

Collaborative Practice and Education

**FRAMEWORK**  
FOR  
change

Background Information for the Collaborative Practice  
and Education Workplan for Change

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Collaborative Practice and Education Framework for Change

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## MINISTER'S MESSAGE

The Government of Alberta wants to ensure that all Albertans have a home in the health care system where people know them and their health needs, can help them manage their health, and can help them get more specialized care if it's needed. We want every Albertan to have access to a health care team that is tailored to local health needs and resources.

Collaborative practice and collaborative education are fundamental to high quality, team-based health care. When I met with health stakeholders at a collaborative practice and education engagement symposium in November 2011, we discussed the importance of team-based care and the ability for health care providers to work to the full extent of their education, skills and experience.

I'm pleased that the symposium was successful and that this Collaborative Practice and Education Framework for Change and accompanying Workplan for Change are the products of those stakeholder discussions. The documents describe Alberta's policy toward person-centred care and how best to achieve the team-based care that Albertans expect.

As we all work together to put collaborative practice and collaborative education into action, I am confident that the commitment stakeholders have shown so far will lead to positive results. By moving forward together, Albertans will receive the highest quality of care possible.

Fred Horne, Minister  
Alberta Health  
Fall 2012



# EXECUTIVE SUMMARY

Over the last few decades, concerns about growing population health needs and the demographic challenges to the health workforce have prompted health systems globally to look at new models of service delivery. Enhancing collaboration among health care providers, individuals, their families, and caregivers is one of the approaches to service delivery that has demonstrated a positive impact on service quality and safety in an effort to improve health outcomes.

Alberta is taking steps to change the health care system to improve quality and ensure sustainability into the future. At the core of these changes is the shift toward a collaborative, team-based model of service delivery to support safe, high quality, person-centred care. To support this change, Alberta developed the *Collaborative Practice and Education Framework for Change* (Framework) and the *Collaborative Practice and Education Workplan for Change* (Workplan) to set policy direction for health system change.

The purpose of the Framework and Workplan is to bring the collaborative practice work happening provincially, nationally, and internationally into a single model founded on a common set of principles and vision for the future. Alberta's vision for collaborative practice and education is that *"health care providers in Alberta deliver the highest quality of safe, person-centred care by collaborating with each other, and individuals, their families and caregivers"*. This vision will only be achieved when health care providers focus on the patient, trust and communicate openly with each other, respect and value each others role on the health care team, share accountability in a just and equitable culture, and make joint care decisions with individuals, and their families and caregivers.

The Framework provides descriptions of key change components in the form of a set of collaborative practice competencies and a model of health system transformation built into practice, regulatory, and learning environments. Building on the collaborative practice and education vision outlined in the Framework, the Workplan presents a change agenda for collaborative initiatives to enable the achievement of health system change. The Workplan specifically identifies 21 actions for change intended to remove barriers to collaborative practice and education, develop provider competencies for collaboration, and align regulatory and organizational policies and practices for collaborative practice and education.

The target groups of interest for collaborative practice include all current health service providers, both regulated and non-regulated; management-level staff in the practice environment; learners, faculty, preceptors and senior administrators in the learning environment; senior administrators, health professionals and government representatives involved in the regulatory environment; and individuals, their families and caregivers, and communities.

Albertans have made it clear that they want the health system to focus on putting people and their families at the centre of the health care experience. Collaborative practice enables health care teams to collaborate with each other, individuals, their families and caregivers to deliver the highest quality of safe, person-centred care to Albertans.



# INTRODUCTION

Over the last few decades, growth in the number of health care professions has coincided with an increasing complexity of diagnostic tools and treatment options. With an increased number of health care professions and specialization of health providers, there is a greater need for co-ordination of services and collaboration of providers to ensure people receive the highest possible quality of care. To meet the challenge of delivering high quality care, health care systems within Canada and elsewhere are focusing attention on how best to leverage various factors that contribute to the quality of health services. Enhancing collaboration among health care team members is seen as one of the enablers to increasing health service quality and safety in an effort to improve individual health outcomes.

In Alberta, health service quality is recognized as a balance of six dimensions from the patient experience perspective: acceptability, accessibility, appropriateness, effectiveness, efficiency and safety (see Appendix A).<sup>1</sup> Collaboration in the delivery of health services is important to Albertans. The 2010 “Satisfaction and Experience with Health Care Services” survey found that among Albertans who received health services, co-ordination of health care efforts is strongly associated with the overall rating of health service quality, contributes to overall satisfaction with health care services received and is associated with their perception of ease of access to health care services.<sup>2</sup>

A growing body of research clearly indicates that a collaborative practice approach to providing health care services can result in improved patient/client health outcomes. Positive effects of collaboration on health outcomes have been documented across a wide range of service areas including geriatric evaluation, neonatal intensive care, management and treatment of people with fractured hips and chronic diseases,<sup>3</sup> as well as improvements in health services, decreases in the length of hospital stays and clinical error rates,<sup>4</sup> and improvements in patient safety.<sup>5-6</sup> This is a sample of a body of research that has continued to grow over the decades.

*Positive relationships have been demonstrated between collaborative practice and health provider job satisfaction and improved workplace quality.*

Positive relationships have been demonstrated between collaborative practice and health provider job satisfaction and improved workplace quality.<sup>7</sup> There is evidence that the nature of the practice environment is an important component of patient safety, quality of care and retention of nurses.<sup>8</sup> Through collaborative models of care, there is also an opportunity to reduce the demand for, and on, the health workforce by improving workforce utilization.

