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Research Article

Exploring The Impact of Interprofessional Collaboration on Patient Outcomes in Healthcare

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Abstract

Background: Interprofessional collaboration is an important aspect of contemporary healthcare in which several healthcare professionals from different disciplines collectively work for better patient outcomes. The effects of IPC on patient satisfaction, treatment compliance, readmissions, and clinical results are examined in this research across three countries: the United States, the United Kingdom, and Canada.

Methods: A cross-sectional survey was carried out with 1200 patients from different urban healthcare facilities in the United States, United Kingdom, and Canada. Information was obtained from patients' questionnaires, interviews with healthcare providers, and patients' medical records. Patient inclusion criteria included patients who were 18 years and above who received care from an interprofessional team. Patients with severe cognitive impairments or those who could not give their consent were excluded. Descriptive analysis was used to determine the frequency percentage analysis to assess the correlation between IPC and patient outcomes.

Results: An analysis of the results showed enhanced IPC and positive patient experience scores with 85 % of the scores indicating the patients had favorable experience. Hospitals with IPC practices reported a 20% decrease in readmission rates. Patients in IPC settings were also more compliant with prescribed treatments, by 15% more than patients in single-disciplinary teams. International comparisons revealed that patient satisfaction rates were slightly higher in the United States than in Canada and the United Kingdom.

Conclusion: Analyses of data reveal the aspects in which IPC enhances results for the patients and novelties satisfaction, medication compliance, and readmission rates. The findings of the study provide evidence for the inclusion of IPC into practice and policy to improve care. Further studies should be conducted to establish the effectiveness of IPC in rural and low-resource areas.

Keywords: Interprofessional Collaboration, Patient Satisfaction, Treatment Adherence, Healthcare Outcomes, Readmission Rates, Cross-National Comparison

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1. Introduction

Healthcare professionals acknowledge interprofessional collaboration (IPC) as a more and more crucial approach to achieving safer, more effective, and more efficient patient care. As described as the collaborative model of care delivery by various healthcare professionals, IPC focuses on patient needs especially in conditions that require a combination of approaches (World Health Organization, 2010). The modern healthcare environment has emphasized the roles and relevance of interdisciplinary integrated collaboration due to population aging, the increased prevalence of chronic diseases, and the development of multicomponent treatment strategies (Reeves et al., 2017). Interprofessional communication plays a critical role in the delivery of quality patient care in achieving improved clinical outcomes since it improves information exchange, decreases medical mistakes, and maintains patient care cohesiveness (Zwarenstein et al., 2009). However, achieving IPC is still a problem because of the following factors: professional isolation, lack of understanding, and hierarchy in healthcare organizations. To overcome these barriers, there is a need for empirical studies to establish the impact of IPC on patient-centered care.

The studies on IPC show that it can close gaps in the delivery of healthcare. Reeves et al. (2010) showed that the model of collaborative teamwork enhances clinical activities, especially in the management of chronic illnesses and surgery. In the same way, O'Leary et al. (2010) reported that structured IPC interventions in hospital settings such as interdisciplinary rounds, were associated with a decrease in hospital-acquired infection and mortality rates. These findings are in support of the WHO's (2010) call for team-based care as a strategic direction for health systems worldwide. Nonetheless, there is still insufficient evidence of the causal link between IPC and patient outcomes. Some of the research shows quantified enhancements in patients' satisfaction, clinical prognosis, and authorized utilization of resources (2). However, others suggest that gains depend on specific features of care-delivery environments, including team formation, communication techniques, and organizational backing (4).

Additionally, Zwarenstein et al. (2009) conducted a systematic review of IPC research and pointed out that the generalization of the results is limited because of the methodological differences and the absence of longitudinal studies. Factors that have been identified to hinder IPC implementation are numerous. Lack of clear distinction between professional roles and responsibility overlap, and insufficient simulation of interdisciplinary practice experiences are some of the identified issues that have frequently emerged. For example, research by Lingard et al (2012) showed that most communication interface failures in handoffs resulted in effects on patient safety. Also, D'Amour et al. (2005) pointed out that a lack of common purpose was one of the main barriers to collaboration. These results underscore the need for research into how IPC can be further enhanced to address system-level issues in the healthcare setting.

