



Barriers to Interprofessional Collaborative Practice in Healthcare: An Integrated Review

Executive Summary

This integrated review synthesizes evidence on barriers to interprofessional collaborative practice (IPCP) in healthcare. Despite evidence of improved outcomes, enhanced patient satisfaction, and system efficiencies, multiple barriers impede successful implementation across healthcare settings.

Upon systematic review using PRISMA guidelines and synthesis of evidence, eight barrier domains consistently emerge:

1. Regulatory and Political
2. Financial
3. Organizational and Structural
4. Communication and Information Exchange
5. Professional Knowledge and Role Clarity
6. Hierarchical and Power Dynamics
7. Provider Attitudes and Beliefs
8. Patient-Related Factors

Findings highlight that while some barriers are universal, such as communication breakdowns, hierarchical power dynamics, and time constraints, others are context-specific. Acute care settings face challenges from rapid decision-making and entrenched hierarchies, home healthcare is limited by fragmented systems and geographic dispersion, outpatient facilities struggle with reimbursement complexity and lack of co-located services, rehabilitation settings encounter resource and workflow constraints, and military healthcare is shaped by command structures and rigid hierarchy.

The majority of barriers are modifiable through interventions such as policy advocacy, bundled payment models, workflow redesign, interoperable health IT, interprofessional education, and leadership training. Patient-related factors remain largely non-modifiable but can be mitigated through targeted engagement, interpreter services, and culturally competent care. This synthesis underscores the need for system-level commitment and tailored strategies to enhance collaboration across healthcare settings.

Abstract

Background: Barriers to interprofessional collaborative practice (IPCP) persist across healthcare settings and systems, undermining collaborative care. The purpose of this review is to examine barriers to IPCP in various health care settings to identify prevalent challenges that must be navigated to effectively provide interprofessional care. This review integrates findings from five settings: military, home health, rehabilitation, outpatient, and acute care, with the aim to identify common themes and setting-specific distinctions, while also seeking to provide possible strategies to address these barriers.

Methods: This review employed an integrative methodology to synthesize findings from literature examining barriers to IPCP within five healthcare environments. Published literature between 2010–2025 were examined across multiple academic and discipline-specific indexes. Results were screened following PRISMA guidelines; inclusion criteria limited articles to peer-reviewed empirical studies, reviews, or position papers addressing barriers to IPCP in one of the five healthcare environments. A final sample of 92 articles was integrated into thematic analysis.

Results: Eight recurring themes were identified: regulatory and political, financial, organizational and structural, communication and information exchange, professional knowledge and role clarity, hierarchical and power dynamics, provider attitudes and beliefs, and patient-related factors. While there was significant overlap of barrier themes among the settings, each setting domain contributed unique emphases.

Conclusions: This paper serves as a call to action to enhance patient care through delivery of interprofessional collaborative care. Barriers to IPCP are persistent but modifiable. Addressing these barriers through systemic, educational, and cultural strategies is essential to advancing interprofessional collaboration, clinician well-being, and healthcare access and quality. Future research should prioritize evaluating targeted, setting-specific interventions to strengthen interprofessional collaboration and advance the goals of patient-centered, equitable, and efficient healthcare delivery.

Introduction

Interprofessional collaborative practice (IPCP) is widely recognized as critical for delivering high-quality, patient-centered care across diverse healthcare environments. Research demonstrates that interprofessional teams improve care coordination, reduce redundancies, and enhance safety, quality, and creates equitable outcomes (Kongkar et al., 2025; Reddy et al., 2021; Levengood et al., 2019; Meyers et al., 2019; Panagioti et al., 2016). These benefits are particularly salient in complex care environments such as rehabilitation, acute care, and home health, where patients' needs cross disciplinary boundaries and require integrated approaches.

Despite robust evidence linking IPCP to improved outcomes and improving system efficiencies, implementation remains inconsistent with multiple interrelated barriers that impede widespread adoption (Bakewell et al., 2025; Essex et al., 2023). These barriers may manifest differently across healthcare settings. Previous literature has documented challenges within varied healthcare settings or setting-specific contexts such as military healthcare, home health, rehabilitation, outpatient, and acute care. However, little scholarship has sought to integrate findings across these settings into a comprehensive framework. The lack of synthesis limits our understanding of how barriers operate across settings, how they interact, and which are most amenable to change. This review contributes to filling that gap, synthesizing barriers into thematic domains, analyzing their setting-specific manifestations, and the degree to which barriers may be modified through targeted interventions. The findings provide implications for education, practice, and policy.

Methods

The review synthesized findings from five healthcare environment-specific literature searches conducted between 2010 and 2025. Search terms included the combination of "barriers," AND "interprofessional OR interdisciplinary OR integrated OR team-based OR whole person care OR collaborative practice," with each of the following setting-specific keywords: military healthcare, home health, rehabilitation, outpatient, and acute care. The search was limited to peer-reviewed academic journals published between 2010-2025 in English language, focusing on US-based research. The search was completed between October 2024 – February 2025. Databases included PubMed, EBSCO (Academic Search Complete, Academic Search Premier, CINAHL Complete, CINAHL Plus with Full Text, Consumer Health Complete, Health Source consumer edition, Health Source Nursing/Academic Edition, Medline complete), ProQuest, Web of Science, Mendeley, Elicit and, Google Scholar.