Collaborative practice initiatives exist in many jurisdictions in Canada and internationally. As an example within Canada, Ontario has been a leader in laying the groundwork for collaborative practice. In 2007, Ontario released *Interprofessional Care: A Blueprint for Action in Ontario* that describes a vision and principles for collaborative practice and

education and sets the province's direction through strategies and actions.<sup>9</sup> In 2010, Ontario followed the Blueprint with *Implementing Interprofessional Care in Ontario*, which reports progress made toward a culture of collaborative practice, particularly in the areas of educational programming and competencies.<sup>10</sup> On the international front, the World Health Organization (WHO) released the *Framework for Action on Interprofessional Education and Collaborative Practice* in 2010.<sup>11</sup> The WHO Framework provides an analysis of the current global state of collaborative practice, identifies factors that influence success, and recommends actions for local implementation. The actions are based on environmental scans of the literature, case studies and experience from global experts.

## The Case for an Alberta Model for Collaborative Practice and Education

Alberta, like other jurisdictions in Canada, has made strides in collaborative practice and education over the last 20 years. Numerous health providers have participated in research studies and/or have incorporated collaborative practices into their delivery of services to improve individual health outcomes. Professional regulatory colleges have partnered to promote collaborative practice through conferences and discussion groups. Post-secondary educators are working on a number of initiatives, including developing curricula to promote collaboration through collaborative education in both classroom and clinical practice components. While these actions may have been successful in creating localized changes, they have not, however, garnered the supports and resources needed to make overall system changes to foster collaborative practice.

*Post-secondary educators are working on a number of initiatives, including developing curricula to promote collaboration through collaborative education in both classroom and clinical practice components.*

Large scale system change toward a norm of collaborative practice in health care delivery requires that current and future efforts be co-ordinated in an integrated, strategic approach. The simple adoption of an existing model for collaborative practice (for example, the Ontario Blueprint) will not adequately meet the specific system change requirements in Alberta. Up to now, system barriers have not been addressed. These barriers include: differential health provider compensation models; service delivery models that prevent individuals from being collaborative partners with their health providers; administrative, policy and regulatory structures that create obstacles for collaborative, team-based practice, and a lack of recognition for faculty efforts to enhance student collaborative experiences. Barriers to collaboration that are inherent to Alberta need to be addressed by a model that is developed within the Alberta context.

## System Building Blocks Supporting Collaborative Practice and Education

Alberta has a history of health care improvements that have created a foundation for building a “made in Alberta” model for collaborative practice and education. During the last three decades, recommendations from studies and reports on Alberta’s health system have prompted actions to improve quality, access and sustainability.<sup>12-16</sup> Recent changes to the governance and organizational structure of health service delivery in Alberta have created opportunities for further action to shift from facility- and provider-based care to providing person-centred care and to increasing the use of collaborative, team-based approaches.

Early in 2010, the Minister’s Advisory Committee on Health (MACH) consulted with Albertans on the future course of Alberta’s health system and recommended new, principle-based health legislation in *A Foundation for Alberta’s Health System*.<sup>17</sup> The report endorsed putting people and their families at the centre of their health care, making a commitment to quality and safety, and fostering a culture of trust and respect. Subsequent consultations with Albertans were documented in *Putting People First*<sup>18-19</sup> and the *Alberta Health Act* (Bill 17), which was passed in November 2010.<sup>20</sup>

The Patient Safety Framework for Albertans released in 2010 and developed by a working group led by the Health Quality Council of Alberta, proposes a set of principles that underpin a new approach to patient safety.<sup>21</sup> The principles call for patients to be the primary focus of health care delivery, for organizations to create a patient safety culture that encourages open communication, and for leaders to be transparent about adverse events in an effort to build trust. Effective teamwork based on open communication and collaboration is recognized as a key factor in providing safe health services.

*Alberta has a history of health care improvements that have created a foundation for building a “made in Alberta” model for collaborative practice and education.*

These past and present efforts shape a vision of health care that promotes the best possible outcomes for people engaging the health system. The direction for change to improve the health system in Alberta is clear and articulated in the *Alberta Health Act* principles that declare:

- › “individuals, families and communities receive quality health services that are safe.”
- › “health services are delivered in ways that understand the experiences, recognize the perspectives, and respond to the health needs of individuals, families and communities.”
- › “health professionals are encouraged and empowered to work collaboratively, ethically, efficiently, and in ways that maximize their skills, training and competencies.”<sup>22</sup>





# FRAMEWORK PURPOSE

For many years, different models have been used by Alberta health care providers, educators and regulators to support collaborative practice and education. The intent of the *Collaborative Practice and Education Framework for Change* (Framework) is to bring these efforts together into a single model with a common vision and set of principles. By aligning and co-ordinating current and future initiatives, system changes toward collaborative practice will grow and be sustained. A common vision will:

- › Advance collaborative practice as a way of improving health outcomes through the provision of safe, high quality person-centred health care services and collaborative education as a way of learning to provide those services;<sup>23</sup>
- › Set the direction for current and future initiatives at all levels of change, from high-level health system work to local-level work in practice and education settings; and
- › Provide encouragement for individual behavioural change toward collaboration with a focus on person-centred care.
- › Supporting health sector management, educators, regulators and government to remove barriers to collaborative practice;
- › Educating current and future health care workers, faculty and preceptors on developing skills to engage in collaborative practice;
- › Aligning regulatory policies and practices, human resources and other administrative and organizational policies to support change; and
- › Supporting applied and evaluative research to promote evidence-based practices.

