

MCP²

Multidisciplinary
Collaborative Primary
Maternity Care Project

Projet de soins
primaires obstétricaux
concertés



Guidelines for Development of a Multidisciplinary Collaborative Primary Maternity Care Model

**The Multidisciplinary Collaborative
Primary Maternity Care Project**

Ottawa

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The analysis and conclusions presented in this report do not necessarily reflect the views of the members of the MCP² or their partner associations. Funding for the research was provided by Health Canada as part of the Primary Health Care Transition Fund. The views expressed herein do not necessarily represent the official policies of Health Canada.

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Executive Summary

Introduction

Primary maternity care contributes to the subsequent health of mothers, babies and their families. Primary maternity care focuses on a healthy pregnancy, a positive birth experience and a healthy mother and child. The purpose of the collaborative model is to recognize and respond to the challenges facing primary maternity care in Canada. A collaborative model has the potential to increase the availability and quality of maternity services for all Canadian women.

This model document is the result of a consultative, iterative review process. Several versions of this document were reviewed on numerous occasions throughout 2005 by key stakeholder associations, providers, researchers and consumers. These reviews, feedback, ideas and editorial suggestions were formalized and transparent through an E-delphi process and also through ongoing communication between the consultants and the diverse stakeholder groups. In particular, the National Primary Maternity Care Committee of the MCP² project and the MCP² project staff were constructive and supportive in their ongoing reviews of this Model document. It is hoped that this engaged collaborative approach to develop the model provides a foundation for its subsequent practical implementation.

The definition of the multidisciplinary collaborative primary maternity care model is as follows:

“The model is designed to promote the active participation of each discipline in providing quality care. It is woman-centered, respects the goals and values of women and their families, provides mechanisms for continuous communication among caregivers, optimizes caregiver participation in clinical decision making (within and across disciplines), and fosters respect for the contributions of all disciplines.”¹

It is important to emphasize that pregnancy is a natural physiological event, but there can also be potential risks that need effective care and management. It is clear that no one profession can effectively address all the health care issues in isolation of the skills, expertise and experiences of other professionals. The evolution of a collaborative model is grounded in the local needs and realities of communities. Providers can work together to develop collaborative relationships and look ahead at longer-term societal benefits in their community. Ideally, the collaborative model evolves into a regional system of integrated primary maternity care.

Collaboration is about working together for a common purpose. Collaboration is a joint communication and decision-making process with the goal of satisfying the health care needs of a target population. The belief is that quality patient care is achieved by the collaborative contribution of all care providers. A true collaborative practice has no hierarchy. The contribution of each participant is based on knowledge or expertise brought to the practice rather than the traditional employer/employee relationship.

¹ Based on Health Canada's definition of collaboration

It is equally important to emphasize that the model framework has been developed and designed to be flexible in composition, structure and location to ensure that it can be used to build models that will meet the unique needs of each community, rural, remote or urban.

Principles of the Multidisciplinary Collaborative Primary Maternity Care Model

It is important that there is agreement on fundamental principles from which to develop a collaborative model. The National Primary Maternity Care Committee of the MCP² project engaged in considerable discussions and interaction to develop and agree upon the following 16 guiding principles for model development.

Woman-Centered: Responsiveness, and informed choice and decision making by women. The model must respect the needs, goals and values of women and their families.

Quality maternity care: Quality maternity care is achieved by the contribution of all care providers. Quality care is based on equity of access to, and integration of, services, timeliness, continuity of care, patient safety, and valuing different providers' expertise.

Best evidence and practice guidelines: Commitment to care based on best evidence and practice guidelines.

Professional competence.

Commitment to the Collaborative Model: Willingness to devote time and energy to the collaborative model. Willingness to discuss differences openly.

Mutual Trust and Respect: For each other's perspective and way of thinking.

Shared values, goals and visions with a philosophy of childbearing as a normal physiological process

Honest, open, and continuous communication.

Responsibility and accountability: Recognizing each professions' standards of practice.

Scope of practice: Understanding of, and respect for, different professions' scope of practice.

Common protocols: Common protocols for clinical and administrative purposes.

Mutually Supportive Environment: Unified front and mutual support by team members.

Acceptance to discuss financial issues: Open and frank discussion of financial issues.

Locally-based: Women receive primary maternity care as close to where they live as possible.

Effective, integrated regional provision of services: To ensure women are cared for and give birth in the most appropriate environment, whether they have normal pregnancies or experience high risk situations.

Knowledge of available services: Women and their families should be informed of the range of services and supports available to them, especially in rural and remote areas where some aspects of care may not be available. Women should be provided with appropriate written information about the different options of maternity care available to them (in terms of cost, continuity, transition between hospital and their home, and other information required as identified by women).

Multidisciplinary Collaborative Primary Maternity Care Model Team Composition

The Multidisciplinary Collaborative Primary Maternity Care Model ('the Model') is centered on a group of individuals with diverse training and backgrounds who work together as an identified team. The model develops the concept of collaborative team practice and is flexible to address the needs and concerns of the respective stakeholders providing and receiving maternity care. The flexibility allows for variations that best suit the different contextual needs of maternity care providers (for elaborations of different contexts please see Appendix 4).

Team members:

- Determine the mission and common goals
- Have a high level of interdependency
- Learn to accept and use disciplinary differences and overlapping roles
- Create formal and informal structures that encourage collaborative problem solving
- Share leadership
- Are community focused, and
- Provide woman-centered care.

Two or more professionals may belong to the core model team. The team uses additional individuals, teams or groups, and/or methods of practice, depending on the particular need or problem.

The Core Team

The model is based around a core team of health professionals who are the direct and continuous contact point for women. These may include family physicians, nurses, nurse practitioners, midwives, and obstetricians. Women may see some or all of these professionals in the model, depending on the context and their specific maternity care needs. In some places, especially in rural locations, general practitioners with expertise in surgical and/or anaesthesia may also be core members.

While most primary care professionals provide maternity care for women with low-risk pregnancies, obstetricians take the lead when attending to high-risk pregnancies. In some communities obstetricians may play a much greater role in the provision of primary maternity care due to individual professional preferences, historical context, and/or pressures associated with the limited supply of other health professionals.

Other Health Professionals and Care Providers

Other health professionals play a vital role in the provision of primary maternity care, depending on the specific needs of the woman and her baby. These may include physical therapists, public health nurses, dieticians, anaesthesiologists, paediatricians, and/or

neonatologists. Care providers such as lactation consultants, social workers and doulas are also used on an as required basis. In some places they may be integral to the collaborative model, while in others they may not be prevalent at all. Again, context and the individual preferences of providers play a key role in determining the nature and extent of their engagement in the collaborative model.²

Collaboration beyond the Model

Collaboration also occurs with providers outside ‘the model’. Ideally the collaborative model is regarded positively by other health providers, who see the potential for providing more effective, integrated care at a systems level. Continuity of care is most visibly recognized by the expecting mother through the interaction and ongoing relationships of the core team members with professionals outside the model. Attention to effective communication and knowledge exchange is paramount at these interfaces.

While many providers feel they *do* collaborate even though they do not have any formal ongoing structured means for doing so, multidisciplinary *collaborative* practice takes on additional meaning with an increase in shared experiences. It is important to recognize that the implementation of a multidisciplinary collaborative maternity care team will have an impact on the existing system and it is vital to ensure that the introduction of a new team does not unduly disrupt those parts of the system that are working well.

The collaborative primary maternity care models reflect the foundation of primary maternity care as well as acknowledging the integral role of secondary and tertiary levels of maternity care (for definitions of primary, secondary and tertiary care please see Appendix 2).

Central themes include continuity, responsiveness to needs and the ongoing improvement of care and health outcomes through evaluation.

The needs of women, their babies and families must be addressed by respective collaborative models regardless of their different contexts. The collaborative team directly provides *or* enables access to all core competencies and other services as required by the expecting mothers.

Ongoing evaluation and improvement is based on the overall goals and objectives of the model as espoused in the mission and principles of the collaborative team approach. The expected outcomes of the collaborative model incorporates the dimensions of improved care, healthy outcomes and responsiveness to community needs.

Continuity of Care

Continuity in primary care is typically the relationship between a single practitioner and a patient that extends beyond specific episodes of illness or disease. Continuity implies a sense of affiliation between patients and their practitioners (loyalty and clinical responsibility). Continuity fosters “*improved communication, trust, and a sustained sense of responsibility*” (Haggerty et al, 2003). Continuity of care in the collaborative primary maternity care model is a focal point of the core team.

² Social workers, for example, could be seconded for a half day a week – and may see all high-risk women and get relevant agencies involved at an early stage. Successful outcomes are possible because there is enough lead-time available to ensure that a child’s safety can be arranged at the earliest stage possible following birth.

There are three types of continuity:³

- *Informational continuity* – The use of information on past events and personal circumstances to make current care appropriate for each individual.
- *Managerial continuity* – A consistent and coherent approach to the management of a health condition that is responsive to a patient's changing needs.
- *Relational continuity* – An ongoing therapeutic relationship between a patient and one or more providers.

Continuity is pivotal for enhancing the pregnancy experience, and typically refers to the organizational and process context of the providers. The woman herself plays a key role in shaping the care that is provided. *Informational continuity* ensures that team members effectively access and communicate to one another the most current up-to-date information on their respective clients.

The model's common underlying philosophy ensures that there is *Managerial continuity*.

Although different providers may be involved in the care at different times and in different ways, the consistent approach to managing the care regardless of the provider strengthens the model.

Relational continuity in the collaborative model refers to the ongoing care being provided. It is enhanced by the integrating capacity of Informational and Managerial continuity.

Evaluation

The collaborative model integrates evaluative methodology and the main tenets of quality care as first articulated by Donabedian; *structure, process* and *outcomes*. Structural elements or variables relate to attributes of the practice environment, populations served and the health care system. Process elements include the activities, behaviour and actions of those working in and with the model. Outcomes result from the interaction between the structural and process variables. The spirit of enquiry stemming from ongoing evaluation and a focus on outcomes provides considerable impetus for development of a learning organization.

Core Components of the Model

There are 22 core components of the Multidisciplinary Collaborative Primary Maternity Care Model. Core components represent those aspects of collaborative primary maternity care that are considered to be important for determining the way the model will work. A collective understanding of these by partners in the collaborative model will be desirable. These components have emerged from extensive consultation for this initiative and from the research literature.

