Teamwork:

A fundamental principle of primary health care and an essential prerequisite for effective management of chronic conditions

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ABSTRACT

Effective interdisciplinary working, in which teams of competent health professionals combine their skills to provide comprehensive care for individuals and populations, is one of the essential underlying principles of primary health care. Chronic condition management is a significant component of the primary care service workload; principles of proven good management closely align with those of primary health care. Teams that are both safe and effective have a number of key characteristics: clear objectives, clear role definition, clear respect for each other's roles and adequate time for teamwork. Teams must also be supported with good organisational and funding structures.

Key words

Teamwork; primary health care; chronic conditions

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'Teamwork implies co-operation rather than conflict and involves social relationships...it [also] implies that solutions to problems can be worked out as a group rather than by individuals.'[1]

Primary health care is an encompassing concept of health that integrates all aspects of health care, and no more so than in the care of the large and increasing number of those with one or several long-term, chronic conditions. Primary health care is underpinned by principles of social justice and equality, self-responsibility, international solidarity, and acceptance of a broad concept of health.[2,3] Health systems which incorporate all or most of these principles have come to be known as primary care–led systems, with the narrower term primary care being used to denote an evolution from primary medical services to primary health service provision. Primary care–led systems have been repeatedly shown to provide better care, and better health outcomes, at lower cost, than secondary care dominated systems.[4]

Primary care services have four essential characteristics:

- They are the first point of contact with the health system
- They provide comprehensive care
- They continue over time, and
- They are well-coordinated, both between different primary care providers and services and between primary and secondary care health services.[5]

There is a commitment to the person and their ongoing health (rather than to a particular body of knowledge, or group of diseases or special technique), in a spirit of self-reliance and self-determination, and where the context of health and illness is also understood within family, peer group, community and society. This commitment to understanding the health and well-being of not only individuals but also community and society, necessitates a well-coordinated, population-based approach in primary care, with effective teamwork and interprofessional working underpinning successful and sustained delivery of best practice patient care.

An excellent example of the international prominence now given to

enhanced interdisciplinary collaboration through teamwork comes from the Enhanced Interdisciplinary Collaboration in Primary Health Care (EICP) Initiative in Canada. Five key principles to guide enhanced collaboration between health professionals have been widely agreed and well described; the interrelated principles highlight the importance of:

- Patient/client engagement
- A population-based approach
- Best possible care and services
- Good access to services
- Trust and respect among health professionals, and
- Effective communication.

A framework based on these principles now guides a wide range of Canadian health organisations and professional associations, including those representing family physicians, nurses, pharmacists, occupational therapists and physiotherapists. Human health resources (the health workforce) are recognised as a core element of this framework; and the need to work in effective teams is considered essential to maximise the skill sets and competencies of all health professionals for the benefits of patients.[6]

So what characterises an effective team?

The characteristics of effective teams have been recognised and described many times and in many settings, including primary care. Although the emphasis varies slightly from setting to setting, effective teams share consistent features about clear objectives, clear role definition and adequate time for teamwork (Box 1).

Conversely, repeatedly identified common barriers to effective team working include:

- Lack of team definition
- Lack of shared goals and task definition
- Lack of time for meeting and feedback
- Lack of leadership
- Poor communication between team members
- Lack of training to work in teams
- Hierarchical structures
- Inaccurate professional stereotypes, and
- Perceived inequalities in status.[9-12]

Good team processes have been shown to reflect team effectiveness. If there are shared team objectives, participative safety (where there is mutual respect for all opinions and ideas), time for open communication, emphasis on quality, and support for innovation, then organisational efficiency, good health care practice, patient-centred care and enhanced job satisfaction and enjoyment for team members will follow.[13]

The management of chronic conditions in primary care

Chronic illnesses and/or long-term conditions are those which limit what a person can do for at least a year, but are often lifelong and/or may be controlled but not cured. The principles of primary health care and the associated provision of comprehensive primary health services are particularly important and increasingly relevant for those with chronic, long-term conditions. They directly align with the key components of effective models of chronic care.[14] Effective interdisciplinary teamwork that can be sustained over time has been shown to greatly improve the coordination of care for people with complex conditions and variable, but ongoing, health needs.[15]

They represent a large and increasing health burden for society globally and locally. In New Zealand chronic conditions already create a large part of the day-to-day work in primary and secondary care; they are the leading cause of illness and account for more than 80% of deaths.[16] All people with chronic conditions benefit from early diagnosis and a structured form of management (including self-management), well-coordinated pro-active care and careful ongoing follow-up.[17] Such care not only improves patient, caregiver and family quality of life and health status, but also reduces numbers of unplanned acute care visits and hospital admissions.

