the FOPH website. It now has nearly 80 entries. The directory will be continued beyond the end of the research programme so that it can continue to provide stakeholders interested in interprofessionality with ideas in the future. Some of these models were portrayed in depth in two publications. They show how collaboration between different professionals (and beyond) can succeed and how IPE is lived out.

Four policy briefs

Another important outcome of the programme was the four policy briefs for the areas of inpatient and outpatient care, the psychiatric-somatic interface, and training. Each policy brief summarises the major findings from four years of research and the recommendations that can be derived from them. "It was important for us that these recommendations were developed jointly with the stakeholders and can now provide guidance or a basis for the next steps," explains Cinzia Zeltner, a member of the scientific staff at the FOPH and the project lead.

Healthcare professionals need to learn early on how to interact with other professions. (Note: this photo was taken before the pandemic.)

"Whether in a hospital, a doctor's practice, an old people's home or a nursing home, IPE and IPC must be both practised and promoted by management."

Yet, after four years of the support programme, one question remains to be answered: what is now needed to establish IPC more firmly in the healthcare system? One major factor in ensuring success here is initial and continuing training and professional development. Healthcare professionals need to learn early on how to interact with other professions. They must learn to speak a common language, develop a common stance and recognise the problems at the interfaces. "All healthcare professionals consequently need to be taught this subject while they are training," explains Lara De Simone-Nalotto, a scientific project assistant at the FOPH. Things have certainly changed for the better in this respect over the past few years, but it will take years, if not decades, for the change to have an effect in practice. In the context of life-long learning, IPE needs to become an integral element of continuing training and professional development so that collective skills are developed continuously (e.g. during in-service training).

Leadership also plays an important role because progress is only possible if leaders are willing to drive interprofessionality. Whether in a hospital, a doctor's practice, an old people's home or a nursing home, IPE and IPC must be both practised and promoted by management. This is the only way in which interprofessionality can succeed in the everyday work situation.

It is clear that this topic will continue to play an important role in the future – the impending shortage of skilled workers will be a problem in the Swiss healthcare system for many years to come, and the results of the support programme show that successfully implemented IPC can help to mitigate the problem.

Contacts:
Cinzia Zeltner and Lara De Simone-Nalotto, Healthcare Professions Division
interprofessionalitaet@bag.admin.ch

Links:
Link to the support programme: https://tinyurl.com/56fs4ncw

Online directory of good practice models: https://tinyurl.com/sy6rpwyc

When pharmacists and general practitioners form a symbiosis

Many family doctor practices in Chur have closed in recent years. Medi Porta has developed an interprofessional business model to counteract the impending shortage of primary care. Combining the resources of pharmacies and doctor's practices allows tasks to be allocated sensibly and generates a wide-ranging service offering for the population.

The gleis d ("platform d") medical centre is right next to the station in Chur. Doctors have set up various practices on the top three floors. Nothing unusual there. The unusual feature is Medi Porta on the ground floor. This is an interprofessional advice and treatment centre – something that a biologist might well refer to as a symbiosis of pharmacy and family doctor practice. And something that, according to the Medi Porta website, "combines the advantages of a pharmacy with those of a doctor's practice".

"We have found room for a retail area, workplaces for the pharmacists, two treatment rooms for general practitioners, a room for X-rays and a laboratory, all in the space of 170 square metres," says Christoph Quack, the medical director of Medi Porta. Space constraints mean that the pharmacy's medicines are stored in the basement; a robot automatically retrieves them as needed.

A shortage of primary medical care

The new business model was a matter of urgency, Quack says. Between 2008 and 2015 the number of consultations with general practitioners at the gleis d medical centre almost doubled. One of the main reasons for this was that many general medical practices closed in Chur when the doctors retired. In 2015, Grisomed, the doctors' network in the canton of Graubünden, warned of an impending shortage of primary medical care. "We knew that we would be getting more patients – and that we could only provide care for a limited number of people with an additional practice," Quack says.

