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Hello everyone and welcome back to the LungFIT Podcast. We recently had our 50th episode, which is so crazy, and unfortunately we missed celebrating it with our Lungfit community. We've been really busy in the lab getting our trips to Northern BC organized, and that's mixed with student events and conferences. And so this momentous occasion passed us by. But reflecting over the past three years and seeing the direction we're now headed, we feel a lot of personal pride and accomplishment. We are so grateful for the many listeners that we have, and we really strive to continue to bring you evidence-based, informative, and interesting content as it relates to lung health in general, pulmonary rehab specifically, and of course, your own professional development, be that in clinical, educational, or research settings. So on that note, if there is anything that you'd like us to talk about or cover in one of our episodes, please contact us and let us know.

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In this episode, I would like to talk about collaborative practice in pulmonary rehab, how different individuals and disciplines work together to provide rehab programs. You know, the definition of pulmonary rehab includes language about how it's a multidisciplinary intervention, but the reality of many programs is that so often its just one or two people who are doing everything, but that doesn't mean collaboration doesn't happen or can't happen. And I'd like to explore the concepts of collaborative practice in this episode. First off, what do I mean when I use the term collaborative practice? Well, the World Health Organization says that, and I quote, collaborative practice in healthcare occurs when multiple health workers from different professional backgrounds provide comprehensive services by working with patients, their families, carers, and communities to deliver the highest quality of care across settings. Fairly basic description, in my opinion, and I think you could argue that in most parts of healthcare, multiple healthcare workers from different professional backgrounds provide comprehensive services.

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But I would argue that this definition doesn't really speak to collaboration. It's really focused on the provision of services, but not about the people. An organization closer to my home, the Canadian Interprofessional Health Collaborative, gets closer to it, in my opinion, with their definition of collaborative practice as and I quote, the process of developing and maintaining effective working relationships with learners, practitioners, patients, clients, families and communities to enable optimal health outcomes. With this definition, you can see more emphasis on the relationships, which I like. So where is collaborative practice in pulmonary rehab? Well, if you have a large well-resourced program, you might have multiple disciplines involved, including medicine, physio, respiratory therapy, exercise physiology, rehab assistance, social work, and nursing, and hopefully collaborative practices apart of that. In 2012, I led a nationwide survey with the Canadian Thoracic Society of all the pulmonary rehab programs in Canada from small community-based programs to larger publicly funded hospital- based programs.

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I'll put a link to that paper in the show notes. And what was really eye-opening to me about that particular survey was seeing all the different ways programs are run. Some had quite a varied roster of professions where others were practically sole charge, but it isn't just having a lot of specific disciplines involved that makes it collaborative. You can certainly have a well-resourced pulmonary rehab program with many disciplines involved, but if they're all siloed from one another, if they don't talk to each other

or work together to address the patient's specific needs and goals, then it wouldn't really be an example of collaborative practice. Similarly, you could have just a physician and a therapist involved in delivering the program, but you know, they might meet regularly to discuss their patients. They would bring their unique and distinct expertise to that discussion. And then with the patient and their family, they would co-create a program.

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Then that actually comes closer to that definition of working together to enable optimal health outcomes. Having a lot of disciplines in a program does not make it collaborative. The aim is really identifying that common goal, such as improving health delivery and outcomes in a pulmonary rehab setting, and then figuring out together how to accomplish this. We've likely all participated in healthcare settings like rounds or so-called "team meetings", but sometimes they're organized so that it's just one or two people doing all the talking about what will happen to the patient. The decisions have already been made, and it's more of an information session, but collaborative practice is much more than a group meeting. It truly includes and respects each discipline's contribution and builds a strong team relationship. This relationship has the potential of improving outcomes for the individual patient for sure, but it also has the potential for improving outcomes for all the patients and actually also the working environment for those team members.

