Barriers and Enablers to Interprofessional Collaboration in Health Care:
Research Report

A Regional Scan of Interprofessional Collaboration in the Champlain Region

Submitted by the Study Team for Research on Interprofessional Collaborative Practice in Champlain Region
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Principal Investigators:
Lynn Casimiro, Pht., Ph.D.
Pippa Hall, M.D., CCFP, M.Ed., FCFP

Co-Investigators:
Doug Archibald, Ph.D. (candidat)
Craig Kuziemsky, Ph.D.
Anne Brasset-Latulippe, O.T., B.Psy., MSc.
Lara Varpio, Ph.D.

Prepared by Denise Beaulieu, Ph.D.
M.D. Beaulieu Consulting Inc.

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1. STUDY OBJECTIVES AND CONCEPTUAL FRAMEWORK

The purpose of this report is to present the findings of a regional scan of interprofessional collaboration in health care in the Champlain Region. The study was conducted by the Academic Health Council (AHC) – Champlain Region, a partnership between Algonquin College, La Cité collégiale and the University of Ottawa. The study looked at the interprofessional experiences of caregivers, students in clinical placements, administrators, patients and patient family members drawn from health care organizations across the Champlain Region Local Health Integration Network (LHIN). The specific objectives of the regional study were to describe the factors that enabled or hindered interprofessional, collaborative patient-centred practice; to identify and evaluate existing theoretical models of interprofessional collaborative practice (IPCP) and interprofessional education (IPE) and the conditions required to develop those further; and finally, to develop proposals for policies supporting and strengthening IPCP and IPE in the Champlain Region.

The general conceptual framework for the study was drawn from D'Amour and Oandasan’s conceptual framework showing the connections between IPCP and IPE, and from the work by San Martín-Rodríguez et al. on interprofessional collaboration. In 2005, San Martín-Rodríguez et al. published “The Determinants of Successful Collaboration: A Review of Theoretical and Empirical Studies” in which they described three key categories of determinants – systemic, organizational and interactional – and their main determinants.
2. METHODOLOGICAL AND OPERATING FRAMEWORK

2.1 GENERAL METHODOLOGICAL FRAMEWORK

This study’s general methodological framework is based on a modified grounded theory, where an iterative process was used through which the research data informed the framework, since the methodology is aimed at having concepts and theories emerge from the data. Researchers do, however, consult existing theories to analyze and interpret their data. This methodology is mainly used to further researchers’ understanding of the experiences and perspectives of study participants. An iterative process is used for data collection and analysis, since preliminary data will influence subsequent data collection activities as well as the adopted methods and instruments.

The study team used a mixed methods study, collecting quantitative and qualitative data from participants in four groups: health facility administrators; caregivers and educators; patients/residents/families (P/R/F); and students from various disciplines in clinical placements. The qualitative component provided researchers with a deeper understanding of participants’ experiences, while the quantitative component allowed them to establish the scope of the observed phenomena.

2.2 DATA COLLECTION AND ANALYSIS

Approval to conduct the scan was given by the Research Ethics Committees of the following organizations: The Ottawa Hospital, The Children’s Hospital of Eastern Ontario (CHEO), Bruyère Continuing Care, Royal Ottawa Health Care Group, Montfort Hospital Study Group, and the University of Ottawa.

The study was conducted between 2008 and 2010 with the collaboration of health facilities in the Champlain Region LHIN. To maintain confidentiality and to protect the integrity of the research process, the AHC commissioned Vision Study (or Vision Research), a firm specializing in this kind of research project. Under the study team’s supervision, the firm took charge of the study rollout from design through data collection. A total of 29 facilities took part in the study: 19 long-term care homes; 7 hospitals; 2 community health centres; and 1 community care access centre. The facilities distributed the questionnaires to study participants.

The study comprised 26 semi-structured interviews of health facility administrators and 26 focus group discussions (FGDs). The focus groups involved caregivers (12 focus groups), P/R/F (11 focus groups) and students in clinical placements (3 focus groups). The average interview length was 40 minutes; the length of focus group discussions varied from one hour to one hour and a half, depending on the number of participants (3 to 8). A survey was also conducted, drawing 1,379 responses.

Participating facilities agreed to distribute the survey questionnaire in such ways that were most convenient to their clientele and facility type, while respecting the rules set by their Research Ethics Committees. The organizations then distributed a total of 13,227 survey questionnaires through internal, external and electronic mail. Of these, 1,379 questionnaires were completed by participants, a response rate of about 11%. Of the total number of survey respondents, 19% were male and 81% were female.

The selected organizations invited potential participants to take part in the study. Caregivers, educators, students and P/R/F were given the survey questionnaire; administrators were invited to in-depth interviews. Participating facilities also put up a poster, and a question at the end of the survey allowed respondents to self-identify as potential participants in the interviews and focus group discussions.
3. FINDINGS: PARTICIPANTS’ EXPERIENCE AND VIEWS

The findings reported in this section focus on participants’ experiences with interprofessional collaboration and their views about the matter.

3.1 INTERPROFESSIONAL COLLABORATION AT PARTICIPATING HEALTH FACILITIES

Generally speaking, the researchers wanted to know whether participants believed that the health care facilities where they worked as administrators or caregivers, or which they knew as patients, long-term residents or members of a patient’s family, had implemented a health care model based on interprofessional collaboration.

The study findings point to differences between the experiences of administrators and caregivers and those of P/R/F and students. Administrators and caregivers were more positive, suggesting there was a high level of interprofessional collaboration. Some went so far as to assert that all care and services at their facility were based on an interprofessional model. The P/R/F and students in clinical placements, however, were more sceptical about how far interprofessional collaboration actually went: they didn’t seem to observe it was as evident as administrators or caregivers did.

Several factors may explain the differences observed in the views of different categories of participants about the extent to which IPCP was being implemented in their facility. Firstly, even if caregivers and administrators invest major efforts in facilitating IPCP, the mechanisms put in place may fail and outcomes may not match their efforts, thus remaining largely invisible to the P/R/F. Secondly, the notion of teamwork may be fragile, especially if team members are spread across several institutions. Thirdly, it seems that P/R/F are not always well informed about how their health team works.

3.2 OUTLINE OF THE INTERPROFESSIONAL TEAM

The study found that various participant groups had a more or less inclusive view of the interprofessional team.

For the P/R/F who took part in the study, an interprofessional team should include everyone whom the patient comes in contact with, whether in regulated professions such as the family doctor, podiatrist, nurse, physiotherapist, occupational therapist, massage therapist and nutritionist, as well as other staff, such as support workers, recreation activity leaders, secretaries, drivers, cleaners and maintenance staff.

In contrast, caregivers, administrators and some students often began with a list of interprofessional team members that included only those in regulated professions – medicine, nursing and psychology, for example. However, as soon as the moderator or researcher mentioned the patient’s or family’s role on the team, several were quick to change their answer, putting more emphasis on the participation of patients and family members, whom they identified as extremely important. Some caregivers added that the non-participation of the P/R/F made their work more complicated, because it meant they had to spend more time, after the fact, explaining decisions that might have been accepted much more readily if taken jointly with the P/R/F.

In addition, long-term care home residents and their families deplored the fact that support workers were sometimes left out of team meetings, an exclusion corroborated by support workers themselves. Many of them said they felt their opinions did not really count in clinical decision-making about the patients they took care of.
Finally, several examples were given to illustrate the central role of the family doctor and other physicians on the interprofessional team. Some examples referred to physicians being unavailable to attend team meetings; their sometimes authoritarian attitude towards other professionals; and the key role that the family doctor could play in coordinating patient care.

As to who should provide leadership to the interprofessional team, it was clear that at the organizational level it should be the facility administrator. Yet, when it came to coordinating care and communication with the P/R/F, participants indicated that the choice should be based on the patient’s needs.

### 3.3 POSITIVE IMPACT OF INTERPROFESSIONAL COLLABORATION

The vast majority of participants across all categories believed that interprofessional collaboration had positive impacts on the quality of care, and in particular on its efficiency and effectiveness, the quality of participants’ experiences, timely provision of care, and the quality of caregivers’ work life.

Having IP collaborative practices in place raised the level of trust that patients felt towards caregivers. When patients noticed that caregivers were collaborating, their trust in caregivers and the entire health facility went up, which increased their willingness to collaborate with caregivers and reduced the number of communications they addressed to them. As for caregivers, administrators and students, they said they saw many benefits to interprofessional collaboration: delivery of care better adapted to patient needs; the lowering of professional barriers as a result of adopting patient needs as a common goal; and increased work satisfaction. Finally, they thought that having an interprofessional team in place was particularly conducive to effective information-sharing with the P/R/F.
4. KEY INFLUENCE FACTORS

The regional scan highlighted four key factors that affected the extent to which IPCP would or would not be implemented in the facilities that took part in the study.

Firstly, having organizational mechanisms in place for the coordination of care and of communication with the P/R/F strongly influenced the efficacy of the interprofessional team. A great many comments from the P/R/F group referred to problems they had trying to find out whom to contact for the information they needed in dealing with the health care facility, whether about services, procedures, or a family member’s health status. These problems may indicate a lack of communication mechanisms, families not knowing these mechanisms exist, or inadequate use of the communication tools available.

Secondly, work organization and resource availability may hinder efforts to implement IPCP. For example, forms of work organization that involve frequent staff rotations (often necessary due to shortages in qualified staff) and the heavy workloads of many caregivers can have a significant detrimental impact on IPCP.

Thirdly, in order to ensure the successful implementation of IPCP, there is a need for organizational policies that support a culture which is responsive to patients’ needs. For example, the fact that interprofessional collaborative practices observed in one department or floor often did not extend to the rest of the facility created confusion, both for caregivers who move between departments in the same facility and for patients.

Fourthly, patient-centred care stood out clearly in the study as a goal that rallied the different disciplinary contributions and helped to lower professional barriers by allowing caregivers to move beyond their own immediate territory to focus on a common goal.

5. DISCUSSION

The following section presents a brief discussion of the scan’s major findings.