This gave rise to the idea of working with a pharmacy that would provide advice to people as their first point of contact, and triage them at the same time. "If somebody has cystitis, for example, we talk to them and use an established algorithm to find out whether we can dispense antibiotics straight away, or whether we need to refer that person to a doctor," says Barbara Caratsch, a pharmacist and manager of Medi Porta.

Caratsch says that many people are glad to be able to talk to a doctor about their problem right away. The two practices behind the pharmacy area have 30-minute appointments available every day that can be booked by Caratsch and her colleagues. She says that it is also advantageous for the pharmacists to be able to refer people immediately if needed. "When the person returns, I find out straight away what was discussed with the doctor," she says.

An enriching exchange

Quack also sees many advantages in this symbiosis. For example, "Since we've had our own medicine experts on hand, we haven't had to talk to pharmaceutical sales reps." Quack had initially hoped for even closer collaboration – he would have liked, for example, to discuss patients' medication schedules with the pharmacists. "But unfortunately this didn't turn out to be possible," he says. In everyday practice, there is often simply not enough time to get together and talk.

Pharmacy assistants and the practice assistants do, however, engage in a lively exchange. The people working in the pharmacy benefit from insights into aspects of medicine such as the evaluation of blood results from the laboratory, or interpretation of heart activity recorded on ECGs, Quack explains. At the same time, the people working in the practice benefit from the proximity to the pharmacy, and a reciprocal understanding of the different philosophies has developed during the four years since Medi Porta was set up. "We see people as patients, the pharmacists see them as customers," Quack says. He has found that approaching the patient as a customer also results in greater service orientation. "As a patient, it's often complicated to get medicines delivered to your home from a doctor's practice. But that's the standard approach for a pharmacy," he says.

This service orientation has also given rise to the low-threshold "advice at the customer's level" which Medi Porta promises on its website and which focuses on the customer's individual needs. As its name suggests, Medi Porta's doors are open to everyone during business hours, even without an appointment.

The "platform d" medical centre seems to have made a virtue out of necessity. It offers a full range of care, from advice and diagnosis to treatment, in one place. "The close networking between pharmacy and medical practice allows us to allocate tasks more effectively – and people get exactly what they need at a particular moment in time," Quack concludes.

At the Medi Porta Interprofessional Counselling and Treatment Centre, you can drop in anytime during business hours without an appointment.

Link:
https://www.mediporta.ch/

At first hand

Bernadette Häfliger Berger
Head Healthcare Professions Division

Focusing on the patient's view

The central focus of interprofessional collaboration (IPC) is the way patients see things. What are their needs? What treatment outcome does the individual want to achieve? To what extent do they want and are they able to be involved in taking decisions? A rethink is required if people are to be provided with optimum, comprehensive care. The central issues are the following: what does a person need at this moment in time, and what can the various healthcare professionals with their specific skills contribute?

I believe that the aim of IPC must be to determine a treatment pathway and a treatment goal in conjunction with the patient, and then to analyse which professional can best cover which aspect. The emphasis must not be on professional considerations. Rather, the knowledge and abilities of the professionals involved should determine who takes which decisions and performs which tasks. We need to think not in terms of professions but in a patient-centred manner. With people who have multiple, perhaps chronic diseases, in particular, it's important not to treat them disease by disease but to maintain a focus on the individual as a whole. It's important for each professional to contribute their view on an equal footing, to accept responsibility and in this way to play a shared part in achieving a successful treatment outcome.

I hope that in future the many building blocks that the FOPH has developed over a four-year period as part of the "Interprofessionality in healthcare 2017–2020" support programme will be deployed by the different stakeholders and implemented in everyday practice. The subject of IPC will remain important – not only for the healthcare system in Switzerland but also for the FOPH in the context of the Strategy 2030, for example. We see two main aims of this strategy, which has been approved by the Federal Council: one is the aim of "ensuring care and funding", the other of "improving the quality of care". I am convinced that the knowledge and experience generated by this support programme can help us to achieve these objectives.