The initial searches yielded broad results (e.g., more than 20,000 for “home health”), which were refined using quotation marks, date filters, and subject headings to produce manageable sets. Screening was guided by PRISMA guidelines. Inclusion criteria required peer-reviewed empirical studies, reviews, or position papers that explicitly addressed barriers to IPCP within one of the five settings in the United States. Excluded materials included opinion pieces, grey literature, studies outside the targeted healthcare environments, and studies outside of the U.S.

Through iterative screening, 92 papers were retained. Thematic analysis coded and synthesized barrier types, grouping into eight overarching domains, and analyzing patterns across settings. Data were triangulated across study designs and healthcare environments to highlight both shared and unique challenges.

Results

Analysis across the five healthcare settings yielded eight persistent themes of barriers to IPCP. Data were analyzed thematically, with findings coded into eight barrier categories: (1) regulatory and political, (2) financial, (3) organizational and structural, (4) communication

and information exchange, (5) professional knowledge and role clarity, (6) hierarchical and power dynamics, (7) provider attitudes and beliefs, and (8) patient-related barriers. While these barriers may be independently identified and defined, they are found to be inter-related (Figure 1).

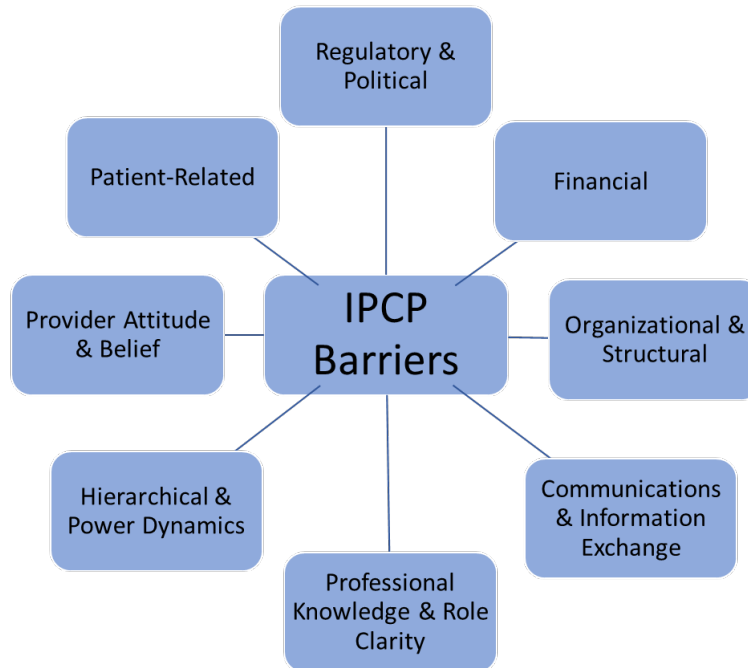


Figure 1. Conceptual framework of IPCP barriers (Regulatory, Financial, Organizational, Communication, Professional Knowledge, Hierarchical, Attitudinal, Patient-related).

Each barrier theme is described below in the discussion section with a synthesized overview followed by setting-specific manifestations. Table 1 further outlines the eight barrier domains with sub-themes or sub-classification examples within each barrier.

Table 1: Barrier domains and sub-classifications

Organizational and Structural Barriers	Communication and Information Exchange Barriers	Professional Knowledge and Role-Related Barriers	Hierarchical and Power Dynamic Barriers
<ul style="list-style-type: none"> • Time Constraints and Workflow Issues 	<ul style="list-style-type: none"> • Communication System Deficiencies 	<ul style="list-style-type: none"> • Role and Leadership Ambiguity 	<ul style="list-style-type: none"> • Traditional Medical Hierarchies
<ul style="list-style-type: none"> • Resource Limitations 	<ul style="list-style-type: none"> • Information Exchange Limitations 	<ul style="list-style-type: none"> • Interprofessional Knowledge Gaps 	<ul style="list-style-type: none"> • Power and Authority Disparities
<ul style="list-style-type: none"> • Physical Infrastructure 	<ul style="list-style-type: none"> • Language and Terminology Barriers 	<ul style="list-style-type: none"> • Educational Preparation Deficits 	<ul style="list-style-type: none"> • Communication Hesitancy

<ul style="list-style-type: none"> • Leadership and Administrative Support 	<ul style="list-style-type: none"> • Patient Involvement in Communication 	<ul style="list-style-type: none"> • Scope of Practice Limitations 	<ul style="list-style-type: none"> • Gatekeeping Behaviors
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Financial and Policy Barriers	Provider Attitudinal and Belief Barriers	Educational and Training Barriers	Patient and Environmental Barriers
<ul style="list-style-type: none"> • Reimbursement • System Limitations • Insurance Coverage Restrictions • Regulatory Policy Barriers • Resource Investment Requirements 	<ul style="list-style-type: none"> • Skepticism and Resistance • Competitive Attitudes • Professional Identity Concerns • Cultural Value Differences 	<ul style="list-style-type: none"> • Inadequate Training and Education • Educational Preparation Gaps • Interprofessional Competency Development 	<ul style="list-style-type: none"> • Patient Characteristics and Needs • Geographic and Access Barriers • Cultural and Social Barriers • Patient Engagement Challenges

While overlap exists among the barrier domains within each healthcare environment, Table 2 depicts the prominent domains within each setting. Table 3 synthesizes and demonstrates a crosswalk of barrier domain examples within each setting.