5.1 THE MOST SIGNIFICANT DETERMINANTS

Within the framework of this study, some determinants stood out more than others. Moreover, the study allowed us to identify new determinants, not specified in San Martín-Rodriguez et al. but which the study team observed as playing an important role in the eyes of study participants.

In this investigation, the most influential systemic determinant was the educational system. As it relates to skill development, acquisition of knowledge about other professions and the socialization of caregivers, education is likely to have a major impact on the extent to which caregivers will or will not implement interprofessional collaborative practices. These elements corroborate the interdependency between education and practice in D’Amour and Oandasan’s model. The regional scan allowed us to identify a fifth and new type of systemic determinant: the regulatory environment, referring to IPCP-related policies.

Two organizational determinants proved especially important: administrative support – closely tied to the regulatory environment – and communication and coordination mechanisms. Both were seen as essential conditions for the successful implementation of IPCP.

Finally, among interactional determinants, those which stood out most clearly in the regional scan involved caregivers’ communication skills, the fact that personal style cannot be ignored, and the importance of helping caregivers develop such skills.
5.2 THE MULTIPLE ROLES OF THE P/R/F

Clearly evident from this scan is the fact that the P/R/F play multiple roles, which can vary depending on the situation. The P/R/F may be: a demanding patient with high expectations of the facility and caregivers; a coordinator of care and communications among caregivers or between caregivers and the family; an active partner in the interprofessional team’s decisions; a reluctant participant; or a passive recipient of care. This broad range of participation levels illustrates the multiple facets of the P/R/F’s role. Some patients and their families said they wanted to receive directions from caregivers, arguing that they were sometimes asked to make decisions when they had no competency to do so. At the same time, they wanted: to be listened to; their needs, expectations, fears and opinions to be considered; and to have their questions answered. They trusted caregivers to answer their questions, convey information to other caregivers, ensure follow-up, and tell them what treatment was most appropriate in their situation.

5.3 PROBLEMS WITH INTERPROFESSIONALITY OR WITH WORK ORGANIZATION?

Some of the problems in implementing IPCP did not, properly speaking, flow from problems linked to interprofessionalism. Rather, they were attributable to problems related to work organization. Worth noting among these were shift handovers; frequent rotations from one floor or department to another; the limited time caregivers had to interact with patients; inappropriate or incorrect use of communication tools; lack of continuous communication among caregivers or between caregivers and the P/R/F; and limited access to information and communication technologies (ICT) for some professional groups.

5.4 CONTEXT IS CRUCIAL

IP collaborative practices can have a very positive impact on the quality and efficacy of care when they respond appropriately to the needs of the P/R/F and when they are instituted with care to make best use of resources. The team’s composition, the way it communicates, its in-house rules and the rules that govern the team’s interactions with other organizations will vary depending on the clinical setting. Therefore, those wishing to implement IPCP models must, address the crucial need to contextualize. A great deal of participants made the point that, in many cases, an intervention involving only one professional may be perfectly satisfactory.

6. RECOMMENDATIONS AND NEW AVENUES OF STUDY

Recommendations issued from the analysis of regional scan data are presented in terms of the depth of organizational change needed to implement these recommendations. Theories of organizational change state that change is either of a first or second order. Thus, the proposed recommendations are presented in two sub-sections.

6.1 RECOMMENDATIONS: FIRST-ORDER CHANGES

First-order changes are aimed at moving an organization towards managing current strategy more effectively and more efficiently, without questioning the basic frames of reference that guide its members’ actions. The recommendations for this type of change involve the coordination of care and communication and the introduction of new educational programs and activities.

Coordination of care and communication

• Clearly establish how the P/R/F and the care team will communicate. In many cases, a simple information sheet listing ‘who does what’ and clarifying whom to contact and how to go about solving specific problems could help resolve many difficulties.
• As needed and when appropriate, assign a person to act as liaison between caregivers and the P/R/F. That person would be designated based on patient needs, and his or her contact information clearly communicated to the P/R/F.

• Review communication mechanisms and tools being used, to enhance their effectiveness.

Caregivers are overworked and have trouble finding time to attend meetings. Therefore, other types of communication mechanisms must be explored, aimed at streamlining communication among caregivers, and between caregivers and the P/R/F. For example, ICT tools such as Skype software or the kind of platforms used in social networking might be especially effective, recognizing the importance of privacy and confidentiality. Still, in some situations, simpler communication tools and methods, such as a whiteboard could be as effective as ICT.

**Introduction of new programs in continuing and undergraduate education**

It is recommended that more efforts be invested towards interprofessional education to adequately prepare future health professionals and other health care workers to join interprofessional teams. Some of the avenues to be explored include:

• Drawing on existing resources: There are different examples of interprofessional education in the region and new programs could be developed based on those experiments.

• Offering joint courses for students in different faculties or disciplines, a practice already in place in some colleges and universities, is known to make a very positive contribution to interprofessional learning.

• Many health facilities run continuing education programs and activities, and it would be appropriate to include IPCP-related programs and to share programs already in place in other institutions.

• Among the concrete means suggested by participants to facilitate professional development around IPCP, we found: courses in which students from various disciplines participate; clinical placements in facilities with interprofessional collaboration in place; continuing education on teamwork and key IPCP concepts; and making sure caregivers have access to new knowledge on relevant topics.

### 6.2 RECOMMENDATIONS: SECOND-ORDER CHANGES

Second-order changes require the introduction of new frames of reference and thus represent a deeper level of change. Recommendations emerging from the regional scan that seem to require this level of change relate to the implementation of organizational policies and the composition of the interprofessional team.

**Organizational policies**

• **Hiring policies:** Several caregivers and administrators emphasized how important it was to recruit people with good teamwork skills and to send a clear message to caregivers – present and future – about the facility’s commitment to IPCP and its expectations of staff in that regard. For caregivers, it was clear that improved working conditions flow from genuine teamwork which is a motivating factor. In a setting where health care personnel is often hard to recruit, offering a high-quality work environment characterized by delivery of care based on an interprofessional model would likely facilitate hiring and retention.

• Setting organizational policies in line with an organizational culture that is responsive to patients’ needs remains a major challenge, mainly but not solely because resources may be limited.

**Composition of the interprofessional team**

• It is recommended that specific efforts be made to determine how to best integrate the P/R/F and support workers more fully into interprofessional teams. This integration would occur especially, but not exclusively, by improving and developing communication mechanisms among caregivers.
6.3 NEW AVENUES OF STUDY

As with any study, the regional scan opened up new avenues of study, which will add to current knowledge. Following are some of the more promising themes identified:

- **Contextualize the interprofessional team according to the clinical setting:** This study’s findings show that the composition and operation of interprofessional teams will vary depending on the clinical setting. What works well at one site may not be appropriate in another. The specific form that an interprofessional team may adopt in a particular clinical setting is a question for further study.

- **Conceptualize the patient/family role in greater detail:** The study revealed that the patient and family were much more than passive recipients of caregiver interventions. A deeper understanding of the multiple aspects of the role of patients and families would result in a more precise concept of “the patient” and of his or her role on the team.

- **IPCP in the context of health facilities with limited resources:** New knowledge is required to articulate more clearly a philosophy of patient-centred care, given the constraints on health facilities, the needs of patients and their families and care requirements in special circumstances.

- **Draw out knowledge about effective ways to coordinate communication with the P/R/F:** Communication problems between caregivers and the P/R/F are often referred to in this report. New knowledge is required in order to identify and test simple mechanisms to resolve these problems.

- **ICT’s role in solving communication problems:** The role of information and communication technologies in solving communication problems deserves further study, since it seems to generate hope among a number of study participants. Still, the exact role of ICT is unclear. Some facilities use numerous ICT communication tools but seem to have no better results than other, less well equipped facilities. The use of ICT in the explicit context of interprofessional collaborative practices should be investigated more thoroughly.
This regional scan allowed us to tease out new empirical knowledge about the perceptions of the key stakeholders in collaborative interprofessional health care in the Champlain Region. We collected information about the positive effects of IPCP; the complex role of the P/R/F; factors that influence the extent to which participating organizations can implement IPCP; and the determinants of interprofessional collaboration. These new insights show that interprofessional collaborative practice is, in many instances, a promising approach to addressing the challenges currently facing health care systems.
On behalf of the study team, we would like to thank all those who took part in the regional scan. Their experiences and suggestions for improvements to the delivery of care by interprofessional teams constitute a major contribution to improving our health services.

Such a commitment on the part of participants can only elicit the same kind of commitment from decision-makers. It is now up to them to study the recommendations that came out of this scan to ensure follow-up.

Denis Prud’Homme, M.D., M.Sc.
CHAIR, ACADEMIC HEALTH COUNCIL, CHAMPLAIN REGION

Lynn Casimiro, Pht., Ph.D.
CO-PRINCIPAL INVESTIGATOR

Pippa Hall, M.D., CCFP, M.Ed., FCFP
CO-PRINCIPAL INVESTIGATOR
The study team chose to begin the report with the voices of participants in the regional scan:

“I have a problem with the team. We’ve been discussing it all in here, but I don’t know, is there a team in here? A formal team that’s looking after my wife? Is there a formal team or is there just a bunch of people who have different jobs that do them?”

A PATIENT’S HUSBAND

“Yes, there are nurses. There are people who are support workers. There are even the ones who do maintenance, who keep the place clean. We all get together and talk about what happened the night before so we can keep doing the same things [...] and so [...] there’s this interprofessional collaboration.”

A SUPPORT WORKER TRAINEE
“If you don’t involve your team, you won’t be able to offer the best care or services to patients and residents, because one person can’t do it all. They won’t be able to. They may want to, but they won’t be able to.”

AN ADMINISTRATOR

“I think what’s needed is more information for support workers. More information because it’s the support workers who always have the most contact with everyone. [...] Sometimes you can even tell them things about a patient, something you saw, because often you’re with them all the time. But it’s as if you’re not respected.”

