Western and Northern
Health Human Resources Planning Forum

"Developing Sustainable Interprofessional Collaborative Practice and Learning Environments"

PRELIMINARY SITE REPORT
JULY 6, 2011

Alberta

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Developing Interprofessional Collaborative Practice and Learning Environments across the Continuum of Care in Western and Northern Canada

Co-funded by Alberta Health & Wellness

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1. Project Background and Participating Sites

Background

Collaborative practice as an interprofessional process of communication and decision making that enables the separate and shared knowledge and skills of health care providers to synergistically influence the client/patient care provided. There is evidence demonstrates that collaborative practice can enhance provider satisfaction, improve the quality of the workplace and lead to better patient outcomes while reducing patient care costs. The Northern and Western HHR Forum in partnership with the Western Canadian Interprofessional Health Collaborative (WCIHC) have secured funding from Health Canada to explore how collaborative practice can be enhanced in different settings. Initiatives were completed in Alberta, British Columbia, Manitoba and Saskatchewan. The project has received considerable attention nationally and provincially. Alberta Health and Wellness (through the Health Workforce Action Plan) is co-sponsoring the Alberta project, which has allowed extending the project timelines to September 30, 2011.

This is a preliminary report; a final report describing the outcomes achieved will be submitted in September 2011.

Goal of the project

The aim of this project was to develop, implement and evaluate innovative interprofessional (IP) approaches to health care delivery in a variety of practice sites. These sites will constitute Collaborative Practice and Learning Environments (CP&LEs) that will demonstrate exemplary collaborative practice and serve as a site for IP clinical student placements.

Specific objectives were to:

- Conduct a comprehensive assessment of participating sites as to existing and desired collaborative practice.
- Assess information and education needs of staff to move towards collaborative practice.
- Design and implement strategies at the organization, practice and education level to support collaborative practice.
- Implement an IP clinical student placements model for fall and winter 2010/11.
- Conduct a final evaluation to capture the outcomes and impact of all strategies implemented.
- Disseminate the findings to interested stakeholders.
- Hold planning session with local and provincial Steering Committees to develop a sustainability plan.

Participating clinics

Two community mental health outpatient clinics, Alberta Health Services (AHS), participate in this project. Both clinics offer services to adults that experience psychiatric problems with pervasive impairments across different areas of functioning (Axis 1 diagnosis). Services are provided by interprofessional team members (i.e. social work, nursing and psychology therapists, independent living support workers, occupational therapist (one clinic only), outreach workers and transition coordinators). Both clinics operate on a primary therapist model where each therapist has a full client load and acts as a case manager for their clients. Psychiatrists act as consultants. Services include intake assessments, psychiatric consultations, individual and group therapy, medication management, outreach and transition support. Both clinics have regular student placements mainly from nursing, social work, occupational therapy, psychology and psychiatry.

Clients require a referral to access services. Prospective clients can be self-referred, referred by physicians or other agencies. All referrals are screened by Access Mental Health – Adult & Senior Services (Access MH) and forwarded to the clinics if appropriate. A triage team in each clinic confirms that a client is eligible for services and what the client's specific needs are. New clients are prioritized, assigned to a therapist and booked for a psychiatric assessment if needed. The total client base for each of the clinics is about 800, with some clients being long-term, staying with a provider for 25 years. There is currently about a six-month wait list.

Trends in patient population and service delivery

A number of trends have impacted the clinics. Mental health services have been restructured a number of times. Originally under the mandate of the Alberta Mental Health Board, services were provided in a centralized location downtown Calgary and were aimed at a broad range of clients including children and youth. Services were also provided to clients with minor issues or adjustment disorder that were otherwise well functioning. With the significant growth of Calgary's population in recent years and the capacity constraints in acute care, demand for outpatient mental health services has increased. This led to a restriction of services to adult clients with severe and persistent issues. Less complex cases are referred out to community services (e.g. catholic family services) or private practitioners. With the most recent reorganization into AHS and the heightened focus on access and patient flow, there is perceived pressure to move towards shorter-term engagement and timely discharge of clients. This may require a shift from a chronic illness model with ongoing, long-term support to a recovery model that builds on people's strength and supports them in moving on.

2. Roles and Relationships within the two Participating Clinics and Opportunities for Collaborative Practice

Baseline assessment (May –July 2010)

A comprehensive assessment of both clinics was conducted to understand the current levels of collaborative practice, structures and processes in place to support collaborative practice and opportunities for improvement. Data was gathered from a number of sources:

- Environmental checklist completed during team meetings; the checklist captures structures and processes that support IP education and collaborative practice
- Individual interviews with staff
- A social network survey to capture interactions between staff around clients

Following the CIHC collaborative practice competency framework, the data are broken down into the different aspects of team functioning, role enactment and role clarity, communication, interprofessional conflict, client/family-centered care, and collaborative leadership.

Team functioning

Staff from both clinics perceived their team as functioning quite well. Team members agreed that there are still ebbs and flow in the team, but that "We've come a long way". Both programs had little staff turnover in the past. The staff mix seems to work well and staff stated that collaboration between team members is excellent. One of the teams has established team rules (e.g. don't talk behind people's back, if you criticize also offer solutions). Staff mentioned that they enjoy working at the clinics and that they have fun as a team. Apart from the manager and the clinical supervisor who have more formal leadership roles, there doesn't seem to be a visible hierarchy between the professions. Some staff mentioned occasional tension around professional backgrounds. Students are purposefully integrated into the health care team.

Both teams have few opportunities for team building and for developing a shared vision. There seems to be some uncertainty created by ongoing organizational restructuring, and by diversity of vision and values, and changes are embraced with various levels of enthusiasm.

Role enactment and role clarity

Understanding of one's role and that of other providers that contribute to a client's care is an important piece of collaboration. Staff recognized that everybody has a different role and that different professions (nursing, social work, psychology) bring different approaches to addressing mental health issues that are not necessarily interchangeable. "It's nice to have the different disciplines because you get the different expertise here". Besides specialty approaches to therapy, it was recognized that significant overlap between the different providers exist. Discussions about specialty therapies occur occasionally, and team members admitted that it takes time to get to know colleagues and fully understand what their specialties are. Therapists stated that they have a client-centred approach and similar philosophies although each profession "creeps their piece in". Therapists felt that they have lots of professional freedom and choice; they work closely with the psychiatrists who act as consultants, and they seek input from other providers based on clients' needs. Overall, providers seemed to be aware of the type of therapies other team members can provide.