Table 2: Prominent barrier domains by setting

Health Care Setting	Prominent Barrier Domains
Acute care	Hierarchical & Power Dynamics Communications & Information Exchange
Home Health	Communications & Information Exchange Professional Knowledge & Roles Organizational & Structural (service fragmentation)
Military Healthcare	Hierarchical & Power Dynamics Organizational & Structural (culture)
Outpatient	Financial Regulatory & Political Organizational & Structural (lack co-located services)
Rehabilitation	Organizational & Structural (time/resources) Communications & Information Exchange Professional Knowledge & Roles

Table 3: Barrier examples within each healthcare setting per domain

Barrier Domain	Acute Care	Rehabilitation	Home Health	Outpatient	Military
Regulatory & Political	Discharge/admission policies; scope restrictions	Medicare rules; insurance constraints	Inconsistent policy support for collaboration	Billing & credentialing complexity	VA/DoD reimbursement & policy barriers
Financial	Having the right team available for patient care Govt. under payment	Insurance payment restrictions	Limited reimbursement for coordination	High out-of-pocket costs; no bundled payments; Fee-for-service limits team billing	Resource allocation constraints
Organizational & Structural	Workflow misalignment High turnover	Time/resource constraints	Staffing shortages; fragmented systems	Space limitations; siloed teams	Rigid operational demands
Communication & Information Exchange	Hierarchy inhibits open dialog	Documentation challenges	Limited tools for coordination; cultural linguistic gaps	Poor inter-clinic dialog EHR silos	Rank-based silos; fragmented information flow
Professional Knowledge & Roles	Training gaps; unclear roles	Knowledge gaps; siloed education	Role ambiguity; few learning opportunities	Limited role awareness; duplication of effort	Role ambiguity during deployment
Hierarchical & Power Dynamics	Entrenched hierarchies silence staff	Physician dominance in meetings	Professional identity conflict	Gatekeeping by physicians	Command structure restricts collaboration
Attitudinal & Beliefs	Skepticism; lack of mutual respect	Mixed attitudes toward guidelines	Resistance to shared decision making	Competition among providers	Tension between military culture & collaboration
Patient-Related	High acuity; limited engagement	Access barriers; condition severity	Patient/family resistance to multiple providers	High costs; preference for physicians	Unique military patient needs; stigma

While barriers manifest differently across healthcare settings, most are **at least partially modifiable** through targeted interventions.

- Regulatory and financial barriers require advocacy, reimbursement reform, and innovative payment models.
- Organizational and structural barriers call for leadership commitment, workflow redesign, and resource investment.
- Communication and role-related barriers demand standardized tools, integrated education, and clear team protocols.

- Hierarchical and attitudinal barriers can be addressed through culture change, training, and collective decision-making.
- Patient-related barriers, though largely non-modifiable, can be mitigated by strategies that improve engagement, reduce financial burdens, and promote equity.

Discussion

Regulatory and Political Barriers

Regulatory and political barriers represent significant systemic obstacles to interprofessional practice, characterized as partially modifiable through policy advocacy and regulatory reform. These barriers consistently emerge across healthcare settings and require coordinated efforts beyond individual provider control.

Federal and state-level policies often lack flexibility to accommodate innovative interprofessional approaches. Medicare waivers and insurance regulations constitute major regulatory impediments, constraining providers' ability to deliver collaborative care (Reddy et al., 2021; Sicklick et al., 2014). The complexity of regulatory compliance creates additional administrative burdens that redirect resources away from direct patient care and collaborative activities. Scope of practice regulations, which vary significantly across states, restrict what services different professionals can provide, limiting team flexibility and comprehensive care delivery (Landman et al., 2014; McCarter et al., 2016). These regulations particularly impact non-physician providers and may prevent them from practicing at the top of their license, reducing the potential effectiveness of interprofessional teams.

In military healthcare settings, financial and policy barriers manifest through reimbursement and resource allocation constraints, particularly within Veterans Affairs (VA) and Department of Defense (DoD) healthcare environments. The unique funding structures and bureaucratic processes inherent to military healthcare systems create additional layers of regulatory complexity that can impede collaborative care delivery. Similarly, home healthcare faces inconsistent policy support and reimbursement challenges for collaborative services, creating systemic barriers to interprofessional practice implementation.

Discharge policies and inpatient rehabilitation facility admission criteria present additional regulatory challenges in rehab institutional settings (Mortin et al., 2020). While these policies can be clarified and standardized at the organizational level, they often operate within broader regulatory frameworks that limit institutional flexibility. The regulatory environment surrounding post-acute facility selection creates barriers that impact care transitions and interprofessional coordination during critical discharge planning phases (Sicklick et al., 2014). Conflicting or unclear policies at state and federal levels create administrative complexity and compliance challenges that divert resources from patient care (Aby, 2020; Ridgely et al., 2014).

Financial Barriers

Financial constraints remain a pervasive barrier to implementing interprofessional practice across healthcare settings. These barriers are partially modifiable but require deliberate

policy reform, strategic resource allocation, or payer negotiation to be effectively addressed. Current reimbursement structures generally favor profession-specific billing codes over team-based models, leaving collaborative care undervalued and underfunded (Landman et al., 2014; Shelley-Tremblay & Lawton, 2025; Goldman et al., 2022; Sicklick et al., 2014; Cliff et al., 2024; Elliott et al., 2023; Gonzalvo et al., 2021; Ely, 2015). As scholars note, there is fundamentally “no process to bill for teams” and no universal model that captures the value of integrated, interprofessional service delivery (O’Connor et al., 2025; Wulsin et al., 2019).