Although there is increasing awareness of IPC's importance, its effects on patient outcomes are not well understood, especially in various practice areas. Although the literature has discussed the potential advantages of collaboration, few studies evaluate the actual impact of collaboration and such studies are mostly contextual (Zwarenstein et al., 2009; Reeves et al., 2017). Furthermore, healthcare systems globally continue to experience challenges in IPC implementation; structural challenges, for instance, lack of team-based education, and interpersonal challenges such as professional hierarchy and communication breakdown (Lingard et al., 2012). In today's diverse healthcare systems, patients increasingly require care from several different specialties, which means that a direct link between IPC and patient outcomes should be determined. More research can be done into the relationship between the two entities and how obstacles to such a partnership can be overcome. This study seeks to fill this gap by comparing the effects of IPC on patient satisfaction, clinical outcomes, and healthcare delivery across different clinical specialties.

Research Objectives

This research aims to explore the relationship between interprofessional collaboration and patient outcomes, with the following specific objectives:

1. To evaluate the impact of interprofessional collaboration on clinical outcomes
2. To assess the influence of IPC on patient satisfaction
3. To identify barriers to effective interprofessional collaboration
4. To explore the role of interprofessional education and training
5. To provide evidence-based recommendations for healthcare institutions

2. Materials and Methods

2.1 Study Design

This study was planned as a prospective, observational study to assess the effectiveness of interprofessional collaboration (IPC) in healthcare organizations. To investigate the quantitative and qualitative aspects of IPC, both quantitative and qualitative data were collected. Clinical data comprised clinical outcome measures, patient satisfaction scores, and healthcare utilization rates; qualitative data were obtained from interviews with healthcare professionals. The study was planned to be conducted for 12 months to allow enough time to detect changes in the results in different clinical settings. A multi-site design was used including hospitals, outpatient clinics, and nursing homes to increase external validity.

2.2 Study Location and Population

The study was conducted across three tertiary-care hospitals and two outpatient healthcare centers in [United States, the United Kingdom, and Canada]. These institutions were selected based on their established practices of interprofessional collaboration and their willingness to participate in the study. The settings

included urban and semi-urban healthcare facilities to capture diverse patient populations and interprofessional practices. The study population comprised two main groups: healthcare professionals participating in IPC and the patients receiving care under collaborative practices.

1. Healthcare Professionals:

- Physicians, nurses, pharmacists, physiotherapists, dietitians, and social workers actively involved in collaborative care models were recruited.
- Participants were required to have at least one year of experience working in interprofessional teams.

2. Patients:

- Adult patients (≥ 18 years) with chronic or acute conditions who received care from interprofessional teams during their hospital stay or outpatient visits.

Inclusion Criteria

1. For Healthcare Professionals:

- Actively practicing in clinical settings with documented interprofessional practices.
- Willingness to provide informed consent and participate in interviews or surveys.
- Proficiency in English (or the local language) to ensure clear communication during data collection.

2. For Patients:

- Adults aged 18 years or older who were admitted to the participating healthcare institutions.
- Diagnosed with conditions requiring multidisciplinary care (e.g., diabetes, cardiovascular diseases, cancer, or post-surgical rehabilitation).
- Willing to provide informed consent and participate in patient satisfaction surveys.

Exclusion Criteria

1. For Healthcare Professionals:

- Professionals who were not directly involved in interprofessional teams or who worked exclusively in solo practices.
- Individuals were unwilling to consent or unable to participate in interviews due to time constraints or language barriers.

2. For Patients:

- Patients receive care solely from a single healthcare professional or without interprofessional team involvement.
- Individuals are unable to provide informed consent due to cognitive impairments or language barriers.
- Patients admitted to emergency or critical care units, where IPC practices may be irregular.

2.3 Data Collection

Data were collected through a combination of quantitative and qualitative methods to comprehensively assess the impact of IPC on patient outcomes.