“Our task areas aren’t strictly separate”

Five questions for Thomas Ihde, Chief Physician Psychiatry at Berner Oberländer Spitäler fmi AG. Different professions have been collaborating closely for more than ten years in the Department of Psychiatry in Interlaken. Tasks are allocated in accordance with the individual needs of the patients.

Dr. Thomas Ihde, Chief Physician Psychiatry at Spitäler fmi AG in Interlaken

1 Mr. Ihde, how did interprofessional collaboration develop at your hospital in Interlaken?

When I started here in 2008, there were 14 people working in Psychiatry. Today we have 150 employees. The team includes not only doctors, psychologists, nurses, social workers and art and music therapists but also peer support workers. These are people who have already experienced mental health problems in their own lives – one of the things they do here is to ensure that we all have the patients’ perspective at the front of our minds at all times. These peers ensure that everyone in the team is always asking themselves one question: “What would I wish for in this situation?” To be understood is a large part of the answer.

2 Does the lack of psychiatrists in rural areas also play a role?

It can indeed be difficult to recruit doctors in the Bernese Oberland region, in spite of the wonderful view of the mountains. But we knew from the outset that we have a mandate to provide healthcare for the region and must carry it out. This is why we moved away from the traditional ideas of professions with clearly defined and distinct role models. We decide who performs which tasks in the course of treatment not on the basis of management hierarchies but by taking patients’ needs as the starting point. We provide person-centred services.

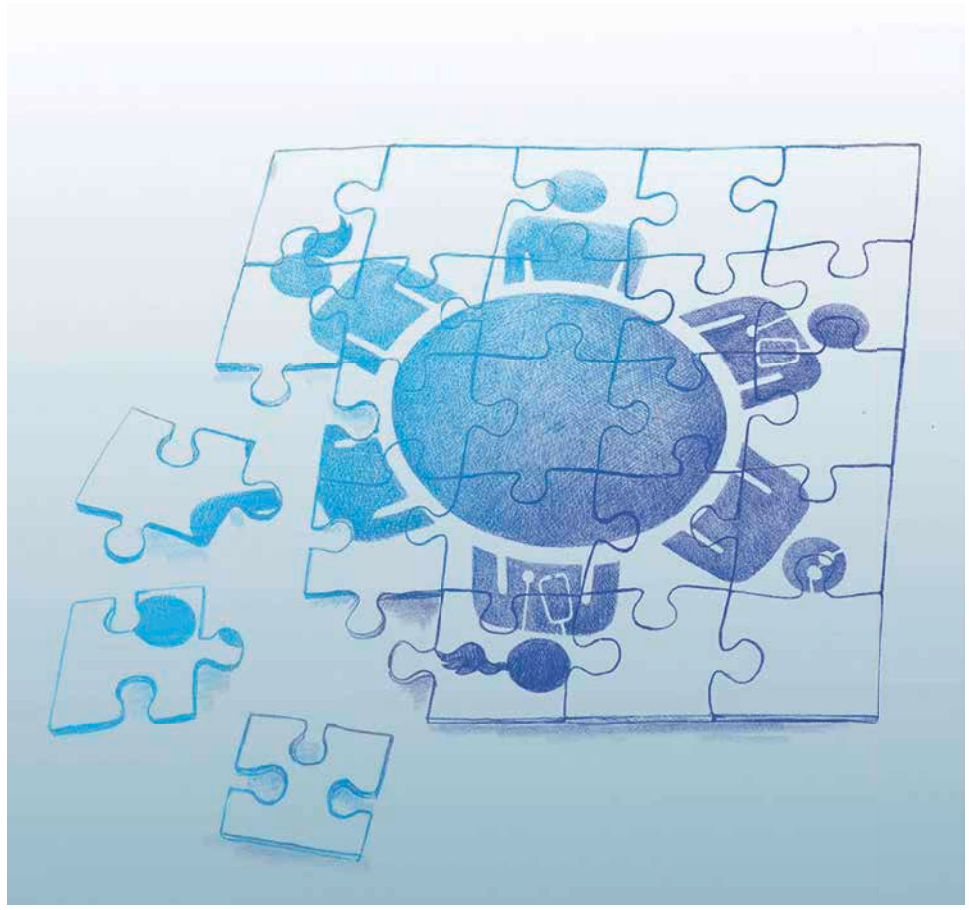
3 What does the person-centred approach look like?