The fee-for-service model exacerbates these barriers by prioritizing volume over value, creating productivity pressures that limit opportunities for coordination (Coombes et al., 2022; Washmuth et al., 2019; Schmidt et al., 2016). Insurance coverage limitations further complicate collaboration, introducing restrictions on which providers can bill, requiring prior authorization, and limiting covered services (Schmucker et al., 2024; Sadang et al., 2023; Taber et al., 2021; Vassilopoulos et al., 2020; Howard & Potts, 2019). Clients often bear the burden of these limitations, facing multiple co-pays for recurring or non-co-located services, which discourages use of the full interprofessional team (Cliff et al., 2024; Dahl-Popolizio et al., 2021; Becker et al., 2017).

Resource allocation challenges intensify the financial strain. Access to specialized equipment, interpreter services, and adequate administrative support is uneven across systems, creating significant delays in implementing collaborative models (Mirza et al., 2020; Grandpierre et al., 2018; Bardach et al., 2017). In home healthcare, reimbursement rarely supports the coordination and communication activities necessary for effective collaboration, while military healthcare faces similar resource limitations that extend to both interprofessional education and practice initiatives. Although the military may address these through internal budgeting processes, traditional systems remain constrained by rigid payer structures.

Regulatory and policy barriers compound these financial challenges. Medicare waivers and insurance regulations often restrict innovative, team-based care approaches, leaving providers with little flexibility to pursue collaborative solutions (Reddy et al., 2021). Federal and state-level policies rarely provide financial incentives for interprofessional practice, and organizations already under resource strain face additional pressures when attempting to implement new collaborative models. These challenges underscore the need for reforms that align reimbursement, insurance coverage, and regulatory frameworks with the realities of team-based care delivery.

Organizational and Structural Barriers

Organizational and structural barriers consistently emerge as predominant impediments to interprofessional practice implementation across healthcare settings. These barriers are considered modifiable through quality improvement initiatives, leadership development, and strategic organizational redesign.

Institutional physical, organizational, and leadership structures often fail to adequately support interprofessional collaboration. This is highlighted by Paxino et al. (2022) who discussed organizational imperatives, such as discharge planning, dominated dialogues about patient care at the expense of more team-based, holistic discussions. The physical layout of healthcare facilities can further exacerbate interprofessional barriers by

promoting professional segregation. Additionally, inadequate leadership support, characterized by "minimal leadership and support from management" and "absence of leadership at administrative level" significantly impedes interprofessional collaboration (Doornebosch et al., 2022). In acute care settings, for instance, the absence of leadership support for cultural improvements or investment in infrastructure further obstructs teamwork among practitioners (Crooks et al., 2023).

Time constraints represent one of the most prevalent organizational barriers, with healthcare professionals reporting insufficient time allocation for interprofessional activities due to competing clinical and administrative demands (Cormican et al., 2023; van der Weerd et al., 2025). Cormican et al. (2023) found that time constraints were reported in all 22 studies they reviewed, highlighting the ubiquitous nature of this barrier. Staffing shortages, workflow inefficiencies, and lack of case management further exacerbate these temporal pressures (Mortin et al., 2020; Cormican et al., 2022; Papadimitriou & Cott, 2015; Akbar et al., 2024; Kong et al., 2024; Cabán-Alemán et al., 2020; Witt et al., 2019; Blasi et al., 2018; Schmidt et al., 2016).

In acute care settings, workflow integration among team members remains a significant barrier. Misaligned schedules and a lack of structured healthcare team rounds are common issues (Nemeth et al., 2014). Decreased team stability, high healthcare provider turnover, skepticism about collaboration, and the widespread use of distributed teams all contribute to undermining effective team dynamics (Manojlovich et al., 2015). Home healthcare faces particular logistical and structural barriers including staffing shortages, scheduling conflicts, and fragmented care delivery systems that complicate coordination among providers working in isolation across multiple patient homes.

Resource limitations constitute another significant organizational barrier, including inadequate staffing, equipment, and physical space (Seaton et al., 2023; Doornebosch et al., 2022; Vranceanu et al., 2021). Doornebosch et al. (2022) specifically noted that a "resource-constrained environment" and "limited opportunity for appropriate team consultation moments and poor availability of space for all disciplines" hindered collaborative practices. Many outpatient facilities have different administrative systems and lack adequate space for co-located team members (Rosenblum et al., 2023; Rawlinson et al. 2021; Ulrich et al., 2020; Powell et al., 2016; Benzer et al., 2015), creating logistical challenges for patients who must navigate to multiple sites for care.

Accessibility in organizational spaces poses particular barriers in acute care settings. Large physical facilities contribute to a lack of personal connections, which are identified as obstacles to effective communication (Liu et al., 2021). Physical accessibility is influenced by structural factors such as inconsistent rounding schedules and clinician presence outside specific units. In larger hospitals or clinics where clinicians are unfamiliar with one another, face-to-face discussions, particularly at the bedside, have been shown to block communication (Ron et al., 2024; Gonzales et al., 2015).

Military healthcare encounters unique logistical and structural barriers through resource shortages, time constraints, and rigid operational demands that restrict collaborative practice. The structured nature of military operations can create inflexibility that conflicts

with the adaptive communication and coordination required for effective interprofessional practice.

Communications and Information Exchange

Communication barriers consistently emerge as foundational obstacles to interprofessional collaboration across healthcare settings, yet they are among the most modifiable challenges through the use of standardized tools, targeted training, and intentional team processes. Fragmented or static communication, omissions in documentation, and insufficient patient involvement represent persistent limitations to collaboration (Polnaszek et al., 2015; Wong et al., 2018; Paxino et al., 2022). Standardized documentation requirements, while designed to improve accountability, may inadvertently constrain authentic dialogue, creating tensions between “scripted” and “unscripted” interactions during team meetings (Paxino et al., 2022). These dynamics underscore the need to balance regulatory compliance with opportunities for meaningful discourse among providers and with patients.