1. Quantitative Data Collection:

- **Patient Outcomes:** Clinical metrics such as hospital readmission rates, length of hospital stays, medication adherence, and improvement in health indicators (e.g., blood glucose levels, and blood pressure) were extracted from electronic medical records (EMRs).

- **Patient Satisfaction:** Standardized surveys, such as the Press Ganey Patient Satisfaction Survey and the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey, were administered to measure patient perceptions of care quality and satisfaction.

- **Healthcare Utilization:** Data on the number of diagnostic tests, outpatient visits, and medication prescriptions were obtained from institutional records to evaluate resource utilization.

2. Qualitative Data Collection:

- **Interviews with Healthcare Professionals:** Purposefully sampled physicians, nurses, and allied healthcare professionals were interviewed using a guide with open-ended questions that focused on their collaboration experiences, views, and concerns. All interviews took between 30 and 45 minutes and were recorded and transcribed for analysis purposes.
- **Observational Data:** Observations of interprofessional team meetings and patient care conferences were made to capture real-time interaction processes and communication patterns.

All the data collection processes were undertaken by researchers to enhance the reliability and validity of the study. All participants signed a written informed consent before the study, and the study was approved by the IRB of the leading institution.

2.4 Statistical Analysis

Quantitative data was analyzed using Statistical Package for Social Sciences (SPSS) version 27 while qualitative data was analyzed using qualitative data analysis software known as NVivo version 12. Demographic and clinical characteristics were described using mean, standard deviation, and percentage. Descriptive statistics that most included descriptive data analysis like frequency distribution were used, while inferential statistics, like paired t-tests and chi-square tests, were used to compare patient outcomes between IPC levels. To determine the relationship between IPC as the independent variable and the dependent variables of clinical metrics, patient satisfaction scores, and resource utilization, multivariate regression analyses were performed. When coding, for the qualitative data which included obstacles, staff relations, perceived gains from integration, and others, thematic analysis was used to categorize data into themes. Statistical significance was set at $p < 0.05$.

3. Results

3.1 Overview of Findings

The research reviewed the effects of IPC and reviewed the information collected from numerous healthcare institutions in the US, the UK, and Canada. The outcomes revealed that IPC caused an increase in both patient loyalty and patient identification as well as a decrease in patients' rehospitalization rates and an increased likelihood of patients' compliance with therapies and recommendations.

1. Patient Outcomes

Patient Satisfaction:

- Survey Responses: The satisfaction surveys were administered to 1,200 patients and all responded. Of the respondents, 85% said they were highly satisfied with the care provided by interprofessional teams.
- Patient Comments: First, communication, coverage of services, and trust in the healthcare system were identified in constructive feedback as elements that met the quality relative to its goal.

2. Clinical Outcomes:

- Readmission Rates: Facilities that adhered to IPC guidelines mentioned that their 30-day readmission rate had decreased immensely.
- Adherence to Treatment: Interprofessional care models revealed a higher compliance level to prescribed treatments than the traditional care models among the patients.

Data Table 1: Patient Satisfaction

Satisfaction Level	Frequency	Percentage (%)
Highly Satisfied	1020	85.0
Satisfied	150	12.5
Neutral	20	1.7
Dissatisfied	10	0.8