A second purpose behind the Framework is to lay out a change agenda and Workplan to identify and implement collaborative practice initiatives that will enable high quality, safe, person-centred care. The Framework and accompanying Workplan that contains actions for change will not replace collaborative work currently underway; rather, they are intended to sustain existing work and support future efforts by:



# DEFINING THE PRINCIPLES

## and Vision for Collaborative Practice and Education

Collaborative practice is an approach that enables health care providers to deliver high quality, safe, person-centred services to achieve the best possible individual health outcomes. Collaborative practice is not the goal in and of itself; rather, it is a means to move the system to a higher level of quality and safety while maintaining a focus on the needs of the individual seeking health services.

The following value proposition statement was derived from a November 17, 2011 Collaborative Practice and Education Stakeholder Engagement Symposium in Edmonton, Alberta. It reflects the benefits of collaborative practice for Albertans receiving health care services.

*Collaborative practice is about teams of providers you can trust to communicate with you, and work together to ensure that you get the best possible care from the appropriate providers, when you need it. You are the most important member of the health team.*

As part of a health care system that uses collaborative practice where and when it makes a positive impact on the provision of care, health care providers<sup>24</sup> will develop competencies for collaborative practice and will demonstrate the principles of collaboration through their actions:

- › Health care providers will give person-centred care by focusing on the needs of individuals and will work collaboratively with them to achieve the best possible outcomes. This collaboration will include the individual's network of family, caregivers and support.
- › Decisions will be made jointly by health care providers, individuals, their families and caregivers.

- › Health care providers will form a partnership with individuals, their families and caregivers based on trust, open communication and the sharing of information.
- › Health care providers will interact with each other, individuals, their families and caregivers in ways that preserve dignity and build respect. Health care providers will honour the individual's choices and recognize each individual's unique circumstances.
- › Health care providers will share accountability in a just and equitable work culture.
- › Health care providers will know their own role and scope of practice, will understand and respect the scopes of practice of all other health care providers and will value all contributions to individual care.

The vision for collaborative practice is:

*Health care providers in Alberta deliver the highest quality of safe, person-centred care by collaborating with each other and with individuals, their families and caregivers.*

Figure 1 shows the vision and principles of health care provider, individual, family and caregiver collaboration.

Figure 1. Vision and principles of collaborative practice



## Defining Collaborative Practice

The term *interprofessional* is found commonly in the literature and has achieved acceptance; however, we choose to use the broader term *collaborative*. The term *collaborative* recognizes that Alberta's health workforce is comprised of non-regulated workers as well as regulated, professional workers and that the individual seeking health services is a central member of the team. As defined by Way, Jones and Busing, collaboration is a "process of communication and decision-making that enables the separate and shared knowledge and skills of health care providers to synergistically influence the client/patient care provided."<sup>25</sup>

## Defining Person-Centred Care

We choose to use person-centred care as synonymous with patient-centred or client-centred care in recognition that not all individuals who access the health system are patients or clients.<sup>26</sup> Person-centred care is defined by the individual's experience of "transparency, individualization, recognition, respect, dignity, and choice in all matters, without exception, related to one's person, circumstances, and relationships in health care".<sup>27</sup> Person-centred care is grounded in a collaborative relationship between health providers and the individual in which the individual and their family members or caregivers act as collaborative partners as far as they are willing and able to do so. This

collaboration provides individuals with “access to the knowledge and skills of team members to arrive at a realistic team-shared plan of care and access to the resources to achieve the plan”.<sup>28</sup>

*Collaborative education is a key strategy for instilling the values and competencies of collaboration in health care providers.*

## Defining Collaborative Education

Collaborative education is a key strategy for instilling the values and competencies of collaboration in health care providers. Collaborative education occurs when learners from two or more health programs or disciplines “learn about, from and with each other to enable effective collaboration and improve health outcomes”.<sup>29</sup> This definition can be applied to post-secondary education for new providers and to continuing education for current providers. It is important to note that collaborative education is not simply a matter of putting learners from different health sector programs together in a classroom; rather, true collaborative education requires interaction and the opportunity to collaborate in the provision of health services.



# THE APPROACH

## for Change in Alberta

In June 2009, the Government of Alberta brought together over 100 leaders from post-secondary institutions, health sector employers and professional colleges at a symposium on collaborative education. The primary objective was to develop a shared direction and model to enhance collaborative practice and education in Alberta. The resulting symposium report formed the basis of this Framework.

Symposium participants recognized that the work ahead requires leadership from all sectors, not just education. Consequently, the Collaborative Practice and Education Steering Committee (CPESC) was formed with representatives from post-secondary institutions, health sector employers, professional colleges and government to set the direction for collaborative practice and education in Alberta through a collaborative, joint process. The CPESC will oversee and guide change toward collaborative practice in Alberta through implementation of the Framework (see Appendix B for CPESC membership list).