Communication

Both teams have a number of formal and informal strategies to communicate about patients. Formally, they have regular weekly meetings to be attended by all staff (including administrative support at one of the clinics). Most staff attend on a fairly regular basis; some part-timers less frequently. Psychiatrists only attend occasionally and physicians don't attend at all. Staff stated that it would be helpful to have psychiatrists at the table more often. These meetings serve as case conferences where therapists discuss difficult cases. Meeting time is also used to discuss business items and new policies (e.g. new syringes). One of the teams uses the meeting time to discuss new clients that have been triaged (presenting history, goals) and assign them to a therapist.

Staff connect frequently on an informal basis to share information about a client, seek advice or consult on treatment plans (see social network map). Some staff members run group therapy sessions together.

Interprofessional conflict

Staff from both clinics agreed "that [conflict] does not seem to occur very much here." Therapists are guided by the best interests of the client when presenting cases at team meetings. They discuss, offer advice or consult, and interactions are respectful. As a rule, the decision about treatment always remains with the primary therapist. There may be some defensiveness because of "ownership" of client (having been with them for a number of years). Some disagreements may arise from different treatment approaches or, with psychiatrists, over diagnosis reported or readiness for discharge. It mainly happens when people forget about teamwork. "We know that the psychiatrists are consultants but they have the prescription pad." Psychiatrists don't always consults with the therapist and may set up patient expectations differently which tends to be considered as "overstepping their boundaries". Team members resolve their disagreements in personal discussions.

Client/family-centred care

The programs target adults; the family only gets involved when the client requests it or if the family specifically asks for it. Lots of clients have no close family here or have a dysfunctional family so they are not interested in family involvement. Staff stated that they need to be reminded at times that the family is part of the team. They suggested to perhaps offering more flexible hours, group sessions or education materials for family members.

Staff commented that they have lots to offer their clients in terms of quality of life compared to past years. Much progress has been made in medications available but also how mental health is viewed and treated. There were some concerns about the perceived pressure of client flow through and how it might affect client care. The pressure to discharge might particularly affect clients that seem stable but are seen for regular check-ups. Staff stated that it is these regular check-ups that help prevent crisis and keep these clients out of the hospital. The perceived focus on outcomes rather than quality of care made some staff wonder if the services are becoming more system centric.

Collaborative leadership

Staff use a template for a care plan that is completed by the primary therapist, although it doesn't seem to be consistently used. There is an annual review of the care plan. Other therapists that work with the client (e.g. occupational therapist, independent living support) add their comments under the progress note section. The ultimate decision about treatment plans are made by the primary therapist. There seem to be some issues around who is responsible for changes in medication (psychiatrist or family physician). Staff exchange information on best practices and therapists often bring forward highly complex cases as examples.

Organizational level support for collaborative practice

Both clinics have no policies on IP education or collaborative practice specifically. Collaboration is implied in the job description that refers to an "interdisciplinary" team but no specific competencies are mentioned. Despite the lack of formal policies, there are some clear expectations around collaboration and supervision. "We are a team. It is understood that you need to come to supervision meetings. The culture here is promotes understanding that you can't do it by yourself". It was identified in the planning stage that staff should collaborate with other mental health programs and other sites within the Centre. "That was the culture piece that was set".

There is no formal training or orientation to collaborative practice for new staff. New staff is partnered for the first few months with experienced staff and they may also shadow physicians. Clinics have some technology available that allows observing staff working with patients that could be used for staff and student training. Staff stated that they need an orientation manual including Q&A, job shadowing, and open-door "policy".

Although leadership is supportive of collaborative practice, there are no formal resources allocated for staff development. Education resources have been pretty much eliminated during the organizational restructuring over the past years. This erosion of education funds is a big concern for staff and impacting their morale and job satisfaction. Staff stated that in the long term, it will also impact the skills in particular of younger staff. There seems to be a desire to reintroduce some learning opportunities such as peer mentoring or rounds.

Interagency collaboration

Staff from both clinics mentioned a number of agencies that are key to their clients and with whom they connect for client referrals, treatment etc. Most commonly mentioned were: Canadian Mental Health Association (CMHA), housing services, social services such as AISH, employment agencies, outpatient mental health clinics, home care, pharmacy and public trustees.

Overall, collaboration with these community agencies and other health and social care providers seem to work well and agency staff has been described as helpful. It has been pointed out that there are a lot

of services in the community with a risk of duplication. Consequently, there is an ongoing need to re-aligned the two clinics and refocus on clients in acute need; once they are more stable they should be referred to community services.

Student placements and IP mentoring

The program has regular placements for students from nursing, social work and occupational therapy (one of the clinics only), and occasionally psychology. However, there are no students from pharmacy or physiotherapy and student placements rarely overlap; if they do, there are typically no interactions between students beyond informal social contacts. "Students from different disciplines have different priorities when they are here". Nursing students come for observations for a short time (undergraduates) while social work and psychology students who are typically at the graduate level are here for longer and with different expectations. All students are invited to observe with members from other teams and agencies and to attend group therapy sessions. They observe therapist-psychiatrist interactions when the psychiatrists are called in. "There is that natural assumption that students are part of the clinical team here and are therefore included in the processes. That's just a given here." Other IP mentoring opportunities include doing mental status exams, attend a group therapy session and sit in on various patient sessions ("patients perk up when student is present").

However, even when spending time with other providers, the focus of students is directed to clinical knowledge to be gained, not the collaborative practice aspects between the providers. For most of these IP mentoring opportunities there are no explicit IP learning goals for the students and students don't really have any accountability as to their learning outcomes. Formal debriefs with the preceptor or other staff are missing. Apart from the AHS preceptor workshop, staff have no formal preceptor training opportunities.

Staff perceived a number of challenges with the student placements:

- The setting may not lend itself to student participation (in acute mental health settings students can be much more hands-on) although staff admit that there are lots of opportunities at the clinics.
- Appropriateness of students they receive for clinical placements: many students come completely unprepared with no previous courses/background on mental health; this makes it hard to organize an interesting placement for them as at times they don't even know what questions to ask; some of them are also not interested in mental health
- Lack of student motivation and initiative "There's got to be some onus on the people who come to this place", "we are not holding their hands", "they've got to be self-directed".
- Short duration of clinical placement for accelerated nursing students: "They are here for only three weeks and before get into it all, they are gone again".
- Student evaluation procedure that doesn't allow for specific feedback: Evaluation is pass/fail for placement although the lack of motivation of some students was reflected in the final evaluation.
- Lack of choice when selecting students: Nursing therapists are being assigned students (mental health is a mandatory placement); social work therapists can chose what students (type, level) they accept.
- It is challenging at times to select clients that are appropriate for students (e.g., some clients are seen only once a month); it creates more work and therapists have to be creative with student placement activities.