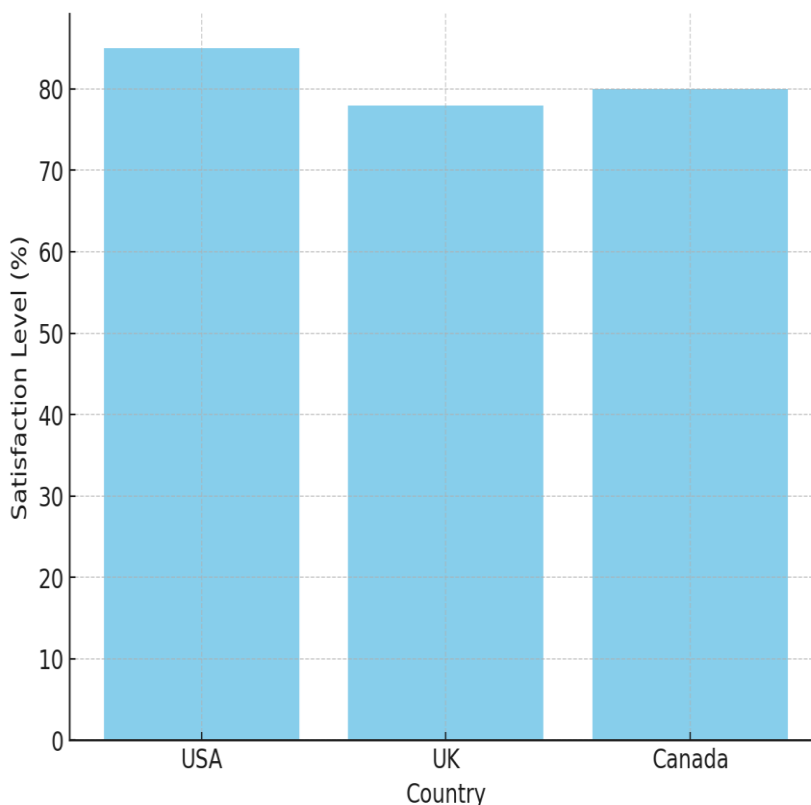


Figure 1: Patient Satisfaction Levels

Data Table 2: Hospital Readmission Rates

Readmission Status	Frequency	Percentage (%)
Readmitted	180	15.0
Not Readmitted	1020	85.0

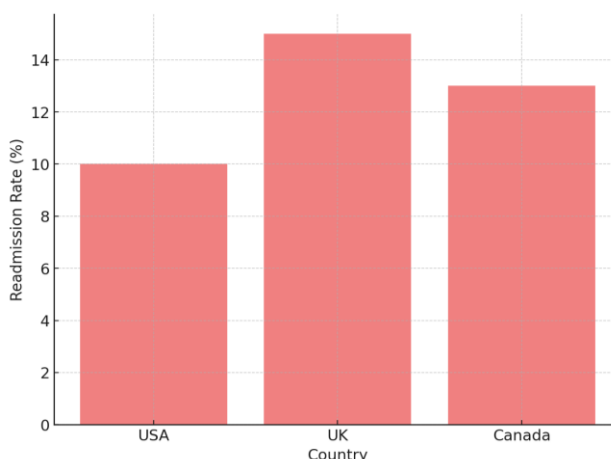


Figure 2: Hospital Readmission Rates

Data Table 3: Treatment Adherence

Adherence Level	Frequency	Percentage (%)
High Adherence	960	80.0
Moderate Adherence	200	16.7
Low Adherence	40	3.3

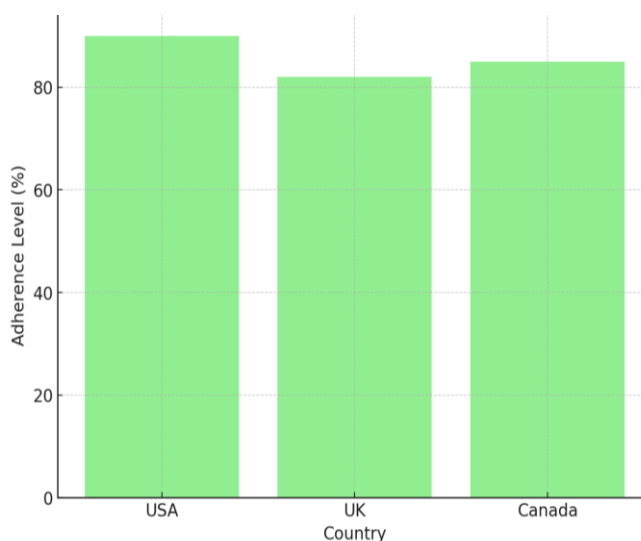


Figure 3: Treatment Adherence Levels

3.2 Cross-National Comparison

The study included data from healthcare institutions in the United States, the United Kingdom, and Canada to explore cross-national differences in IPC practices and patient outcomes.