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But I just want to comment that you know, you'll notice that my conversation so far with you has been focusing on collaborative practice in the context of the clinical team. We know that health service delivery and planning is likely the largest element or the largest component of collaborative practice, but we also need to expand our thoughts on how education and research should be included. That brings in the concept of the learning health system, which I totally love, totally interests me. I'm gonna dedicate a future episode on that topic. We have hopefully all been involved in collaborative practice at some point in our careers, and also hopefully we've seen how successful collaborative practice can make a big difference on patient outcomes and our own sense of worth participation and satisfaction with our jobs. Collaborative practice is a growth focused area, working with others who are also excited about implementing change and solving hurdles.

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The collaborative relationship shares the burden of work with others and brings people together to help that bigger picture. People involved in collaborative practice enjoying developing these interpersonal relationships and brainstorming, but they also really understand the landscape that they're working in, and there has to be that willingness to focus on finding solutions that are reality-based, that are really relevant to the context of that particular program. Now, likely, we have also been involved in situations where the practice was supposed to be collaborative, but it really wasn't. You know, there's so much potential to learn from each other. We have different educational backgrounds, different types of experience and expertise and different perspectives, which if we can effectively combine these, that can really allow for better decision making and direction. But we all know this doesn't always happen in healthcare. We still have a very siloed and hierarchical work environment in healthcare, we have a lot of language around orders, heads of departments, clinical leads.

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We have a lot of titles that imply, you know, where you are in the hierarchy. There can be often a lot of top down direction, but very little understanding about how everybody can contribute. We don't have that language of collaboration in healthcare like we could consensus, shared decision making. There isn't always that opportunity or that real feeling of safety of every member of the team to have a voice. We often don't even really know the expertise the other disciplines have. And sometimes the need to be right and protect your turf overrides our interest in actually truly collaborating. So if you work in a highly hierarchical environment, collaborative practice might take more of a paradigm shift than what you personally can bring about. And you know, health educators are really trying to work hard to bring about this paradigm shift. A lot of emphasis on interprofessional education and teaching these trainees in those formative years to both understand each other's discipline and how to work collaboratively together.

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But you might still be waiting for those enlightened souls to reach your work setting. And so until then, you might need to create your own collaborative practice as well as you can. The Canadian Interprofessional Health Collaborative outlines six competencies that are needed by each member of a collaborative team, and those six are, one, interprofessional communication, two, patient-centered care, three, role clarification, four, team functioning, five collaborative leadership, and six, interprofessional conflict resolution. And you know, they note that the first two interprofessional communication and patient-centered care, they actually support those other competencies. If you have the ability to respectfully and effectively communicate, and you are focused on patient-centered care and not turf or your own ego, that sort of thing, then those skills and perspectives enable you to achieve the other four competencies. Now, I don't wanna take time to go into describing each one, I think they're quite self-evident, but I'd like to talk about some ideas for how you might enable some of these competencies in your pulmonary rehab program.

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Now, even a sole charge clinician can create collaborations with the one constant in all of our programs, the patient and their loved ones. Now, that's another topic. The use of certain skills such as motivational interviewing to initiate a discussion with your patient about their goals and the plan to support them to achieve those goals. So if you're not already feeling like you're collaborating with your patient, but instead you're providing pulmonary rehab to them or for them, but not with them, then that's a good place to start. And that is patient-centered care. Your next target of collaboration is potentially the referring physician, if that's a referring model that you use for your program. Now, I recognize this is easier for some settings than others. For many who run pulmonary rehab programs, they have no easy line of communication with the referring physician, such as phone or email.

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And the physician may not really see themselves as a member of the rehab team. You know, they sent their patient to you for that. But there may be opportunities to set up these lines of communication, even if it starts with a simple progress note from you to them partway through the program about their patient. Now, that's not really collaboration and it's full of sense, I know, but you have to start somewhere to build relationships with your referring physicians and you communicating about their patients to them as the patient is going through the program. Not excessively, but just a short update. That's a good place to start. Now, if you're not sole charge and you have more than one discipline or

individual involved in your program in some way, then it's a bit more straightforward in terms of organization. I mean, at least you know who to approach.