A SUPPORT WORKER
TABLE OF CONTENTS

SUMMARY 4

1. STUDY OBJECTIVES AND CONCEPTUAL FRAMEWORK 4

2. METHODOLOGICAL AND OPERATING FRAMEWORK 5
   2.1 General Methodological Framework 5
   2.2 Data Collection and Analysis 5

3. FINDINGS: PARTICIPANTS’ EXPERIENCE AND VIEWS 6
   3.1 Interprofessional Collaboration at Participating Health Facilities 6
   3.2 Outline of the Interprofessional Team 6
   3.3 Positive Impact of Interprofessional Collaboration 7

4. KEY INFLUENCE FACTORS 8

5. DISCUSSION 8
   5.1 The Most Significant Determinants 8
   5.2 The Multiple Roles of the P/R/F 9
   5.3 Problems with Interprofessionality or with Work Organization? 9
   5.4 Context is Crucial 9

6. RECOMMENDATIONS AND NEW AVENUES OF STUDY 9
   6.1 Recommendations: First-order Changes 9
   6.2 Recommendations: Second-order Changes 10
   6.3 New Avenues of Study 11

CONCLUSION 12

ACKNOWLEDGEMENTS 13

FOREWORD 14

TABLE OF CONTENTS 16

LIST OF TABLES 18

LIST OF FIGURES 18

ACRONYMS AND ABBREVIATIONS 19

INTRODUCTION 20

1. STUDY PRESENTATION 21
   1.1 Background 21
   1.2 Objectives 21
   1.3 Conceptual Framework: The Determinants of Collaboration 22
2. METHODOLOGICAL AND OPERATING FRAMEWORK 24
   2.1 Grounded Theory as General Methodological Framework for a Mixed Study 24
   2.2 Operating Framework 25
       2.2.1 Data Collection 25
       2.2.2 Recruitment of Participants 26
       2.2.3 Ethics 28
   2.3 Data Analysis 28
   2.4 Study Validity and Reliability 28
       2.4.1 Study Design 28
       2.4.2 Data Collection 28
       2.4.3 Data Analysis 28

3. FINDINGS: PARTICIPANTS’ EXPERIENCE AND VIEWS 29
   3.1 Interprofessional Collaboration at Participating Health Facilities 29
   3.2 Outline of the Interprofessional Team 31
       3.2.1 Composition of the Interprofessional Team: A More or Less Inclusive View 31
       3.2.2 Leadership and Coordination of the Interprofessional Team 34
   3.3 Positive Impacts of Interprofessional Collaboration 35
       3.3.1 The Perspective of Patients, Residents and Families 36
       3.3.2 The perspective of Caregivers, Administrators and Students 37

4. KEY INFLUENCE FACTORS 38
   4.1 Coordination of Communication and Care 38
       4.1.1 Organizational Mechanisms for Coordinating Care and Communication 38
       4.1.2 Communication Mechanisms Used 39
   4.2 Work Organization and Resource Availability 41
   4.3 Organizational Policies that Foster a Culture Attentive to Patient Needs 41
   4.4 Caregiver Socialization and Education 42

5. DISCUSSION 43
   5.1 A Review of the Most Significant Determinants of Interprofessional Collaboration 43
   5.2 Multiple Patient Roles: Evidence of the Complex Health System Interface 44
   5.3 Problems with Interprofessional or with Work Organization? 45
   5.4 Context is Crucial 46

6. RECOMMENDATIONS AND NEW AVENUES OF STUDY 46
   6.1 Recommendations: First-order Changes 46
   6.2 Recommendations: Second-order Changes 47
   6.3 New Avenues of Study 48

CONCLUSION 49
SELECTED REFERENCES 50

APPENDIX A

APPENDIX B
LIST OF TABLES

Table 1: San Martín-Rodríguez et al.’s three categories of determinants. 23
Table 2: Number of participants, by category and collection method. 26
Table 3: Overview of communication mechanisms identified. 39
Table 4: Participants’ views on the effectiveness of communication mechanisms for interprofessional collaboration. 40
Table 5: Problems related to work organization. 45

LIST OF FIGURES

Figure 1: Number of participating health care facilities by category 25
Figure 2: Participants from key clinical settings as a percentage of total participants 27
Figure 3: Profile of study participants 27
Figure 4: Perceived proportion of care delivered by an interprofessional team 30
Figure 5: How much more interprofessional work could be done in your workplace? 31
Figure 6: With whom do people collaborate most? 33
Figure 7: Administrators, caregivers and students who thought that interprofessional collaboration had positive or very positive effects, as a percentage 35
# ACRONYMS AND ABBREVIATIONS

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>AHC</td>
<td>Academic Health Council</td>
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<tr>
<td>CCAC</td>
<td>Community Care Access Centre</td>
</tr>
<tr>
<td>CPCP</td>
<td>Collaborative Patient-Centred Practice</td>
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<tr>
<td>FHT</td>
<td>Family Health Team</td>
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<tr>
<td>ICT</td>
<td>Information and Communication Technologies</td>
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<td>IPE</td>
<td>Interprofessional Education</td>
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<tr>
<td>IPCP</td>
<td>Interprofessional Collaborative Practice</td>
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<tr>
<td>MHC</td>
<td>Mental Health Centre</td>
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<tr>
<td>LHIN</td>
<td>Local Health Integration Network</td>
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<tr>
<td>P/R/F</td>
<td>Patient/Resident/Family</td>
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<td>WDMH</td>
<td>Winchester District Memorial Hospital</td>
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INTRODUCTION

The purpose of this report is to present the findings of a regional scan of interprofessional collaboration in the Champlain Region. The report comprises six sections. The first section presents the study context and objectives, as well as a summary of the two main theoretical frameworks used in its design and implementation. The second section contains the methodological and operating framework for the study. The third section presents the key findings about the experiences and views of participants in relation to interprofessional collaborative practice (IPCP). The fourth section looks at the key factors that affect the implementation of interprofessional collaboration. The fifth section is a brief discussion of the findings. The sixth and final section contains recommendations intended for decision-makers and suggestions for new avenues of study.

The following are clarifications of terms used in this report. The abbreviation P/R/F replaces the term “Patient/Resident/Family” when we are referring to this category of participants. When the text refers to only one of those three groups, however, we use the specific term: for example, “family” when dealing particularly with the needs or role of the family. We use the term “patient” to designate any person receiving care in a health care facility. The term “resident” refers specifically to someone living in a long-term care home or chronic care facility.

We use the term “caregiver” to designate anyone whose work consists of providing care within the framework of services delivered by a health care facility, whether that work is regulated or not. The term is therefore inclusive of health professionals and of persons exercising various other occupations in the delivery of care, such as personal support workers, whom we designate as “support workers” in this document. When needed, we use the specific: for example, “physician”, “occupational therapist” or “physiotherapist”.
1. STUDY PRESENTATION

This section begins with a presentation of the broad context for the study, followed by its specific objectives. A third and final subsection presents the conceptual framework used to guide its completion.

1.1 BACKGROUND

Several issues are currently being addressed regarding the financial capacity and viability of the Canadian health system. Notable among those are the transfer of responsibility for health care facilities to communities, the challenges of delivering care in rural settings, the economic pressures to streamline health costs, and the growing number of Canadians with complex or chronic illnesses.

Fundamental changes are needed to improve and maintain the continuity, coordination and quality of health care. Several organizations, including the World Health Organization, view interprofessional collaborative practice (IPCP) as a very promising approach to solving these problems. Champions of IPCP in health care believe that no one individual can possess all the competencies and knowledge needed to ensure successful clinical outcomes, and that combining the strengths of individuals on a team is the answer to the challenges entailed by health reform. Health Canada and the Ontario Ministry of Health have made interprofessional education (IPE) and interprofessional collaborative practice (IPCP) an action priority as a way of responding to the particular challenges of health care delivery in Canada.

However, regarding the level of knowledge, a number of gaps were detected. These gaps must be filled in order to support decision-making processes on delivering care using an interprofessional approach. Among these gaps, we note the limited understanding of the factors that encourage or hinder the adoption of interprofessional health care models in the Champlain Local Health Integration Network (LHIN). Further development of a theoretical model for the implementation of interprofessional programs should be undertaken, along with efforts to develop and implement targeted policies designed to foster an interprofessional approach to health care delivery and to help eliminate barriers to such practices. Production of new knowledge is clearly needed if these new challenges are to be met.

1.2 OBJECTIVES

This regional study is a project of the Academic Health Council (AHC) – Champlain Region, a partnership between Algonquin College, La Cité collégiale and the University of Ottawa. The AHC set up a team to do a multi-site IPCP research study in Champlain Region. The study was aimed at identifying the factors that encouraged or hindered the adoption of interprofessional practices in the Champlain LHIN. It looked at the interprofessional experiences of caregivers, students in clinical placements, administrators, patients, and family members sampled from health care organizations across the LHIN. Specifically, the goals of the regional study were:

To describe the factors that foster or hinder interprofessional collaborative patient-centred practice, and in particular, the professional philosophies, communication systems, work-related practices and programs, and interprofessional education that contribute to the maintenance, enrichment and mastery of skills for interprofessional, collaborative, patient-centred practice.

To find and assess current theoretical models; and to identify the institutional, technological, social and communication conditions needed to support the further development of theoretical models of interprofessional collaborative practice (IPCP) and education on interprofessional collaboration (IPE).

To develop proposals for policies that will support and strengthen the practice of and training in interprofessional collaboration in the region.
The recommendations in section six of this report were articulated with the aim of providing decision-makers with detailed guidelines for developing locally adapted, evidence-based policies on IPCP and IPE.

In tandem with the study we report on here, a case study was conducted to explore the experiences of patients, families, students in clinical placements, practitioners and administrative staff at the Winchester District Memorial Hospital (WDMH), a centre that promotes IPCP and IPE.

1.3 CONCEPTUAL FRAMEWORK: THE DETERMINANTS OF COLLABORATION

The general conceptual framework for the study was drawn from the conceptual framework developed by D’Amour and Oandasan and supplemented by the work of San Martin-Rodriguez et al. on the determinants of interprofessional collaboration.