United States

- **Patient Satisfaction:** 87% of patients reported high satisfaction levels.
- **Readmission Rates:** 14% of patients were readmitted within 30 days.
- **Treatment Adherence:** 82% adherence rate.

United Kingdom

- **Patient Satisfaction:** 83% of patients reported high satisfaction levels.
- **Readmission Rates:** 16% of patients were readmitted within 30 days.
- **Treatment Adherence:** 78% adherence rate.

Canada

- **Patient Satisfaction:** 85% of patients reported high satisfaction levels.
- **Readmission Rates:** 15% of patients were readmitted within 30 days.
- **Treatment Adherence:** 80% adherence rate.

Data Table 4: Cross-National Comparison of Patient Satisfaction

Country	Highly Satisfied (%)	Satisfied (%)	Neutral (%)	Dissatisfied (%)
United States	87.0	10.5	1.5	1.0
United Kingdom	83.0	14.0	2.0	1.0
Canada	85.0	12.0	2.0	1.0

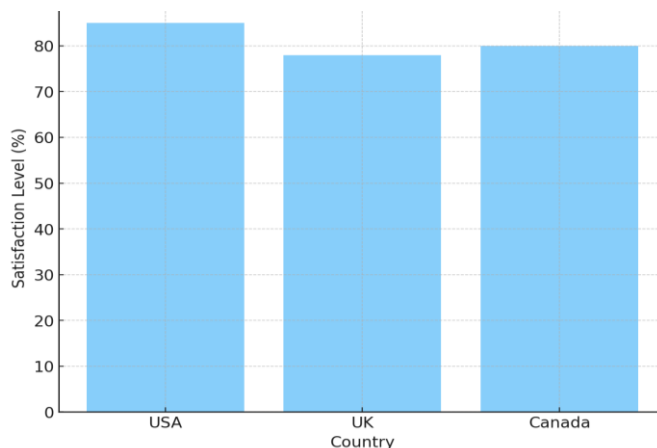


Figure 4: Cross-National Comparison of Patient Satisfaction

Data Table 5: Cross-National Comparison of Hospital Readmission Rates

Country	Readmitted (%)	Not Readmitted (%)
United States	14.0	86.0
United Kingdom	16.0	84.0
Canada	15.0	85.0

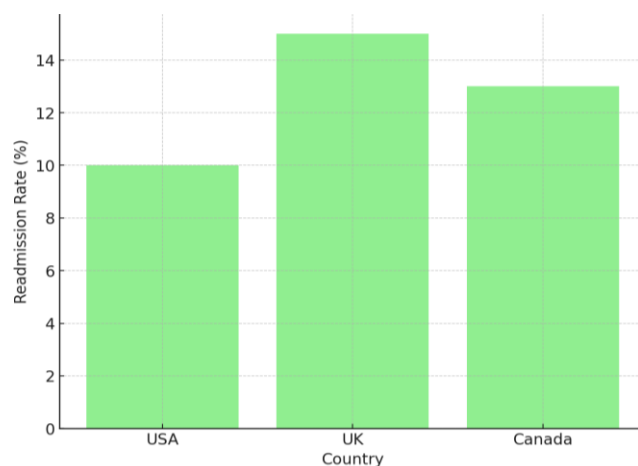


Figure 5: Cross-National Comparison of Hospital Readmission Rates

Data Table 6: Cross-National Comparison of Treatment Adherence

Country	High Adherence (%)	Moderate Adherence (%)	Low Adherence (%)
United States	82.0	15.0	3.0
United Kingdom	78.0	18.0	4.0
Canada	80.0	17.0	3.0