Identified need

1. Woman centered
2. Community Consultation
3. Access and availability

³ Based on a systematic review of the research literature by Haggerty et al (2003)

4. Choice of birthplace

Structure

5. Standards of Practice
6. Scope of Practice
7. Shared philosophy and common understanding
8. Organizational structure
9. Support structures
10. Size of the model
11. Location
12. Work-life balance
13. Remuneration
14. Accountability, Liability and Malpractice
15. Community linkage
16. Learning organization

Process

17. Collaborative culture
18. Effective communication
19. Common record
20. Flexibility
21. Decision supports

Outcomes

22. Evaluation

The Multidisciplinary Collaborative Primary Maternity Care Model⁴

Introduction

Primary maternity care can be seen as part of a much broader population health approach. The goal of a population health approach is to improve the health of the entire population and to reduce health inequities among population groups.⁵ Primary maternity care is a foundation for the subsequent health of mothers, babies and their families. Primary maternity care focuses on a healthy pregnancy, a positive birth experience and a healthy mother and child.

The purpose of this multidisciplinary collaborative model is to recognize and respond to the challenges facing primary maternity care in Canada. A collaborative model has the potential to increase the availability and quality of maternity services for all Canadian women.

This model document is the result of a consultative, iterative review process. Several versions of this document were reviewed on numerous occasions throughout 2005 by key stakeholder associations, providers, researchers and consumers. These reviews, feedback, ideas and editorial suggestions were formalized and transparent through an E-delphi process and also through ongoing communication between the consultants and the diverse stakeholder groups. In particular, the National Primary Maternity Care Committee of the MCP² project and the MCP² project staff were constructive and supportive in their ongoing reviews of this Model document. It is hoped that this engaged collaborative approach to develop the model provides a foundation for its subsequent practical implementation.

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It is important to emphasize that pregnancy is a natural physiological event, but there can also be potential risks that need effective care and management. It is clear that no one profession can effectively address all the health care issues in isolation of the skills, expertise and experiences of other professionals. The research literature and health professionals consulted in the process of developing this model identified many benefits of collaborative care. Potential positive outcomes include:

- Improved family satisfaction
- Improved provider satisfaction
- Enhanced continuity of care
- Fewer complaints

⁴ This model was developed from the academic and grey literature and primary research engaging stakeholders from across Canada. A summary of the overall project, the research process and list of Project members is provided in Appendix 1. A synopsis of the research literature on *collaboration* is provided in Appendix 3.

⁵ In a population health approach, health is a positive concept, more than just the absence of disease. It is complete physical, mental and social wellbeing. Health is a capacity or resource rather than a state.

⁶ Based on Health Canada's definition of collaboration. Further definitions are provided in Appendix 2.

- More efficient use of time
- More effective use of human resources
- Decreased length of hospital stay
- Improved working relationships
- Lower costs

The evolution of a collaborative model is grounded in the local needs and realities of communities. Providers need to work together to develop collaborative relationships and look ahead at longer-term societal benefits in their community. Ideally, the collaborative model evolves into a regional system of integrated primary maternity care. Fundamental to the process of developing the collaborative model is an approach that is phased-in (gradualist) and community-based (developed locally at the community level, respecting and addressing individual and community needs). The collaborative model reflects the interaction of different health professionals and a diverse range of services and supports they provide. Such an approach requires that the timing of development best reflects the respective community contexts. The community and those providers that constitute the *community of maternity care practice* decide at what pace the model can and should evolve.

The model presented here is a blueprint to guide and assist maternity care professionals and organizations should they choose to develop new working relationships with one another. There are 22 core components of the primary maternity care collaborative model. They are identified and described later in this document.⁷

Multidisciplinary Collaboration

Collaboration is about working together for a common purpose. Collaboration is a joint communication and decision-making process with the goal of satisfying the health care needs of a target population. The belief is that quality patient care is achieved by the collaborative contribution of all care providers. A true collaborative practice has no hierarchy. The contribution of each participant is based on knowledge or expertise brought to the practice rather than the traditional employer/employee relationship.

Collaboration is the enabler to effective, integrated care. Multidisciplinary collaboration is inclusive of collaboration at many levels and across many disciplines. This model includes collaboration among the same professionals, between different professionals within the same stage of care (i.e., antepartum, intrapartum or postpartum), collaboration with women and their families, collaboration with other providers outside the model, and importantly, collaboration with support staff who are integral to the effectiveness of the model for both receivers and providers of care. The *collaborative spirit* is paramount.

⁷ They are based on the research literature and empirical work conducted for this project. Implementation modules provide decision support tools for developing the model (see Appendix 5).

Principles of the Multidisciplinary Collaborative Primary Maternity Care Model

It is important that there is agreement on fundamental principles from which to develop a collaborative model. The National Primary Maternity Care Committee of the MCP² project engaged in considerable discussions and interaction to develop and agree upon the following 16 guiding principles for model development.

Woman-Centered: Responsiveness, and informed choice and decision making for women. The model must respect the needs, goals and values of women and their families.

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Best evidence and practice guidelines: Commitment to care based on best evidence and practice guidelines.

Professional competence.

Commitment to the Collaborative Model: Willingness to devote time and energy to the collaborative model. Willingness to discuss differences openly.

Mutual Trust and Respect: For each other's perspective and way of thinking.

Shared values, goals and visions with a philosophy of childbearing as a normal physiological process

Honest, open, and continuous communication.

Responsibility and accountability: Recognizing each professions' standards of practice.

Scope of practice: Understanding of, and respect for, different professions' scope of practice.

Common protocols: Common protocols for clinical and administrative purposes.

Mutually Supportive Environment: Unified front and mutual support by team members.

Acceptance to discuss financial issues: Open and frank discussion of financial issues.

Locally-based: Women receiving primary maternity care as close to where they live as possible.

Effective, integrated regional provision of services: To ensure women are cared for and give birth in the most appropriate environment, whether they have normal pregnancies or experience high risk situations.

Knowledge of available services: Women and their families should be informed of the range of services and supports available to them, especially in rural and remote areas where some aspects of care may not be available. Women should be provided with appropriate written information about the different options of maternity care available to them (in terms of

cost, continuity, transition between hospital and their home, and other information required as identified by women).

Multidisciplinary Collaborative Primary Maternity Care Model Team Composition

The Multidisciplinary Collaborative Primary Maternity Care Model ('the Model') is centered on a group of individuals with diverse training and backgrounds who work together as an identified team. The model develops the concept of collaborative team practice and is flexible to address the needs and concerns of the respective stakeholders providing and receiving maternity care. The flexibility allows for variations that best suit the different contextual needs of maternity care providers (for elaborations of different contexts please see Appendix 4).

Team members:

- Determine the mission and common goals
- Have a high level of interdependency
- Learn to accept and use disciplinary differences and overlapping roles
- Create formal and informal structures that encourage collaborative problem solving
- Share leadership
- Are community focused, and
- Provide woman-centered care.

Two or more professionals may belong to the core model team. The team uses additional individuals, teams or groups, and/or methods of practice, depending on the particular need or problem.

The Core Team

The model is based around a core team of health professionals that are the direct and continuous contact point for women. These may include family physicians, nurses, nurse practitioners, midwives, and obstetricians. Women may see some or all of these professionals in the model, depending on the context and their specific maternity care needs. In some places, especially in rural locations, general practitioners with expertise in surgical and/or anaesthesia may also be core members.

While most primary care professionals provide maternity care for women with low-risk pregnancies, obstetricians take the lead when attending to high-risk pregnancies. In some communities obstetricians may play a much greater role in the provision of primary maternity care due to individual professional preferences, historical context, and/or pressures associated with the limited supply of other health professionals.

Other Health Professionals and Care Providers

Other health professionals play a vital role in the provision of primary maternity care, depending on the specific needs of the woman and her baby. These may include physical therapists, public health nurses, dieticians, anaesthesiologists, paediatricians, and/or neonatologists. Care providers such as lactation consultants, social workers and doulas are also used on an as required basis. In some places they may be integral to the collaborative model, while in others they may not be prevalent at all. Again, context and the individual

preferences of providers play a key role in determining the nature and extent of their engagement in the collaborative model.⁸

Collaboration beyond the Model

Collaboration also occurs with providers outside ‘the model’. Ideally the collaborative model is regarded positively by other health providers, who see the potential for providing more effective, integrated care at a systems level. Continuity of care is most visibly recognized by the expecting mother through the interaction and ongoing relationships of the core team members with professionals outside the model. Attention to effective communication and knowledge exchange is paramount at these interfaces.

While many providers feel they *do* collaborate even though they do not have any formal ongoing structured means for doing so, multidisciplinary *collaborative* practice takes on additional meaning with an increase in shared experiences. It is important to recognize that the implementation of a multidisciplinary collaborative maternity care team will have an impact on the existing system and it is vital to ensure that the introduction of a new team does not unduly disrupt those parts of the system that are working well.

Maintaining the Foundation

The collaborative primary maternity care models reflects the foundation of primary maternity care as well as acknowledging the integral role of secondary and tertiary levels of maternity care (for definitions of primary, secondary and tertiary care please see Appendix 2).

Central themes include continuity, responsiveness to needs and the ongoing improvement of care and health outcomes through evaluation.

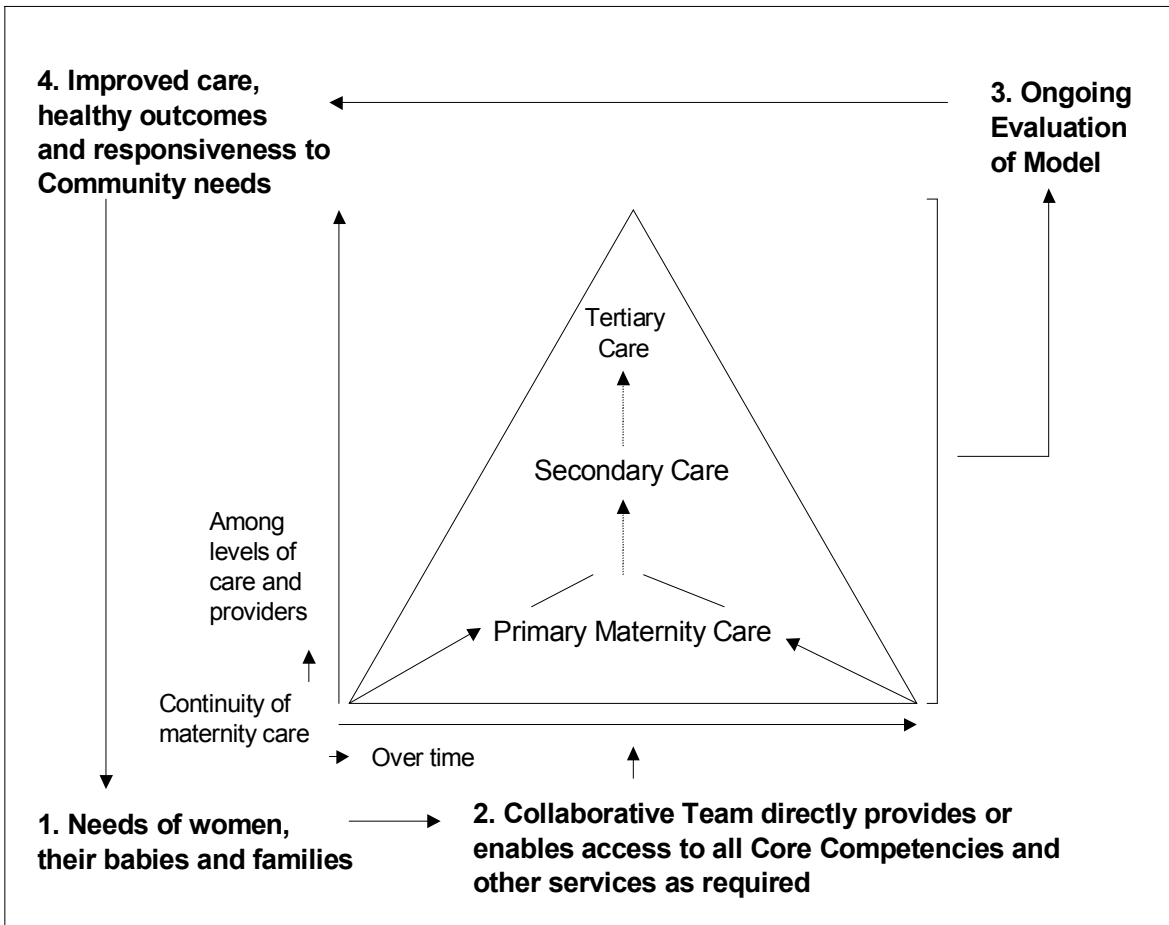
The needs of women, their babies and families must be addressed by respective collaborative models regardless of their different contexts. The collaborative team directly provides *or* enables access to all core competencies and other services as required by the expecting mothers.

