

EDITORIAL

## Interprofessional collaborative practice and relational coordination: Improving healthcare through relationships

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### INTRODUCTION

Interprofessional collaborative practice (IPCP) and relational coordination (RC) are two concepts with much in common. IPCP is a concept that is familiar to many readers of this journal but the definition is worth repeating in order to consider its connection to RC. As stated in the WHO Framework for Action (WHO, 2010), interprofessional “collaborative practice happens when multiple health workers from different professional backgrounds work together with patients, families, carers and communities to deliver the highest quality of care. It allows health workers to engage any individual whose skills can help achieve local health goals” (p. 7).

RC is defined as “a mutually reinforcing process of communicating and relating for the purpose of task integration” (Gittel, 2002, p. 300) or more simply as “coordinating work through relationships of shared goals, shared knowledge and mutual respect” (Gittel, 2006, p. 74). After this concept first emerged from a study of flight departures within the commercial aviation industry (Gittel, 2000, 2003), its applicability to another highly interdependent, uncertain and time-constrained work process – patient care – became apparent (Gittel et al., 2000). RC is measured as a network of communication and relationship ties among workgroups engaged in a common work process (Figure 1) – for example, flight departures, patient care, the transfer of patients from the operating room to the intensive care unit or their discharge across organizational boundaries, for example, from the hospital to the community. It is a validated measure based on seven survey questions, including four survey questions that assess the frequency, timeliness, accuracy, problem-solving nature of communication and three survey questions that assess the quality of the underlying relationships – in particular the degree of shared

goals, shared knowledge and mutual respect. The overlap between RC and IPCP is obvious, particularly their common focus on sharing, respect and communication.

RC is also a theory about how people and organizations work. According to the theory, and as supported by the evidence, higher levels of RC produce higher levels of quality and efficiency performance by enabling participants to manage their task interdependencies with fewer dropped balls and less wasted effort (e.g. Gittel et al., 2000; Gittel, 2002, 2003). RC also improves job satisfaction by enabling participants to effectively carry out their work, and by providing the social support to enable their resilience in the face of stress (Gittel, 2008; Gittel, Weinberg, Pfefferle & Bishop, 2008).

The organizational structures that predict high levels of RC are those that connect across workgroups rather than reinforcing the silos that separate them (Gittel, Seidner & Wimbush, 2010). The theory, therefore, calls for organizations to replace traditional bureaucratic structures with more relational structures – such as hiring and training for cross-functional teamwork, cross-functional conflict resolution, cross-functional performance measurement and rewards, cross-functional boundary spanners (such as case managers or care coordinators), cross-functional protocols (such as clinical pathways) and cross-functional information systems (Gittel & Douglass, 2012).

But communication and relationship patterns are deeply embedded in professional identities and organizational cultures, and not easily changed. What are the leverage points for changing these patterns? The Relational Coordination Research Collaborative was formed in 2011 to bring scholars and practitioners around the world together to transform these deeply embedded patterns of interaction. These transformational efforts are captured in the Relational

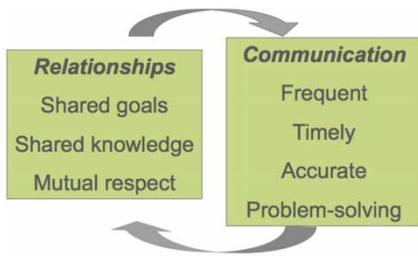


Figure 1. Relational coordination.

Model of Organizational Change (Figure 2), which identifies relational, structural and work process interventions as leverage points for changing deep-seated patterns of interaction (Gittell, Edmondson & Schein, 2011).

Clearly, IPCP and RC have much in common. The core values of both IPCP and RC include the provision of the best possible care through optimal communication between all participants involved in that care including professionals and support staff as well as patients and their families. Both approaches stress the need to build shared goals, shared knowledge and mutual respect across professional boundaries. However, the interprofessional literature tends to focus mainly on practice at the level of individual practitioners within their teams or on looser alliances in clinical practice. The interprofessional literature has also focused on education and “learning together to work together,” often from an atheoretical standpoint (Hean, Craddock & O’Halloran, 2009). IPCP uses language such as common goals and shared values, while RC also describes task integration and organizational change.