The achievement of person-centred, collaborative practice requires changes within and between practice, learning and regulatory environments. The following principles describe how system changes will be undertaken and supported by the CPESC through the Framework.

### Principles for Change

- › The CPESC will model collaboration in the approach to change among practice, learning and regulatory environments, while considering the needs and circumstances of individuals, their families and caregivers.
- › The needs of individuals seeking health services are at the forefront of health service delivery and will be the focal point for decisions on changes to support collaborative practice to enable high quality, safe health services.

*The achievement of person-centred, collaborative practice requires changes within and between practice, learning and regulatory environments.*

- › It is recognized that collaborative practice is not a “one size fits all” approach. Collaborative practice will take different forms depending on the practice context, setting and the nature of the individual’s needs.
- › Process and procedural changes will be developed and applied when there are identifiable and expected benefits to health outcomes and safety.
- › Collaborative practice and education tools and supports will be practical and relevant for provider use.
- › The Alberta model will be informed by current and future models developed by international, national and provincial organizations. Adoption of existing work will be given priority over development of new initiatives.

## Audience of Change

The target groups of interest for collaborative practice include all current health providers, both regulated and non-regulated, as well as management-level staff in the practice environment; learners, faculty, preceptors and senior administrators in the learning environment; senior administrators, health professionals and government representatives involved in the regulatory environment; and individuals, their families and caregivers, and communities.

## Collaborative Practice Competencies

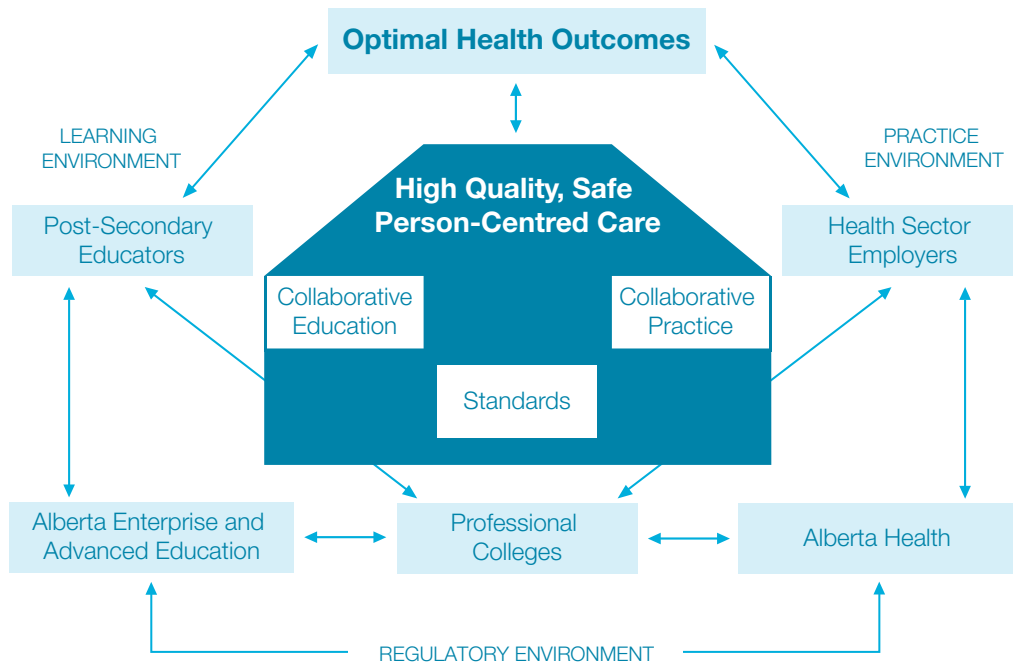
One of the grounding mechanisms that will support the principles of collaborative practice and the consistency of changes across practice, learning and regulatory environments is a unifying set of collaborative practice competencies that create a standard of behaviour required by all health providers. The CPESC has adopted the *Interprofessional Competency Framework* released by the Canadian Interprofessional Health Collaborative (CIHC) as the set of competencies that will be used in Alberta.<sup>30</sup> Adoption means that the competency domains in the framework will be the standard to which all current and future collaborative practice and education initiatives (including educational curricula) in Alberta will be aligned.

Most health disciplines use a competency profile to describe the skills, knowledge and behaviours required for practice. Although many profiles acknowledge the importance of collaborative practice, not all of them explicitly incorporate collaborative practice competencies. The CIHC intended that the *Interprofessional Competency Framework* would serve as a set of competencies to guide collaborative practice and education across all health disciplines and across Canada. The following set of six domains is quoted from the competency framework (a model of the framework is shown in Appendix C).<sup>31</sup>

*Most health disciplines use a competency profile to describe the skills, knowledge and behaviours required for practice.*

1. **Role Clarification** – Learners/practitioners understand their own role and the roles of those in other professions, and use this knowledge appropriately to establish and achieve patient/client/family and community goals.
2. **Individual/Client/Family and Community-Centred Care** – Learners/practitioners seek out, integrate and value, as a partner, the input and engagement of the patient/client/family/community in designing and implementing care/services.
3. **Team Functioning** – Learners/practitioners understand the principles of team work dynamics and group/team processes to enable effective interprofessional collaboration.
4. **Collaborative Leadership** – Learners/practitioners understand and can apply leadership principles that support a collaborative practice model.
5. **Interprofessional Communication** – Learners/practitioners from different professions communicate with each other in a collaborative, responsive and responsible manner.
6. **Interprofessional Conflict Resolution** – Learners/practitioners actively engage self and others, including the individual/client/family, by positively and constructively addressing disagreements as they arise.