Ongoing evaluation and improvement is based on the overall goals and objectives of the model as espoused in the mission and principles of the collaborative team approach. The expected outcomes of the collaborative model incorporates the dimensions of improved care, healthy outcomes and responsiveness to community needs.

The collaborative primary maternity care model is shown below in Figure 1.

⁸ Social workers, for example, could be seconded for a half day a week – and may see all high-risk women and get relevant agencies involved at an early stage. Successful outcomes are possible because there is enough lead-time available to ensure that a child’s safety can be arranged at the earliest stage possible following birth.

Figure 1: The Multidisciplinary Collaborative Primary Maternity Care Model



Stages of Primary Maternity Care

There are three stages of primary maternity care; antepartum, intrapartum or postpartum care. The core professionals – family physicians, nurses and/or nurse practitioners, midwives, obstetricians – are involved in each of the three stages.

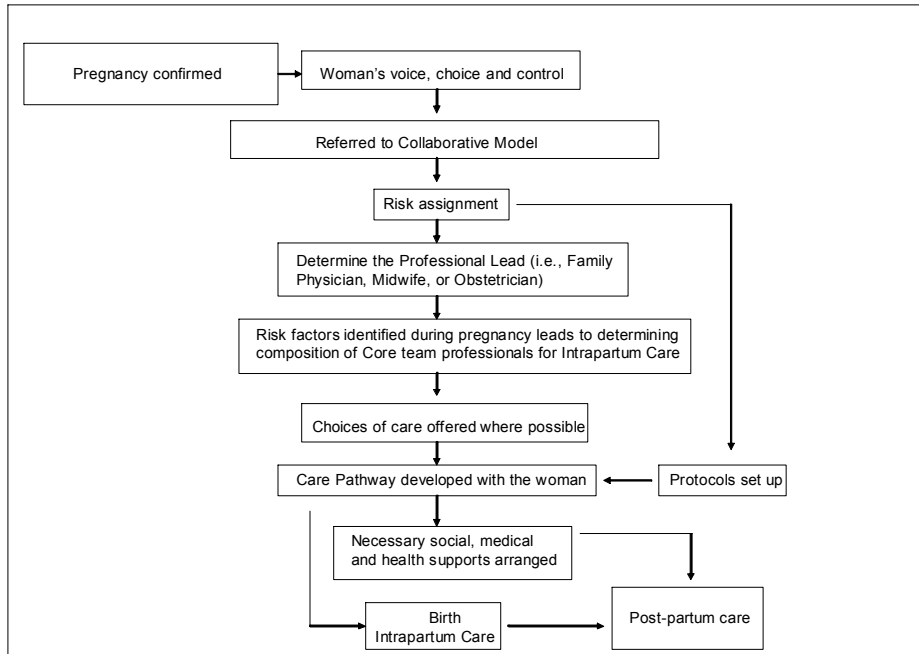
➤ Antepartum Care

Leading the provision of antepartum care is the core team comprised of a mix of some or all of the following: family physician, midwife, obstetrician, nurse and/or nurse practitioner. The collaborative model attempts to ensure there is *continuity of care* among the providers, although the woman requiring care will also be able to request *continuity of carer*. This may or may not be possible, but at a minimum the core team will explain to the woman if and why obtaining her choice of care provider may not be possible. In some cases it may be that continuity of the care provider is through the nurse or nurse practitioner, although a midwife or a family physician from the collaborative model may actually attend the birth. If it is known that the delivery could be high risk, an obstetrician is introduced to the woman prior to giving birth. In some cases there could be an automatic referral to an obstetrician or consultations sought, which may influence the nature of the primary maternity care being provided. The

collaborative team will ensure that fundamental elements of care are available to women. Other providers may also be involved, depending again, on the needs of the woman (e.g., doulas).

The Antepartum care stage of the model is part of the continuum of maternity care provision.

Figure 2: Maternity Care



➤ Intrapartum Care

Team members, or other professionals as required, will provide the necessary care when the baby is delivered. Again, who that is will depend on a) the choice of the expecting mother where possible, and b) the supply of various qualified professionals in a given community. If there are unexpected complications or the pregnancy has been assessed as high risk in the antepartum stage, an obstetrician may be present at the birth. The important point here is not the collaborative model per se, but the needs of the mother. If there is not the obstetrical expertise present in the collaborative model, then this expertise will be made available and integrated seamlessly for the expecting mother. Ideally this will be possible locally, although this may be less likely in rural and remote areas.

Nurses working in the collaborative model can enhance continuity of care by visiting mothers and babies at the respective birthplaces following the birth. They can also facilitate discharge planning if needed.

➤ Postpartum Care

As with antepartum care, a range of providers may be called upon depending on the needs of the mother and child (e.g., lactation consultants, social worker, physical therapists, pediatricians, neonatologists, public health nurses, dieticians/ nutritionists). The care received from these providers is coordinated by the core team.

The Continuity Triad

Continuity in primary care is typically the relationship between a single practitioner and a patient that extends beyond specific episodes of illness or disease. Continuity implies a sense of affiliation between patients and their practitioners (loyalty and clinical responsibility). Continuity fosters “*improved communication, trust, and a sustained sense of responsibility*” (Haggerty et al, 2003). Continuity of care in the collaborative primary maternity care model is a focal point of the core team.

There are three types of continuity:⁹

- *Informational continuity* – The use of information on past events and personal circumstances to make current care appropriate for each individual.
- *Managerial continuity* – A consistent and coherent approach to the management of a health condition that is responsive to a patient's changing needs.
- *Relational continuity* – An ongoing therapeutic relationship between a patient and one or more providers.

Continuity is pivotal for enhancing the pregnancy experience, and typically refers to the organizational and process context of the providers. The woman herself plays a key role in shaping the care that is provided. *Informational continuity* ensures that team members effectively access and communicate to one another the most current up-to-date information on their respective clients.

The model's common underlying philosophy ensures that there is *Managerial continuity*.

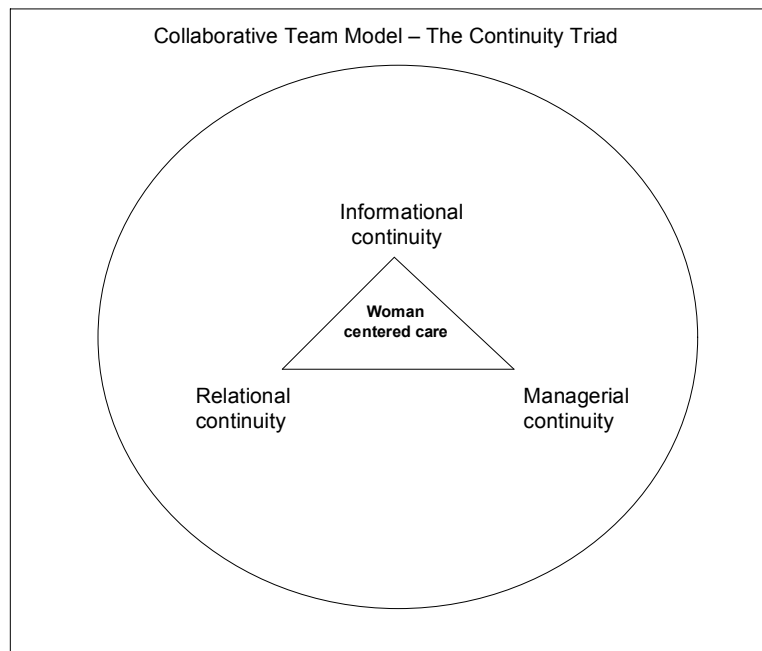
Although different providers may be involved in the care at different times and in different ways, the consistent approach to managing the care regardless of the provider strengthens the model.

Relational continuity in the collaborative model refers to the ongoing care being provided. It is enhanced by the integrating capacity of Informational and Managerial continuity.

The *continuity triad* is shown in Figure 3. It is central to the integrated quality focus which links structure with processes and expected outcomes, thus achieving desired outcomes for women, their babies and families, and the providers within, and interacting with, the collaborative model.

⁹ Based on a systematic review of the research literature by Haggerty et al (2003)

Figure 3: The Continuity Triad



Quality Care

The collaborative model integrates evaluative methodology and the main tenets of quality care (Donabedian, 1966, 1980, 1982, 1985, 1988).

There are attributes of the practice environment, the populations served and the health care system. These are known as *structural* elements.

There are the activities, behaviour and actions of those working in and with the model. These are known as *process* elements.

Outcomes result from the interaction between the structural and process variables.

The spirit of enquiry stemming from ongoing evaluation and a focus on achieving expected outcomes provides considerable impetus for development of what is known as a *Learning Organization* (see the next section on core components of the model).

Core Components of the Model

There are 22 core components of the Multidisciplinary Collaborative Primary Maternity Care Model. Core components represent those aspects of collaborative primary maternity care that are considered to be important for determining the way the model will work. A collective understanding of these by partners in the collaborative model will be desirable. These components have emerged from extensive consultation for this initiative and from the research literature.