Despite this knowledge, health systems worldwide have struggled to provide recommended care to many people with chronic conditions. In New Zealand, difficulties with access to primary care services, high rates of preventable hospital admissions and poor coordination between health professionals and with social services have been clearly identified as obvious deficiencies.[18] Comprehensive and integrated action also is recognised internationally as required not only for control, but also the prevention of chronic diseases.[19]

Supporting more effective teamwork

A broad, population-based approach to primary health care has been heavily promoted in New Zealand since 2001 with the introduction of the Primary Health Care Strategy.[20]

Box 1. Characteristics of effective teams[6-8]

- Clear and appropriate shared objectives, team goals and tasks
- Built-in feedback about performance
- Clearly articulated roles, responsibilities and identifiable tasks for each member of the team
- Understanding of and respect for all team members, not only of their own role but also the roles of the other members of the team
- Dedicated time for meetings, feedback and negotiation about clear role definition within the team
- Appropriate leadership with open communication
- Manageable size

While the strategy has regarded multidisciplinary teams as essential for effective delivery of primary health care and primary care services, there has been poor alignment of health and social system structures. Funding models neither support, nor actively promote, interdisciplinary primary service/secondary service/social service team working as the norm. Team working is not necessarily the easiest way of working despite its theoretical and practical advantages; all or most of a number of supportive precursors need to be in place. (Box 2)

Responsibility for ongoing workforce development needs to be acknowledged at all levels of organisation, but especially at DHB and Ministry level; coordinated workforce development is well beyond resources available at practice or PHO level. Interprofessional education should be actively promoted for new and existing health professionals. For the experienced workforce, postgraduate interprofessional education fosters mutual interprofessional respect, good leadership skills and good team working.[25-28]

At health system level, structures that properly recognise the work of all members of the health care team need to be assured. For example, in primary care, both doctor-patient contacts and nurse-patient contacts, and non-contact time for both, need to be taken into account in the estimation of workload and for payment. Funding models should be flexible enough to allow skill mix to be negotiated at practice level; task-based funding and time-limited funding waste administrative time and often preclude most efficient use of complementary skills. Performance indicators should not just focus on or reward the efforts of one professional group. Long-term care plans for those with chronic conditions need to be simply and reliably funded so that health care teams can easily and efficiently meet variable health needs over time; often many years. The primary care–secondary care interface needs to be better supported with improved e-communication systems, and improved processes for patient care across the interface, so that primary care professionals are freed up from lengthy patient advocacy across the interface.

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At practice level, employers and their agents, regardless of professional group (shareholders, community boards, doctors, nurses, managers) have obligations and responsibilities to both employees and independent contractors at an individual and collective level to ensure workload is containable, leadership is appropriate and structures and times are in place to support effective teamwork.

At an individual level, there is often ready acceptance of shared values and common goals:

'I think it's more teamwork than, that I'm the doctor and you're the nurse. I just think it's...we are both working together...for the patient. (Interview NZ practice nurse)

The combined skills of a nurse and a doctor together create a team much more than the sum of its parts.'[29]

But this willingness to work together on an individual basis is not sufficient on its own to ensure that fully collaborative practice is the norm. Good supporting structures need to be firmly in place for interdisciplinary teams to be able to not only develop, but just as importantly to sustain, their synergism.

Box 2. Necessary prerequisites for successful team working[21-24]

- Prior and/or concurrent interprofessional education, training and learning about working in teams
- Organisational and structural support at both health system and practice level
- Dedicated, uninterrupted and adequately funded time for team development and reflection
- Effective leadership

Competing interests

None declared.

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Breastfeeding and codeine

'The FDA issued a Public Health Advisory with important new information about a very rare, but serious, side effect in nursing infants whose mothers are taking codeine and are ultra-rapid metabolizers of codeine. When codeine enters the body and is metabolized, it changes to morphine, which relieves pain. Many factors affect codeine metabolism, including a person's genetic make-up. Some people have a variation in a liver enzyme and may change codeine to morphine more rapidly and completely than other people. Nursing mothers taking codeine may also have higher morphine levels in their breast milk. These higher levels of morphine in breast milk may lead to life-threatening or fatal side effects in nursing babies. In most cases, it is unknown if someone is an ultra-rapid codeine metabolizer.'

MedWatch posted 17 August 2007 http://www.fda.gov/medwatch/safety/2007/safety07.htm#Codeine

The pubertal clock

'In an extraordinary display of nature's myriad intricacies, in higher mammals the gonadotropin-releasing hormone (GnRH) pulse generator, which drives the pulsatile secretion of gonadotropin and sex steroids, is kept in abeyance until the onset of puberty, when it is reactivated with remarkable predictability during the pubertal transition. Its role in this transition is to promote sexual maturation in synchrony with somatic growth and maturation of sexual and social behaviors. In an earlier era, when most humans died before their 25th birthday, food availability was precarious, and environmental conditions were unpredictable, failure of the reproductive axis to activate in a timely manner, or even at all, could threaten reproductive potential and survival.'

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Atrial fibrillation

'Atrial fibrillation affects patients by increasing their risk of stroke and decreasing their quality of life. Unfortunately, even if restoration of sinus rhythm is possible, most patients remain at risk for stroke and need continued protection with anticoagulation therapy. Patients with atrial fibrillation usually have shortness of breath, palpitations, and chest pain. An additional and less well appreciated symptom is fatigue, a nonspecific symptom in the elderly population that has a broad differential diagnosis. Since the risk of atrial fibrillation increases with age and since the mean age of Western populations is steadily rising, the well-described projected increase in the incidence of atrial fibrillation will probably continue for the foreseeable future.'

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