Imagine you’ve been lying awake at night for weeks and at some point, you call our number. You’ll be talking to a member of our triage team. These people have different professional backgrounds, but one thing they all have in common is a great ability to listen. It won’t take them long to find out whether you need treatment and, if so, which type. If you are treated here, most of your care will be provided by a case leader who is part of our team. The case leader will involve other people as necessary. The case leader is the “conductor” who guides all the other people in the team, like in an orchestra.

4 What do you feel are the advantages of this type of fluid division of labour?

There is usually not much difference between the things a psychotherapist and a doctor do during treatment. The human aspect – the ability to establish a relationship – plays a much greater role than the professional aspect, which makes up maybe 20 per cent of the treatment. We usually consult doctors if the patient has physical health problems in addition to their mental health needs. If someone has damaged kidneys, for example, and needs dialysis, we have to look very carefully at which psychoactive drugs they can take.

We don’t have a fixed range of tasks; we provide complementary expertise so that we can respond to the patient’s needs as well as possible. This leads almost automatically to cooperation on an equal footing. If care is organised differently for each case and indeed is changing all the time, the power dynamic tends to become a bit smoother. At the same time, though, there is no avoiding the fact that unfavourable dynamics and deprecation on a micro level do occur. Patients repeatedly reproach psychologists for “simply not being doctors”. And our current salary system unfortunately doesn’t do justice to the principle of equal pay for equal work.



Professionals from different areas of healthcare together form an interprofessional treatment team.

5 What are the challenges posed by this division of labour?

In comparison with other sectors – finance and insurance, for example – people working in the healthcare system have a very conservative attitude. In healthcare you’ll come up against rejection or resistance much faster if you question time-honoured practices and try to change them. In addition, Switzerland lags far behind the English-speaking countries in terms of empowering the non-medical professions. The United Kingdom, for example, has long had “nurse practitioners”, in other words nurses with an expanded skill set, who can do things like listen to a patient’s lungs without the need for a doctor. Our fluid working model promotes adaptable all-round employees – and to some extent it allows us to ward off the general trend towards increasing professionalisation and specialisation in the healthcare system.

Contact:
Dr. Thomas Ihde, Chief Physician Psychiatry at Spitäler fmi AG in Interlaken. thomas.ihde@spitalfmi.ch

Impressum: spectra 131, October 2021

spectra is a newsletter of the Federal Office of Public Health published four times a year in German, French and English. Some of the views expressed in it may diverge from the official stance of the Federal Office of Public Health.
Published by: Federal Office of Public Health (FOPH), CH-3003 Bern,
tel. +41 (0)58 463 87 79,
fax +41 (0)58 464 90 33
Realisation: Adrian Heuss, advocacy ag
Head of Editorial Board: Adrian Kammer, adrian.kammer@bag.admin.ch
Editorial Board: Rahel Brönnimann, Claudia Brunner, Lea von Wartburg, Selina Lusser-Lutz, Daniel Dauwalder
Contributors: advocacy ag, members of staff of the FOPH, as well as external authors, Ori Schipper
Photos: authors, telek.grafik (illustration p. 4), Fotolia, iStock by Getty Images
Layout: bom! communication ag, Basel
Printed by: Büetiger AG, 4562 Biberist
Print-run: German: 5,000, French: 2,500, English: 800.
Individual issues and free subscriptions to spectra can be ordered from: Bundesamt für Gesundheit, Sektion Gesundheitsinformation und Kampagnen, 3003 Bern, kampagnen@bag.admin.ch

www.spectra-online.ch