The framework developed by D’Amour and Oandasan demonstrates the association between IPCP and IPE. The key components of this framework, found in the appendix A to this report, are represented by two circles at the centre of which are the learner and the patient. Each circle contains the key factors for IPE and IPCP at the three levels of change targeted: micro (factors linked to individuals); meso (factors linked to organizations committed to these processes); and macro (factors linked to the systems in which education and practice occur). The regional scan focused specifically on the impact of factors that influence the quality of patient care.

In particular, the study team used the work of San Martin-Rodriguez et al., published in a 2005 article as “The Determinants of Successful Collaboration: A Review of Theoretical and Empirical Studies”. They describe the determinants of collaboration identified through an exhaustive review of relevant literature published between 1980 and 2003.
Table 1 describes the determinants they identified and classified them in three categories.

<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>DETERMINANTS</th>
</tr>
</thead>
</table>
| **Systemic determinants:** Components outside the organization that have an impact on the extent to which collaborative interprofessional practices can be implemented. | **Social system:** Social factors that can lead to power imbalances between members of a team. Includes the ways in which professionals are socialized during their education.  
**Cultural system:** The society’s attitudes towards and perception of collaborative work. Includes the organizational culture.  
**Professional system:** The process of professionalization and its emphasis on autonomy and control leading to professional differentiation. Includes professional roles and fields of practice.  
**Educational system:** The socialization of the various professions and the acquisition of their respective values, professional ethics, and theoretical perspectives. |
| **Organizational determinants:** Attributes of the organization that define the team’s work environment. | **Organizational structure:** Whether it is hierarchical or horizontal, and its potential for shared decision-making and open communication.  
**Administrative support:** The extent to which administrators support and foster interprofessional collaboration, and how they support it.  
**Resources available to team members:** Various kinds of resources that can encourage or hinder interprofessional collaboration, such as time, space, funding, and knowledge.  
**Coordination and communication mechanisms:** Availability of interprofessional standards, policies and protocols, and standardized instruments and procedures for information-sharing between team members and the P/R/F. |
| **Interactional determinants:** Components that contribute to team members’ interpersonal relationships. | **Willingness to collaborate:** Commitment to the collaborative process.  
**Trust:** Demonstrations of trust in other members of the team.  
**Communication:** Active listening and open communication.  
**Mutual respect:** Knowledge and recognition of the complementarity of contributions from various professionals. |

**TABLE 1:** SAN MARTÍN-RODRÍGUEZ ET AL.’S THREE CATEGORIES OF DETERMINANTS.
2. METHODOLOGICAL AND OPERATING FRAMEWORK

2.1 GROUNDED THEORY AS GENERAL METHODOLOGICAL FRAMEWORK FOR A MIXED STUDY

The study’s general methodological framework is based on grounded theory according to which researchers usually do not apply a conceptual framework in the study design, since the methodology is aimed at having concepts and theories emerge out of the data. Researchers do, however, consult existing theories to analyze and interpret their data. This methodology is used especially to further researchers’ understanding of the experiences and perspectives of study participants. An iterative process is used for data collection and analysis, since preliminary data will influence subsequent data collection activities as well as the adopted methods and instruments.

As the study progressed, researchers used this iterative process of constant comparison, by which the first stage of data collection – the AHC’s case study of the WDMH – contributed to the set-up of stage two, the regional scan designed on the basis of initial findings. In this way, the study team could grasp new themes as they emerged in order to fine-tune, test and develop second-stage activities.

The study team decided to conduct a mixed study, collecting both quantitative and qualitative data from participants in four categories: administrators of health care facilities; caregivers and educators; patients/residents/family members (P/R/F); and students from various disciplines in clinical placements. During the qualitative step, the study team was especially interested in better understanding participants’ own perspectives about their experiences. To do so, they used in-depth interviews and semi-structured focus group discussions (FGDs). The quantitative component allowed them to establish the scope of the phenomena they identified: to that end, they designed and distributed a survey to reach the greatest possible number of participants in each of the four categories.
2.2 OPERATING FRAMEWORK

2.21 Data Collection

The study was conducted between 2008 and 2010, with the collaboration of the health care facilities served by the Champlain Region LHIN (see map boundaries in Appendix B). To preserve confidentiality and the integrity of the research process, the AHC commissioned a firm specializing in this kind of research project, Vision Study (or Vision Research). Under the supervision of the study team, the firm took charge of the study rollout from design through data collection.

Figure 1 shows the number of health care facilities that took part in the study, by facility category.

![Figure 1: Number of Participating Health Care Facilities by Category. N=29](image)

The study comprised a survey to which 1,379 persons responded, 26 semi-structured interviews of health care facility administrators, and 26 focus group discussions. The focus groups involved caregivers (12 focus groups), P/R/F (11 focus groups), and students in clinical placements (3 focus groups).

The average length of the interviews was 40 minutes. FDGs varied from one hour to one hour and a half in length, depending on the number of participants (3 to 8).
Table 2 identifies the number of study participants, by category and collection method used.

<table>
<thead>
<tr>
<th>Category</th>
<th>Survey</th>
<th>Focus Group</th>
<th>Individual Interview</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administrators</td>
<td>110</td>
<td>-</td>
<td>26</td>
<td>136</td>
</tr>
<tr>
<td>Patients/ Residents/ Family members</td>
<td>486</td>
<td>66</td>
<td>-</td>
<td>552</td>
</tr>
<tr>
<td>Caregivers</td>
<td>671</td>
<td>81</td>
<td>-</td>
<td>752</td>
</tr>
<tr>
<td>Students</td>
<td>112</td>
<td>20</td>
<td>-</td>
<td>132</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1379</strong></td>
<td><strong>167</strong></td>
<td><strong>26</strong></td>
<td><strong>132</strong></td>
</tr>
</tbody>
</table>

**TABLE 2: NUMBER OF PARTICIPANTS, BY CATEGORY AND COLLECTION METHOD**

2.2.2 Recruitment of Participants

The recruitment of participants was completed in two steps. Firstly, a convenience sampling of 88 facilities was drawn from among the 215 organizations in the Champlain Region LHIN. Of those, 29 facilities agreed to take part in the study and to distribute the survey in such ways that were most convenient to their clientele and facility type, while respecting the rules set by their Research Ethics Committees. For example, questionnaires may have been sent by internal mail to practitioners, students in clinical placements and administrators. The organizations then sent out a total of 13,227 questionnaires through internal and, external and electronic mail: of these, 1,379 were completed, for a response rate of about 11%.

The selected organizations invited potential participants to be part of the regional scan. Caregivers, educators, students and P/R/F were asked to complete the survey. Administrators were invited to in-depth interviews. Participating facilities also used a poster, and a question at the end of the survey questionnaire let respondents self-identify as potential participants in the interviews and focus groups.
Figure 2 shows the main locations at which participants worked, received care or did work placements.

Focus group discussions were held on Vision Study (or Vision Research’s) premises or in a meeting room, centrally located for participants from organizations outside Ottawa. Interviews were conducted by telephone at a time and place convenient to the participant. The interviewer called the participant and Vision Study (or Vision Research) covered all long-distance charges. The interviews and focus group discussions were recorded and transcribed for coding and data analysis. About 80% of participants across all categories were female. Among caregivers, nurses had the strongest representation, making up 46% of survey respondents and 25% of focus group participants. Figure 3 provides a detailed profile of participants according to their role.
2.2.3 Ethics
Requests for approval were submitted to various ethics committees. The study started after a 20-month process resulting in its approval by the ethics committees at the following organizations: The Ottawa Hospital, The Children’s Hospital of Eastern Ontario (CHEO), Bruyère Continuing Care, Royal Ottawa Health Care Group, Montfort Hospital Study Group, and the University of Ottawa.

2.3 DATA ANALYSIS

Analysis of the quantitative data was performed through analysis of variance, correlation analysis and Kruskal-Wallis tests.

The analysis of qualitative data was done using ATLAS qualitative analysis software, and involved compiling a preliminary code list using the two main conceptual frameworks and the findings of the AHC’s Winchester case study mentioned above. That step was followed by the initial coding of a sample of 10 transcriptions to identify emerging codes and check the validity of codes already assigned. Once this step was completed, the codes were validated by members of the study team using the inter-code method. The coding of a second sample and a second validation by study team members was then completed, followed by the coding of the 52 transcriptions of semi-structured interviews (26) and focus group discussions (26). Coding was followed by various intra/inter-category analyses to identify differences and similarities within and across participant categories.

2.4 STUDY VALIDITY AND RELIABILITY

The means used by the study team to ensure the validity and reliability of the study at all stages of the rollout are described below.

2.4.1 Study Design
In the initial six months, qualitative and quantitative research methods were tested to ensure their validity and reliability. Testing was done as follows:

- Design of protocols for interviews and focus groups.
- Validation of the survey instrument by an expert researcher in quantitative study methods to ensure its rigour and robustness.
- Validation of the content of data collection instruments by an expert committee composed of people representing groups targeted by the study: practitioners, students in clinical placements, administrators, and patients and family members, recruited from across the Champlain LHIN.
- Pilot-stage focus groups, each with a maximum of six participants from a range of health care sectors within the Champlain LHIN. The groups comprised practitioners (3 groups), students in clinical placements (2 groups), and patients and members of patients’ families (2 groups).
- A pilot study involving respondents from an LHIN member facility.

2.4.2 Data Collection
Moderators and interviewers were trained to ensure the standardized use of data collection instruments and complete adherence to the protocols for semi-structured interviews and focus group discussions.

2.4.3 Data Analysis
During the qualitative analysis, the reliability of the codes being used was checked in meetings involving inter-coding activities completed with four study team members participating. In addition, the preliminary findings were validated within the framework of a focus group in which eight participants took part: three family members, four caregivers and one student.
3. FINDINGS: PARTICIPANTS’ EXPERIENCES AND VIEWS

In this section, we report on participants’ experiences and their views on whether interprofessional collaboration had been implemented, the composition of the interprofessional team and the positive effects of interprofessional collaboration.