Figure 2. Stakeholder involvement in health system change toward collaborative practice



## Models for Change

Figure 2 shows how the regulatory, learning and practice environments interact to enable collaborative practice through collaborative education. Starting at the base of the triangle, the *regulatory environment* is comprised of professional colleges and the Government of Alberta departments of Health and Enterprise and Advanced Education (EAE). The professional colleges set standards of practice and competencies for their members to become licenced and maintain licensure often in alignment with the general direction of national associations who may control access to licensure examinations and national competency profiles. Government also sets the policy direction and standards for post-secondary education (EAE) and health service delivery (Alberta Health) and together the two departments facilitate collaboration among the systems.

The *learning environment* is centred on post-secondary institutions as they develop educational programming to meet the requirements set by national associations, accreditation standards, employers, competencies, professional colleges, educational standards and policy direction from EAE. Health education programs are specific to each discipline but there are opportunities to foster collaboration among learners from different programs through classroom and practicum learning. Health sector employers also play a role in the learning environment as they provide in-service education and professional development programs to their staff.

Health sector employers (including publicly funded and privately funded) are the hub of the *practice environment* as they determine models of care in response to people's needs and with consideration

Figure 3. A model for achieving high quality, safe, person-centred care through collaborative practice and education



given to the standards and health care policy set by Alberta Health and the standards and scopes of practice for different health providers. The practice and extent of collaboration is determined by models of care, practice settings and individual needs. Current and future health providers are all learners in the context of providing services collaboratively. Individual health providers act as agents of change through their own collaborative behaviours while system supports for collaboration are developed. Individuals, their families and caregivers are central participants in the collaborative process of providing person-centred services. Ultimately, the goal of the model is to improve health outcomes through increased safety and quality of care.

Figure 3 presents a change model to achieve high quality, safe, person-centred care through collaborative practice and education. Structures within practice, learning and regulatory environments require change to move the overall health system toward collaborative practice. Desired outcomes from changing the practice environment include: collaborative workers and collaborative practice environments; collaborative graduates in learning environments; and collaborative members in the regulatory environment. Ultimately, these outcomes are contributors to increasing the quality and safety of care in the interest of achieving the best possible health outcomes. As described below, areas of change are parallel across the three environments.



*The vision and principles have been developed by the CPESC based on prior consultation with stakeholders and extensive research.*

A fundamental starting point for change in all environments is dissemination of the agreed upon vision and principles for collaborative practice and education. These will build a foundation for change at organizational and individual levels. The vision and principles have been developed by the CPESC based on prior consultation with stakeholders and extensive research. In order for individuals to gain the most from being partners in the collaborative process, health providers will need to understand and share the vision and principles of collaborative practice with individuals, their families and caregivers.

Each environment will need to develop key leaders in accordance with the CIHC competency domains. These leaders will facilitate change and model collaborative practice behaviours. To begin the change process, the main focus in practice environments will be on developing management staff and then providers. In the learning environment, the focus of development will be on faculty and preceptors. Regulators will start by focusing on all players involved in developing regulations, policies and standards. Later in the change process, the regulatory focus will shift to members engaged in life-long learning through continuing competency requirements that support collaborative practice. Providers will need to exercise their competencies in

interactions with each other, individuals, families and caregivers to focus on the individual's needs and deliver the appropriate services in accordance with individual choices.

Each organization will need to review the way it does its main business to ensure it reflects a focus on individual needs through collaborative practice. In practice environments, clinical services will need to be re-structured to support a person-centred, collaborative, team-based perspective. In learning environments, educators will need to review curricula and the learning context to align with the expectations of the practice environment. Regulators will need to ensure that standards of practice, codes of ethics, regulations, etc. all reflect collaborative practice.

Change will not occur or be sustained without the alignment of policies and other supports within workplaces, educational institutions and regulatory bodies. This alignment will remove barriers and create opportunities for key players to continue building collaborative practice environments. In all three environments, many of these structures currently exist and may require only minor changes to be aligned.

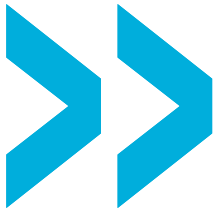
In addition to the areas of change described above, there is an overarching context that applies to the environments involving accreditation, research and evaluation. Accreditation standards for service providers and educators are a key context for organizations involved in providing services, educating providers or regulating the system or providers. Alignment with, and influence on, the work of groups such as Accreditation Canada and the accrediting bodies for education programs is critical to ensuring that competing goals are not inadvertently created.

*Evaluation is important for continuous improvement of planned programs, practices and tools.*

Research and evaluation are integral to system change. In all three environments, research contributes by helping change leaders and providers examine practices and tools for effectiveness in supporting collaboration. Evaluation contributes to overall system change by helping change leaders and providers understand why and how the system changed. It helps to identify what really works in each environment and practice context and, consequently, where to put

resources. Developing an evaluation framework will be a future action incorporated into the implementation of the Framework and Workplan. Examples of the types of metrics to capture important indicators of success could include improvements in the quality of health services as a result of collaborative practice and the nature and magnitude of workforce impacts attributed to collaborative practice.