Identified need

1. Woman centered
2. Community Consultation
3. Access and availability
4. Choice of birthplace

Structure

5. Standards of Practice
6. Scope of Practice
7. Shared philosophy and common understanding
8. Organizational structure
9. Support structures
10. Size of the model
11. Location
12. Work-life balance
13. Remuneration
14. Accountability, Liability and Malpractice
15. Community linkage
16. Learning organization

Process

17. Collaborative culture
18. Effective communication
19. Common record
20. Flexibility
21. Decision supports

Outcomes

22. Evaluation

The components described in this section can be considered as either *fixed* or *variable* (see Table 1 below). '*Fixed*' refers to the essential features of the model that are fixed in terms of their purpose, content and function. In other words, they should be consistently present in the locally-based collaborative models regardless of location, professional composition and so on. The *variable* classification refers to the flexibility that is necessary to respect local realities and individual professional expectations and preferences. Indeed, flexibility is critical to the sustainability of the model in its variant forms.

Note that evaluation is fixed. This is because there are expected outcomes of primary maternity care that should be common to all locally-based models. There are common indicators for these outcomes that can, if the various local models are willing, be used as benchmarks and thus develop a spirit of enquiry within and among the respective locally-based teams. At the same time, there is scope within the evaluation framework for locally-specific indicators to be developed and measured that can further instill the learning organization precepts and enable the respective locales to learn from one another. The promise and potential exists; it is the commitment of those working within the model to make things happen that will perhaps be the enduring criteria for long-term success for the collaborative model.

Table 1: Fixed/ Variable Components of the Collaborative Model

| Collaborative Model Components | Fixed/ Variable |
|--------------------------------------------|------------------------|
| Women centered | Fixed |
| Community Consultation | Fixed |
| Choice of birthplace | Variable |
| Access and availability | Variable |
| Standards of Practice | Fixed |
| Scope of Practice | Fixed/variable |
| Shared philosophy and common understanding | Fixed |
| Organizational structure | Variable |
| Support structures | Variable |
| Size of the model | Variable |
| Location | Variable |
| Work-life balance | Variable |
| Remuneration | Variable |
| Accountability, Liability and Malpractice | Fixed |
| Community linkage | Variable |
| Learning organization | Variable |
| Collaborative culture | Fixed |
| Effective communication | Fixed |
| Common record | Fixed |
| Flexibility | Fixed |
| Decision supports | Fixed |
| Evaluation | Fixed |

Woman-Centered

The model must be woman-centered. Where possible, women should be provided with written information on models of care prior to their first visit. This is due to the high volume of information that women are required to process and the decisions required at their first (booking) and subsequent visits.

Individual preferences regarding the model of care should be established and discussed in the first two antepartum visits. It is desirable and important that there is:

- Choice for women
- An understanding what the woman wants and needs to know
- Continuity of care, knowing who will be there at birth
- Appropriate time and understanding

- Competence of providers
- Recognition of the desire for the woman to be heard
- The minimizing of uncertainty
- Responsivity to unique individual needs
- Acknowledgment of continuity in the philosophy of care
- Provision of relationship-based care
- The ability to meet members of team – all care providers
- A focus of control with the woman
- Cultural competency

Community Consultation

To fully recognize gaps in services and to provide local solutions to local needs the community must be engaged. It is essential that a new model accurately reflects the context in which it is emerging. Failure to do so will lead to a model that does not reflect true needs and the contextual relationships into which it enters.

The development of a collaborative model should be based on a comprehensive environmental scan at the start of the initiative (see the Knowledge Transfer Modules). Depending on the context, time, resources and skill-sets available, a number of analytical activities can be undertaken. These include surveys of relevant stakeholder groups and women who have just had babies, focus groups with specific population groups (e.g., aboriginal community, ethnic minorities, interviews with local hospital administrators and staff, obstetricians and family physicians and so on). The key point is to have contextual information that is accurate, current and relevant. This is the foundation for successful collaborative model development (or, indeed, the enhancement of existing collaborations).

It may be necessary for an external group or individual to conduct the environmental scan, as they will be considered more impartial and disengaged from the political context in which maternity care is currently being provided. The evolving model must recognize the community needs, especially the psycho-social needs of expecting mothers and their families.¹⁰

Choice of Birthplace

The choice of birthplace needs to be discussed by the woman and the collaborative care team. Discussion should be based on an informed choice perspective and recognize the situational context when considering potential home or institutional birthplaces. If the team is not able to provide the choice preferred by the woman then it should identify options for the woman that may be outside of the collaborative primary maternity care model.

Access and Availability

Primary maternity care should be accessible and available for all women who become pregnant. There should be ease in finding a maternity care provider and easy transfer of care between primary, secondary and tertiary levels of care.

¹⁰ For example, it makes a huge difference to marginal populations (e.g., a mother with a drug addiction, with a goal to get the expecting mother off the drugs and to ensure the pregnancy is longer which will support child development). Resources can be planned and directed to the baby, such as essential social supports.

Standards of Practice

Team members must respect and adhere to appropriate standards of care. Each professional group has its own standards of care that regulate how they should be clinically responsible and accountable. It is not within the scope of this paper to detail the range of standards across the country. Rather, standards are noted here because they are fundamental to how care is provided. They create a consistent and expected structure to primary maternity care, and collaborative model team members must conform to these standards. Of more significance to the collaborative model is that the team can ensure the required fundamental elements of care are present.

Scope of Practice

It is important for team members to respect each other's scopes of practice and to maintain appropriate standards of care. At the same time, collaborative models offer opportunities to share care and build upon the expertise of others, thus building broader core competencies as a team. Scope of practice may be variable or change over time as providers in the core team acquire new or different skills.

Although there are well known inherent contextual barriers to addressing scope of practice issues in the respective jurisdictions across the country, the ability for different professionals to overlap practice functions offer strong benefits to both the providers and recipients of care.

There are two main benefits of a collaborative model with regard to the scopes of practice:

- **Benefits to Providers:** While there may be concerns expressed over potential loss of professional autonomy, a key benefit of overlapping scopes of practice is that team members may be better able to provide more timely care to women, and also learn more about and respect other professionals' activities.
- **Benefits to Women:** As the overall *raison d'être* of the collaborative model is to provide positive outcomes for women and their babies it should be expected that, to the greatest extent possible, the collaborative team will be able to respond to a woman's needs with a caregiver that will have the ongoing support, influence and interaction of other professionals on the collaborative team.

Shared Philosophy and Common Understanding

Team members develop a shared philosophy and a clear, common understanding of what the model is, and what it is not. This derives from the vision and mission statements and the underlying principles of the collaborative model. It is reflected in the day-to-day practices and longer-term planning of the team. It is easily communicated beyond the team to other providers and the general public.¹¹

Agreed upon foundational statements such as principles, mission or vision statements are essential to the collaborative model (there does not have to be voluminous details written on respective roles and functions in the model). The model must be flexible enough to suit

¹¹ A shared philosophy does not mean pages and pages of text attempting to articulate roles and responsibilities, structure, unduly bureaucratic policy manuals and so on. More simple and effective are mission and vision statements, and underlying collaborative model principles. And in a truly effective model these may not even be referred to very often.

everyone's needs and not become so administratively burdensome with policy manuals that its attraction is nullified.

Potential new team members would want to know what is meant by 'collaboration'. What is it based on? What are the expectations? They would want to know if all their skills are going to be used, or if they will be limited in their role and function. They would want to know who they are working with, and how.

Organizational Structure

By necessity or choice, the organizational structure can be highly variable depending upon the context in which the model is developed, and the functional work needs of the core team members. A number of permutations are possible, ranging from a free-standing clinic controlled by the collaborative team itself, to others that are hospital-based in rural areas and under the organizational umbrella of the hospitals' governing structure. In some places the model may be under the auspices of a regional health authority. Regardless, the non-hierarchical collaborative environment is maintained, with the leadership and overall coordination of the team potentially changing from year to year.

The administrative component is one of the critical elements of the model. Important considerations other than day-to-day operations, such as billing processes and consistent approaches to the use of medical records, include compensation to professionals for administrative time, the administrative relationships with other organizations (e.g., hospitals), the reporting structure with support staff, and the ongoing administrative inter-relationships among the team members. The casual, every day exchange is critical, as is where and how the team members are located together.¹² Working together over time moulds and builds a sense of trust.

The day-to-day functioning of the model will vary according to many factors. At a general level a typical model *could have*, for example, two nurse practitioners or midwives fulltime, and one part-time in administration, with several family physicians and or midwives on different shifts or blocks of call to ensure maternity care providers are present throughout the regular work week, including someone always on-call. Similarly, in another location the model may be led by obstetricians. The important point is that the fundamental elements of care are covered by the team. The precise functional delineation among the core collaborative team will be determined by its members.

Other providers may work within the model on various days – for example, dietitians, social workers, anaesthesiologists, general practitioners, therapists, doulas and lactation consultants. It will be expected that they too will work from the underlying philosophy of the collaborative model. There will be a constant changing blend of professionals – some working part-time, and others full-time. The mix will be a function of the context and the process by which the models are developed.

Support Structures

It is the support structure that makes the collaborative model possible. Clerical, secretarial, medical assistant support staff and the associated communication, knowledge exchange and information processes are pivotal to effective collaborative team functions. They are the

¹² The proximity of the team members to one another, while desirable, is not an essential component of the model. Indeed, it is unlikely the model will have all team members in close proximity to one another in rural, northern or remote areas of the country.

mainstays of the model, providing a common maternity care face and voice for women and their families.

The number and precise type of support staff will be determined by the core team members. As supportive staff, they too need to respect the principles, mission and vision statements, and be afforded, also, the same respect of the collaborative core team members.

Size of the Model

Collaborative models in urban areas could range considerably in size depending on many things, such as client and locational factors, with the number and type of providers, including full-time and part-time mix in the team appropriately corresponding to the number of clients.¹³ Models will evolve. Over time additional clients will be able to receive care from providers in the collaborative model.

Several key benefits are cited by proponents of urban models of this type and range of sizes:

- **Improve Work-life balance:** Sufficient numbers to maintain on-call arrangements that enable better work-life balance.
- **Enhance clinical skills:** Enables a sufficient number of clients for team members to be maintaining and enhancing their clinical skills.
- **Enable better continuity of care:** Enables core team members to be engaged with clients at some point in the antenatal stage as required to ensure continuity of care.
- **Avoid bureaucracy:** Avoids a potentially overly bureaucratic administrative structure of a larger organization.
- **Enhance ease of collaboration:** A smaller size will make it easier to foster collaborative relationships among team members.

If volumes rise too high it may be more appropriate to place a cap on the number of clients in urban areas. The more pragmatic approach to increasing size may be to replicate the smaller size collaborative models over a different geographic area (especially within urban areas) as opposed to expanding the size of collaborative models of primary maternity care. This better responds to local needs, can better maintain closer interaction with expecting mothers and can be closer to their homes.