Opportunities for practice improvement
Both programs can draw on highly experienced professional staff from different disciplines that bring different perspectives to the treatment of the clients. Overall, team members demonstrate a collaborative, client-centred care philosophy. They have a number of formal and informal processes and structures in place that support collaborative practice and client-centred care:

- Professionals with a wide range of background and complementary skills
- Regular case meetings attended by most of the staff
- Opportunities to co-teach therapy groups
- Regular student clinical placements that offer opportunities for co-supervision and IP mentoring
- Close proximity of staff that allows for quick access and informal information exchange
- Clinical supervisor that acts as support to therapists
- Flat hierarchy that allows for contributions by all professions and roles

A number of opportunities for further examination were highlighted:

- Role clarity to optimize the unique contributions of individual staff
- Review of triage, client assignment, referral and discharge processes
- Review of treatment approaches
- Processes around client sharing and shared care plans
- Team dynamics including integration of psychiatrists into the teams
- Shared program vision
- Client access to family physicians
- Formal policies around collaborative practice
- Staff education about collaborative practice
- Continuing staff development
- Staff, preceptor and student education around IP student placements

3. Key Outcomes Targeted for Improvement

The primary outcomes targeted were at the provider and system levels. Specifically, we intended to:

- increase IP competencies of providers
- develop staff competencies to act as IP mentors for students
- increase capacity for IP student placements
- develop structures and processes to facilitate collaborative practice

4. Interventions Introduced

4.1. Staff Interventions (September 2010 – June 2011)

Approach to project implementation
The project was guided by a philosophy of participant engagement to create ownership of the work to be conducted. Two project team members acted as external facilitators; program managers at both sites acted as internal champions. The facilitators meet approximately every two weeks for about one hour with each project team to guide discussions about areas for change and to assist with the design of the strategies. Tools and approaches from Human Systems Dynamics were used to structure the conversations and arrive at meaningful strategies. The CIHC collaborative practice competency framework was core to all conversations. Care was taken to devise IP strategies at the education, practice and organization level. The importance of sustainability was discussed early on and a tool to

create sustainable strategies was introduced. Both clinics introduced a number of strategies over ten months:

Clinic 1:

- IP mentoring strategy: a clinical placement approach was implemented that creates IP learning opportunities for students from different professions. Each student still has a discipline-specific supervisor; however, all staff members at the clinic act as IP mentors and support students' development of IP competencies. This strategy will be described in more detail under 4.2.
- Addictions expertise: due to the recent inclusion of addictions into the mental health mandate, therapists identified a need to increase their knowledge and skills around concurrent disorders. A strategy was implemented that accessed the expertise of an addiction councillor to model treatment approaches for patients with concurrent disorders, educate on assessment tools for addictions and appropriate referrals.
- Team functioning: the team developed "simple rules" to guide team behaviour.
- Vision: the team created a shared vision for their program. Due to ongoing restructuring over the past years, this was seen as an important step to create alignment amongst all staff.
- Sustainability framework: we introduced a framework to guide discussions around maintenance of the strategies implemented.
- Education series: staff organized three continuing staff development sessions in areas of common interest with a focus on collaborative practice approaches.
- Access to family physicians: we facilitated a conversation about unattached clients that resulted in a solution for increasing access of those clients to family physicians.
- Team retreats: we hosted one full-day and two half-day retreats for staff to conduct focused work around the strategies outlined above.

Clinic 2:

- IP mentoring strategy as outlined above and discussed in 4.2.
- Restructuring of weekly team meetings to allow for more structured conversations and case presentations.
- Comprehensive review of the patient journey through the program (i.e. from triage to discharge including roles of different therapists and psychiatrists at various stages of the process)
- Protocol for co-sharing of complex clients between two therapists.
- Sustainability framework: we introduced a framework to guide discussions around maintenance of the strategies implemented.
- Education series: staff organized three continuing staff development sessions in areas of common interest with a focus on collaborative practice approaches.
- Access to family physicians: we facilitated a conversation about unattached clients that resulted in a solution for increasing access of those clients to family physicians.
- Team retreats: we hosted one full-day and two half-day retreats for staff to conduct focused work around the strategies outlined above.

Staff evaluation interviews were completed in June and data analysis is in progress. Preliminary findings indicate an overall positive impact of the project activities in a number of areas:

- Increased staff awareness of team dynamics
- Increased awareness of team practices and opportunities for collaboration/referrals
- Increased team cohesion and team functioning

- Increased collaborative practice competencies
- Increased collaboration(e.g. sharing of complex clients)
- More effective team meetings
- Improved client care processes (e.g. triage, discharge, concurrent disorders)
- Improved access to family physicians for unattached clients

4.2. Student Intervention (September 2010 – April 2011)

A second focus of the Alberta CP&LE project was on providing collaborative practice education to students to enhance their training in IP competencies as part of their professional development. Prior to the project, both sites have had regular student placements (nursing, social work, occupational therapy, psychology, psychiatry) from various academic institutions. Staff at the sites related their challenges with previous students who were early in their training (1st or 2nd year), had little knowledge about mental health issues and spent a short time at a site (3-4 weeks).
The primary research question for the student component was "How did the IP clinical placement influence students' IP competencies and their collaborative practice during their placement?"

The students were not placed in teams; instead the project supported the placement of individual students at the sites. Project staff contacted the placement coordinators from the academic institutions in social work and nursing to place a short project summary on the site profiles. This would ensure knowing about the project in advance and showing commitment by students. Further, project staff requested more senior students with an interest in mental health for the sites, given that the project would require a good understanding of professional identity and acquiring IP competencies. The student facilitator also discussed this project with the academic advisors who were the liaison between practice and academic programs.
Six students were placed at the clinics during the fall 2010 and winter 2011 semesters. Three were from the faculty of social work and three from nursing. The nursing students spent one semester on site while the social work students stayed for both semesters. The students received a certificate of participation at the end of their placement. Other students were also placed at one of the sites but their advisors chose not to participate in the project.

The interprofessional clinical placement model
For this project, the project team developed and implemented the IP Clinical Placement Model (Figure 1) which builds on our previous research and other contributions in this field. As part of this model, interprofessional practice activities and seminars were held with students.

Through interprofessional mentoring, students were taught about IP competencies and collaborative practice. IP mentoring includes the facilitation of opportunities for students, their supervision and evaluation by members of the team. In this arrangement, students work with a range of different practitioners at their setting rather than exclusively with mentors from their own profession. When implemented to its fullest, the IP mentoring of students is shared among the members of a team rather than being the sole responsibility of the discipline-specific, primary mentor.