3.1 INTERPROFESSIONAL COLLABORATION AT PARTICIPATING HEALTH FACILITIES

Generally speaking, the researchers wanted to know whether participants believed that the health care facilities where they were employed as administrators or caregivers, or which they knew as patients, residents of long-term care homes, or members of a patient’s family, were using a health care model based on interprofessional collaboration.

Each interview and focus group discussion started with the interviewer or moderator reading Herbert’s definition of interprofessional collaboration:

**Collaborative patient-centred practice is a practice orientation, a way of health care professionals working together and with their patients. It involves the continuous interaction of two or more professionals or disciplines, organized into a common effort, to solve or explore common issues with the best possible participation of the patient. Collaborative patient-centred practice is designed to promote the active participation of each discipline in patient care. It enhances patient- and family-centred goals and values, provides mechanisms for continuous communication among caregivers, optimizes staff participation in clinical decision-making within and across disciplines, and fosters respect for disciplinary contributions of all professionals.**

The study findings point to differences between the experiences of administrators and caregivers on one hand, and those of P/R/F and students on the other. Administrators and caregivers were more positive, suggesting there was a high level of interprofessional collaboration. Some went so far as to assert that all care and services at their facility were being delivered based on an interprofessional model. Those participants supported their positive views with examples showing how the different professional and occupational groups collaborated to develop interdisciplinary care plans, find out what others were doing, solve specific problems around patient care, and communicate regularly to ensure patients received care that met their needs. They believed that using a model based on IPCP was needed “now more than ever”, mainly because of the complexity of the care to be delivered and the constantly evolving health status of the patient/resident requiring periodic adjustments to the care plan.

A care coordinator at a long-term care facility described the process as follows:

“We have different departments coming together to discuss the progress of care, that kind of stuff. And we also do the same thing when we have resident care conferences. That is where family members, the residents, our staff from different departments come together, including the family, and discuss the care of the resident and come up with suggestions as to which way forward.”

However, the P/R/F group and students in clinical placements appeared to be more sceptical about the extent of interprofessional collaboration. They didn’t seem to observe as clear evidence of it as administrators or caregivers did. When asked if there was interprofessional collaboration in the settings with which they were called on to interact, these groups spontaneously replied in the affirmative but, surprisingly, tended to support their answers with examples of communication breakdowns among caregivers and between caregivers and P/R/F. The following comment from a student in an unidentified discipline is a good illustration of the situation:

“I’m not saying collaboration doesn’t happen, but it’s obvious no one’s in charge of collaboration in the unit where I’m currently assigned.”
This apparent contradiction seems to indicate that both groups acknowledge caregivers’ efforts to communicate and to work towards a shared objective – that of delivering patient-centred care – but that these efforts do not produce the outcomes that the P/R/F expect. This is partially explained by the survey results, which show that 71% of the P/R/F said they received more than half their care from interprofessional teams, while 40% said that health care teams never or almost never asked their opinion, thus confirming that the P/R/F did not feel that they were truly part of the caregiver team.

The Kruskal-Wallis test revealed significant differences between the participants’ respective views on the proportion of care delivered by interprofessional teams, which supports the qualitative data presented above. These differences are shown in Figure 4, where we observe that 27% of the P/R/F believed that more than half the care was delivered by interprofessional teams, while in the other groups, the number of respondents who had such a view was higher.
As shown in Figure 5, these differences in group responses also appeared when we asked participants to tell us how much additional care they thought could be provided by an interprofessional team.

![Bar chart](image)

**FIGURE 5: HOW MUCH MORE INTERPROFESSIONAL WORK COULD BE DONE IN YOUR WORKPLACE?**

Several factors may explain the differences observed in the views of different categories of participants about the extent to which IPCP has been implemented in their health care facilities. Firstly, even if caregivers and administrators invest major efforts in facilitating IPCP, the mechanisms put in place may fail and outcomes may not match their efforts, these mechanisms then remaining largely invisible to the P/R/F. Secondly, the notion of teamwork may not be well established, especially if team members are spread across several institutions. Thirdly, it seems that P/R/F are not always well informed about how their health team works.

Nonetheless, groups of participants agreed on the characteristics of a good interprofessional team: continuous two-way communication among caregivers and between caregivers and the P/R/F; harmonious work atmosphere; flexible team members who agree to work on the basis of patient needs and not solely their own professional dictates; and the active participation of the P/R/F in decisions taken by the team.

### 3.2 OUTLINE OF THE INTERPROFESSIONAL TEAM

In this section, we deal with two different aspects of the interprofessional team: its composition and its leadership.

#### 3.2.1 Composition of the Interprofessional Team: A More or Less Inclusive View

The study findings show that different groups of participant have a more or less inclusive view of the interprofessional team.

According to the P/R/F who took part in the study, an interprofessional team should include everyone whom the patient comes in contact with, whether in regulated professions, such as the family doctor, podiatrist, nurse, physiotherapist, occupational therapist, massage therapist and nutritionist; or other staff, such as the support worker, recreation activity leader, secretary, driver, cleaner and maintenance staff. This list was compiled from comments by residents in long-term care homes and their families: its composition will vary, of course, depending on how the clinical setting operates.
On the other hand, caregivers, administrators and some students often began their list of interprofessional team members with professionals in regulated disciplines only – medicine, nursing science and psychology, for example. However, as soon as the moderator or interviewer mentioned the patient’s or family’s role on the team, several were quick to change their answer, putting greater emphasis on the participation of patients and family members, whom they qualified as extremely important. Some caregivers added that the non-participation of the P/R/F made their work more complicated, because it meant they had to spend more time, after the fact, explaining decisions that might have been accepted much more readily if they had been taken jointly with the P/R/F.

Numerous examples mentioned during focus group discussions and interviews revealed some disconnection between regulated and unregulated caregivers.

Firstly, participants – and not only support workers – mentioned and deplored the many examples of support workers being excluded from meetings and from communications shared with other caregivers, as evidenced by the following conversation between a support worker and a residential care home nurse during a focus group:

"Support worker: I just want to add something to this, Monsieur. As a support worker... our files... I think what’s needed is more information for support workers. More information because it’s the support workers who always have the most contact with everyone.

Nurse: And often you’re not even part of the meetings.

Support worker: People don’t know what’s changed. Sometimes you can even tell them things about a patient, something you saw, because often you’re with them all the time. But it’s as if you’re not respected. Like, ‘Oh well, it’s not serious.’ But if we could at least have more information, maybe we’d be taken more seriously when we gave an opinion.”

This exclusion is corroborated by support workers themselves. Many of them said that they felt their opinions did not really count in clinical decisions about the patients they took care of.

Secondly, some caregiver groups, mainly those in unregulated occupations, seemed to have less access to communication tools being used and to information and communication technologies (ICT) in particular, which they said was a factor in their being excluded from team conversations.

When participants were asked to say which caregivers they collaborated with most and to give examples, the majority of participating caregivers mentioned collaborating with colleagues in a professional or occupational category close to their own. For example, one support worker said she collaborated mainly with kitchen staff on meal preparation but said she never collaborated with the nutritionist.
Figure 6 shows the occupations with which the three groups of participants associated with delivering care collaborated most. As we can be observed, only 2% of caregivers said that support workers were the group they collaborated with most, while 34% of caregivers said they collaborated most often with physicians. These facts corroborate P/R/F’s observations about the inclusion of support workers in the interprofessional team. Among the P/R/F group, we noted that 8% said they collaborated mainly with support workers, a higher percentage than found among other groups of participants.

“...the three groups of participants associated with delivering care collaborated most. As we can be observed, only 2% of caregivers said that support workers were the group they collaborated with most, while 34% of caregivers said they collaborated most often with physicians. These facts corroborate P/R/F’s observations about the inclusion of support workers in the interprofessional team. Among the P/R/F group, we noted that 8% said they collaborated mainly with support workers, a higher percentage than found among other groups of participants.

If you think back over the past year, which health care occupations or professions (besides your own) did you collaborate with most frequently?”

Some patients and family members, as well as some support workers and students, mentioned that they felt their contributions were not always respected by caregivers.

In light of this diverse evidence, we can perceive a two-tiered interprofessional collaboration. At one level, IP collaborative practices involving caregivers in regulated disciplines, and at the other level, IP collaborative practices adhered to by those in unregulated occupations. Several participants in the administrator and caregiver groups mentioned collaborations they maintained with professionals and other caregivers and administrators attached to other facilities: they saw these colleagues as full members of their interprofessional team. This view indicates that for them, interprofessional collaboration extends beyond the borders of their organization to include inter-organizational collaboration. An administrator in the mental health field explained the importance of these inter-organizational collaborations:

“We have partnerships with about 35 agencies that serve homeless people. They include shelters and drop-ins and so forth. So a lot of the collaboration they have [her team members] is with them.”

This collaboration can take many forms depending on the clinical setting and patient needs. It might be collaboration to care for the patient or provide information to the family; to transfer someone to another facility; with private companies supplying services to the health facility; or with other health facilities the patient goes to.

Finally, several examples were given to illustrate the central role of the family doctor and other physicians on the interprofessional team. Some dealt with physicians being unavailable to attend team meetings, as mentioned by a patient who took part in a focus group:

“I find that doctors are often too busy to take part. You know, sometimes I go see the surgeon and he’s running around as though he doesn’t have a minute to himself.”
Others talked about the family doctor’s key role in coordinating patient care, as described to us by an older woman who had spent a short period of time in a care home:

“I was at [name of the facility] for a month and I thought [the collaboration] was excellent. They interact. They really do work with each other and they have a team and you can ask that team if you want to know something. And there is a leader, the doctor directs the team. I found that excellent, everyone knew what was going on. But it was a small place.”

Finally, some participants – both P/R/F and staff – made the point that there were situations in which physicians treated them in authoritarian ways, which they saw as a major deterrent to collaboration.