Location

Location is important to the development of collaborative models in several ways. Recommended is that the core team be based at one location rather than be diffused over many. Co-locating the Model with family physicians offices and other professionals is one possibility, as there is already an existing infrastructure in place. Co-location may also offer other opportunities to encourage efficiencies by linking with other non-maternity care health professionals in close proximity depending on the respective needs of clients. Other primary health care needs may also be addressed through co-location with primary health care sites.

Ideally, the closer the care is to the home, the better. Where possible the location of the collaborative model site in urban and rural areas would also be close to a hospital where the core team already has, or could establish, clinical relationships. In urban areas, satellite sites or outreach clinics closer to women's homes may be appropriate for certain aspects of the

¹³ The numbers and geographical area will vary considerably in the rural and remote areas of the country.

maternity care. This would help to bring women into stronger focus at the center of the care system.

In rural and remote settings women should have access to care as close to home as is logistically and economically feasible. Underlying policy decisions are made on the basis of economic, geographic and care provider resource realities. These are reflected in the collaborative model as a functional, geographically dispersed model of care, which is in stark contrast to the urban environment where there is closer proximity of providers with each other and with women requiring maternity care.

In rural areas the challenge is less one of size and inter-relationships and more the enduring questions regarding access to and availability of care, and who provides that care. It is well known that the rural hospital closures and downsizing occurring across the country is placing new challenges on maternity care providers. A collaborative model may be the best solution for ensuring a capacity for maternity care is maintained and for maximizing professionals' composition and commitment to continuing primary maternity care practice in rural areas.

The mix of the model's core team members in rural areas will likely be predicated on the current mix of providers in the respective rural communities and the future plans for the local and regional delivery of health care more generally. It is important also to recognize and include traditional birth attendants as primary care providers as they can and do fill a large gap in providing antepartum and postpartum care.

In northern and remote areas care is always provided in a collaborative way. In northern communities, it is very often the community health nurse that is the first point of entry. In the collaborative model, the point of entry could also be other providers as determined by availability in these remote locations (e.g., public health nurses, social workers). More important than the availability of different providers is the presence of the team fundamentals, many of which can be provided by a range of different health professionals. Traditionally, nurses have always been the core of the northern model, with other professionals as required or as available.

Recognizing the cultural specificities is very critical in northern communities, as the dislocative effects of taking birth away from the communities has a rippling effect on family dynamics, the growth and development of children, and the cultural traditions of First Nations and Inuit people. Innovative collaborative models that recognize the more southern perception of human resource supply constraints, remoteness and cultural uniqueness need to be expanded.

Work-Life Balance

At the heart of much of the research for this collaborative model has been the nature of call arrangements. The paradox is that on one hand the on-call nature of the professional commitment has often been, and still is, seen as a fundamental contribution to a positive birthing experience – both for the mother and the provider. On the other hand, on-call arrangements, especially with growing human resource shortages, are seen increasingly as far too demanding for maternity care professionals, resulting in burn-out and less incentive for new professionals to work in maternity care.

Collaborative models offer potential advantages to address work-life balances for several different professional groups. This is particularly evident with regard to the on-call scheduling for obstetricians, family physicians and midwives. Effective sharing of on-call time into blocks

of time simply makes life more manageable. Not only is the life-balance made more possible, the on-call freedom makes it possible to do other work related activities such as continuing education or teaching.

A range of possible on-call combinations exist in current collaborative models in urban areas. The consistent theme is fewer on-call periods yet more actual care being provided (e.g., some current arrangements state an absolute minimum of 4 professionals – family physician, and/or midwives and sometimes obstetricians). There is always someone on-call in the collaborative model.

Remuneration

Remuneration is a significant issue that needs agreement and resolution by the collaborative model team members, the overarching governing organization of the model, and the government that funds the delivery of care. The important points are that equity should be achieved and time spent ‘collaborating’ is not assumed to be unpaid time.

A range of funding options is possible. It would be instructive to pilot the different options as collaborative models emerge. These could include blends of fee-for-service (FFS), course of care, salary and sessional fees, shared positions, paying more for night work, and different options for the pooling of on-call remuneration. Different remuneration arrangements are in place in current collaborative arrangements with no fundamental difference in outcomes.

One generally accepted funding arrangement is a salaried model. In times where there are low numbers of expecting mothers, midwives and nurses, for example, could be involved in other related activities such as breastfeeding clinics, nutritional counselling and so on. Similarly, family physicians and obstetricians may not be “funded” for providing maternity care or specific birth services, but could still be remunerated for being part of the team, recognizing that some days they would be more active than others. The precise relationships and structures need to be determined to best suit the local contexts and needs of providers and recipients of care. It would be counter-productive at this point to rigidly recommend one remuneration option over the other, especially as evidence is limited on the relative cost effectiveness of different options, and professionals currently considering a collaborative model may want to explore different options as part of a gradualist approach in which they evolve the collaborative model more fully.

Another remuneration option is an alternative funding arrangement that ensures everyone is paid a set amount (e.g., \$x a ½ day clinic). With all billings that are generated, funds go into an account and are then divided up based on the number of shifts that a professional does in that given period. For the actual births, if required obstetricians could be on an on-call basis, and be paid not for the “delivery” of the baby, but on retainer – a flat rate over the course of a year. Thus in effect remuneration is based on availability, and not the number of deliveries.

Regardless of the options chosen, funding arrangements must be clear and transparent. Providers should be rewarded for working in a collaborative care model and not be punished for doing so. If professionals currently in a FFS arrangement will lose financial ground compared to entering a model, there will need to be consideration as to how incentives could be made for continuation within the model without financial disincentives (e.g., payment for time working in non-clinical collaborative model activities). That said, the opposing view is that those working in the model may have to accept less pay in exchange for the work-life balances that the model may provide.

Overriding all the different funding options, are the essential elements of equity and fairness in the remuneration of team members. In the absence of evidence to say otherwise, ultimately that will best be decided by the members of the model themselves who will determine what works best for them and the willingness of government to be innovative and flexible with funding arrangements. A grand-parenting clause that would ensure current funding arrangements could remain for professionals interested in developing collaborative models but would in essence be a salaried model for anyone else coming into the model subsequent to its initial development.

Accountability, Liability and Malpractice

Statistics from Canadian Medical Protective Association, Canadian Nurses Protective Society, and Healthcare Insurance Reciprocal of Canada reveal that obstetrical litigation is common. Realistic planning for the legal costs of defending a negligence suit is necessary. Negligence is the failure to take the care that a reasonable, careful midwife/ nurse/doctor in similar circumstances would have taken. The following elements must be proved by the plaintiff(s):

1. Duty of care;
2. Breach of the standard of care;
3. Foreseeable harm was caused by a breach in the standard of care; and
4. The value of the harm or loss, known as damages.

A successful defense to an allegation of negligence is that the practitioner's actions were reasonable and prudent in the circumstances. Canadian courts are capable of understanding that different professionals have different roles to play in one pregnancy. While there may be recognition by the court of the team effort, each defendant's role will be analyzed individually. Each practitioner is responsible for their own actions. A health professional is not held directly liable for the negligence of another professional who was acting autonomously within their scope of practice.

A finding of negligence by the court may have a financial impact on the defendant(s) in three ways:

1. Direct Liability

Each health care professional, both individually and as a member of the collaborative practice team, is accountable for his or her own professional practice. Therefore, if a practitioner is found to have been negligent, a court may award damages to the plaintiff that is to be paid by the individual defendant. This form of liability is called direct liability.

A defendant employer or facility may also be found negligent and held directly liable for breaching duties it owed to the client. These could include, for example, the duty to: select professional staff using reasonable care; review staff performance on a regular basis; have and enforce appropriate policies and procedures; provide reasonable supervision of staff; and provide adequate staffing, equipment or resources.

2. Vicarious Liability

If an employee is found negligent, the court may order that damages be paid by the employer pursuant to the doctrine of vicarious liability. This legal doctrine provides that an employer, which may be an individual or an institution, can be held financially responsible for the negligence of its employees. An employment relationship must have existed at the time of the incident and the defendant employee must have been sued for work done within the scope of

his or her employment. It will be up to the court to decide, based on all the facts and circumstances, whether an employer/employee relationship existed. Some of the indicators of an employment relationship are the level of control the employer has over the employee's activities, any agreements which describe the relationship and requirements to follow the employer's policies or procedures.

3. Joint and Several Liability

When a court finds more than one defendant negligent, the court will assess the amount of damages (often expressed as a percentage of the total damage award) to be paid by each defendant. Defendants can be jointly and severally liable for the damages awarded. This means the plaintiff may recover full compensation from any one of the negligent defendants, even though that defendant may then be paying for more than their share of the damages. That defendant may then seek contribution from the other negligent defendant(s). For this reason, it is essential for those working in collaborative practice to verify that all members of the collaborative practice team and the facility or institution have adequate professional liability protection in place.

Legal Risk Management Recommendations

Planning

Ascertain the nature of your legal relationships with others in the collaborative team at the beginning of your collaboration. Establish a system of annual review of current professional credentials of team members, along with proof of current legal defense protection/insurance. You should know the source of your legal defense funding. All members of the collaborative health care team and the institution or facility must have appropriate and adequate professional liability protection to protect themselves and the clients they treat. For those leaving obstetric practice, this may include 'tail coverage' which extends the reporting period in which a claim can be made to an insurer.

Communication

Clear communication between team members and the client should reduce the risks of miscommunication or lack of meaningful planning and coordination (who does what when) where more than one professional is concurrently involved in the care. Establish a method for addressing issues of miscommunication between team members or between a team member(s) and a client. This may include establishing a formal process to ensure complaints or concerns are addressed by the collaborative.

Evidence

Your daily practice can create evidence of your reasonable actions. Policy development and agreed guidelines or protocols are a good way for a team to show it maintains safe systems for clients. Proper documentation on the health record is a requirement of your professional practice and can be your best defense in a legal action. A regular audit of the collaborative's health records will be useful in helping assure the quality of the care you provide is reflected in the records and allows for quality of improvement, where necessary.

Community Linkage

Ongoing linkages with the community are essential. This includes the general public as well as other providers. The more that other non-model providers see the advantages of the collaborative model the more receptive they will be to the integration of the model with the local system of primary maternity care. This is especially the case if the model takes a population health perspective and embraces an advocacy role for clients. There are a number of benefits that can accrue to communities from a collaborative model, especially with fewer physicians in the community providing maternity care.

In urban areas in particular, the model (or a group of teams if possible) would be recognized as a *specialized* primary maternity care model. With an agreement that clients would return to their existing family physicians following the birth, there would not be concerns that other professionals were losing their client base. For those that come to the model without a referral (e.g., teens, drug dependents, low income, refugees, etc), the model could play an advocacy role and assist these individuals in finding a regular family physician. This is when a social worker can play a significant role as a team member, again reflecting the population health perspective and holistic approaches to health and health care.