Hierarchical structures within acute care settings present significant barriers to communication. Power differentials may discourage clinicians from voicing concerns, resulting in gaps in decision-making and patient care (Liu et al., 2021). Medical interns, for example, often hesitate to contribute outside of hierarchical pathways, even when communication relies on a single channel to the attending physician (Manojlovich et al., 2019). Closing the communication loop has been identified as a critical strategy for fostering interprofessional trust and ensuring safe, patient-centered care (Ron et al., 2024). Comparable rank-based silos within military healthcare further reinforce these patterns, limiting open dialogue and collaborative decision-making. Such hierarchical dynamics not only undermine efficiency but also pose risks to patient safety when critical information is withheld or delayed.

Technology simultaneously facilitates and obstructs communication among interprofessional teams. Electronic medical records (EMRs), while enhancing documentation and continuity of care within a system of care, have been associated with a reduction in face-to-face interactions and difficulties in interpreting notes across specialties (Bardach et al., 2017; Keenan et al., 2018; Ron et al., 2024). The persistence of fragmented electronic health record (EHR) systems exacerbates these challenges, particularly when platforms lack interoperability across clinics or health systems (Balasubramanian et al., 2021; Nothelle et al., 2021; Smith et al., 2020; Blasi et al., 2018; Khoong et al., 2018). These deficiencies increase duplication of services, reduce provider confidence in shared records, and place administrative burdens on staff. Moreover, the overreliance on digital platforms risks diminishing relational aspects of communication, such as trust-building and mutual understanding, which are vital to interprofessional collaboration.

Distinct challenges are evident in home healthcare, where the distributed nature of service delivery magnifies communication barriers. Providers often work independently across multiple sites with inconsistent documentation and limited access to real-time coordination mechanisms. These limitations are compounded by cultural and linguistic differences that necessitate interpreter services and culturally competent strategies (Grandpierre et al., 2018; Mirza et al., 2020). Terminological differences also create barriers across disciplines, as specialized jargon can inhibit mutual understanding (Doornebosch et al., 2022). Jabbar et al. (2023) found that 50.7% of participants identified the absence of timely information

exchange mechanisms as a barrier to effective collaboration. Without standardized approaches for rapid communication, home healthcare teams face systemic challenges in achieving coordinated and comprehensive service delivery.

System-level fragmentation further exacerbates communication barriers across and within organizations. Poor inter-clinic and interagency communication (Rosenblum et al., 2023; Reedy-Cooper et al., 2020; Renfro et al., 2018; Tennison et al., 2019) reinforces professional silos, while departments within single institutions frequently lack formal structures to facilitate collaboration (Schmidt et al., 2016). The absence of interoperable electronic records compounds these divisions, isolating professionals and undermining integration across disciplines (Balasubramanian et al., 2021; Nothelle et al., 2021; Smith et al., 2020). Addressing these systemic deficiencies requires significant investment in interoperable health information technologies as well as organizational policies that mandate cross-institutional communication and accountability.

Finally, insufficient patient involvement represents a critical yet underexamined dimension of communication barriers. Team discussions often prioritize organizational or administrative imperatives rather than patient-centered perspectives, reducing opportunities for shared decision-making (Paxino et al., 2022). When patients are excluded from the communication process, care plans risk becoming fragmented or misaligned with individual needs. Overcoming these limitations necessitates not only technical and organizational solutions but also a sustained commitment to incorporating patient voices at every stage of the collaborative process. This integration is essential for advancing both the quality and the effectiveness of interprofessional practice.

Professional Knowledge and Role Clarity

Professional knowledge and role clarity consistently emerge as significant impediments to effective interprofessional collaboration across healthcare environments. These barriers, while persistent, are modifiable through interprofessional education, structured training initiatives, and the establishment of clear protocols. Unclear roles, limited knowledge of other disciplines, and insufficient educational preparation combine to hinder collaborative practice and restrict the full potential of team-based care (Doornebosch et al., 2022; Jabbar et al., 2023; Riopel et al., 2024).

Role and leadership ambiguity remains one of the most frequently cited challenges. When responsibilities are poorly defined, boundaries within teams become reinforced, creating confusion and tension among professionals. In one study, 68.6% of healthcare providers identified ambiguity in roles and leadership as a major barrier to collaboration (Jabbar et al., 2023). This lack of clarity may lead to duplication of tasks or the neglect of essential responsibilities, with providers reluctant to defer to colleagues whose roles are not well understood (Zaletel et al., 2022; Vordenberg et al., 2021; Carroll et al., 2020; Sangaleti et al., 2017). Military healthcare illustrates these dynamics acutely, as deployment and operational care settings require rapid adaptation, often leading to blurred or undefined professional boundaries (Doornebosch et al., 2022).

Knowledge gaps concerning the roles and responsibilities of other professions compound these challenges. Misunderstandings of disciplinary expertise create initial barriers to collaborative practice and hinder mutual respect (Riopel et al., 2024). For instance, Seaton

et al. (2023) observed that physical therapists sometimes held limited or incorrect conceptions of other providers' functions, impeding integration within care teams. Outpatient settings are particularly susceptible to such gaps, as providers frequently lack familiarity with the contributions of colleagues in other specialties (Nothelle et al., 2021). Without a foundational understanding of role differentiation, interprofessional collaboration is weakened at the outset.