3.2.2 Leadership and Coordination of the Interprofessional Team

The findings around the leadership of the interprofessional team show varying responses depending on the context. Nevertheless, the study did reveal three discrete but interrelated areas where the exercise of leadership is needed to ensure the smooth operation and efficacy of the interprofessional team: firstly, at the organizational level, championing IPCP and instituting targeted provincial and organizational policies; secondly, coordinating caregiver interventions within the health facility and with those of caregivers at other facilities; and thirdly, exercising leadership in the area of communication with the P/R/F.

As to who should assume this leadership role, it was clear that at the organizational level, it should be the health facility administrators. When it came to coordinating care and communication with the P/R/F, however, participants indicated that it was not helpful to appoint someone ahead of time, who would always be the person responsible in that facility or department. The person should be chosen by the health care team based on patient needs.
3.3 POSITIVE IMPACT OF INTERPROFESSIONAL COLLABORATION

A vast majority of participants across all categories believed that interprofessional collaboration had positive impacts on the delivery of care. More than 82% of the P/R/F group believed that the quality of their experience was greatly improved when care was delivered by an interprofessional team. The three other groups of participants were even more positive in this regard, as shown by the data in Figure 7.

Following is more detailed evidence of these positive impacts, first from the perspective of the P/R/F, and then from the perspective of administrators, caregivers and students.
3.3.1 The Perspective of Patients, Residents and Families

Having IPCP in place enhanced patients’ trust in caregivers and gave them a sense that the care received met their needs. When patients and families noticed that caregivers were collaborating, their trust in caregivers and in the entire health facility went up, which increased their willingness to cooperate with caregivers and to reduce the number of communications they addressed to them. Several patients and family members said things like “I’ve stopped calling” or used expressions such as “peace of mind” to show that they were more trusting and felt less need to communicate or to seek out information from other caregivers. Some even said they had stopped going from one professional to another for a second or even third opinion because they felt more secure and did not feel the need to double-check information received. This opens up the possibility of reducing transaction costs across the entire health care system, a hypothesis that remains to be tested but which shows the cost-saving potential of IPCP. In addition, having several disciplines involved reassured the patient, as shown in the following conversation between a focus group moderator and a patient:

“Moderator: ... do you sense a difference if it’s teamwork or not?

Patient: Well, like I say, when I got operated, it felt like teamwork.

Moderator: How did that make you feel?

Patient: Better, because there’s more than one brain there.”

Conversely, when they noticed that caregivers did not communicate well with each other, participants in the P/R/F group reacted by putting more pressure on caregivers and checking up on them more often. The P/R/F supplied a wealth of examples of the clever and resourceful ways in which they were able to fill the gaps in the system to make sure they received the right care. Several of them described being highly proactive in creating their own mechanisms for communicating with caregivers and finding out how the facility operated and what other care might be available when care was inadequate. The P/R/F said they occasionally stepped in to communicate information to a caregiver, which was confirmed by some caregivers who admitted they had been embarrassed when they realized the family had information about their specific intervention. One support worker explained this kind of situation as follows:

“And it’s very...how can I says this, very embarrassing for the employee providing care and then the family asks a question and the family knows what’s going on, because another employee has told them, and you’re not even aware of it. You say, ‘Oh, right. There were some changes.’ You look like a complete... It’s very difficult.”

But not everyone agreed on the patient’s exact role on the health care team. One nurse, who did not agree with giving patients or families a role in coordinating care or communication, put it this way:

“A family member should be a family member and not become a professional caregiver.”
3.3.2 The perspective of Caregivers, Administrators and Students

According to administrators and caregivers, adopting a patient-centred view of care within a framework of interprofessional collaboration would have numerous benefits in terms of quality of care and their own work satisfaction. Interprofessional collaboration would mean providing care better adapted to patient needs, with contributions from different disciplinary perspectives that bring the team to see the patient in a more holistic way. This process was eloquently described by an administrator employed at a long-term care home:

“[…] if you have an interdisciplinary team that bring expertise, I as an OT, if I was working here as an OT, I could bring that level of expertise that no one else on the team can bring. So you have a better ability to look at the person from all aspects as opposed to just the nursing perspective or just the social work perspective. So it gives a much more holistic picture.”

Interprofessional collaboration would also allow caregivers to focus more specifically on patient needs, making it easier to remove professional barriers. That view was shared by several administrators who said they were trying to promote IPCP, as this administrator of a long-term care home was doing:

“I think we’ve been effective in breaking down a lot of the barriers: this is your job, this is my job. No, it’s not. It’s not your resident or my resident, it’s our resident, and we’re all here to work together.”

Many administrators and caregivers insisted that once a team is focused on the patient and has a good understanding of each team member’s role, it becomes harder to maintain professional barriers – the hierarchy of professions and occupations. A social worker on a family health team explained this process, pointing out the importance of caregivers communicating in terms of the patient:

“[…] what I find helps […] in the family health team at work, is to try and get to know each and everyone’s roles. […] Let’s say if I didn’t know what the nurse practitioner did, and she didn’t know what the social worker did, I mean, we could not communicate in terms of the patients.”

This better understanding of the roles of other caregivers meant a sharing of knowledge and thus a better understanding of the patient’s situation and more effective communication with them.

Caregivers saw IP collaborative practices as a way of improving their work satisfaction and working relationships. This seemed to emerge because patient care became a team responsibility, a source of mutual support welcomed by caregivers struggling with heavy workloads. In addition, when there was continuous communication between caregivers and the P/R/F, the latter called on caregivers less often, thus freeing them to devote more time to other tasks.

According to caregivers, making the patient and the family full members of the team was more conducive to educating the P/R/F than interacting with them on an individual basis.

In the following section, we address the major factors that influenced the extent to which interprofessional collaborative practices would be implemented in the health facilities that took part in the study.
4. KEY INFLUENCE FACTORS

The regional scan highlighted four main factors that influenced the extent to which interprofessional collaborative practices would or would not be implemented in the facilities taking part in the study. The factors were: whether mechanisms were in place for the coordination of care and of communication; whether work organization and resource availability supported IPCP; whether organizational policies fostered a culture that is responsive to patient needs; and, how caregivers had been socialized and educated. Following is a description of these factors.

4.1 COORDINATION OF COMMUNICATION AND CARE

In this section, we present two aspects of the coordination of communication and care: organizational mechanisms and communication mechanisms.

4.1.1 Organizational Mechanisms for Coordinating Care and Communication

Study participants across all categories established a very clear difference between coordinating interprofessional care for the patient and coordinating communication between caregivers and the P/R/F. At the request of the focus group moderator, one participant whose mother was in a long-term care home provided a detailed description of these two roles and how they worked in her particular case:

*Moderator: Talk to me about the difference between coordinating communication and coordinating care.*

*Participant: Well, one is the one who’s saying, we need to do this, this and this, and finding out... or maybe that person, the caseworker finds out what all’s being done and provides notes to, say, the primary care or the doctor. But I see them as two different roles. I don’t see the social worker as coordinating the care.*

Another participant: No, no, but she was coordinating, you’re right, communication. Which made the team cohesive. It meant that I wasn’t having to call six different people. I had to call one person and it stopped at them.*

A great many comments from the P/R/F group referred to problems they experienced trying to find out whom to contact for information they needed in their dealings with the health facility, whether about services, procedures, or a family member’s health status. Faced with these problems in communicating with the health facility, they said they felt frustrated and powerless. In addition, when the P/R/F did not understand the mechanisms for communicating with the facility, IPCP could seem more complicated.

These problems may indicate a lack of organizational mechanisms for coordinating communications with the P/R/F, or the latter’s limited knowledge of what mechanisms do exist – the result of not being informed by those responsible at the facilities in question. For many participants, the question of who is in charge of P/R/F-caregiver liaison should be resolved in terms of patient needs rather than with a policy that appoints one particular type of caregiver.
4.1.2 Communication Mechanisms Used

We looked at the communication mechanisms in use, starting with an overview of the main mechanisms we found, presented in Table 3.

<table>
<thead>
<tr>
<th>TYPE OF MECHANISM</th>
<th>COMMUNICATION BETWEEN CAREGIVERS AND THE P/R/F</th>
<th>COMMUNICATION BETWEEN CAREGIVERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Speaking face-to-face, verbal communication.</td>
<td>Meetings, telephone calls, sharing information during family visits.</td>
<td>Meetings, telephone calls, informal contact, such as at lunch.</td>
</tr>
<tr>
<td>Handwritten and other written materials.</td>
<td>Newsletter mailed to families’ street address (rare).</td>
<td>Follow-up tools in various formats: logbooks, care plans, forms.</td>
</tr>
<tr>
<td>Information and communication technologies.</td>
<td>Email communication with families (rare).</td>
<td>Email, text messages, telephone, voice messages, centralized computer system for managing patient files.</td>
</tr>
</tbody>
</table>

TABLE 3: OVERVIEW OF COMMUNICATION MECHANISMS IDENTIFIED

If we take a closer look at communication mechanisms in use, we learn that caregivers communicated with the P/R/F mainly in person, during visits and appointments, and by telephone. A few rare examples of electronic or printed newsletters were provided by participants asked to describe how caregivers communicated with them. As for communication between caregivers, that was mediated by a range of mechanisms relying on spoken conversation, handwritten notes, and the use of various ICT, mainly email and electronic files.

Some mechanisms were mentioned as conferring benefits beyond the sole objective of communicating. This was the case for electronic file management systems, which allowed people to consult a care plan and find information on how a patient was doing; with that function, the systems became management tools providing teams with a shared focus on patient care.

In addition, the interdisciplinary care plan was thought by students and caregivers to be an important learning tool, since it allowed them to learn what other caregivers were doing. Still, other comments highlighted the limitations of these administrative tools, which should be taken into account in their implementation.