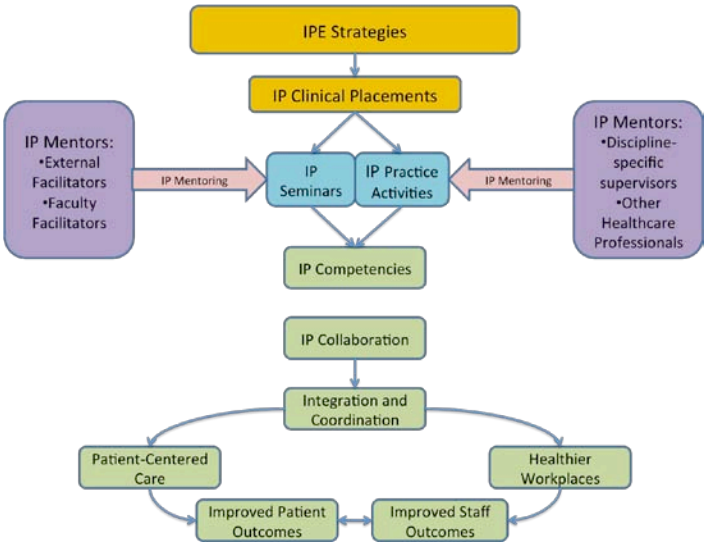


Figure 1 IP Clinical Placement Model
(developed by Suter & Deutschlander, as adapted from Marshall & Gordon, 2005)

Student participation
At the beginning of their placement, the students received an orientation to the project and expectations for their participation were outlined. Not all students were aware of the project when they chose their placements since they were recruited before the start of the project. The students were expected to select IP competencies for one of their learning goals, write a reflection on their experiences, carry out IP practice activities and attend IP seminars. Students were encouraged to seek out students and staff from other disciplines which they may not have done at previous placements. Depending on their educational level and length of placement, students could engage in the various IP practice activities that were outlined in the mentoring guide (to be revised). These included IP activities such as shadowing other providers, developing an IP care plan, acting as practice consultant to the team, joining staff meetings and case conferences, and conducting small IP projects.

Interprofessional practice activities
Students participated in a range of IP activities. For example, students accompanied other practitioners on home visits (nurses, Independent Living Support workers, occupational therapist) and joined particular client sessions with other providers (e.g., medication reviews with psychiatrists, group therapy sessions for specific disorders). Two students attended an interprofessional conference in Edmonton. Some of the students also attended the bi-weekly staff discussions on collaborative practice, the regular team meetings or the triage meetings. Programs or organizations outside their own teams were also visited (e.g., forensic psychiatric centre, DBT team, chronic pain clinic). The nursing students facilitated a few of the social support group therapy sessions by discussing lifestyle choices with the clients (smoking cessation, healthy eating, stress management, etc.). One nursing student researched different types of injections as potential option for future practice by nurses on the team.

Debriefs with the students on IP competencies are part of the supervision process and crucial to learning IP skills and knowledge. The discipline-specific mentors and other staff were encouraged to explicitly discuss the IP competencies with their students in formal debriefs. A series of questions were distributed to staff and students highlighting the major characteristics of each IP competency. For example, communication between providers may be discussed in terms of how well they communicated

around a specific issue, whether there were gaps in communication, or whether a different process should be followed. We found that the debriefs were focused primarily on the discipline-specific, clinical skills of the students. Only one student mentioned that she and her discipline-specific mentor had a conversation about the IP competencies or guiding questions to evaluate her performance.

Evaluation is the formal assessment of how well the learning objectives were achieved. All discipline-specific advisors must complete evaluation forms for their students that vary widely across the disciplines. Based on previous feedback, the student facilitator encouraged the mentors to integrate the IP competencies into existing evaluation templates. The evaluation forms for nursing and social work make repeated reference to collaborative practice or collaboration that should be "established" or "demonstrated". Overall, the discipline-specific mentors did not appear comfortable with assessing the IP competencies of their students beyond writing about role clarity. They listed the activities that were carried out with other team members. One mentor referred to the student's understanding of her own role as a nurse in the clinic. A few of the IP mentors gave feedback to the discipline-specific mentors about their students but "that was not very helpful". The student facilitator wrote brief assessments of the IP competencies for each student to supplement the official student assessment.

Comments from students

The students commented favourably on the practice activities. Individual differences existed in how their mentors approached it ("a lot of it is … dependant on their personal approach and their comfort level and experiences"). Some of the students spent a lot of time with other practitioners ("I've had a ton of support and encouragement from everybody, so that's been really helpful") while others noted that they would have liked "to see other people working with actual clients". The students who travelled to an IP conference in Edmonton said this experience was very valuable for developing a background understanding of IP concepts and "insight into how it does affect patient outcomes". The debriefing about the competencies was not done explicitly ("I think they just kind of come in"; "It's kind of embedded in what we already do"). The students said preceptors would have benefited from more support in discussing and evaluating the IP competencies.

Interprofessional seminars

Besides the IP practice activities with IP mentors at the sites, the students participated in bi-weekly IP seminars that were held by one of the project facilitators. In the two-hour sessions, interactive activities and discussions among the students to promote knowledge exchange were facilitated. Altogether, twelve student sessions were held to discuss the IP competencies (CIHC Competency Framework 2010), the importance of IP collaborative practice, review client cases from the clinics, and to debrief on their practice experiences at the clinics. Most of the literature did not specifically address collaborative practice at community mental health settings and students were encouraged to think about how practices at the clinic could be made more collaborative (for example, what would that mean for this context?). In the first semester, all students attended the IP seminars which were held alternatively at the two clinics. In the second semester, the students at one of the clinics dropped out of their program and the CP&LE project, and the seminars were continued at one site only. Some students also participated in special sessions with the staff (e.g., IP mentoring workshop, staff retreats).

The students were asked to introduce and discuss a client at the seminars. The client was a new client at one of the clinics and assigned to one of the social work students. The client discussions focused on how nursing and social work would approach care, the providers needing to get involved in her care, and other resources available for the client. The discussions were useful for the students who recognized that nursing and social work would approach the care of this client in different ways. For instance, social

work students were concerned about the basic needs of the client whereas the nursing student was more concerned about her medical issues. The students were also encouraged to approach their advisors with questions about IP competencies and client issues that were discussed in the student sessions.

The discussions on the IP mentoring experiences were also important components of the seminars. These discussions helped to assess the progress of IP mentoring with the team members. They were useful feedback for the project facilitators to become aware of obstacles or challenges that the students were facing. At several occasions, the facilitator also practiced debriefs with the students around the IP competencies.

Comments from students
Students reported that the seminars provided them with basic knowledge, a greater appreciation and more awareness around collaborative practice. The seminars allowed them to understand theory and reflect on their practice. They found the IP seminars very useful since it was the only time they discussed IP competencies and collaborative practice issues. The client discussions created incentives to participate in IP activities. Teaching materials (for example the CIHC competency framework) helped students to apply the competencies ("It gives some examples under each competency and it really helps you to envision how to go about achieving those competencies"). Overall, the seminars encouraged students to think about the issues discussed when working with their clients or other team members. The IP clinical placement as a whole was perceived to support knowledge and appreciation of collaborative practice.