Evaluation is important for continuous improvement of planned programs, practices and tools. When implemented early, evaluation methods can also be used to capture emergent change, meaning the effects of change that only emerge once the initiative has started. A key aspect of this Framework is to address and support research and evaluation activities early and to create an environment where ongoing research and evaluation becomes part of the way work is done. A dissemination infrastructure will be critical.



# A WORKPLAN FOR CHANGE

The CPESC's objective is to improve the quality and safety of health care in Alberta through collaborative practice and education. Based on the model shown in figure 3, the CPESC has identified an initial set of change actions in a multi-year Collaborative Practice and Education Workplan for Change (separate document). A high-level list of these actions is shown in Appendix D, which lays out the actions in the form of initiatives that stem from the change areas identified in figure 3. The initiatives are grouped into two categories: those that build upon the foundation of collaborative practice and education activities already underway, and those that maintain the momentum. Details on deliverables, milestones, timelines, resources and evaluation methods will be identified for individual initiatives separately.



## NEXT STEPS

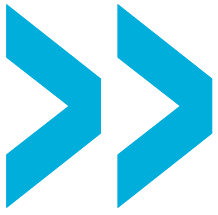
### for the Future of Collaborative Practice and Education

Alberta is taking steps to make positive health care system changes in order to increase access, improve quality and ensure its sustainability for the future. At the heart of these changes is the shift toward person-centred care with a renewed focus on safe health services. High quality, safe, person-centred care cannot be realized without collaboration and teamwork among health providers, individuals, their families and caregivers.

In person-centred service delivery, the individual will be engaged as a partner on the care team to provide input, communicate expectations, hopes and concerns, participate in health care planning and make decisions about services to be provided. For some people and their families and caregivers, this will be a significant shift in how they interact with the health system. Moving to collaboration will require changes in workforce skills and how those skills are learned by all providers – both current and future. Educators will need to align curricula on models of care so they are educating current and future health care providers in the skills, values and competencies that are required by their employers, regulators and government standards. Organizational and regulatory policies, standards and regulations will need to be structured and aligned to support changes in individual behaviour.

*Moving to collaboration will require changes in workforce skills and how those skills are learned by all providers – both current and future.*

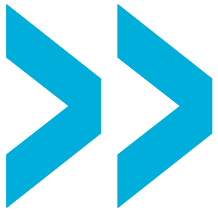
Changing Alberta's health system is a work in progress and the changes being made now and in the future will result in improved health outcomes if Albertans, educators, employers, regulators and government work together.



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23. Person-centred is used to denote a number of descriptors that are used interchangeably – patient-centred, client-centred, patient- and family-centred. As in the MACH report (see note 17 above), the term person-centred recognizes that people who engage the health system are not always patients or clients.
24. Health care provider is used to denote all health care workers including regulated professionals and non-regulated workers.
25. Way, D., Jones, L., Busing, N. (2000). *Implementation strategies: Collaboration in primary care: Family doctors & nurse practitioners delivering shared care*. Toronto: The Ontario College of Family Physicians.
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31. Ibid. p. 11.



# GLOSSARY

## of Common Collaborative Practice Terms

Term	Definition	Source
Collaboration	An interprofessional process of communication and decision-making that enables the separate and shared knowledge and skills of health care providers to synergistically influence the client/patient care provided.	Way, D., Jones, L., Busing, N. (2000). Implementation strategies: Collaboration in primary care: Family doctors & nurse practitioners delivering shared care. Toronto: The Ontario College of Family Physicians.
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 all professionals.	Health Canada. (2003). <i>Interprofessional Education for Collaborative, Individual-Centred Practice</i> .
Competency	A complex 'know act' that encompasses the ongoing development of an integrated set of knowledge, skills, attitudes, and judgements enabling one to effectively perform the activities required in a given occupation or function to the standards expected in knowing how to be in various and complex environments and situations.	McNair, R. P. (2005). The case for educating health care students in professionalism as the core content of interprofessional education. <i>Medical Education</i> , 39: pp 456-464.
Interprofessional competencies	Describe the complex integration of knowledge, skills, attitudes, values, and judgements that allow a health provider to apply these components into all collaborative situations. Competencies should guide growth and development throughout one's life and enable one to effectively perform the activities required in a given occupation or function and in various contexts.	Canadian Interprofessional Health Collaborative. (2010). <i>A National Interprofessional Competency Framework</i> . Accessed at <a href="http://www.cihc.ca/files/CIHC_IPCompetencies_Feb1210.pdf">http://www.cihc.ca/files/CIHC_IPCompetencies_Feb1210.pdf</a>
Interprofessional Education	Occasions when two or more professions learn from and about each other to improve collaboration and the quality of care.	Centre for the Advancement of Interprofessional Education (CAIPE). (1997). <i>Interprofessional Education - A Definition</i> . London.
Teamwork	Is the process whereby a group of people, with a common goal, work together, often but not necessarily, to increase the efficiency of the task in hand.	Freeth, D., Reeves, S., Koppel, I., Hammick, M., & Barr, H. (2005). <i>Evaluating Interprofessional Education: A Self-Help Guide</i> . Accessed at <a href="http://www.health.heacademy.ac.uk/publications/occasionalpaper/occp5">http://www.health.heacademy.ac.uk/publications/occasionalpaper/occp5</a>