Learning Organization

The essential elements of a learning organization¹⁴ – personal mastery, shared vision, mental models, team learning and systems thinking are core ingredients of collaborative models. Briefly, they are as follows:

- **Personal mastery:** Professionals seek to gain higher levels of proficiency.
- **Shared vision:** Where there is a merging of the individual and organizational visions of the future development of the model.
- **Mental models:** Everyone has mental models of the way the world works. These may actually limit thinking and hamper innovative ways of thinking. Learning new ways of thinking, new skills and understandings from one another and from the outside can contribute to improving the way care can be provided.
- **Team Learning:** Building on personal mastery and a shared vision the team can learn together with the dynamics building knowledge beyond what one person can achieve.
- **System thinking:** At the heart of the collaborative model are closer relationships among professionals both within and beyond the model. Keeping sight of the integrated nature of maternity care will help to ensure that the range of services and supports can be maintained and improved upon.

There are clear and sustainable synergies with the educative role that collaborative models can play for and among health professionals, with students of different disciplines through electives, and the general public. The spirit of collaboration can work synergistically with a spirit of enquiry. The model can take on this responsibility.

With the new learnings the accumulating body of knowledge works to improve health outcomes for primary maternity care in the respective communities, while at the same time being able to be transferred to other collaborative models elsewhere in the country, and potentially beyond.

¹⁴ See Senge (1990) and Senge et al (1994)

Collaborative Culture

A spirit of collaboration should infuse the model. Team members of a collaborative model need to be *'like-minded'* on the fundamental aspects of working in a collaborative model. And if there is not always agreement then team members must be willing to work through differences.

Key elements of the collaborative culture are:

- **Respect:** Respect for one another. Mutual respect for the expertise of all team members is the norm. This respect is communicated to the women receiving care and support.
- **Trust:** Which team members get by knowing each other clinically (and socially in ideal cases)? Trust among all team members establishes a quality working relationship that evolves over time as the team members become more acquainted with one another.
- **Knowledge:** Knowledge is a necessary component for the development of trust. Knowledge and trust remove the need for supervision.
- **Accountability:** Team members must accept responsibility for their actions. There should be transparent clinical decision-making by team members, agreed upon processes for determining which team member is the primary clinical decision-maker, and agreed mechanisms to transfer primary care to another team member.
- **Freedom:** Freedom for team members to say what they feel.
- **Shared responsibility:** At times there will be shared responsibility, with joint decision making for patient care outcomes and practice issues within the organization.
- **Cooperation and coordination:** Cooperation and coordination promote the use of the skills of all team members, prevent duplication, and enhance productivity of the practice.
- **Optimism:** Optimism that this is the most effective method of delivery of quality care (which promotes success).

Team members also should be willing to give credit to their partners for their work. There must be openness by the team to ideas. There should be a willingness to work in a flexible model. Team members should be willing to put opinions on the table, and to still express their views even if there are disagreements.

Effective Communication

Communication is central to relationships, which are themselves the essence of collaboration. Although the relationships reflect the basic principles, ideally the principles never have to be referred to.

Effective and ongoing communication among providers in the collaborative model and with other professionals outside is a fundamental necessity. Without it, the model will unlikely realize its full potential, could lead to inefficiencies in care, and create complications for providers and those who are receiving care. Ineffective communication will also lead to team members leaving the model disillusioned – because effective communication is a central enabler of a common philosophy of care – and frustrated with the poor (or no) communication that results in problems with how and when they provide care.

Members of a collaborative model need to accept that there is significant time commitment and investment required. This is both *structured time* commitment such as meetings each week, and *unstructured time* through social interaction. Both investments of time are important for building rapport and respect. The ideal form of communication is face-to-face –

even if it is occasional hallway consultation, then telephone, followed by notes. Regardless, ongoing communication in any form is essential.

Two forms of effective communication are required. One is the formalized communication such as protocol development and use for the coordination of care, reports on activities and utilization, and so on. The second is the day-to-day informal communication among the team and with support staff. Exchange of information is continuous at the interface of the activities among and between the health professionals' and the support staff. Informal, communicative ties bind the members into a cohesive team. Both informal and formal communication requires consistent and clear messages. Effective communication also extends to the relationships with professionals outside the model, such as the informal and formal consultations with obstetricians when required.

Similarly, it is vital to have effective communication between institutions for a range of interactions, such as exchanging information on laboratory results or information required from patient records.

Communication is not hierarchic but rather two-way, facilitating sharing of patient/ client information and knowledge. If there is any questioning of the approach to care by team members this should be delivered in a manner that enhances knowledge and improves care without being seen as criticism.

Ongoing discussions and consultations by health professionals with support staff are fundamental because it reaffirms the importance of everyone's role on the team. A team's effectiveness is based on the engagement of everyone meeting or exceeding their expected roles and functions, and helping others do the same. Although technology is a significant enabler for this exchange, ultimately it is the face-to-face and verbal communications of all team members that make it happen effectively.

Regular team and staff meetings are important, as are the ongoing opportunities to freely discuss issues that are of importance to those in the model. Social interaction can also strengthen the workplace.¹⁵

Very simply, collaboration is about sharing – sharing space, sharing respect, sharing knowledge and sharing experiences. Inherently it is about relationships and relationship building – stemming from trust and common understanding and a willingness to see other points of view. To fully understand other perspectives often means having a better understanding of the person with those different perspectives. This is enhanced considerably if individuals get to know one another on different levels, and in different ways. Often this requires the space – the possibility – for that to occur.

Common Record

A common medical record is a central and essential feature of the collaborative model. The common record is an essential single point of reference for the professionals and support staff working with the woman. The common record enhances the capacity for sharing

¹⁵ For example, a collaborative team meets regularly once every two weeks. Examples of the details to be addressed include the transfer times and processes for on and off call, and who is doing the billings and when. If possible meeting regularly on a social basis is useful for building relationships and enhancing communication (e.g., monthly breakfast meetings, dinner a couple times a year, and possibly other social events during the year).

information – accurate information that can be easily updated and accessible to those who need it. The various professionals have access to the chart but not necessarily all of it.

An electronic record is ideal for enhancing communication. Current collaborative models that use a common electronic record are strong advocates for its use, because it is efficient, quick, minimizes data entry error, can be accessed from different sites, and minimizes paperwork while still respecting patient/ client confidentiality and providing opportunities for notes to be included in the record.

At the centerpiece of one model is a common chart but the ‘*chart*’ is paper-based. An electronic medical record such as OSCAR¹⁶ is not necessarily a pre-condition for a collaborative model, but it is a strong enabler, especially if there are multi-site issues that need to be addressed, or several different staff needing quick and easy access to records at the same time.

Flexibility

Flexibility is important as the model will evolve over time due to the changing needs in the community, changing human resource compositions and the evolving and changing personal and professional needs of providers working in or along with, the model. Flexibility in the model is also important because it has to be responsive to considerable variations in contexts, and changes over time. The most desirable compositions of the model may simply not be available for a variety of reasons in many communities, especially in rural areas. What makes the most sense in this situation is to ensure that basic needs can be provided (even then this may not be possible).

Flexibility is central, reflecting the fact that the model is a “*Living Organism*”. The key element of flexibility is due to human resource factors. Human resource flexibility is required for several reasons, including:

- Current composition of primary maternity care professionals in a community
- Work-life balance preferences of the team members
- Proportion of time team members spend in the model (e.g., a range of part-time/full-time options; a family physician may only spend 2 days a week in the model, while a midwife may be full-time. Nurses could be in job-sharing arrangements, and there may also be variable options for obstetricians).
- Changes in call arrangements due to increased demand for services, or unforeseen shortages with staff.
- The roles, functions and use of time by team members in the model may reflect the strengths, capacities and professional interests of the individuals’ vis-à-vis one another much more than their professional training would indicate.

The key factor with flexibility is that the core fixed elements of the collaborative model are protected, providers and clients are satisfied, the clients’ needs are addressed, and positive outcomes are achieved. If the expected outcomes are achieved, there is no need for a rigid inflexible organizational structure.

¹⁶ OSCAR is open-source software. It is a web-based application designed for the delivery of evidence resources and decision support at the point of care for both patients and providers. The software was initially developed by the Department of Family Medicine, McMaster University. There are now collaborators from many parts of the world. Expansion of the program is also under way in the United States, Europe, South Africa and possibly several other developing countries. OSCAR, like all Open Source software, is based on a philosophy of academic development and information sharing and is not intended to be marketed for profit.

Decision Supports

Decision supports should be available to ensure that local model developers can maximize the knowledge of others and minimize the logistical work required to get the models up and running effectively. Tools and templates need to be created to ensure that supports are available to assist decision-making. That is the purpose of the knowledge transfer modules, which provide a range of tools and templates to assist in the development and ongoing evolution of the model (e.g., access to protocols, information on software, how to implement change, tools for sustainability and so on). The knowledge transfer modules serve as a consistent frame of reference for stakeholders.

Evaluation

Evaluation is essential to the model for a number of reasons:

- It reinforces a spirit of enquiry and response, and the precepts of a learning organization
- Enables ongoing improvement in the way care is provided
- Creates opportunities for benchmarking with other primary maternity care groups
- Reinforces the focus on the core components of the model and the expected and desired outcomes
- Provides a focal point for stakeholders to assess the utility of the model compared to non-collaborative models.

It is important to establish the parameters for success. Metrics can be developed that link organizational and provider outcomes with health outcomes for babies and mothers. Critical success factors must be defined to show whether the models are working, and there must be capacity developed to enable evaluations and ongoing improvements to occur. While some outcomes and indicators will be fixed, others will need to be dynamic and capable of reflecting changes in practice and health priorities.

While it is not within the scope of this current paper, the evaluation framework is useful to present an example of how the evaluation could look. Quite simply, the key feature is to show the linkages between mission, vision, principles, structure, process and outcomes, with outcomes being short term, medium and long term.

Outcomes are benefits or changes for individuals or populations. Outcomes may relate to health outcomes, behaviour, skills, knowledge, attitudes, values, condition, status, or other attributes. As the collaborative model evolves it is very useful to develop a '*logic model*', which synthesizes and graphically portrays the model's own theory of practice.

Logic models show the linkages of the core components, activities, and the outcomes (which can be short, medium and long-term). Logic models communicate the logic behind the collaborative model – its rationale. Logic models are typically diagrams, flow sheets, or some other type of visual schematic that conveys relationships between contextual factors, inputs, processes, and outcomes. The initial logic model may need to be revised periodically as the collaborative model evolves from its early phases.

In concert with the logic model is the linkage of principles and outcome measures. Systematically building from the logic model, a number of measures can be developed using a common template. A working template would look something like the following:

Principle:

Indicator:

Key Questions:

Description:

Rationale:

Current Evidence:

Calculation:

Data sources:

Ultimately, the evaluation will incorporate indicators that assess the collaborative model on a number of measures and range of expected outcomes, including, for example;

- Positive maternity experiences
- Decreases in maternal morbidity
- Decreases in low birth weight
- Decreases in infant mortality
- Decreases in costs
- Satisfaction with care
- Satisfaction with work environment
- Successful births and associated sub-elements.