Staff support for interprofessional mentoring
To support staff in IP mentoring, the project team held an IP mentoring workshop and consultations with mentors throughout the project.

In late September, a three-hour workshop was held with staff at each clinic to provide some support for the different aspects of IP mentoring including facilitation, supervision and evaluation. The workshop reinforced the importance of collaborative practice through examples of initiatives occurring at the provincial, national and international levels. Staff were also asked to assess the level of collaboration within their team and their own IP competencies. They were encouraged to offer IP practice activities to their students who would reflect on these activities by describing the competencies gained. An initial template for evaluating the students was developed which was not used because the evaluation of the IP competencies was integrated into the discipline-specific template.

In addition to the mentoring workshop, the student facilitator also met with the discipline-specific mentors. Initially it was suggested to meet monthly but that time commitment was not feasible. These sessions were short reviews of the IP competencies and offered additional support for evaluating the students. At one meeting the academic advisor was also present. Staff commented that the support was helpful for them.

Preliminary evaluation of the IP clinical student placements
The IP practice activities with the IP mentors at the clinics were moderately successful. Given that there was no standardized process for IP clinical placements at the clinics, students were dependent on their discipline-specific mentors and their openness to making placements more collaborative. Some students missed the staff discussions on collaborative practice which put them at a disadvantage in thinking about collaborative alternatives in clinical practice. While a number of IP practice opportunities were

facilitated, none of the team members at the clinics carried out in-depth debriefs or evaluations on the IP competencies. These are crucial pieces that were not implemented as intended. The discipline-specific mentors also talked about the IP practice activities as additional obligations for the students for which "extra time" must be allocated. Some staff members were reluctant to get their students involved in the project.

The evaluation of the IP competency outcomes are based on interviews, student sessions, written student reflections and the evaluations of their mentors. Most students and mentors provided very general comments about their competencies that were lacking concrete examples. All students gained greater awareness about how other practitioners work at the clinics and that collaborative practice is an important part of client care. Since the immersion in the IP mentoring activities was not complete, strong acquisition of IP competencies seems unlikely. The self-assessments of the students need to be supplemented with independent observations and clear examples of how they applied the competencies. The qualitative interviews were insightful because they clarified how students defined the competencies.

Here are some preliminary insights into the competencies gained by the students:

Role clarification
Students gained a better understanding of the roles of other professionals by observing provider/client interactions and asking questions about these. Care options for clients were clarified, and students became more confident about making referrals for some of their clients. With role clarification, students also noticed role overlap between different providers and wondered about the implications for client care. One student stated that the roles of psychology and social work overlap significantly.

Interprofessional communication
The students observed IP communication between practitioners at team meetings. Few commented on the quality of interactions between practitioners at these meetings (e.g., some individuals tending to dominate, talking over each other, talking behind people's backs). With their own clients, the students practiced their IP communication skills by discussing client issues and needs with other providers who were involved in their clients' care. They were consulted by other providers to share their opinion on a client's progress or approached by other members of the team for their insights.

Patient-centered care
All students commented that client-centered care is a "top priority" or a "core value" of their profession. They regarded themselves as mastering this competency. All students were aware of their interactions with the clients and avoided jargon, promoted clear information and feedback. One student mentioned that she coached her client to ask relevant questions when meeting with other providers and to advocate on her own behalf. Everybody talked about the client having the ultimate decision about their care. Several students commented on the need to make triage, and the process of assigning clients to staff, more patient-centered. One student suggested: "…initially having more of a team approach in terms of discussing the client case amongst all the team members and then honing in on what their specific needs are and perhaps finding the best fit that way." They commented on their strong skills in client-centered care by including all of the dimensions of this competency. Two students criticized "the big picture" in terms of the system providing the best care"(e.g., clients are put on a waitlist for community mental health services).

Team functioning
The students had few comments about team functioning. Some students remarked that practitioners worked well together and showed collaboration if necessary (e.g., by consulting each other on client matters). Others found that practitioners tended to limit their consultations to the same people. One student wrote that "the team functions more as individuals rather than a unit" by working independently on their own client caseload. Another student commented that admin staff were not necessarily viewed as members of the team.

Conflict resolution
The students assessed their own conflict resolution skills by completing the standard Thomas-Kilmann Conflict Mode Instrument. Besides having gained greater awareness, the students commented that they did not have an opportunity to practice their conflict resolution skills due to "a lack of conflict at the sites". One student observed disagreements on a client care issue which she considered being resolved "in a respectful way". Some students did not assert their interest on attending a particular meeting which could have allowed them to practice their newly gained understanding of how to approach disagreements. Another student commented on her "relatively powerless feelings that accompany being the student" when trying to resolve an issue with her supervisor. As a rule, students tend to feel vulnerable in their lower position ("in relation to professionals") and most likely avoid disagreements with staff.

Collaborative leadership
The students found it difficult to put this competency into practice. They commented that they did "assume a leadership role with their clients," but not in the team. Leadership with the clients was demonstrated by advocating for them and referring them to other providers.

Overall, students and staff found the IP mentoring experience valuable and some of the mentors have indicated their interest in continuing this approach with their new students in the fall. Although the IP clinical placements have not been fully implemented as intended, they demonstrate great promise for creating more collaborative practice opportunities for students. The model is easy to implement as it does not require coordinating student placements across disciplines or major changes in existing placement processes. We will continue to develop this approach to ensure that IP mentors and students benefit from the IP clinical placements.

5. List of Documents and Tools Used/Produced

The following documents/tools were used or produced for the project.

1. Collaboration rubric: Gajda R and Koliba C. Evaluating the imperative of intraorganizational collaboration. Am J Evaluation 2007, 28(1):26-44. Tool to assess level of collaboration across four dimensions. The tool was completed by all participants at baseline and follow-up to monitor perceived changes in collaboration.
2. Observation checklist: A checklist developed by Suter et al. in 2009 to check for evidence of structures and processes supporting interprofessional education and collaborative practice at acute care and community settings. The tool captures frequency and quality of structures and processes at the education, practice and organizational levels.
3. Legacy sustainability framework: Holladay R, 2005. Legacy: Sustainability in a complex human system. www.Hsdinstitute.org. A framework to guide the development of sustainable strategies in complex adaptive systems such as healthcare systems.