# APPENDIX A

## Alberta Quality Matrix for Health

Dimensions of Quality	Description
<p><b>Acceptability:</b> Health services are respectful and responsive to user needs, preferences and expectations.</p>	<p>This dimension includes qualities such as compassion, empathy and responsiveness and refers to care and service that establishes a partnership between providers, patients/clients and their families (when appropriate) to ensure decisions respect patient/client wants, needs and preferences. It also means patients/clients have the information and support they need to make decisions and participate in their own care.</p>
<p><b>Accessibility:</b> Health services are obtained in the most suitable setting in a reasonable time and distance.</p>	<p>This dimension is characterized by smooth and continuous flow through the areas of need and stages of care within an area and by co-ordination across services and providers for specific or diverse problems. It means getting needed care and minimizing unnecessary delays.</p>
<p><b>Appropriateness:</b> Health services are relevant to user needs and are based on accepted or evidence-based practice.</p>	<p>This dimension is viewed primarily from the user’s perspective but is also viewed from that of the health care provider. Quality health care includes selecting the intervention that is most likely to produce the optimal results. It is based on individually assessed needs, risk factors and costs. It requires that providers of care avoid overuse (i.e. providing a service in circumstances where the potential for harm exceeds its potential benefit) as well as underuse (i.e. failure to provide a service when it would have produced a favourable outcome for a patient/client). It means that “people get the care they need” and “need the care they get.”</p>
<p><b>Effectiveness:</b> Health services are provided based on scientific knowledge to achieve desired outcomes.</p>	<p>This dimension is viewed primarily from the provider’s perspective but is also viewed from that of the user. Health care services are provided using evidence-based science and accepted practices that lead to improved outcomes in terms of health status and quality of life. It requires continuous monitoring and evidence of the results of care to know which services are likely to be effective and to use this information to improve care for all patients/clients.</p>
<p><b>Efficiency:</b> Resources are optimally used in achieving desired outcomes.</p>	<p>Efficiency is about using resources wisely, including eliminating or avoiding waste. Concern for efficiency addresses short- and long-term value for money, and includes both the resources of the individual, family or community and the health system.</p>
<p><b>Safety:</b> Mitigate risks to avoid unintended or harmful results.</p>	<p>Patients should not be harmed by the care that is intended to help them. Safety means designing and implementing health care service delivery processes to avoid, prevent and improve preventable adverse outcomes.</p>

Source: Health Quality Council of Alberta (2005). Alberta Quality Matrix for Health. Calgary, Alberta, Canada





# APPENDIX B

## Collaborative Practice and Education Steering Committee Membership

The Collaborative Practice and Education Steering Committee (CPESC) was comprised of senior representatives of the health service delivery sector, post-secondary institutions, professional regulatory colleges and the Government of Alberta and reported to Glenn Monteith, Assistant Deputy Minister of Health Workforce, Alberta Health and Connie Harrison, Assistant Deputy Minister of Post-Secondary and Community Education, Advanced Education and Technology (now known as Enterprise and Advanced Education).

### Committee members were:

**Paula Burns** - Vice President Academic and Provost, Northern Alberta Institute of Technology (Co-Chair)

**Crista Carmichael** - Director, Education and International Workforce, Alberta Health (Co-Chair)

**Linda Mattern** – Executive Lead, Health Workforce, Alberta Health (previous Alberta Health Co-Chair when in the role of Executive Director, Workforce Policy and Planning)

**Jasvinder Chana** - Director, Primary Care, Alberta Health

**Jane Drummond** - Vice-Provost, Health Sciences Council, University of Alberta

**Charlene McBrien-Morrison** - Executive Director, Health Quality Council of Alberta

**Dianne Millette** - Registrar, College of Physiotherapists of Alberta

**Betty-Lynn Morrice** - Vice President, Health Professions Strategy, Alberta Health Services

**Sheli Murphy** - Vice President and Senior Operating Officer, Covenant Health

**Pam Nordstrom** - Director, School of Nursing, Mount Royal University

**Thuy Pade** - Manager, Primary Care, Alberta Health

**Lynn Redfern** - Director, Policy and Practice, College and Association of Registered Nurses of Alberta

**Laura Schneider** - Manager, Health Programs, Alberta Enterprise and Advanced Education

**Trevor Theman** - Registrar, College of Physicians and Surgeons of Alberta

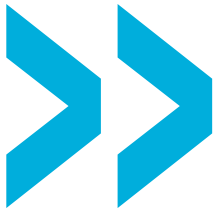
**Dale Wright** - Quality and Safety Initiatives Lead, Health Quality Council of Alberta.