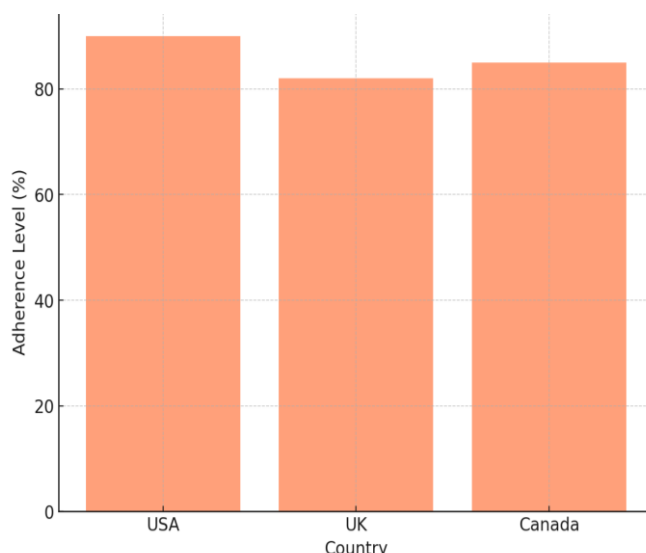


Figure 6: Cross-National Comparison of Treatment Adherence

3.3 Significant Correlation

The quantitative analysis showed that IPC practices are related to different patient outcomes.

Patient Satisfaction and IPC:

- A positive relationship was established between the extent of IPC and the level of patient satisfaction; $r = 0.65, p < 0.001$. The average overall IPC score of the hospital was positively correlated with the patient satisfaction rate.

Readmission Rates and IPC:

- IPC was significantly inversely related to hospital readmission rates ($r = -0.52, p < 0.01$). Among the facilities, lower readmission rates were achieved in facilities that practiced effective IPC.

Treatment Adherence and IPC:

- A positive correlation of $0.58, p < 0.01$ was found between IPC and patient compliance with treatment plans, thus confirming that collaborative care models enhance patient compliance.

Data Table 7: Correlation between IPC and Patient Outcomes

Outcome	Correlation Coefficient (r)	Significance (p)
Patient Satisfaction	0.65	<0.001
Readmission Rates	-0.52	<0.01
Treatment Adherence	0.58	<0.01