Educational preparation deficits contribute significantly to these barriers. Traditional healthcare education often occurs in discipline-specific silos, which do not adequately prepare students for interprofessional communication and teamwork (Montano et al., 2023; Sangaleti et al., 2017; Schmidt et al., 2016). Although classroom-based interprofessional education has been introduced in many curricula, students report these experiences as insufficient to prepare them for the complexities of real-world collaboration (Riopel et al., 2024). Authentic experiential or clinical education opportunities remain essential for reinforcing the communication skills and collaborative confidence required in practice.

The consequences of educational gaps are particularly evident in clinical environments. In acute care, inadequate training may leave team members lacking confidence in their patient care skills, resulting in hesitation to interact with colleagues from other disciplines. Deguzman and Wayner (2015) noted that discrepancies between adherence to approved protocols and actual interprofessional practice often stemmed from insufficient education and limited experience. Similarly, Hendricks et al. (2017) found that staff nurses reported discomfort when participating in bedside rounds with interprofessional teams due to inadequate preparation. Home healthcare settings face parallel challenges, where isolated practice environments and weak integration of interprofessional curricula restrict providers' opportunities to learn through observation or direct engagement.

Finally, scope of practice restrictions intersect with professional knowledge barriers by limiting the degree to which providers can contribute to team-based care. Regulatory constraints, often varying by state, prevent many professionals from practicing at the top of their license, curtailing both flexibility and efficiency in collaborative service delivery (Landman et al., 2014). These structural limitations, when combined with deficits in training and professional development, reinforce a workforce culture that prioritizes autonomy over collaboration (Schmucker et al., 2024; Balasubramanian et al., 2021). Addressing these challenges requires not only curricular reform and professional development but also policy change that expands practice authority, ensuring that providers are empowered to fully contribute to interprofessional models of care (Penner et al., 2020; Cormican et al., 2022; Barnard et al., 2018).

Hierarchical and Power Dynamic Barriers

Professional hierarchies and power imbalances represent enduring barriers to interprofessional collaboration across healthcare settings. Although deeply embedded in healthcare culture, these barriers are not immutable; they may be addressed through leadership development, collective decision-making processes, and intentional organizational culture change. Hierarchies structure how authority is distributed within teams, influencing who speaks, who is heard, and whose expertise is considered central to patient care (Paxino et al., 2024; Ron et al., 2024).

Traditional medical hierarchies are particularly influential in shaping interprofessional interactions. Physicians and senior clinicians often assume dominant roles in interprofessional meetings, leaving junior team members with fewer opportunities to contribute. Paxino et al. (2024) noted that “relational factors relating to power, hierarchy, leadership, and membership” significantly influenced participation during interprofessional meetings, with more experienced clinicians consistently exerting greater influence. Such dynamics create unequal participation, constraining diverse perspectives and limiting the integration of broader expertise into patient care. In outpatient settings, resistance to shared decision-making and professional gatekeeping further weaken the collaborative foundations of team-based practice (Landman et al., 2014).

Disparities in authority, power, income, and professional status further entrench these barriers. Jabbar et al. (2023) reported that 53.3% of healthcare professionals strongly agreed such disparities create barriers to collaboration, a finding that underscores the systemic nature of these imbalances. Power differentials can foster environments where some disciplines dominate, others are marginalized, and decision-making is skewed toward those with greater authority. This dynamic reduces willingness among less powerful team members to participate fully, perpetuating professional silos and undermining collaborative decision-making (Doornebosch et al., 2022; Kearns et al., 2021; Barnard et al., 2018; Olufson et al., 2023).

One consequence of hierarchical inequities is communication hesitancy. Providers may fear embarrassment, dismissal, or professional repercussions if their contributions are disregarded, leading them to withhold important information (Liu et al., 2021). Reese et al. (2016) found that respiratory therapists, nurses, and case managers often refrained from advocating for patients due to concerns about their position within hierarchies. In acute care settings, these concerns are particularly profound. Liu et al. (2021) demonstrated how social norms, cognitive biases, and hierarchical relationships restricted participation in decision-making processes, preventing frontline clinicians from contributing key insights necessary for patient-centered care.

Military healthcare illustrates how cultural and structural hierarchies intensify barriers to collaboration. Rank-based command structures reinforce rigid authority lines, prioritizing compliance with chain-of-command decision-making over open, dialogic exchange. This emphasis on command authority may limit lower-ranking healthcare providers’ ability to challenge decisions or share expertise, even when such contributions could improve patient outcomes. Ron et al. (2024) observed that these entrenched hierarchies directly limit the implementation of interprofessional, consensus-based approaches. Consequently, while clear chains of authority may benefit operational efficiency, they can stifle the collaborative practices essential for comprehensive care.

Hierarchical barriers are also evident in home healthcare, though they manifest differently. Providers in home care frequently work in relative isolation, where formal hierarchies may appear less visible. Yet professional values, referral practices, and decision-making processes remain influenced by subtle hierarchical dynamics. For example, differing reasoning approaches, skepticism toward the expertise of other professions, and

territorialism have been identified as contributing to fragmentation and mistrust within interprofessional home care teams (Washmuth et al., 2019; Schmidt et al., 2016; Savill et al., 2024; Benzer et al., 2015). Even in decentralized care environments, such dynamics limit collaboration and reduce the effectiveness of service delivery.