Summary

It is one thing to recommend a model of care with 22 core components, but quite another to effectively make it operational. This model *and* the support tools to enable communities to create an operational collaborative model of primary maternity care reflect the need to have a strong inter-relationship between both the product (the model) and process (supports for the ongoing development and evolution of the model).

Fundamental to the process of developing the collaborative model is a gradualist, community-based approach – an approach that incorporates the appropriate timing required in different locations for the adoption of the new models. The community and the *Community of Maternity Care Practice* decide.

The evolution of the model is grounded in the local needs and realities of communities. Providers need to work closer together and be able to look ahead at longer-term societal benefits in their community. Ideally, the collaborative model evolves into a regional system of integrated primary maternity care. The availability of core competencies by the team is central to the model.

It is important to build relationships even if they are difficult to begin with, as people have been seen to “*come around and work together when they see the benefits that emerge*”. Model development requires a considerable amount of ‘unpaid time’. As one stakeholder in the primary research noted: “*You must create time to make a collaborative model work*”.

Community consultation is an essential first step for developing the model. Failure to do so will fly in the face of strong opinion from those who have developed collaborative models, and would cause considerable angst among existing communities of maternity care practice.

There is no ‘one size’ model that fits all the permutations of the different community contexts. What is far more palatable and marketable is a model from which interested organizations or professionals can draw upon as further required, again depending on their needs in that community context. In this regard the decision support tools in the knowledge transfer modules make a difference to the nature and extent to which a collaborative model is developed.

The important thing is to ensure women receive the care and support they require, and that the desired outcomes of the model formations can be achieved. The appropriate care and support of women must remain at the centre of the model.

Finally, there is a fundamental belief that a collaborative primary maternity care model will lead to:

- Better health outcomes,
- Healthier babies and mothers,
- Greater efficiencies in the system, and
- Improved working environments for primary maternity care professionals.

Appendix 1 – Background

For a number of years, the SOGC worked collaboratively with key stakeholders involved in primary maternity care, including the Association of Women’s Health, Obstetric and Neonatal nurses (AWHONN), Canadian Association of Midwives (CAM), College of Family Physicians of Canada (CFPC), and the Society of Rural Physicians of Canada (SRPC). In 2003, under the leadership of The Society of Obstetricians and Gynaecologists of Canada (SOGC), these organizations formed a partnership to submit a funding proposal to the Primary Health Care Transition Funds Program of Health Canada for the implementation of a national initiative to “reduce key barriers and facilitate the implementation of national multidisciplinary collaborative care strategies as a means of increasing the availability and quality of maternity services for all Canadian women”. The proposal was accepted by the Primary Health Care Transition Funds Program and funding was approved in May 2004. The Canadian Nurses Association joined the project as a full partner in November 2004. These partners formed the Executive Committee for the project.

More specifically, the objectives of the project were:

- To develop guidelines to facilitate the establishment and implementation of multidisciplinary and collaborative models of primary maternity care team for various health care settings that are patient centered (women and babies).
- To develop national standards regarding terminology and scope of practice for all primary maternity care providers, including nurses, midwives, family practitioners and obstetricians.
- To facilitate the harmonization of legislation and policies of governments, professional regulatory colleges, professional associations, funding agencies, insurers and educational institutions throughout Canada as it relates to the provision of multidisciplinary primary maternity care.
- To facilitate information sharing on collaborative primary maternity care experiences.
- To facilitate collaboration among professionals involved in primary maternity care.
- To facilitate change in practice patterns for primary maternity care providers.
- To promote to the public and maternity care providers the need for and benefits of multidisciplinary collaborative maternity care.

The purpose of this current paper is to present an approach for Guidelines for Development of a Model proposed in the Multidisciplinary Collaborative Primary Maternity Care Project. Once the model has been defined the challenge is to introduce it in the care delivery environment. A framework for change can guide this implementation. This framework is provided by the seven knowledge transfer modules associated with the collaborative model implementation.

Appendix 2 – Definitions

Primary Care: primary care is a term used for the first point of consultation for all patients. The aims of primary care are to provide the patient with a broad spectrum of care, both preventive and curative, over a period of time and to coordinate all of the care the patient receives.

Primary Care Provider or Primary Caregiver: a physician, midwife or other health professional who has the legal authority to provide health services within their scope of practice without being supervised by another health professional. The primary care provider is the member of the health care team who is ultimately responsible for the client/patient/woman's care.

Primary Maternity Health Care: is the umbrella term for the fundamental healthcare services that women access during pregnancy, childbearing and the postpartum period. Primary maternity health care takes a holistic, woman-centred approach to service delivery, health promotion and the prevention and treatment of disease and illness. Primary maternity care is the first contact with our health care system for maternity care needs.

Primary maternity health care is part of a comprehensive maternity care system for a community and includes plans for addressing the needs of women and their infants who need care from other providers. It is based on the philosophy that pregnancy and childbirth are natural processes that require a focus on health and should be individualised. Within the context of primary health care, it is an important way of working towards developing healthy communities.

Secondary Care: Services provided by medical specialists who generally do not have first contact with patients (e.g., cardiologist, urologists, dermatologists). In the US, however, there has been a trend toward self-referral by patients for these services, rather than referral by primary care providers. This is quite different from the practice in England, for example, where all patients must first seek care from primary care providers and are then referred to secondary and/or tertiary providers, as needed (Source: www.wikipedia.org).

Tertiary Care: Specialized consultative care, usually on referral from primary or secondary medical care personnel, by specialists working in a center that has personnel and facilities for special investigation and treatment. (Secondary medical care is the medical care provided by a physician who acts as a consultant at the request of the primary physician.) (Source: www.hopkinsmedicine.org).

Multidisciplinary Care: Of, relating to, or making use of several disciplines at once. Multidisciplinary means that health-care providers from different professions provide diagnoses, assessments and treatment, within their scope of practice and competence. And that funding models for any primary health system respect the autonomy of the disciplines involved and is multidisciplinary in nature (Source: <http://www.physiotherapy.ca/pdfs/> Ken Higgs Presentation)

Collaboration: Collaboration is the act of working jointly. It consists of working together with one or more other people; joint work toward a common end (Source: www.medical-dictionary.thefreedictionary.com).

Appendix 3 – The Logic of a Collaborative Model

What is a Model?

There are many definitions of a ‘model’. The Oxford Dictionary has a range of definitions, depending on the context, but the core message is the same. A model is “*a simplified description of a system ... a particular design or style of a structure ... an exemplary person or thing ... ideal, exemplary ... a person or thing used, or for use, as an example to copy or imitate ...*” The key elements are simplicity, exemplary and ability to copy or imitate. More scientifically based models can be regarded as *representation containing the essential structure of some object or event in the real world*” (Stockburger, 1996).

Models are necessarily incomplete and as representations, do not include *every* aspect of the real world of primary maternity care. In order to create models, there must first be the assumptions about the essential or core structure and relationships that can be expanded upon in the real world. These assumptions are about what is necessary or important in the models. It should be possible to change or modify the models with relative ease. Indeed, it should be easier to manipulate the model than the real world.

The scientific method for building models consists of four key phases: 1). Simplification/Idealization – the essential structure of objects or events. This phase identifies the relevant key features. 2). Representation – the features are given meaning as objects, events, or relationships in the real world. 3). Transformation – Implications of the model are derived. 4). Verification – Here, the selected implications derived previously are compared with observations in the real world. Fundamentally, the important consideration is whether a model is adequate for the purpose at hand – the *raison d’être* for the model development.

Collaboration in Health Care

Collaboration is a complex and sophisticated process that requires hard work, and an investment of time to develop and maintain. Quite simply, almost too simply perhaps, Keleher (1998:8) writes; collaboration can be defined as “*working together in partnership*”. Citing Henneman et al (1995), Stapleton (1998:13) notes that “*collaboration is a process which occurs between individuals, and only the persons involved ultimately determine whether or not collaboration occurs*”. Collaborative practice can range from two practices of professionals from different professions to fully integrated joint multi-specialty teams (Miller and King, 1998). There are far ranging definitions of collaboration, so much so that it is important to situate it within the context of given initiatives. This then defines the process of the new initiative and its content, while recognizing and respecting the context in which new models may emerge. Indeed, it is unlikely that guidelines for new model development will satisfy all the various specific and unique geographical, jurisdictional and organizational contexts in which new models may be developed, and there will be a necessity for flexibility that recognizes these different contexts.

Equally significant in today’s health care environment is the role of evidence-based decision-making. Effective knowledge transfer can enhance the capacity of providers to deliver care in innovative ways that respond to the needs of women while using more effective integration of providers and services. Indeed, “*with an increasing focus on evidenced-based practice, the potential of innovative models of maternity care that incorporate these features cannot be overestimated*” (New South Wales Government, 2000:15).

Clark-Coller (1998:2) notes that, “*collaborative practice requires a non-hierarchical relationship between the professions, with an equitable distribution of work, authority, responsibility, and credit for success*”.

Stapleton (1998:12) offers the following definition of collaboration:

“Collaboration is significantly more complex than simply working in close proximity to one another. It implies a bond, a joining together, a union and a degree of caring about one another and the relationship...”

A collaborative relationship is not merely the sum of its parts, but it is a synergistic alliance that maximizes the contributions of each participant, resulting in action that is greater than the sum of individual works.”

Collaboration thus:

“Involves attempts to find integrative solutions where both parties’ concerns are recognized and important concerns are not compromised. It merges the insights of persons with differing perspectives, and consensus is gained among those in the problem-solving effort through examination and working through reservations regarding particular aspects of the decision” (Weiss and Davis, 1984:299).

Benefits of Collaboration

The literature is clear that no one profession can effectively address health care issues in isolation of the skills, expertise and experiences of other professionals. Indeed, the overriding goal of collaboration is to improve the quality of care. Several studies have identified positive outcomes for patients, families and providers when care is collaborative (e.g., Alpert et al, 1992; Evans, 1994; Fagin, 1992). Under this overarching goal is the achievement of many interrelated sub-objectives (see, for example, Brita-Rossi et al, 1996; Casto and Julia 1994; Chimmer and Easterling 1993; De Angelo, 1994; Gray, 1989, Gray and Wood, 1991, Jones 1994a, 1994b; Kelleher, 1998; Leppert, 1997; McClain, 1988; and Miller, 1997), including:

- Improved provider satisfaction
- Improved family satisfaction
- Fewer complaints
- More efficient use of time
- Decreased length of hospital stay
- Improved working relationships
- Enhanced continuity of care
- Lower costs

The benefits of an interdisciplinary collaborative approach in health care have included better health outcomes, and the opportunity for professionals to gain a greater understanding and respect for one another (Singleton and Green-Hernandez, 1998). Indeed, collaboration must be based on mutual respect and recognition of the specific role that each practitioner plays along the continuum of care (WHO, 2004).