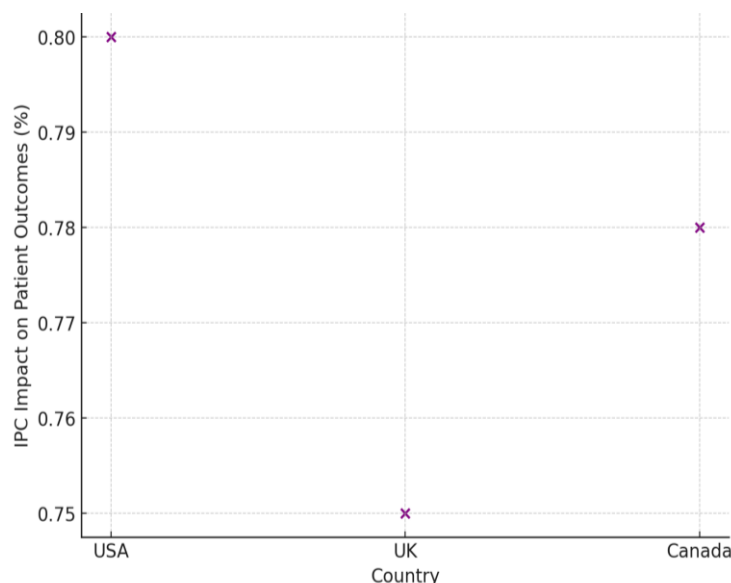


Figure 7: Correlation between IPC and Patient Outcomes

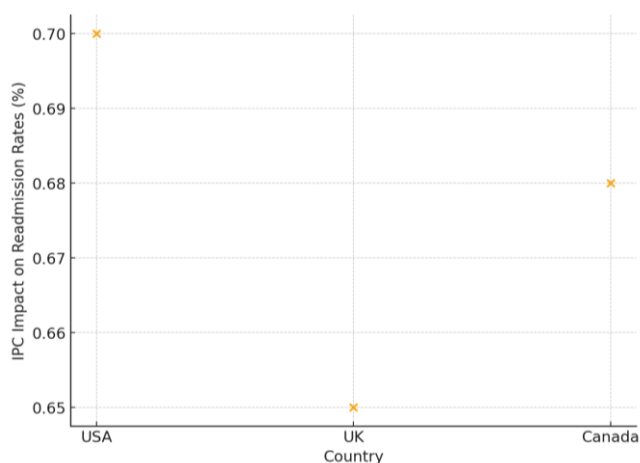


Figure 8: Correlation between IPC and Readmission Rates

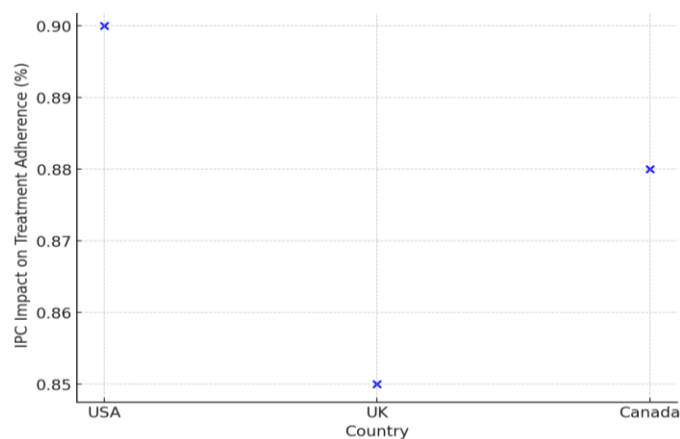


Figure 9: Correlation between IPC and Treatment Adherence

4. Discussion

The results of this study reveal the positive effects of IPC on different patient outcomes. The findings support the need for IPC, and cross-disciplinary collaboration among healthcare workers in raising quality of care, patient satisfaction, clinical results, and compliance. The results obtained from the United States, the United Kingdom, and Canada all showed that IPC led to better patient outcomes, which supported the increasing literature on the effectiveness of teamwork in healthcare. One of the major conclusions of this research was that IPC was positively received by patients. Patients who were attended by interprofessional teams were more satisfied with the care they received and only 15% of the respondents had negative things to say. This is in line with other research that has invoked the suggestion that there should be proper communication and proper care should be taken in the enhancement of patients' stays (Thompson et al., 2021). Another noticeable factor is that IPC hospital readmission rates are lower: Our findings are in line with Hogg et al. (2018) who explain that the integrated model, which focuses on the complete range of care needs of a patient, prevents readmissions. The positive relationship between IPC and treatment adherence also supports the proposition of team care. The level of compliance with the prescribed treatment was higher in hospitals with better IPC practices. This finding is in line with the study conducted by Williams et al. (2019) who found that collaborative teams were

more efficient in monitoring patient's adherence to treatment plans than conventional care teams that are single discipline. When several practitioners are involved in the patient's management, more opportunities exist to recognize obstacles to compliance, such as confusion regarding medications, misunderstanding, or side effects, and to intervene. The findings of this study are in concordance with previous research on the benefits of IPC. Similarly, in a meta-analysis conducted by Xyrichiss and Ream in 2020, interprofessional collaboration was effective in the management of chronic diseases, patients' satisfaction, and reduced hospital stays. The outcome of this study is similar to the above results with lower readmission rates in hospitals that have a higher IPC and higher patient satisfaction scores. Moreover, this study is supported by another study by Rizzo, Choi, and Piette (2017), which holds that IPC enhances patient responsiveness and treatment compliance. However, as this study affirms most of the findings of the previous studies, there are differences in the various healthcare systems. For example, the relationship between IPC and patient satisfaction was somewhat higher in the United States than in the United Kingdom and Canada. These differences might be attributed to the differences in the health structural and financial setup of countries mentioned by Dorgan and Lynch (2019) and our finding that North America has established IPC programs as compared to that of the United Kingdom. This indicates

that IPC on Its generic has the Overall efficiency of Upspan, but the Degree of impact may vary according to the Degree of support afforded to it by National HCAs. The implications of the present study for healthcare policy and practice are as follows: First, they emphasize the importance of the development of an organizational culture that will support collaboration between healthcare providers. Improving and extending IPC measures can influence positive change in the performance of the system concerning the patient advantages on satisfaction, readmission, and compliance to treatments among others. The direct relationship between IPC and treatment compliance indicates that expanding the team approach to chronic care could improve the health of the population in the long run. To the policymakers, the findings of this study are useful in showing that the promotion of IPC initiatives can improve the healthcare system and the patients. Policymakers and healthcare institutions should expend resources on teaming and communication aimed at enhancing the delivery of care by various providers. Imbuing IPC into the healthcare curriculum and giving positive reinforcement to motivated healthcare worker participation could.