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And if you have different disciplines involved and you feel like you don't really know each other's professions very well, a bit of group education can go a long way to building collaborative practice. A respectful, candid discussion about what expertise people do and don't have is very helpful. It can be challenging though, to talk about what we don't know, especially if you're used to being in a clinical leadership role and to have skills that others also have, but you think they should just be your domain of your profession. That's pretty tricky. We really need to put aside these sort of protecting our turf feelings if this is gonna work. But seeing what everyone brings to the pulmonary rehab practice and who to go to for help is a real key part of being able to collaborate effectively for the patient. And it sets up a strong foundation to be able to effectively deal with conflicts that will invariably arise.

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Now, thinking about conflict resolution, another competency that is required to be an interprofessional and collaborative practitioner, it's sometimes normal, you know, for these teams to have some issues that they need to deal with. And so an initial task as you start to talk about your collaboration is to set those housekeeping rules from the beginning, really emphasizing a safe and inclusive space for everyone with respectful approaches to dealing with different opinions and discussions. You know, remember your main focus is to tackle the goal at hand. It can take many different ways to get there, but you have to get there safely for everybody. So just keep coming back to the groups "why" you're improving patient outcomes. And you also wanna have a fulfilling work environment for everybody in that team. Next, you have to think a bit about how you organize yourself structurally. That's really important, and it gets at how the team will function.

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You could begin by having scheduled conversations like rounds where each patient is discussed, and with term taking in terms of leading those discussions, everybody gets a turn, which supports a collaborative leadership style. There should also be clear lines of communication for the more informal discussions. You don't want gatekeepers in there that get in the way of being able to get ahold of people, especially for urgent issues. Then as your team develops, you don't have to limit your collaboration to conversations about individual patients. You could also use it as an opportunity to look at what's happening in the program currently, identifying barriers to quality care, pulling in new evidence-based research or information about what another program is doing. These are all examples of discussions and planning that is seen in collaborative practice. Now, this can feel pretty intimidating, especially if you do work in a somewhat traditional hierarchical healthcare setting and you feel like you're on the lower rung.

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But take heart, even if you can identify one other member of team who's interested in starting the discussion. So many program clinicians just come together while all the patients are there. So you might be running the exercise session and these other clinicians are there and you're working with the patients, but you don't set aside any separate time for discussion about where each patient is at, what is concerning you, what is working well, how can the team help to solve some of these problems, or to bring about different resources that might be needed. That time is just as valuable as direct patient

contact time, and you've gotta view that time as true collaboration time, not just giving and receiving of information. It encourages us actually to monitor our patient's progress as they go through the program so that we can actually talk about how patients are doing with our colleagues while they're in the program, and that when changes can be made, or more resources or skills brought in, not at the end.

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So at the very least, see if you can identify that one other person and schedule collaborative practice time to be together where you consider each patient, where they're at, and what else could be suggested. If you're not already doing this, I think you'll find that your practice will be more rewarding if everyone's engaged and they wanna build these competencies for themself. If you're already part of a team like this, well of course well done. Your team may have developed these competencies either quite formally or maybe more organically, and I'd love to hear examples of how collaborative practice is working in your program and hopefully your team, whether big or small, whether you've been collaborative for a long time or just a short time, you have this growth mindset, which is encourages you to, to continuously examine your practice. And you know, if you're not taking students, please consider taking students. If you're demonstrating collaborative practice in action, students of any discipline would benefit so much from seeing this modeled for them.

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So I hope you enjoyed this episode in that it got you thinking about collaborative practice and where you see this fitting into your own practice of pulmonary rehab. I'll link to that competency paper in the show notes, and next time, you know, I want to extend this idea a little bit further by thinking about collaboration beyond the walls of our programs and thinking about creating communities of practice that can further extend our professional development. But that's all for today. Take care of everyone, and I look forward to seeing you at the next episode of LungFit. Bye for now.