Inappropriate or ineffective use of the tools available, rather than their unavailability, seemed to be the cause of numerous communication breakdowns among caregivers and between caregivers and the P/R/F. A closer examination of the team meeting, one of the most frequently mentioned communication tools in the IPCP context, revealed major problems: the exclusion of some groups, such as support workers, from team meetings; the non-participation of physicians in those meetings; the lack of time caregivers have to attend team meetings; the frequent lack of accuracy and detail in the minutes – notwithstanding which technologies were used; and the limited access of some occupational groups to ICT. The communication challenges posed by the work of “virtual” teams whose members are spread throughout the community were especially obvious.
Lastly, depending on the specific circumstances of clinical settings, some communication mechanisms could be either obstacles or enabling factors. Several participants pointed out that the introduction of ICT had meant less and lower quality face-to-face communication, and that technology could not replace interpersonal contact. This was especially true for people working in hospital settings, although people who worked in the community where caregivers were spread across a wide territory or different organizations said they were very hopeful that using ICT would help them maintain contact with their colleagues and collaborate on patient care. These comments on the relative usefulness of ICT are corroborated by the survey responses presented in Table 4, which indicates the percentage of total respondents who said they were “in favour of” or “strongly in favour of” various methods.

<table>
<thead>
<tr>
<th>METHOD USED</th>
<th>CAREGIVERS</th>
<th>STUDENTS</th>
<th>ADMINISTRATORS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Working relationships</td>
<td>67%</td>
<td>62%</td>
<td>62%</td>
</tr>
<tr>
<td>Spoken communication</td>
<td>62%</td>
<td>65%</td>
<td>55%</td>
</tr>
<tr>
<td>Written communication</td>
<td>47%</td>
<td>56%</td>
<td>38%</td>
</tr>
<tr>
<td>Electronic communication</td>
<td>38%</td>
<td>42%</td>
<td>35%</td>
</tr>
</tbody>
</table>

TABLE 4: PARTICIPANTS’ VIEWS ON THE EFFECTIVENESS OF COMMUNICATION MECHANISMS FOR INTERPROFESSIONAL COLLABORATION

Not surprisingly, the data reveals that an appropriate combination of communication mechanisms must be used and that they must include in-person discussions which provide benefits that the other mechanisms do not, as pointed out by a long-term care home administrator:

“[…] Just reading it isn’t the same as discussing it. So really having the opportunities for some team discussion, team case review adds to the richness, more than in-the-hallway conversation briefly.”

The main problems encountered in interpersonal communication among caregivers in the same organization or between caregivers in different organizations relates to a lack of continuity and follow-up. Study participants attributed these difficulties to overworked caregivers having little time, a poor understanding of other professionals’ roles, the hierarchy that may exist among caregivers, or simply the personal style of the people involved.
4.2 WORK ORGANIZATION AND RESOURCE AVAILABILITY

Issues around the organization of work and the availability of resources were mentioned very frequently as factors affecting the implementation of IPCP. Forms of work organization based on frequent staff rotations often put a significant brake on interprofessional collaborative practice because they hinder the creation and consolidation of work teams and. In some cases, these rotations prevented the P/R/F from getting to know caregivers, resulting in a definite drop in the quality of patient care and in caregiver work satisfaction. Such rotations were, nevertheless, often made necessary by staff shortages.

Various types of human, financial and technological resources, such as communication mechanisms and meeting space to facilitate informal as well as formal encounters among team members, were mentioned by all participants as key conditions for the successful implementation of IPCP. The heavy workloads faced by so many caregivers were a real obstacle to IPCP implementation: time pressure was widespread, which hampered the participation of some professional groups, chiefly physicians. Lack of time was mentioned by many participants as the leading cause of frequent absences at team meetings, resulting in numerous problems in designing and maintaining continuity in interventions.

4.3 ORGANIZATIONAL POLICIES THAT FOSTER A CULTURE ATTENTIVE TO PATIENT NEEDS

As has been the case with other studies, the regional scan revealed the need for a culture that is responsive to patient needs. But it is insufficient to ensure the successful implementation of IPCP: it must be supported by policies aligned with that culture and which foster interprofessional collaborative practices. Communication breakdown among caregivers and between caregivers and the P/R/F, partly attributable to the lack of appropriate organizational policies or the ineffective application of existing policies, was mentioned to illustrate this type of problem. For example, the fact that IP collaborative practices observed in one department or one floor were very often not applied across the entire facility led to confusion, both among patients and among caregivers working in more than one department in the same facility, as described by this long-term care home administrator:

“[…] It depends on the environment. So in that same hospital, the rehab environment was a very rich experience. The medicine environment, they rarely sat together to talk. It was more on paper. So there wasn’t the same transfer of knowledge and information.”

Administrators who supported the implementation of IPCP said they wanted to have targeted policies at their disposition, understood as mechanisms aimed at supporting their efforts. In particular, they pointed to the usefulness of human resource policies that favoured collaborative interprofessional skills and encouraged teamwork, as well as policies that encouraged forms of work organization designed to maintain stable teams.
4.4 CAREGIVER SOCIALIZATION AND EDUCATION

It became clear from the study that patient-centred care was an objective that rallied the various disciplinary contributions and made it easier to lower professional barriers, while giving caregivers more leeway to move beyond their immediate field of practice and focus on a common goal.

- Administrators told us that they were very familiar with the roles and responsibilities of the different professional and occupational groups with whom they worked. This is not surprising, considering their fundamental role and the importance of that knowledge in administrators’ daily decision-making.

On the other hand, while many participants in the three other groups began by telling us they had adequate knowledge of the roles of different caregivers, more pointed questions from the moderator – and often from other participants – revealed that this knowledge was in fact fairly general, and often lacked an understanding of the caregiver roles in specific relation to their own facility. For example, several students and caregivers told us they did not have a very detailed understanding of other caregivers’ fields of practice or of what they did at the facility – a situation to which they attributed numerous misunderstandings and professional barriers. In addition, this lack of understanding of other caregiver roles meant they could not answer P/R/F’s questions about them, which was a source of stress for many because it made them feel incompetent. To address these difficulties, one administrator suggested a more precise definition of the roles within the team:

“I think, maybe define the roles for those who do not know their role on the team or what their contribution will be. Maybe that should be clarified.”

- The P/R/F very often found themselves in the same situation, saying they knew the exact boundaries between professional groups fairly well – between the pharmacist and the physiotherapist, for example. But in other cases the boundaries were rather vague. Within this group, there was fairly widespread misunderstanding of the different levels of nursing interventions: How do you tell the difference between a nurse’s aid, a registered nurse, and a nurse practitioner?

- Students had a unique perspective, some expressing fears about whether it would be possible to preserve what they had learned about interprofessional collaboration when they made the transition from training to practice and found work in settings that did not have IPCP in place.

There was agreement among participants on the topic of mutual trust, whether among caregivers, or between caregivers and the P/R/F. It was seen as a crucial component in successful teamwork. Some patients and family members mentioned that they felt their contributions were not always respected by caregivers, as did some support workers and some students. They attributed that situation to the fact that other caregivers, mainly physicians and nurses, believed they were more competent than other team members to decide on what was to be done.
5. DISCUSSION

5.1 A REVIEW OF THE MOST SIGNIFICANT DETERMINANTS OF INTERPROFESSIONAL COLLABORATION

All the determinants identified by San Martín-Rodríguez et al. and classified in three categories – systemic, organizational, and interactional – play an important role in the implementation of interprofessional collaborative practices. Within the framework of this study, some determinants stood out more than others. Moreover, this study allowed us to identify new determinants not described in San Martín-Rodríguez et al., which the study team found to be very important in the eyes of study participants. Below, we address the determinants that stood out most clearly in each category. We also describe the new determinants we identified.

The regional scan revealed two key systemic determinants. The first is the educational system. As it relates to the development of competencies, the acquisition of knowledge about other professions and the socialization of caregivers, it is likely that education will play a significant role in the extent to which caregivers will or will not implement IPCP. These elements corroborate the interdependency between education and practice described in D’Amour and Oandasan’s model.

The second key systemic determinant identified in the regional scan is a fifth and new determinant: the regulatory environment. This determinant refers to IPCP-related policies that when adopted and implemented and combined with adequate resource allocation, seem to play a central role in the successful implementation of IPCP. For many administrators and caregivers, having meaningful policies in place provided the kind of framework within which they felt enabled to move towards health care and management models more informed by IPCP. Still, while having an adequate regulatory system in place is seen as a necessary condition for the successful implementation of IPCP, it is clearly not enough in the eyes of the participants. Many emphasized the importance of seeing policies supported by financial, human and technological resources required for their implementation.

Two organizational determinants proved especially significant: administrative support, closely tied to the regulatory environment we dealt with above, and communication and coordination mechanisms. Both were seen as essential conditions for the successful implementation of IPCP.

Finally, among the interactional determinants, those that stood out most in the regional scan involved caregivers’ communication skills and the fact that individual style and the importance of helping caregivers develop those skills cannot be ignored. Some administrators and caregivers pointed out that the increased team interaction essential to interprofessional collaboration could elicit and even exacerbate personality conflicts.
5.2 MULTIPLE PATIENT ROLES: EVIDENCE OF THE COMPLEX HEALTH SYSTEM INTERFACE

The complex role of the P/R/F emerged as one of the major findings of this study, making an important contribution to new knowledge about IPCP. The question surrounding the conceptualization of the patient and family has been dealt with before, by D’Amour et al. in one of their articles on the IPCP concept: “This review identified an important drawback in all the proposed definitions of collaboration: the absence of the patient’s perspective, reflecting a poor conceptualization of the role of the patient/client/family in the collaborative process.”

Indeed, the patient and the family in particular, may play various roles depending on circumstances. They may be in turn a demanding client with high expectations of the facility and caregivers; the person coordinating care and communications among caregivers and between caregivers and the family; an active partner in the interprofessional team’s decisions; a reluctant participant; or a passive recipient of care.

This broad range of participation levels highlights the multiple facets of the P/R/F role. Some patients and their families said they wanted to receive directives from caregivers, arguing that they were sometimes asked to make decisions when they had no competencies to do so. At the same time, they wanted caregivers to listen to them, to answer their questions and their needs, expectations, fears and opinions to be taken into account in care planning. They trusted caregivers to answer their questions, convey information to other caregivers, ensure follow-up, and tell them which treatment was most appropriate in their situation.