We see tremendous potential for these two conversations to connect to provide more powerful solutions to the challenges we currently face – (1) achieving high-quality cost-effective care as required by all current healthcare reforms, (2) achieving person- or relationship-centered care

and (3) learning to work better together through the redesign of professional education.

**WHAT WE CAN LEARN BY INTEGRATING THESE TWO APPROACHES**

**Achieving high-quality cost-effective care**

In health systems around the world, the focus of current reform efforts is to achieve higher quality, more cost-effective care. The motivation for these efforts is the rise of healthcare costs due to the aging of the population and the increase in chronic illness. Policy-makers and leaders are beginning to converge on a core set of solutions, most of which call for increased coordination among care providers across professional boundaries. IPCP, with its focus on learning to work together, is helping to transform our education and training systems to produce the professionals and non-professionals who can make these proposed reforms a reality.

RC theory can help by (1) providing an evaluation tool to measure baseline relational coordination and the new relational coordination dynamics that result from new ways of educating care providers and from other interventions; (2) providing a way to assess the impact of relational coordination on critical performance outcomes such as quality, efficiency and worker well-being and (3) informing the transformation of healthcare systems to reinforce and support the new patterns of RC rather than putting care providers back into their old silos, thereby wasting educational investments that have been made.

**Person and relationship-centered care: Patient inclusion in interprofessional teams**

Fundamental to high performing front line teams are the focus and inclusion of patients and families in all aspects of care delivery and design. Interprofessional care teams around the world are increasingly experiencing the benefits of full partnership with all people involved in healthcare

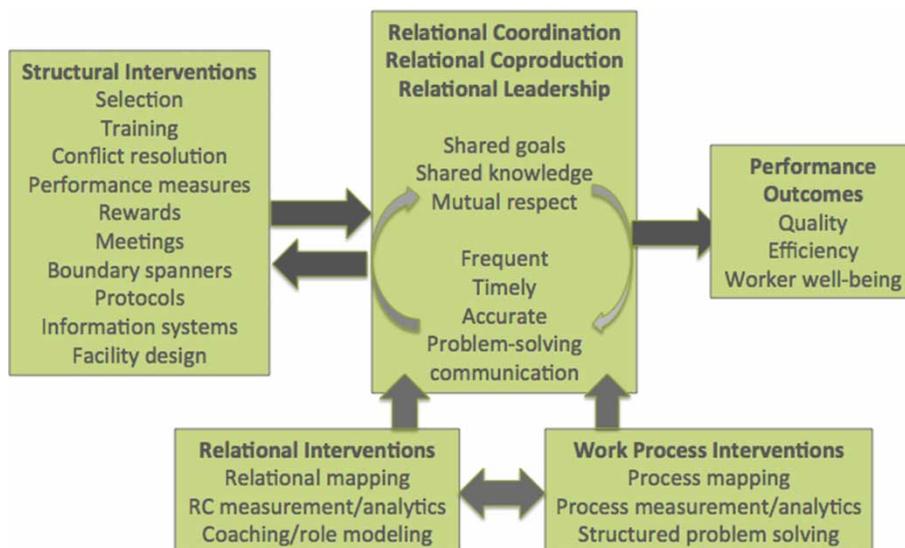


Figure 2. Relational model of organizational change.

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delivery systems. There is increasing evidence of the involvement of interprofessional care teams in person-centered care including:

- Creation of patient advisory boards in healthcare organizations aimed to partner in the design and improvement of care delivery in the USA (Institute for Patient and Family Centered Care <http://www.ipfcc.org/>),
- Individual care units including patients and families in the assessment and improvement of care (e.g. Cystic Fibrosis Foundation <http://www.cff.org/> and Vermont Oxford Network <http://www.vtoxford.org/>),
- Development of technology including supportive computer programs and patient registries to co-design care with patients and families through sharing of patient reported outcomes and experience measures (Hvitfeldt et al., 2009). Research of registry data (Rosengren, Höglund & Hedberg, 2012) combined with co-design by an interprofessional team including patients has resulted in a self-dialysis unit in Ryhov Hospital in Jönköping Sweden (Ageborg, Allenius & Cederfjäll, 2005).

