16 Interprofessional Quality Improvement Strategies

Asha S. Payne and Heather Walsh

Introduction

Lauren and Dayna, both physicians, decided to embark on a quality improvement project. They organized meetings, developed a key driver diagram, undertook a thorough analysis of the problem, and decided on the appropriate metrics to measure improvement. After a few months of work, they approached their nursing colleagues, Dory and Chris, to assist with the project. Dory and Chris jumped right in, and the combined team began executing PDSA cycles. Chris helped with collecting data but found it difficult to collect accurate data as she was unfamiliar with the proposed metrics. Though not able to make most of the meetings because she worked the night shift, Dory attended the meetings when she was able. She assisted in executing the PDSA cycles on night shift, but often felt they did not run smoothly as she was not as familiar with the operational aspects of the project. Lauren and Dayna appreciated the help Chris and Dory provided with the project but felt they were not as engaged as they had hoped. In addition, they enjoyed the praise from their senior leadership for creating an interprofessional quality improvement (QI) project. After several months of PDSA cycles, the team achieved improvement in their metrics. Lauren and Dayna eagerly presented the results of the

A. S. Payne (✉) · H. Walsh
Children's National Hospital, Washington, DC, USA
e-tmail: ASpayne@childrensnational.org; HWalsh@childrensnational.org

R. Roberts-Turner, R. K. Shah (eds.), *Pocket Guide to Quality Improvement in Healthcare*,
https://doi.org/10.1007/978-3-030-70780-4_16

work to their senior leadership, eventually publishing a paper to disseminate the findings. What a great example of interprofessional quality improvement! Would Chris and Dory agree? What were the missed opportunities?

Interprofessional Quality Improvement Is More than Working with Another Discipline

In the scenario above, multiple clinical disciplines participated in the QI project, yet they did not have true interprofessional collaboration. Interprofessional collaboration requires sharing, partnership, interdependency, and shared power [1]. In QI, all of the relevant disciplines should actively be involved in each aspect of the project, from assembling the team, determining the scope of the project, conducting PDSA cycles, analyzing the data, and to sharing the results of the work. Lauren and Dayna were the project leaders, and though they eventually partnered with Chris and Dory, there was not true interprofessional collaboration from the beginning. Lauren and Dayna, both physicians, formed the team among themselves; there was no indication of shared power of the project. As such, the above represents a project that Chris and Dory helped with, not a project they owned. Further, there is no indication that Chris' and Dory's perspectives were included in the project, either by updating the key driver diagram or by incorporating additional metrics. Moreover, simply assisting in the execution of the PDSA cycles does not constitute true interprofessional collaboration. There was no interdependency between the physicians and nurses. Lauren and Dayna needed the assistance from Chris and Dory, but there is no indication the converse is true. Finally, there is no indication of shared decision-making or shared power.

Interprofessional Quality Improvement Is More than Doctors and Nurses

Though physicians and nurses are important members of healthcare teams, they are not the only members. Pharmacists, social workers, language interpreters, respiratory therapists,

environmental services, information technology, nutrition services, and administrative staff are just a few of the disciplines who may be needed to execute a successful QI project. Each discipline contributes to patient care and the functioning of an organization. In the example above, it is likely that Lauren and Dayna probably could have included at least one other clinical discipline in the work, either pharmacy, social work, or respiratory therapy. The scope of each QI project determines which disciplines should be included, whereas Organizational culture will dictate which clinical disciplines are the easiest to bring together. For some organizations, simply getting two clinical disciplines to meet together is the first step on their interprofessional journey. If that is your organization, start there!

Why Is Interprofessional Collaboration Important for Quality Improvement?

Health care, with all its complexity, is a team sport. Despite this, each clinical discipline learns mostly in silos, with each discipline only perceiving the health-care process from their narrow perspective, without understanding all of the processes impacting patients. Further, understanding complex health-care systems is difficult, and *changing* complex systems is even more so without the input from all disciplines involved. Successful QI work depends on truly understanding all aspects of a health-care system, which cannot happen without all clinical disciplines. As such, limited interprofessional collaboration represents a lost opportunity for understanding health-care complexities and the subsequent improvement that comes from learning these complexities. QI projects are more successful when addressed holistically with the collaboration of interprofessional team members. Look for natural partners: anesthesia and surgery; nurses, physicians, and pharmacists; lactation specialists and nurses. Additional disciplines and service lines can be added as interprofessional collaboration becomes more entrenched in the organization.