Addressing hierarchies and power imbalances requires more than individual-level adjustments; it necessitates systemic organizational change. Leadership development initiatives that cultivate inclusive decision-making, cultural change processes that emphasize equality of voice, and structures that institutionalize shared authority can reduce the influence of entrenched hierarchies. However, such reforms face resistance from established power structures and require long-term commitment. Evidence suggests that intentional efforts to restructure leadership and embed collaborative practices into organizational norms can gradually shift cultures away from dominance and marginalization, creating more equitable and effective interprofessional environments (Savill et al., 2024; Schmidt et al., 2016).

Provider Attitudinal and Belief Barriers

Professional attitudes and beliefs represent a critical yet highly modifiable category of barriers to interprofessional collaboration. These barriers, while rooted in professional culture and individual dispositions, can be addressed through training, reflective practice, and the cultivation of supportive environments that reinforce collaborative values. The literature demonstrates that attitudes toward collaboration may be ambivalent, with some professionals perceiving interprofessional practice as beneficial while others regard it with skepticism (Cormican et al., 2023). Such ambivalence underscores the complex role of professional attitudes in either facilitating or hindering team-based care.

Negative attitudes toward interprofessional practice are frequently linked to skepticism about the evidence base supporting collaborative approaches and doubts regarding the applicability of guidelines to “real-world” clinical settings. Cormican et al. (2023) observed that professional attitudes toward interprofessional guidelines often functioned bi-directionally, at times enabling but more often obstructing implementation. These findings highlight how attitudinal barriers are not merely individual but are shaped by broader professional norms, perceptions of evidence, and the alignment between policy and practice.

In acute care settings, attitudinal barriers are amplified by the absence of psychological safety and low levels of mutual respect. Teams characterized by skepticism, ego-driven behavior, or resistance to collaboration encounter greater difficulty integrating interprofessional practice into their routines (Foronda et al., 2016; Penner et al., 2020; Becker et al., 2017). These attitudes can erode trust, foster disengagement, and compromise patient outcomes. Moreover, an educational system that historically privileges autonomy over collaboration may reinforce such attitudes, producing a workforce insufficiently oriented toward the benefits of team-based models.

Home healthcare also faces distinctive cultural and attitudinal challenges. The isolated nature of service delivery fosters independence, but it may also perpetuate resistance to shared decision-making and collaborative accountability. Differing professional values and identity conflicts can emerge, as providers accustomed to working autonomously may view

collaboration as intrusive or inefficient. These dynamics complicate efforts to integrate interprofessional models of care in a context already constrained by limited opportunities for direct observation of collaboration.

Military healthcare presents another unique context in which professional attitudes intersect with broader cultural expectations. Military training emphasizes teamwork, discipline, and mission accomplishment, values that align in principle with interprofessional practice. Yet hierarchical command structures may generate tension, as they emphasize compliance and authority in ways that conflict with collaborative, patient-centered approaches. This duality illustrates how organizational culture can both support and hinder interprofessional attitudes depending on context (Ron et al., 2024).

Competitive attitudes further undermine collaboration in certain practice environments. Seaton et al. (2023) documented how physical therapists in private practice settings often regarded other providers as competitors rather than collaborators, leading to resistance in information sharing and referrals. Similarly, professional identity concerns may cause practitioners to resist interprofessional practice out of fear of losing autonomy or status. Riopel et al. (2024) found that both students and practitioners sometimes perceived interprofessional collaboration as a threat to professional identity, even while acknowledging its potential benefits. Van der Weerd et al. (2025) further observed that prioritizing personal or professional goals at the expense of collective objectives constitutes a significant barrier to effective collaboration.

Despite their persistence, attitudinal barriers remain highly modifiable. Evidence suggests that targeted training, reflective exercises, and organizational cultures that normalize collaboration can significantly shift professional beliefs. Military healthcare systems, with their structured training environments and emphasis on team performance, may be particularly well-positioned to implement such interventions. More broadly, addressing professional attitudes requires deliberate efforts to cultivate respect, clarify roles, and reinforce the value of collaboration in both education and practice (Zaletel et al., 2022; Nothelle et al., 2021; Wulsin et al., 2019). By reshaping the cultural and attitudinal foundations of healthcare practice, interprofessional collaboration can be strengthened across diverse settings.

Patient-Related Barriers

Patient-related barriers constitute a distinct category of obstacles to interprofessional collaboration, frequently described as largely non-modifiable. Unlike structural, professional, or organizational barriers, patient-related factors often lie outside the direct control of providers. Nevertheless, their effects can be mitigated through supportive interventions such as targeted resource allocation, interpreter services, and policies that actively promote patient engagement in collaborative care processes.

Clinical condition severity is one patient-related factor that can hinder interprofessional practice. Cormican et al. (2023) found that patients with severe impairments, particularly in stroke rehabilitation, often presented challenges to guideline implementation and interprofessional coordination. Similarly, patient access and availability for therapy sessions in acute settings can limit the feasibility of sustained team-based approaches.

These limitations highlight how clinical realities constrain collaborative models even when providers are willing to implement them.

Patient communication and engagement with interprofessional teams also play a decisive role in care outcomes. In acute care settings, inconsistent communication, underuse of interpreter services, and limited respect for patient input undermine the effectiveness of partnerships between patients and providers (Opper et al., 2019). Such failures are linked to poorer outcomes, including higher perceptions of medical errors, prolonged hospital stays, and increased readmission rates (Opper et al., 2019; Schenk et al., 2019). Moreover, inadequate inclusion of family members in care planning contributes to fragmented transitions and diminished trust in team-based approaches.