4. Social network survey: Using UCINET software, we created network maps for different staff communication around clients. Differences between referrals, informal information sharing, development of shared care plans etc. were used to guide discussions on preferred communication practices.
5. Baseline assessment reports: We developed a comprehensive report for each of the participating sites summarizing our findings from the baseline assessment. The report was used to identify opportunities for enhancing collaborative practice and guide conversations about appropriate strategies to be implemented.
6. Workshop on IP mentoring: A workshop on IP mentoring was held at the Canadian Association for Continuing Health Education (CACHE) annual conference in Banff, April 2011.
7. Abstract submission: an abstract on IP mentoring was submitted to the Collaboration Across Boarders III conference.
8. IP mentoring guide: A guide for preceptors outlining the concepts of IP mentoring, their role as IP mentors, IP activities for students, reflective questions for students, and how to evaluate students' collaborative practice competencies is being developed.
9. Collaborative practice seminars for students: One-page outlines for IP student seminars that focus on deepening students' understanding of collaborative practice competencies are being developed.

6. Acknowledgements

We wish to sincerely thank staff and managers from the two clinics for participating in this project and for generously sharing their time, experiences and wisdom with us. We also thank Hannah O'Riain for her assistance with the student evaluation.

A special thank you to Alberta Health and Wellness for co-funding this project. This allowed us to extend our time with the two teams and to more fully implement collaborative practice at the two clinics.

7. List of Appendices

- Collaboration rubric (Appendix 1)
- Observation checklist (Appendix 2)
- Legacy sustainability framework (Appendix 3)
- Social network maps (Appendix 4)

APPENDIX 1
Collaboration Assessment Rubric (Gajda & Koliba, 2007)

Low-Quality Collaboration ←→ High-Quality

	Dialogue	Decision-making	Action	Evaluation
6❑	• All team members meet face to face for report and rounds • Each team uses a common format and structure for report and rounds • The team discussion focuses on relevant patient information and practice questions and issues • Disagreements exist and are discussed at the time and resolved right away • The shared purpose and outcomes of the team are frequently raised and referenced by members	• Team decisions are informed by group dialogue • The process for making team decisions is transparent, agreed to and followed by members • Leadership and facilitation is shared among the team members • The team consistently makes decisions about individual and collective actions they will initiate, cease, maintain or develop • Decisions are directly related to the shared purpose and goals of the team	• Each team member consistently takes specific action as a result of group decision making • Members' actions are coordinated and interdependent • Members' actions are communicated to other team members and providers consistently • Actions usually are directly related to a shared purpose or outcome	• Each team member reflects on the effect of his/her practice on the outcomes of the team • Each team member engages others in evaluating the team's effectiveness • Informal evaluations and reflections are shared publicly and inform group dialogue
5❑				
4❑	• Most team members regularly meet face to face for report and rounds • There is a similar format and structure for report and rounds • The team discussion is unstructured and improvised but generally focused on relevant patient information and practice questions and issues • Professional tensions tend to be unrecognized or unresolved • The shared purpose and outcomes of the team are occasionally raised and referenced by members	• Decisions are usually informed by group dialogue • Decision making processes are not always purposeful and transparent • Leadership and facilitation is not shared among the team members • Sometimes the group makes decisions about which individual and collective actions they will initiate, cease, maintain or develop • Decisions are generally related to the shared purpose and goals of the team	• Each team member takes action but not necessarily as a result of group decision making • Members' actions may be or are somewhat coordinated and interdependent • Members' actions are often communicated to other team members and providers consistently • Actions generally relate to a shared purpose or outcome	• Most team members reflect on the effect of his/her practice on the outcomes of the team • Most team members engages others in evaluating the team's effectiveness • The team may rely on "hearsay" or "anecdotes" and "opinions" to inform dialogue and decision making
3❑				
2❑	• Face to face team meetings of the team is rare or full attendance by members is sporadic • There is no consistent format and structure for report and rounds • The team discussion is completely unstructured and improvised • Disagreements do not exist or are unrecognized and members may air disagreements privately after meeting • Some or most members of the group are unclear or uninterested in the purpose and outcomes of the team	• A process for team decision making is not transparent or does not exist • Decision making processes are minimally informed by group dialogue • Leadership and facilitation is not evident on the team • Decisions are rarely made as a team • Decisions are rarely related to the shared purpose and goals of the team	• Individuals take minimal action as a result of joint decision making • Team members' actions are independent and tend to lack coordination • Members' actions are seldom communicated to other team members and providers consistently • Actions are typically unrelated to a shared purpose or outcome	• Team members do not regularly reflect on the effect of his/her practice on the outcomes for the team • Team members do not regularly engage others in evaluating the team's effectiveness • The team evaluates its effectiveness randomly or not at all
1❑				

APPENDIX 2

CP&LE Observation Checklist

for Evidence of Structures and Processes Supporting Interprofessional Education and Collaborative Practice at Community Settings

Indicators (note examples and supporting data for ratings on a separate page)	**Frequency**				**Quality**			
	0	**1**	**2**	**3**	**0**	**1**	**2**	**3**
Educational Strategies								
1. Site has regular IP placements (i.e., students from various disciplines have learning activities together with a focus on IP/collaborative competencies).								
2. Site offers IP education training fostering collaboration (e.g. simulation, IP case studies).								
3. Site measures student satisfaction/experience with the IP practice placements.								
4. They monitor student interest in employment on the unit after graduation.								
5. They provide training for staff to mentor students from different disciplines.								
6. They provide orientation to all new staff regarding collaborative practice.								
Practice Setting								
Communication								
7. They have hand-off reports (e.g. to update patient status) between providers that care for the same client.								
8. They have case conferences with participation/contributions from all providers.								
Interprofessional Conflict								
9. They use a process to resolve disagreements among professionals from different disciplines.								
10. Staff members feel comfortable expressing their opinions and raising issues at staff meetings.								
Client/Family-Centred Care								
11. They use a process (e.g., orientation to the program, family meetings, regular updates) to make families feel part of the team.								
12. They provide a family-friendly environment (e.g., place to relax or visit, flexible meeting hours).								
13. They use a process to respond to client emergencies quickly and by the appropriate provider.								
14. Staff referrals to other agencies ensure access to the appropriate providers for clients								
15. Staff members are well informed about each client's history (e.g., client doesn't have to repeat story to each provider).								
16. They have a process for linking the client back into the community, to the right provider.								
Collaborative Leadership								
17. They develop care plans for every client with input from appropriate providers.								