Interprofessional Collaboration Is Beneficial to Its Participants

Clinicians, including physicians, nurses, therapists, social workers, and pharmacists, involved in interprofessional quality improvement work cited participating in a highly functioning interprofessional team as the dominant theme for their participation [2]. This indicates that interprofessional collaboration may be a key motivation for many disciplines to engage in QI initiatives. Active interprofessional collaboration in quality improvement projects can streamline processes, improving the delivery of patient care and workflow for staff. Other benefits of interprofessional collaboration include an association with higher teamwork and better inpatient satisfaction scores [3] and better patient outcomes [4]. Additionally, interprofessional collaboration enhances nurse retention through positive practice environments, which include collaborative nurse-physician relationships (e.g., interprofessional involvement in creation of order sets, protocols, interprofessional education activities, and defined roles and responsibilities) [5]. With health care reform, the need for interprofessional teams has never been greater to improve health-care costs, efficiency, and patient outcomes [6].

Every QI Project Does Not Have to Be Interprofessional

Given the complexity of health care, significant or wide-reaching QI projects should be interprofessional collaborations. However, *every* QI project does not have to be interprofessional. Each clinical discipline has skills and perspectives developed within, and improved by, discipline-specific efforts. For example, a QI project aimed at improving the consistency of physician documentation does not require nursing support. Similarly, a QI project to improve nurse retention would not require an interprofessional approach unless poor nurse-physician collaboration was cited as the reason nurses left the organization. If the

goal of the QI project is discipline-specific improvement, interprofessional collaboration is perhaps not needed, but if a QI project impacts patients, it likely needs to be interprofessional. Consult with team members to determine the scope of disciplines to be included.

Successful Interprofessional QI Collaboration and Learning

Develop a Culture of Interprofessionalism

Successful interprofessional QI collaboration is driven by an organizational culture that expects and supports interprofessional engagement. In turn, organizational culture is driven by the actions of senior-level and local-level leadership. Consequently, senior-level and local-level leaderships need to authorize, actively support, and engage in, interprofessional collaborations. Individual QI leaders can begin developing a local culture of interprofessionalism by beginning new projects with interprofessional leads. Similarly, existing projects can be reorganized to include interprofessional membership or leadership, as appropriate, being sure to actively incorporate all new participants.

Leadership Support

Local-level leadership for each relevant discipline should be knowledgeable of all interprofessional QI projects. Senior-level support should also be informed, as appropriate. Staff who volunteered (or were appointed) should feel empowered and supported by local leadership to participate in QI activities. Keeping all leaders updated on the progress of initiatives is key. QI project leaders should provide regular updates (presentations, email) to leaders from all the clinical disciplines involved. Getting all leaders together in the same room is preferred, so the QI work can develop and support their interprofessional relationships as well!

Creating Interprofessional QI Teams

Interprofessional QI teams begin with interprofessional leadership. However, interprofessional leadership may not be possible or necessary, depending on the scope of the project. Indeed, the culture of your organization may not be ready for true interprofessional collaboration.

If interprofessional leadership of the team is not possible, then the QI leader should have an eye for creating and fostering an interprofessional team. For example, a QI project to improve antibiotic stewardship may be led by a physician but should be composed of several clinical disciplines. Inviting representatives from other disciplines at the outset of the project is critical. In the scenario at the beginning of the chapter, Laura and Dayna did not involve Chris and Dory until after the project was established. They would have had more engagement and support for the project had they thought to invite them to participate at the outset.

It takes effort to build a high-performing team! Finding engaged staff is the key. Those recruited to join should ideally have experience, or at least a reputation of, working well with others. In addition, appropriate incentives for participating in QI work should be tailored to each clinical discipline. Physicians at academic institutions may be incentivized to participate for either MOC credit, CME credit, or possible publications. Nurses may be encouraged to participate in QI projects if their participation can count towards clinical advancement, promotion, or faculty appointment. Laura and Dayna eventually published the results of the project, but did they include Chris and Dory as authors? Is publication useful for Chris and Dory, or would their careers benefit from another type of reward? Establish the incentive needs of each clinical discipline, including authorship in publications and abstracts, at the beginning of a project or when new members join a preexisting project.

Consider having at least two representatives from each clinical discipline as team members, as this may be necessary to enable regular attendance of each discipline at all team meetings. It is

sometimes impossible for a team member to leave clinical care to attend a meeting. Address any possible attendance limitations with each team member at the beginning of their participation.

As mentioned earlier, interprofessional collaborations require sharing, partnership, interdependency, and shared power [1]. Initial team meetings should begin with introductions beyond name and role to begin to build trust and rapport among members. Effective teams identify clear goals, share clarity on roles and responsibilities, communicate openly and honestly, engage all team members, and appreciate diversity within the group. In contrast to multidisciplinary teams where decisions are typically made by one individual, interprofessional teams make decisions jointly [6]. Create equal partnerships among team members through respect and true engagement.