Home healthcare presents distinct patient-related challenges stemming from the influence of the home environment. Patients and families may resist interprofessional care due to preferences for specific providers or discomfort with having multiple clinicians involved in their care. The decentralized and unsupervised nature of home care delivery also creates difficulties in maintaining consistent patient engagement with care plans, especially when patients perceive collaboration as disruptive to their established routines. These dynamics illustrate how environmental and cultural contexts shape patients' attitudes toward interprofessional practice.

Military healthcare also encounters unique patient-related barriers influenced by cultural and experiential factors. Service members and veterans often bring distinct perspectives shaped by military culture, including attitudes toward authority, teamwork, and hierarchy. These factors may affect their engagement with interprofessional models of care. In addition, the complex health needs of military populations, such as combat-related injuries and post-traumatic stress, demand specialized interprofessional approaches that may not align with civilian care models (Ron et al., 2024). These unique contexts underscore the need for tailored strategies to address patient engagement in military systems.

Socioeconomic and logistical factors remain pervasive patient-related barriers across settings. Limited financial resources, inadequate insurance coverage, and high out-of-pocket costs can prevent patients from accessing multiple providers involved in interprofessional care (Cliff et al., 2024; Elliott et al., 2023; Montano et al., 2023; Taber et al., 2021; Gallo et al., 2020; Howard & Potts, 2019; Becker et al., 2017; Bridges et al., 2017; Powell et al., 2016; Jeon et al., 2016). In the outpatient setting, transportation barriers and time constraints due to employment or caregiving responsibilities further exacerbate difficulties, particularly when providers are not co-located (Schmucker et al., 2024; Gallo et al., 2020; Gleason et al., 2017; Bellamy et al., 2016; Schmidt et al., 2016). These socioeconomic realities often create persistent inequities in access to team-based models of care.

Finally, patient preferences, beliefs, and cultural contexts significantly shape interprofessional engagement. Many patients continue to prefer physician-led care, reflecting traditional hierarchies in healthcare (Zaletel et al., 2022; Vordenberg et al., 2021; Osborne et al., 2021; Sangaleti et al., 2017; Becker et al., 2017; McCarter et al., 2016). Stigma surrounding mental health services remains a significant barrier to participation in integrated models, particularly when behavioral health providers are embedded in primary care (Savill et al., 2024; Schmucker et al., 2024; Vassilopoulos et al., 2020; Wulsin et al.,

2019). Furthermore, low levels of patient motivation and engagement in care planning have been observed across settings, with Paxino et al. (2022) emphasizing the lack of patient involvement in dialogue and decision-making. Cultural and language differences further compound these challenges but can be mitigated through interpreter services and culturally competent approaches (Grandpierre et al., 2018; Mirza et al., 2020). Collectively, these findings illustrate that although patient-related barriers are largely non-modifiable, strategic interventions can significantly reduce their impact and improve the effectiveness of interprofessional care.

Conclusion

This integrative review demonstrates that barriers to interprofessional practice occur across eight domains: regulatory, financial, organizational, communicative, professional, hierarchical, attitudinal, and patient-related. While these barriers manifest differently across care environments, the majority are at least partially modifiable through targeted interventions. Organizational and interpersonal barriers, including time constraints, communication challenges, role ambiguity, hierarchical dynamics, and attitudinal resistance, are the most consistently identified and the most amenable to strategies such as workflow redesign, interprofessional education, leadership training, and culture change (Cormican et al., 2023; Ron et al., 2024; Jabbar et al., 2023).

Setting-specific nuances highlight the importance of tailored interventions. Acute care environments require structured communication tools, streamlined rounds, and decision-making processes suited to high-acuity situations. Home healthcare necessitates innovative coordination mechanisms and technology-enabled solutions for distributed teams, while military healthcare must reconcile command authority with collaborative models by leveraging its training infrastructure and team-oriented culture (Liu et al., 2021; Ron et al., 2024). These findings underscore that while many barriers are universal, their expression and the pathways to address them vary significantly across settings.

Patient-related barriers, in contrast, remain largely non-modifiable, reflecting socioeconomic realities, cultural preferences, and condition severity. Nevertheless, their impacts can be mitigated through resource allocation, interpreter services, culturally competent care, and strategies that enhance engagement and trust. Financial and regulatory barriers, such as fragmented reimbursement systems, licensure restrictions, and malpractice liability are less easily addressed at the organizational level but can be influenced by policy advocacy, innovative payment models, and regulatory reform (Landman et al., 2014; Goldman et al., 2022; Reddy et al., 2021).

Future research must prioritize evaluating interventions that address these modifiable barriers across diverse healthcare settings. Areas for development include setting-specific organizational redesign strategies, expanded interprofessional education tailored to different practice environments, leadership programs that reduce hierarchical rigidity, interoperable health information systems, and sustainable payment models that incentivize team-based care. By addressing multilevel barriers systematically, healthcare systems can strengthen interprofessional collaboration and improve outcomes across the continuum of care, advancing the goals of accessibility, efficiency, and patient-centeredness (Savill et al., 2024; Montano et al., 2023).

In sum, interprofessional practice is constrained by barriers that span regulatory, financial, organizational, communicative, professional, hierarchical, attitudinal, and patient-related domains. While patient-related barriers remain largely non-modifiable, the majority of obstacles can be addressed through organizational redesign, interprofessional education, leadership development, and policy reform. By adopting evidence-based, setting-specific strategies that emphasize accessibility, collaboration, and cultural change, healthcare systems can reduce fragmentation, strengthen teamwork, and advance the quality and safety of care delivery across the continuum.

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