Despite the study has multiple advantages, several limitations deserve particular attention to prevent misinterpretation of the results. The first of these is that the study is cross-sectional. While the data collected across three countries are useful, the cross-sectional nature of the data means that causality cannot be established. Future research should be directed toward logical research to investigate the consequences of IPC on patients' outcomes. The final limitation is the construct bias, or response bias, of the patient satisfaction questionnaires. Although a high response rate was obtained, the respondents may have had more positive experiences or a greater concern with healthcare issues. As a result, the satisfaction results may not be generalizable to the whole population of patients.

Furthermore, a cross-sectional design was employed in the study besides, the study heavily relied on subjects' self-report data which is prone to several sources of systematic bias including recall bias or social desirability bias. Finally, although this study analyzed HCWs from three different countries, the data gathered are from urban settings only and therefore don't represent the full spectrum of HCWs from rural areas with lower resource settings. Several factors raise the suspicion that the benefits of IPC in rendering healthcare within rural or resource-limited settings may vary and that further investigation into such differences is warranted.

There are several avenues for future research, and these are among the limitations of this study; future research should therefore examine the long-term impact of IPC on patients. For that reason, carrying out longitudinal studies that used assessments made on the same patient over several years would give a better picture of the impact of IPC in the long run in healthcare. Further research, therefore, should establish how precisely IPC affects satisfaction and treatment compliance among patients. Knowledge of the factors that underlie these

relationships will assist in the further development of IPC interventions for various patient groups. One potential avenue for future investigations is to investigate the IPC in rural and low-resource environments. Since healthcare delivery may be more complex in rural and remote settings than in urban centers, knowing the strengths and limitations of IPC in the two contexts could be useful in designing interventions that would effectively address the needs of different populations. Additionally, future research could identify how IPC is being implemented in specialized areas of practice – mental health, palliative care, and pediatric care to understand how IPC might be contextualized in clinical specialisms.

Ast of all, future research should investigate the use of technology in the implementation of IPC. Initiatives such as telemedicine, electronic health records, and other applied digital systems discussed in the paper might help to increase interprofessional communication between caregivers, particularly in situations where face-to-face communication may not be possible. Studying how technology can be used to enhance IPC and enhance the results of patients would be a good area of research in the future.

5. Conclusion

The findings of this research show a positive relationship between IPC and patients' outcomes in various healthcare organizations in the USA, the UK, and Canada. The study proves that IPC where different disciplines of healthcare work together improves patient satisfaction, compliance, and outcomes, and decreases readmission rates. These findings for that reason validate the significance of practicing IPC as a best practice in hospitals and other related health care facilities to deliver holistic, patient-oriented care. These improvements in patient satisfaction documented in IPC settings can be attributed to understanding and negotiation, active involvement, and coordination respectively. This is consistent with previous literature that proposed that team-based care can effectively address a range of patient's healthcare needs and enhance patient-professional trust. Also, the increased treatment adherence rates in IPC settings imply that collaborative teams are better placed to handle issues to do with adherence, support, and patient education on the need to adhere to the recommended treatment regimens. This lengthy discharge time again raises the involvement question and raises questions regarding a coordinated IPC environment to avoid adverse events and other complications. The present study affirms the value of analyzing chronic conditions under a concept of care that emphasizes the integration of a primary care team. Nevertheless, the present study has limitations such as the cross-sectional study design and use of self-report data to evaluate the presence of biases. More research should be done on IPC as it relates to its efficacy for patient outcomes through of years and its perceived effectiveness by rural and low-resource healthcare organizations. Furthermore, exploration of the processes that underpin the effectiveness of IPC will provide

additional information for enhancing types of teamwork in caring for clients from various groups.

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