Working in Interprofessional Teams

Coordinating interprofessional QI projects requires careful planning and constant communication. Clinical responsibilities and daily work schedules vary among clinical and nonclinical disciplines. In the scenario at the beginning of the chapter, Chris was not able to attend most of the meetings because of her clinical schedule. Were there any accommodations for her? When planning interprofessional QI meetings, team leaders should consider the schedules of each discipline, scheduling meetings to ensure adequate participation for all members. QI team leaders may need to conduct meetings earlier or later in the traditional workday to account for the demands of shift work. Facilitating coverage for staff members to attend meetings should also be considered. For example, to increase bedside nurse participation in a QI project, consider having an educator or charge nurse cover that nurse's assignment to facilitate meeting attendance. Also, holding shorter, more frequent meetings limits time away from clinical duties. The worst possible times for meetings are between 7 and 8:30 AM and from 3 to 4 PM as this is usually when clinical teams are changing shifts, signing out, or rounding.

Additionally, QI leaders should be aware of the location and accessibility of team meetings. To facilitate attendance from physician and nursing staff on a unit-based project, hold meetings on the unit as opposed to a conference room away from clinical areas. Teleconferencing options should be available for all meetings to encourage staff involvement. To ensure active participation during the meeting, QI team leaders should set an agenda for the meeting. The agenda should be shared in advance. Clear and thorough notes should be taken at each meeting and shared in a timely fashion after the meeting. Of note, email dependence and requirements vary among clinical disciplines. Some staff do not use email as part of their daily work, so email communication may not connect with all team members equally. To account for this, QI leaders or a designee should consider quick, in-person meetings to engage and update those team members as needed.

During meetings, QI leaders should ensure that all professions have the opportunity to share their expertise. If necessary, consider seating arrangements either in an open forum meeting or roundtable. In these meetings, some participant groups may naturally dominate the conversation. An effective QI leader should proactively facilitate sharing from all disciplines. For example, "We haven't heard from the therapists yet. How will this impact you? What has your experience been?"

While the main outcome of the project will be determined by the project charter and leaders, all team members should be involved in the decision-making for additional metrics and the execution of PDSA cycles. When executing PDSA cycles, ensure adequate representation from all disciplines. Also, consider having cross-discipline participation. For example, consider having a pharmacist facilitate the nursing portion of the PDSA cycle. This provides an opportunity for interprofessional learning. During feedback sessions after PDSA cycles, discipline-specific feedback to their peers may yield more useful feedback; however, cross-discipline feedback may elicit more honest responses. Organizational culture and the individual participants will determine which method is best. Experience with QI tools and techniques will also vary among clinical disciplines. Consider

incorporating brief educational components to ensure participants have a sufficient understanding of the QI process.

Dissemination of the Work

For public presentations of the work (e.g., abstracts or posters), the presenters should represent as many disciplines as possible. Some disciplines are more comfortable speaking publicly, but all should be provided the opportunity. Senior leadership of all divisions and departments included in the project should be invited to the presentations. For written publications, authorship order should be determined before writing begins. Consider using the acknowledgment section for those who participated in the project but for whom writing credits are not necessary.

If the project is spread to other parts of the organization, make sure each discipline serves as a trainer or resource for the new areas. Any tools created should be shared widely among all the disciplines involved.

Conclusion

In the example presented at the beginning of the chapter, different disciplines were invited to participate in a QI project, but the execution fell short of true interprofessional collaboration. True interprofessional learning and collaboration is more than the participation of different disciplines in a QI project but rather, involves a true partnership through all aspects of a project. The journey to successful interprofessional collaboration begins with leaders and teams understanding where their organizations are on their respective interprofessional journeys. An interprofessional approach to improving complex clinical care systems is difficult, but it creates increased job satisfaction for participants and better experiences for patients. Successful interprofessional collaboration and learning involves following the lead of senior leaders by creating teams with interprofessional leaders and members who

truly integrate the strengths of each discipline. QI team leaders need to account for the needs, desires, and limitations of all clinical disciplines. Start with who is willing and available, and expand efforts from there.

References

1. D'Amour D, Ferrada-Videla M, San Martin Rodriguez L, Beaulieu MD. The conceptual basis for interprofessional collaboration: core concepts and theoretical frameworks. J Interprof Care. 2005;19(Suppl 1):116–31.
2. Cumbler EKP, Hagman J. Motivation of participants in an interprofessional quality improvement leadership team. J Interprofessional Educ Pract. 2016;3:5–7.
3. Meterko M, Mohr DC, Young GJ. Teamwork culture and patient satisfaction in hospitals. Med Care. 2004;42(5):492–8.
4. Baggs JG, Schmitt MH, Mushlin AI, et al. Association between nurse-physician collaboration and patient outcomes in three intensive care units. Crit Care Med. 1999;27(9):1991–8.
5. Twigg D, McCullough K. Nurse retention: a review of strategies to create and enhance positive practice environments in clinical settings. Int J Nurs Stud. 2014;51(1):85–92.
6. Eggenberger T, Sherman RO, Keller K. Creating high-performance interprofessional teams. Am Nurse Today. 2014;9(11):12–4.