Multiple forces are thus currently in play to increase the use of interprofessional teams and person-centered care. Academic development and research specific to interprofessional teams and patients includes an annual interprofessional meeting that includes patients as full participants at the Summer Institute for Informed Patient Choice at the Geisel School of Medicine at Dartmouth (<http://www.tdi.dartmouth.edu/centers/informed-choice/siipc>). Led by Dale Collins Vidal, the July 2012 meeting theme focused on measuring shared decision making in practice including faculty thought leaders Elliot Fisher, Glyn Elwyn, Susan Edgman-Levitan, Al Mulley and Chris Trimble. The Affordable Care Act in the USA includes making every preference-sensitive decision an informed patient decision using patient decision aids in the flow of care delivery. The “meaningful use” electronic medical record requirements of patient engagement and shared decision making will further mesh interprofessional teams and patients in the processes of care delivery, design and improvement to result in high value care delivery.

How and why are interprofessional teams connected to person-centered care? Evidence thus far suggests that RC among care providers promotes improved relationships with patients (Gittell, 2002), as well as with family members (Weinberg, Lusenhop, Gittell & Kautz, 2007). A series of studies are now beginning to explore this important dynamic in greater depth, asking whether and how RC among care providers foster relational coproduction between care providers, patients, families and the broader community, where both are characterized by relationships of shared goals, shared knowledge and mutual respect, with early results that are promising (Frosch et al., 2012).

### Learning together to work together

The premise of interprofessional education is that learning “with, from and about” other professionals, either pre or post qualification, will enable practitioners to work more

optimally together either in well-defined teams or in looser collaborative groups. The literature focusing specifically on IPE activities has so far not shown conclusive proof that such learning together does in fact enhance the quality and outcomes of working together. The extensive literature focuses predominantly on the development and delivery of education with any evaluation mainly concerned with participant reaction rather than impact (short or long term), including changes in behavior (Thistlethwaite, 2012). As noted above, critics also note that the activities are rarely informed by educational and/or psychological theories (Hean, Craddock & O’Halloran, 2009). Relational coordination offers a tool to assess the impact of interprofessional education on patterns of coordination. Relational coordination also offers a theory to inform curriculum design, and to inform the design of structures that support the new patterns of coordination.

If we turn our gaze to other industries and disciplines, there is an extensive literature on teamwork outside healthcare settings as well as evidence within such settings from an organization’s perspective. The experience of the aviation industry is often referenced in this regard. While healthcare educators stress the increased complexity of working within the more uncertain clinical environment, there is evidence that crew resource management training has a role in healthcare teamwork training under certain conditions (Zeltser & Nash, 2010). In the business world more broadly, there are clear indications of how and why teams dysfunction (Edmondson, 2012; Gittell, 2003; Lencioni, 2002). Given the origins of RC in the aviation industry and its application across industry settings, RC theory can contribute to this sharing of insights.

### CONCLUDING COMMENTS

The recent announcement of major funding by the American Health Resources and Services Administration to develop a national health education centre, the focus of which will be team-based care, is to be welcomed as a step toward enhancing the research agenda for IPCP. This initiative is likely to foster education and patient care that is not only interprofessional but interdisciplinary and cross-sectoral as well. To support this new centre, scholars and practitioners representing IPCP, RC and social construction perspectives have come together to form the Collaborative Care Alliance. On the whole, we conclude that bringing RC and other perspectives to bear on the advancement of IPCP is a positive development that we should embrace.

### Declaration of interest

The authors alone are report no conflicts of interest. The author alone are responsible for the content and writing of this paper.

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