Collaborative practices between GPs and secondary care specialists: a review of barriers and enablers

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5 – 7 June 2024 - Bucharest, Romania
Politehnica University of Bucharest, Bucharest, Romania
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Topic’s relevance

Since ...
- Shift towards proactive and preventive medicine

...and...
- Considering multiprofessionals groups
- Improve hospital-community relationship

Interprofessional collaboration in healthcare is typically described as an active and ongoing partnership between professionals from various backgrounds and distinctive professional cultures, who may represent different organizations or sectors, working together to provide services that benefit healthcare users (Morgan et al., 2015).
Research methodology

Research question

Which are the enables and constrains that affects the redesign of governance mechanisms and operational structures in the collaboration between primary and secondary care physicians (community and hospital)?
Research methodology

**Database search:** PubMed, Scopus, Web of Science (extraction date: March 2024)

**Keywords:**

- **TITLE-ABS AND**
  - collabor*
  - integr*
  - coordin*
  - inclusi*
  - interaction*
  - relation*
  - link*
  - team*
  - govern*
  - institution*
  - regul*
  - operation*
  - manage*
  - strateg*
  - develop*
  - Healthcare
  - health AND care

- **AND NOT government**

- **ALL AND**
  - general AND pract*
  - family AND pract*
  - office AND visit*
  - primary AND care
  - primary AND health*
  - multiprofess*
  - interprofess*
  - interdisciplinar*
  - transdisciplin*
  - secondary AND care
  - specialist*
  - community
  - Barriers
  - Constrains
  - Challenges
  - Cons
  - Limitat*
  - Enables
  - Facilitators
  - Empowers
  - support*
  - Pro
  - enhancers

**Database search:** PubMed, Scopus, Web of Science (extraction date: March 2024)
Research methodology

Inclusion criteria

1. Qualitative and quantitative studies
2. Focused on the relationship between GPs and secondary care
3. Language: Italian and English

Exclusion criteria

1. Focused only on primary or secondary care
2. Focused on the figure of the nurse
3. Integration with non-healthcare figures (e.g., social workers) or pharmacists
4. Full text not available online OA
5. No abstracts, conference posters, study protocols, reviews or open forums were selected
Results

PRISMA Model

- Total records identified: 2,471
- Total records included: 28
- Main reasons for the exclusion:
  - Focus on collaboration between doctor and patient at different levels of care
  - Interrelationships at the same care level
Preliminary analysis

1. Publication year

2. Place of the study

North America; 10
Europe; 14
Australia; 1
Asia; 2
South America; 1
Preliminary analysis

1. Type of studies

- **Qualitative (57%)**
  - Interviews (9)
  - Case study (4)
  - Focus Group (1)
  - Document analysis (1)
- **Mixed (18%)**
  - Interviews
  - Case study
  - Focus Group
  - Survey
- **Quantitative (25%)**
  - RCT (1)
  - Retrospective study (2)
  - Survey (4)

2. Clinical field/disease

- **Mental health (29%)**
  - Pediatrics (1)
  - Dementia (1)
  - Generic (8)
- **Other (32%)**
  - Fibromyalgia (1)
  - Infectious diseases (1)
  - Osteoporosis (1)
  - Palliative care (1)
  - Rare (1)
  - Generic (5)
- **Chronic diseases (39%)**
  - Cancer (3)
  - Diabetes (2)
  - Palliative care (1)
  - Generic (8)
  - Rare (1)

3. How many studies provide structured model(s) of interprofessional collaboration?

- **Yes (39%)**
- **No (61%)**
## Results

### Institutional characteristics

<table>
<thead>
<tr>
<th>Enablers</th>
<th>Barriers</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1.</strong> Aligned incentives for collaboration (insurance reimbursement and technologies)</td>
<td><strong>1.</strong> Non-remuneration and coding of e-health activities (teleconsultation)</td>
</tr>
<tr>
<td><strong>2.</strong> Insight into manner of working (best practices)</td>
<td><strong>2.</strong> Patients’ choice of specialists (unstructured referral networks)</td>
</tr>
<tr>
<td><strong>3.</strong> Case and disease management programs</td>
<td><strong>3.</strong> Administrative burden</td>
</tr>
</tbody>
</table>
## Results

### Organizational characteristics

<table>
<thead>
<tr>
<th>Enablers</th>
<th>Barriers</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Validated innovative paths for communication</td>
<td>1. Uncompleted critical clinical information (referrals)</td>
</tr>
<tr>
<td>2. Co-location</td>
<td>2. Not having access to joint clinical case conferences / multidisciplinary groups (shared decision making)</td>
</tr>
<tr>
<td>3. Resource sharing</td>
<td>3. Absence of clinical management mechanisms for standardization (e.g. clinical guidelines)</td>
</tr>
<tr>
<td>4. Definition of common objectives</td>
<td></td>
</tr>
<tr>
<td>5. Organizational culture</td>
<td></td>
</tr>
<tr>
<td>6. Structured management plan</td>
<td></td>
</tr>
</tbody>
</table>
Results

**Individual characteristics**

<table>
<thead>
<tr>
<th>Enablers</th>
<th>Barriers</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Mutual trust and mutual knowledge</td>
<td>1. Undefined roles and identity</td>
</tr>
<tr>
<td>2. Decision-making autonomy</td>
<td>2. Lack of training</td>
</tr>
<tr>
<td>3. Involvement in active surveillance</td>
<td>3. Feeling of helplessness towards the system</td>
</tr>
</tbody>
</table>
Implications

Institutional
- Define remuneration consistent with collaboration needs
- Speed up review of performance coding for bundle payments
- Encourage pilot projects and the introduction of communications technologies

Organizational
- Encourage the creation of clinical pathways that include:
  - frequent standardized communications
  - colocation and sharing of resources
  - the clear definition of roles and autonomy
- Encourage mutual knowledge through training
- Bottom-up "listening".

Individual
- Collaboration with managerial levels to promote bottom-up logic
- Proactive approach to service innovation
Thank you!
Your advice is welcome

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