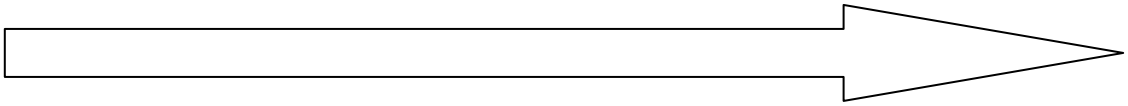
Indicators (note examples and supporting data for ratings on a separate page)	Frequency				Quality			
	0	1	2	3	0	1	2	3
18. They share decision-making about client assignments and client care (evidenced in note books, reflections, meeting notes, care plans).								
19. They have regular IP meetings attended by all providers to address practice issues.								
20. They use a process for sharing knowledge and experiences on "best practices" in collaboration among the IP team.								
Team Functioning								
21. Providers display trust towards their colleagues (e.g. can be assigned together on a client, no turf wars)								
22. They coordinate client care to cover staff (on breaks, vacation, illness).								
23. Students are purposefully integrated into the health care team.								
24. Allied health and other disciplines are purposefully integrated into the team.								
25. They have a process to support ongoing dialogue and negotiation around provider roles.								
26. Staff treat each other as equal members of the team.								
27. Staff have discussions on the shared values and common purpose of the team.								
Role Clarity								
28. Providers are clear about their own roles.								
29. Providers are clear about the roles of other professions.								
Organizational Level								
30. They use policies and procedures related to IP education.								
31. They use policies and procedures related collaborative practice.								
32. Staff performance evaluations include aspects of collaborative practice.								
33. Leadership consistently and visibly supports IP education and collaborative practice (reward collaborative practice or student mentoring, allows time for continuing education)								
34. They use job descriptions that clearly outline competencies and expectations for collaborative practice.								
35. They allocate quality resources to promote collaborative practice (e.g. designated educators, continuing education funds, in-services).								
36. They intentionally create a staff mix that is interprofessional and aligned with client needs.								
37. They monitor staff engagement in collaborative practice.								
38. They created space to facilitate collaboration (e.g. office shared by allied health and nursing, shared assessment room).								

Collaboration Observation Rating Scheme
March 18, 2010

In order to quantify progress toward IPE and collaboration and also to assess the quality of the intervention, the following matrix is proposed for rating evidence of processes supporting interprofessional education and collaborative practice in clinical settings. Most questions may only be answered by following up with prompts on the frequency or the quality.

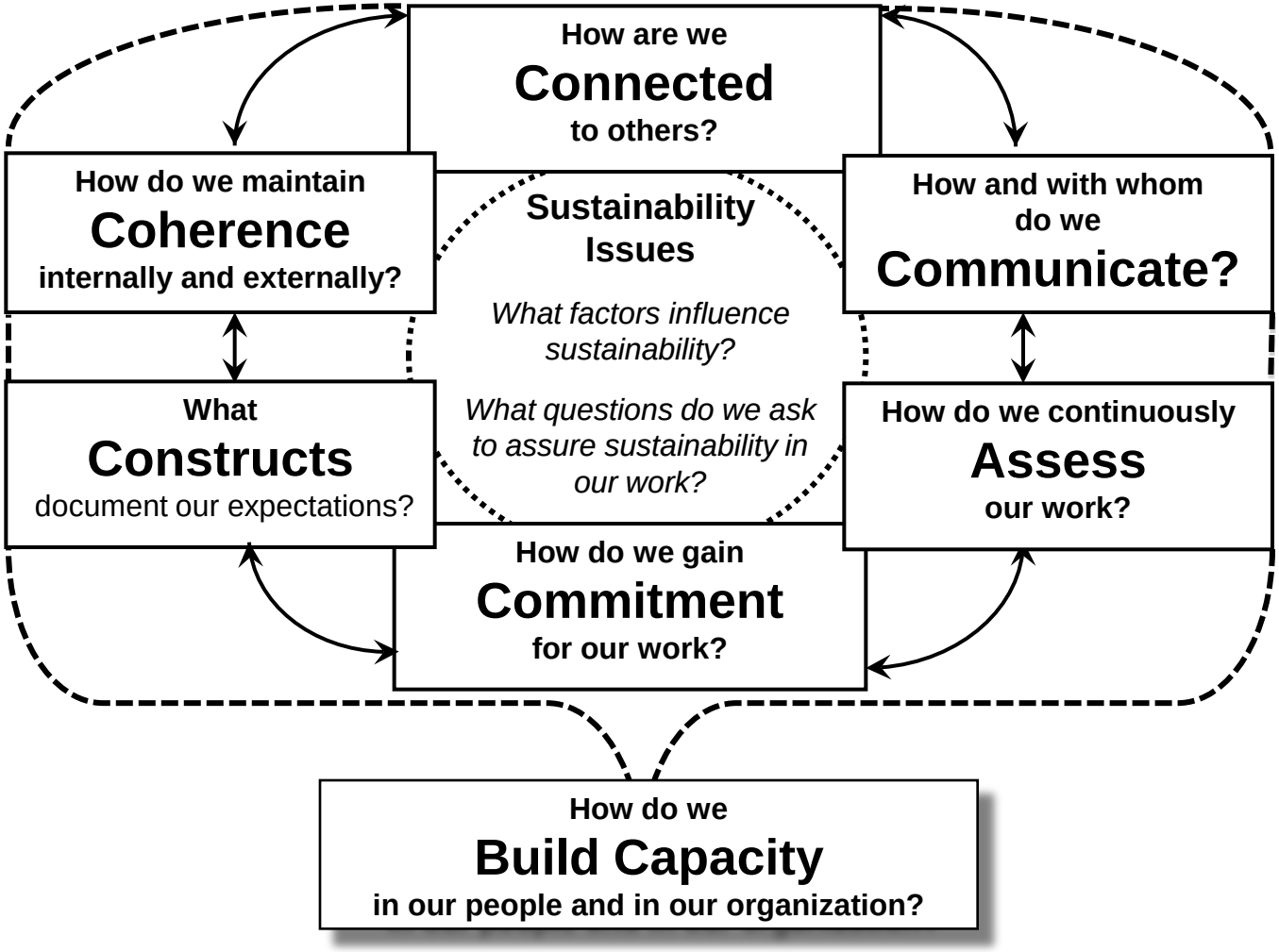
	0	**1**	**2**	**3**
Frequency • a formalized, agreed upon process in place • a process consistently used on a regular basis by all IP team members (regular IP rounds, regular application of policies, regular student placements, regular monitoring of student satisfaction)	None observed or reported	**Low** 1. there is a formal process in place but it is not used 2. there is some process being used by some providers but it is neither formalized nor consistent	**Medium** 1. there is a formalized process in place and being used, but not consistently or not by all IP members	**High** 1. there is a formalized process in place that is consistently used all (most) IP members
Quality 1. intentional focus on IP 2. participation of multiple disciplines (e. g. rounds) 3. use of high quality tools (for example to monitor student satisfaction) 4. high complexity of an IP activity; active rather than passive (e.g. student develop IP shared care plan vs. shadowing another professional) 5. complexity/meaningfulness of information that is communicated	None observed or reported	**Low** 1. mainly discipline-specific focus with few IP elements 2. occasional participation of IP members 3. assessment tool is not standardized 4. low complexity/ passive activity (e.g. shadowing) 5. shared information is very basic	**Medium** 1. IP focus but quality can be improved 2. Participation of IP members but some key players are missing 3. standardized tool used 4. medium complexity/ medium level of participation (e.g. IP rounds) 5. shared information considers some provider/patient needs	**High** 1. High IP quality 2. All key IP team members are participating 3. standardized tool used and regular follow-up on the results 4. high complexity/ active participation (e.g. shared care plan) 5. shared information considers complex patient/provider needs