There have been a number of papers that have identified models of collaborative practice among professions (e.g., between nurses and physicians – Alpert et al, 1992; Norsen et al, 1995; Pike and Albert, 1994, and between nurse-midwives and physicians – Graham, 1991;

Miller, 1997; Sullivan and Witte, 1995; Vande Vusse and Hanson 1997). The continuing themes of these papers are the articulation of the essential features discussed for effective collaboration, the benefits and the challenges to overcome.

Key Features of a Collaborative Practice Model

The literature reviewed as part of the background research for this model development identifies six key features of a Collaborative Practice model:

- A common group of patients
- Common goals for patient outcomes and a shared commitment to meeting these goals
- Member functions are appropriate to an individual's education and expertise
- Team members understand each others' role
- A mechanism exists for communication
- A mechanism exists for monitoring patient outcomes

There are also a number of values/behaviours that underlie collaborative practice models. These include:

- **Trust** among all team members establishes a quality working relationship that evolves over time as the team members become more acquainted with one another.
- **Knowledge** is a necessary component for the development of trust. Knowledge and trust remove the need for supervision.
- **Shared responsibility** suggests joint decision making for patient care outcomes and practice issues within the organization.
- **Mutual respect** for the expertise of all team members is the norm. This respect is communicated to the patients.
- **Communication** is not hierarchic but rather two-way, facilitating sharing of patient information and knowledge. Questioning of the approach to care of either partner cannot be delivered in a manner that is construed as criticism but as a method to enhance knowledge and improve care.
- **Cooperation and coordination** promote the use of the skills of all team members, prevent duplication, and enhance productivity of the practice.
- **Optimism** that this is the most effective method of delivery of quality care (which promotes success).

Although no foundational evidence is provided, Stapleton (1998) identifies 12 critical attributes for collaborative practice. In a similar vein to those characteristics shown above, these are:

- Open, honest communication
- Mutual trust and respect
- Understanding and valuing each other's perspective and way of thinking
- Familiarity with and valuing each other's style and scope of practice
- Equality and shared power
- Professional competence
- Shared responsibility and accountability
- Shared values, goals and visions
- Willingness to openly discuss differences
- Unified front and mutual support

- Willingness to devote time and energy to the relationship
- Frank discussion of financial issues

Similarly, Keleher (1998) identifies several key elements of successful collaborative practices:

- Willingness to move beyond basic information sharing
- Willingness and ability to challenge distortions and assumptions
- Belief system based on critical self-reflection
- Other key elements included: coordination, respect, cooperation, mutual trust, valuing and sharing.

Baggs and Schmitt (1988), in an extensive review of medical and nursing literature and interdisciplinary care, refer to six key attributes of collaboration:

- Cooperation
- Assertiveness
- Shared responsibilities for planning
- Shared decision-making
- Open communication
- Coordination.

And through a review process and reading of the literature Way et al (2000:3) identify seven key elements required for successful collaborative practice:

- Responsibility/ accountability
- Coordination
- Communication
- Cooperation
- Assertiveness
- Autonomy and mutual trust
- Respect.

Finally, three key features of collaboration identified by Weiss and Davis (1984) are:

- The active and assertive contribution of each party
- Receptivity to, and respect for, the other parties' contributions
- A negotiating process that builds upon the contributions of both parties to form a new way of conceptualizing the problem.

Clearly, there are common themes that emerge from the lists presented above.

Coeling and Wilcox (1994) suggest that *openness to information presented* and *adequate time to communicate* as important variables for effective collaboration. What is also important is the *appreciation of other professionals and their scope of practice*, which can best be illustrated in the education and training of new professionals. Successful examples of these exist that combine physicians, nurse midwives and nurse practitioners (e.g., Howard and Leppert, 1998; Leppert and Howard 1997). Aside from developing respect and understanding of the different scopes of practice, the exchange of learning early on in career development also increases the available patient population and provides a wider variety of clinical settings for the different professions (Howard and Leppert, 1998).

Respect and trust are expressed through open and honest communication. Communication requires effective listening and willingness to express one's views. Each person must be aware of the others' style of communication and thought processes. Styles need to complement one another, and adaptation may be required. Poor communicators make for poor collaborators. Trust also needs to be invested in the clinical competence of others. Mutual trust develops over time as a result of many positive experiences with one another. There is also a need to respect and understand differing perspectives or underlying philosophies of care, which will, in itself, enable a more comprehensive understanding of the patient/client. Moreover, "*individuals who feel secure and competent professionally can communicate their discipline's strengths, value, limitations, and contributions to colleagues from other disciplines*" (Stapleton, 1998:14). Stapleton adds that; "*the development of a mature collaborative relationship is an ongoing process requiring much time and effort on the part of each individual involved*".

In a cautionary vein, Celia Davies (2000) asks the question "Is there any content in the "C" words, so popular in government policy documents – coordination, collaboration and cooperation?" She notes that researchers are beginning to understand what working together can actually achieve. Stapleton (1998) questions whether health care providers really fully appreciate what collaboration means and know how to put it into practice in their day-to-day professional lives, or even recognize what it requires of each of its participants. Davies (2000) goes on to say that it is not what different partners have in common that is important, but rather that their differences make collaborating more "powerful" than working separately. While agreement and acknowledgement of each others skills and recognition are important it is the *challenging* and *questioning* that bring out the full potential of collaboration – and in many respects that may be the distinction between collaboration in its traditional sense in maternity care versus new models of *collaborative practice*.

In new collaborative models, asserts Davies (2000:1022), participants need to "*be confident enough to face the unfamiliar [and] respectful and trusting enough to listen openly to others*". There need to be ground rules, and power differentials among practitioners need to be resolved. Again, Davies notes:

"...along with deference to doctors, nurses still work "around" others. Individually, nurses and doctors may strive to overcome the lingering images of their professions, but there is a weight of tradition, including a tradition of gender thinking to contend with. Nursing is no more conducive to collaborative working than is medicine. Both need to change if a collaborative model is to work".

Barriers and Challenges to Collaboration

There are a number of barriers and challenges to face when developing collaborative practice models (Kelleher, 1998; King and Shah, 1998; Stapleton, 1998).

These include, for example:

- Separate training for different health care providers (none fully understands the other practice perspectives)
- Different financial incentive (and disincentive) structures
- Hierarchical health care system
- Due to different professional socialization and training, barriers to effective communication between physicians, nurses and midwives (i.e., different ways of looking at the same problem)
- Dominance of the medical profession in health care

- Traditional independence of medical practice
- Differences in social status (power differential)
- Gender issues
- Satisfying professional autonomy

Rogers (nd) adds that there a number of challenges to developing collaborative models, including:

- The natural resistance to change
- Shortages of nurses, physicians, and midwives
- Current educational models
- Regulatory barriers
- Funding barriers
- Liability insurance barriers.

More generally, McLain (1988) notes that nurses and physicians failed to collaborate due to distorted communication and non-meaningful interactions.

Summary

In summary, it is clear that there are many elements that consistently emerge in the research literature as positive attributes of collaborative models. They provide a sound empirical basis for the core components identified in this Guidelines for Model Development document and reinforce the observation that there are known attributes that can be built upon to support model development. Indeed, that is the intent of the knowledge transfer modules that serve as supporting material for this Guideline for Model Development document.

Appendix 4 – Understanding Context

It was initially assumed that because of differences in the *context* of maternity care providers and the communities themselves, there would be a number of different models. What emerges from the research data for this project, however, is agreement on what a model would look like. The differences that are apparent are due to variations caused by many different *contextual factors*.

With this in mind, developing different models due simply to contextual differences undermines the purpose of this initiative.

There are four main categories of contextual factors:

- Community
- Human Resources
- Political-regulatory environment
- Location

By necessity there will always be variations on any ‘Model’ put forward. We run the risk of complicating the organization and delivery of primary maternity care if we arbitrarily develop different models due to context alone.

☞ **Community**

‘Community’ refers to the primary maternity care needs of a community, and the current configuration of individual and organizational resources available to meet those needs. Without this understanding it would be unwise to attempt to develop collaborative models. The underlying social structures that connect different providers and organizations will be pivotal in the development of successful models. It may well be, for example, that one hospital is preferred over another because of the strong relationships already established with that hospital by those providers working within the collaborative model.

☞ **Human Resources**

An understanding of the human resource dimension is essential: First, the models have an explicit human resource dimension, and in many respects *shortages* of health professionals have been the catalyst for examining the potential for collaborative models. Second, the models cannot be developed if there is no sense of the *availability* of health professionals to work in the models. If there are acute shortages of family physicians in a community it may not make sense to commit to a model that requires significant time commitments by family physicians. If there are no midwives in a community (or even the region) it will be unwise to advocate for a model based solely on the presence of midwives. A central tenet of the collaborative models is flexibility to enable different professionals to work according to their own needs, professional aspirations, and work-life balance.

☞ **Political-regulatory environment**

The political-regulatory environment refers to ability to legally perform the various activities required for effective maternity care. Simply put jurisdictional legislation and professional regulations may not allow the participation of various providers in the respective models that are proposed. Although there may be merit in recommending and advocating new models of primary maternity care in an environment that cannot allow providers to function outside their

scope of practice, or where there is no political will to look at new ways of providing care, this contextual domain is an enabler or limiting factor for developing collaborative models.

☞ **Location**

A dominant theme to emerge from the interviews was the difference that location makes to the nature and extent of primary maternity care. While it can be understood at a variety of different spatial levels, (for example, the location of a clinic in close proximity to the expecting mothers and/or a hospital), the main issue was the differences that must be accommodated for in rural and remote settings. In other words, the spatial organization of primary maternity care is itself conditioned by the layers of historical practice and the politico-regulatory environment. It is also closely tied to the human resource and community dimensions.

The model will be required to meet the challenges of the rural and remote settings because if it does not there is little likelihood it will be supported by these often under-resourced communities. Thus the members of the multidisciplinary collaborative team will by necessity reflect the needs of the rural and remote locations and the available, often limited supply of maternity care providers. As "*rural communities have their own way of looking at things*", that too, will influence the shape and scope of the multidisciplinary collaborative team models. The locational dimension's importance is further ensconced in rural and remote areas in the winter.

Appendix 5 –The Seven Knowledge Transfer Modules

- 1) Environmental Scan**
- 2) Getting Started**
- 3) Building Teams**
- 4) Communicating Effectively**
- 5) Improving the Collaborative Model**
- 6) Evaluating the Collaborative Model**
- 7) Evaluating the Cost Implications of the MCPMC Model**

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