In some cases, the notion of patient-centred care may run up against the fact that the needs of patients and families are not always perfectly aligned. There may be tensions between the respective needs of these two groups, pointing to yet another aspect of the complex notion of patient-centred care and the patient’s participation on the interprofessional team.

Finally, some types of participation may be more appropriate than others, depending on the context. For example, a resident with cognitive disabilities in a long-term care home does not have the same needs or the same ability to be part of the interprofessional team as a young, educated mother of a child receiving care at a children’s hospital.
5.3 PROBLEMS WITH INTERPROFESSIONALITY OR WITH WORK ORGANIZATION?

Some problems in implementing IPCP are attributable to how the work is organized, and do not flow directly from problems of an interprofessional nature. Table 5 lists the main instances of this type of problem drawn from the regional scan.

<table>
<thead>
<tr>
<th>THE FOLLOWING PROBLEMS HARM INTERPROFESSIONAL COLLABORATION:</th>
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<tbody>
<tr>
<td>Breakdowns in communication resulting from shift handovers.</td>
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<tr>
<td>Frequent rotations from one floor or department to another.</td>
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<tr>
<td>Limited time for caregivers to interact with patients;</td>
</tr>
<tr>
<td>Inappropriate communication tools or their ineffective use.</td>
</tr>
<tr>
<td>Lack of continuous communications among caregivers and between caregivers and the P/R/F.</td>
</tr>
<tr>
<td>Limited access to information of Communication Technologies for some groups.</td>
</tr>
</tbody>
</table>

TABLE 5: PROBLEMS RELATED TO WORK ORGANIZATION

Several of these problems are familiar, having been addressed in the study by Couturier on the problems of implementing collaborative care in a palliative unit in Switzerland: broadly speaking, he found that some problems were not caused by insufficient interprofessional collaboration but by interpersonal difficulties and work organization. Although the solution may not automatically appear with the introduction of interprofessional collaborative practices, they could certainly help.
5.4 CONTEXT IS CRUCIAL

IP collaborative practices can have a very positive impact on the quality and efficacy of care when they are an appropriate response to the needs of the P/R/F and when they are used carefully to make best use of resources. The team’s composition, the way it communicates, its in-house rules, and the rules that govern its interactions with other organizations will vary depending on the clinical setting. Therefore, sites intending to implement IPCP models must address the crucial need to contextualize.

The following are illustrations of this clinical diversity drawn from the regional scan:

- **Health care delivered in the patient’s home:** In this situation, the structure and organization of work make it difficult to set up an interprofessional approach, because caregivers are rarely in the same place at the same time. Thus, what is needed is greater emphasis on organizational and interpersonal mechanisms to facilitate communication among caregivers on these “virtual” teams.

- **Obstetric care:** Hospital stays for new mothers are short, which means that their interactions with the caregiver team must be well planned and coordinated if they are to be effective.

- **Health care delivered in long-term care homes:** The medium- and long-term interactions between caregivers and residents in care homes and their families should make it possible to set up mechanisms for continuous coordination and communication. In some cases mentioned by P/R/F receiving long-term care, the resident felt overwhelmed by the presence of so many caregivers in meetings dealing with their care. It may be equally helpful for the resident to name one person to act as liaison between the P/R/F and the caregiver team, rather than inviting the resident to take part in team meetings.

- **A final and essential point:** Many participants in focus group discussions insisted that, in many situations, an intervention involving only one professional may be perfectly satisfactory.

6. RECOMMENDATIONS AND NEW AVENUES OF STUDY

Recommendations issued from the analysis of regional scan data are presented in terms of the depth of organizational change needed to implement these recommendations. Theories of organizational change state that change is either of a first or second order. Thus, the proposed recommendations are presented in two sub-sections.

6.1 RECOMMENDATIONS: FIRST-ORDER CHANGES

First-order changes are aimed at moving an organization towards managing current strategy more effectively and more efficiently, without questioning the basic frames of reference that guide its members’ actions. The recommendations for this type of change involve the coordination of care and communication as well as the introduction of new educational programs and activities.

- **Coordination of care and communication**
  - Clearly establish how the P/R/F and the care team will communicate. In many cases, a simple information sheet listing ‘who does what’ and clarifying whom to contact and how to go about solving specific problems could help resolve many difficulties.
  - As needed and when appropriate, assign a person to act as liaison between caregivers and the P/R/F. That person would be designated based on patient needs, and his or her contact information clearly communicated to the P/R/F.
  - Review the communication mechanisms and tools being used, to enhance their effectiveness.
• Caregivers are overworked and have trouble finding time to attend meetings. Therefore, other types of communication must be explored, aimed at streamlining communication among caregivers, and between caregivers and the P/R/F. For example, ICT tools such as Skype software or the kind of platforms used in social networking might be especially effective, with mechanisms to ensure confidentiality and privacy. Still, in some situations, simpler communication tools and methods, such as a whiteboard, could be as effective as ICT.

Introduction of new programs in continuing and undergraduate education

It is recommended that more efforts be invested towards interprofessional education to adequately prepare future health professionals and other health care workers to join interprofessional teams. Some of the avenues to be explored include:

• Drawing on existing resources: There are different examples of interprofessional education in the region and new programs could be developed based on those experiments.

• Offering joint courses for students in different faculties or disciplines, a practice already in place in some colleges and universities, is known to make a very positive contribution to interprofessional learning.

• Many health facilities run continuing education programs and activities, and it would be appropriate to include IPCP-related programs, and to share programs already in place in other institutions.

• Among the concrete means suggested by participants to facilitate professional development around IPCP, we found: courses in which students from various disciplines participate; clinical placements in facilities with interprofessional collaboration in place; continuing education on teamwork and key IPCP concepts; and making sure caregivers have access to new knowledge on relevant topics.

6.2 RECOMMENDATIONS: SECOND-ORDER CHANGES

Second-order changes require the introduction of new frames of reference, and thus represent a deeper level of change. Recommendations emerging from the regional scan which seem to require this level of change relate to the implementation of organizational policies and the composition of the interprofessional team.

Organizational policies

• Hiring policies: Several caregivers and administrators emphasized how important it was to recruit people with good teamwork skills and to send a clear message to caregivers – present and future – about the facility’s commitment to IPCP and its expectations of staff in that regard. For caregivers, it was clear that improved working conditions flow from genuine teamwork and that they were a motivating factor. In a setting where health care personnel are often hard to recruit, offering a high-quality work environment characterized by delivery of care based on an interprofessional model would likely facilitate hiring and retention.

• Setting organizational policies in line with an organizational culture that is responsive to patients’ needs remains a major challenge, mainly but not solely because resources may be limited.

Composition of the interprofessional team

• It is recommended that specific efforts be made to determine how to best integrate the P/R/F and support workers more fully into interprofessional teams. This integration would occur especially, but not exclusively, by improving and developing communication mechanisms among caregivers.
NEW AVENUES OF STUDY

As with any study, the regional scan opened up new avenues of study, which will add to current knowledge. Following are some of the more promising themes identified.

• **Contextualize the interprofessional team according to the clinical setting:** The findings of this study show that the composition and operation of interprofessional teams will vary depending on the clinical setting. What works well at one site may not be appropriate in another. The specific form that an interprofessional team may adopt in a particular clinical setting is a question for further study.

• **Conceptualize the patient/family role in greater detail:** The study revealed that the patient and family were much more than passive recipients of caregiver interventions. A deeper understanding of the multiple aspects of the role of patients and families would produce a more precise concept of “the patient” and of his or her role on the team.

• **IPCP in the context of health facilities with limited resources:** New knowledge is required to articulate more clearly a philosophy of patient-centred care, given the constraints on health facilities, the needs of patients and their families, and care requirements in special circumstances.

• **Draw out knowledge about effective ways to coordinate communication with the P/R/F:** Communication problems between caregivers and the P/R/F are often referred to in this report. New knowledge is required in order to identify and test simple mechanisms to resolve these problems.

• **ICT’s role in solving communication problems:** The role of information and communication technologies in solving communication problems deserves further study, since it seems to generate hope among a number of study participants. Still, the exact role of ICT is unclear. Some facilities use numerous ICT communication tools but seem to have no better results than other, less well equipped facilities. The use of ICT in the explicit context of interprofessional collaborative practices should be investigated more thoroughly.
This regional scan has allowed us to tease out new empirical knowledge about the perceptions of the key stakeholders in collaborative interprofessional health care in the Champlain Region. We collected information about the positive effects of IPCP; the complex role of the P/R/F; factors that influence the extent to which participating organizations can implement IPCP; and the determinants of interprofessional collaboration. These new insights show that interprofessional collaborative practice is, in many instances, a promising approach to addressing the challenges currently facing health care systems.
SELECTED REFERENCES


APPENDIX A:

Interprofessional Education for Collaborative Patient-centred Practice: An Evolving Framework

Interprofessional Education to Influence Learner Outcomes ↔ Interdependent ↔ Collaborative Practice to Influence Patient Care Outcomes

Educational System (e.g., Accreditation, Institutional Structures)

Systemic Factors

Professional System (e.g., Regulation, Codes, Health)

Government Policies: Federal/Provincial/Regional/Territorial (e.g., Education, Health, Social Services)

Social & Cultural Values

Research to Inform & to Evaluate

- Understand the processes related to teaching & practicing collaboratively
- Measure & benchmark marks with rigorous methodologies that are transparent
- Disseminate findings

Educational System:
- Institutional Factors
- Teaching Factors
- Accountability/Resource
- Faculty Development
- Support/Engagement

Systemic Factors:
- Healthcare Leadership
- Organizational Function
- Interorganizational Function
- Health Professional Learner Outcomes

Professional System:
- Organizational Factors (e.g., Governance, Setting)
- Interpersonal Factors (e.g., Sharing Goals, Values
- Health Professional Task Performance

Patient/Provider Outcomes:
- Patient-Centric Outcomes
- Quality of Care
- Professional Education
- Wellness
- Organization
- Environment
- Health Settings
- Health Systems

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