### Support to CPESC was provided by:

**Megan Harder** - Workforce Analyst, Alberta Health

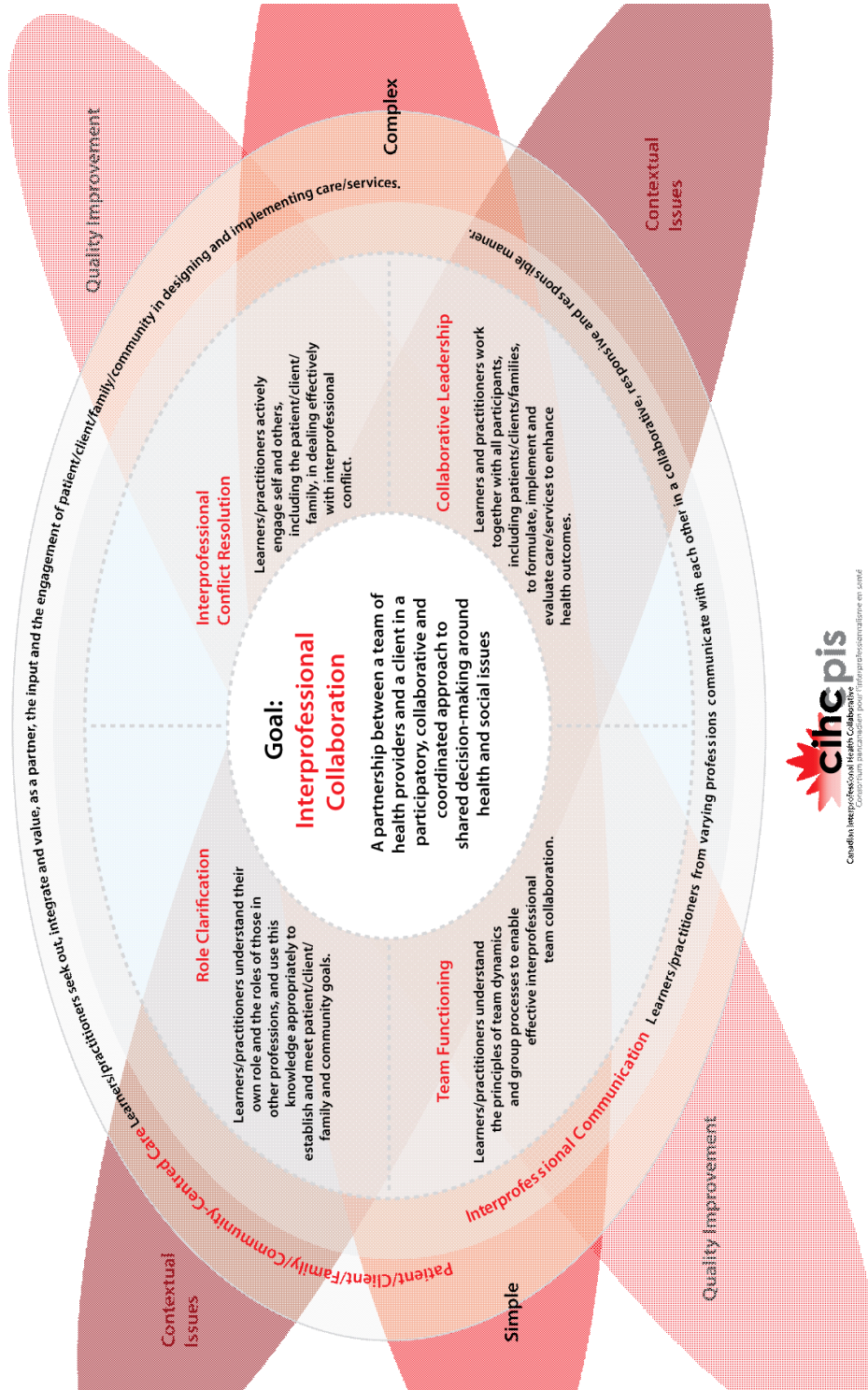
**Gerald Karegyeya** - Workforce Analyst, Alberta Health

**Alisha Petryshyn** - Workforce Analyst, Alberta Health

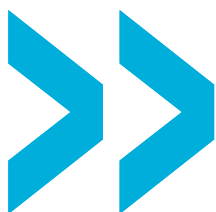


# APPENDIX C

## National Interprofessional Competency Framework



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# APPENDIX D

## Collaborative Practice and Education Workplan for Change Highlights

The Collaborative Practice and Education Steering Committee Overview	
<b>Building Upon the Foundation (Actions 1-10)</b>	
Action 1	Form the Collaborative Practice and Education Steering Committee (CPESC)
Action 2	Identify collaborative practice competencies and adopt/adapt a common core competency framework to support collaborative practice
Action 3	Develop an engagement strategy
Action 4	Develop a communications plan
Action 5	Engage individuals receiving health care services, their families and care givers
Action 6	Establish an implementation coordination structure
Action 7	Develop a collaborative practice change leadership program applicable to leaders in practice, learning, regulatory, and government settings
Action 8	Develop methods to identify and gather barriers to and enablers of collaboration that are responsive to the care setting and the health system
Action 9	Establish an evaluation framework for system change
Action 10	Create a research agenda
<b>Maintaining the Momentum (Actions 11-21)</b>	
Action 11	Review compensation models for different health providers
Action 12	Structure health care services to support collaboration (practice settings take the lead)
Action 13	Encourage continuous learning opportunities for health service providers
Action 14	Develop methods to inform health providers about other team members
Action 15	Promote understanding of roles, responsibilities, scope, and practice across the regulatory community to maximize collaborative practice
Action 16	Provide faculty development opportunities
Action 17	Develop preceptors
Action 18	Engage students
Action 19	Structure and align health sector curricula for post-secondary programs with practice
Action 20	Align learning environment, administrative policies, structures, and funding to support collaborative practice
Action 21	Align organizational policies, structures, and supports across multiple settings