Increased ratings indicate increased effect/structure/process/consistency/quality



APPENDIX 3

Legacy Sustainability Model



Legacy Sustainability Model (Holladay, 2005)

We conceptualize health care settings as complex adaptive systems (CASs). CASs are organic and constantly evolving; relationships between people are dynamical and not adequately captured in cause-and-effect modelling. Seeing an organization as a CAS requires that we look at sustainability in a different way.

Some rules to create sustainable change in CAS:

- Embed the work in the organization by making sure that the work is widely connected throughout
- Ensure interventions are sensitive to their environment so that changing patterns are detected in time to adapt
- Design interventions flexible enough to respond to changing patterns and to continue meeting the original need
- Design interventions robust enough to withstand emergent challenges and changing trends within the organization

According to Holladay, developing the six factors based on the rules above builds capacity and leads to sustainability by ensuring that the initiative is being embedded into the ongoing operations of the organization. While it is important to consider all of the factors when implementing practice change, it is impossible to determine which factors are most relevant as they are intertwined.

We will use the Legacy Sustainability Model to guide the planning and implementation of our practice interventions.

Questions to be considered when designing sustainable interventions:

1) **Connections:** How can we connect this project to current work across the program/organization to other departments/staff, to the community and the customers?
2) **Coherence**: How can we assure coherence between the project and other parts of the program/organization? Coherence with internal direction, policies & procedures and external variables/trends?
3) **Constructs**: What constructs will support this intervention? E.g. planning documents, frameworks we draw upon, resources and documentation.
4) **Commitment**: How can we garner commitment for the intervention? Commitment of individuals, leadership, resources, the organization? Who will act as champions?
5) **Continuous Assessment**: What measures will indicate progress or success? How can we assess our work for continuous "fit" and improvement? How can we collect the data?
6) **Communication**: How can we communicate about this intervention effectively? Who needs to know about this? What do they need to know?

Capacity building: What skills, processes, policies and supports are needed to build capacity for the larger initiative? How can we prepare individuals (through training, evaluations, feedback systems) to ensure that individuals have the skills they need to do the work on specific interventions?

APPENDIX 4

Diagram: Patient Discussions

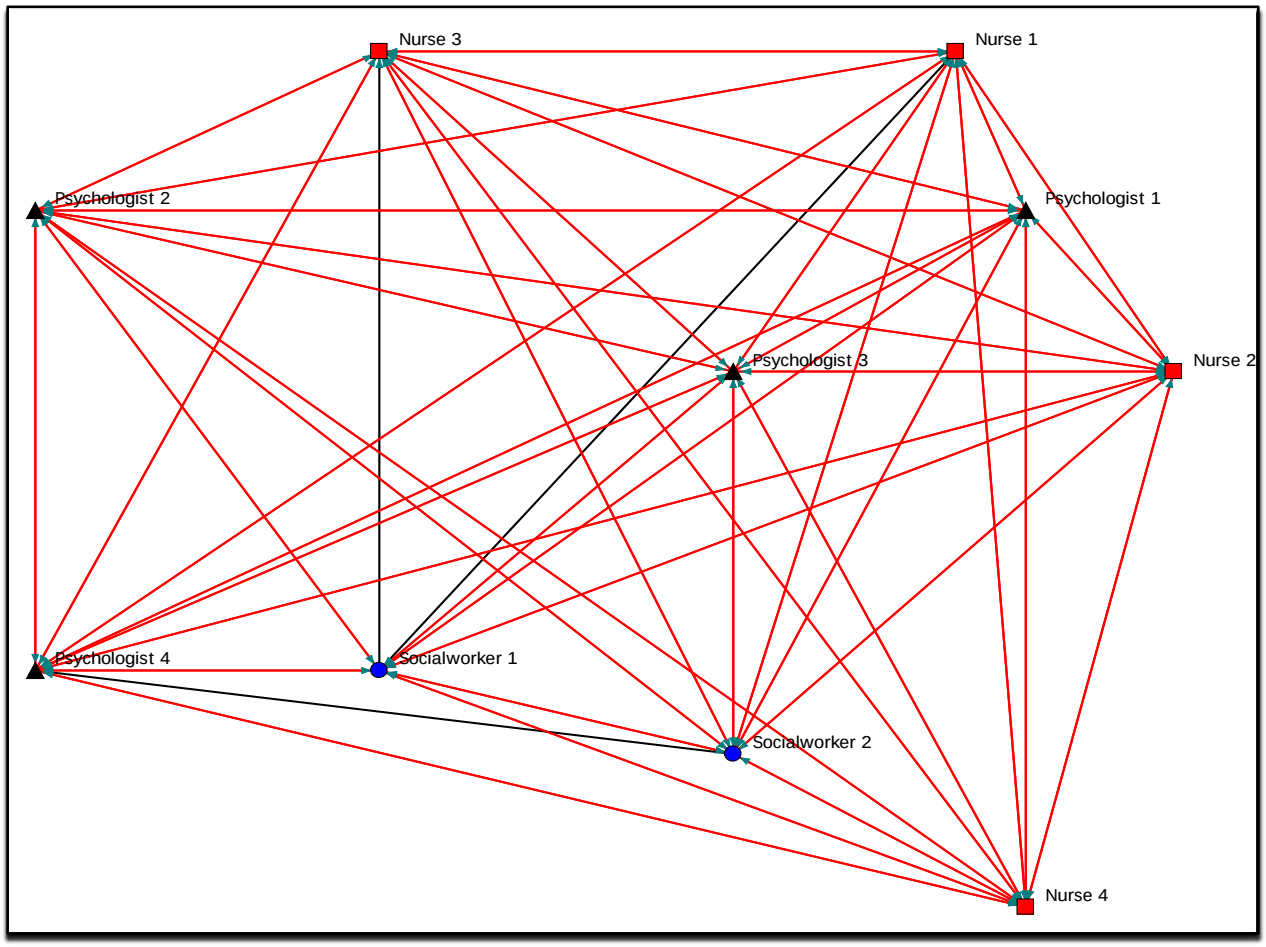


Diagram: Referrals