Developing and Sustaining Interprofessional Health Care: Optimizing patient, organizational, and systems outcomes
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Executive Summary

Developing and Sustaining Interprofessional Health Care: Optimizing patient, organizational, and systems outcomes

Within the RNAO best practice guidelines, there is a BPG on collaborative practice among nursing teams which is fundamental to nurses working as a team. Recognizing that nursing teams need to function collaboratively, the BPG also reinforces the need for interprofessional teams to function collaboratively. With a broader focus and interface between professions and practitioners, utilizing their full scope of practice is needed to benefit the patient. This signals the need for an evolution of multidisciplinary teams into a model of collaborative interprofessional care.

The need for an IPC Guideline

The development of an interprofessional care best practice guideline serves to provide a repository of the best available evidence on a specific topic in one location in a format that is usable by direct care providers, administrators, and educators and fills a void which currently exists.

In spring 2011, the Registered Nurses Association of Ontario convened a panel of healthcare practitioners to discuss the need for a Best Practice Guideline (BPG) that focused on Interprofessional Care. The panel consisted of individuals with expertise in professional practice, education, and research within the topic of Interprofessional Care (IPC). The panel developed consensus on the scope and major purpose of the Interprofessional guideline and research with a focus on quality outcomes for patients/clients, teams, organizations and systems.

IPC contributes to patient care and improve outcomes

Current evidence about interprofessional care was accessed, appraised, and utilized for the IPC Guideline. The intent is that this Guideline will contribute to the overall improvement of patient care and the efficiency of the healthcare system.

Interprofessional care is defined as: The provision of comprehensive health services to patients by multiple health caregivers who work collaboratively to deliver quality care within and across settings. [Interprofessional Care Steering Committee, Health Force Ontario, July 2007, p. 44].

Interprofessional models of care have recently been gaining attention as the healthcare system seeks a model that emphasizes the benefits for patients and the system. In Ontario, the Interprofessional Care: a Blueprint for Action in Ontario was released in [year] to support and encourage the adoption of IPC. The expanded scope of practice and incentives recently extended to Nurse Practitioners and Pharmacists is an example of an IPC initiative that encourages the move to these models.
Key findings from the literature to support IPC

Several models of IPC have been described in the international literature including:
- case management
- multidisciplinary teams
- primary health care teams
- nurse/physician tandem practice
- shared care
- nurse-led multidisciplinary teams

There are numerous strategies to enhance IPC, some of which are presented in Table 1. Although the methodological quality of the studies was generally weak regardless of study design, these models and interventions contributed to optimal client satisfaction and health outcomes such as reduced mortality, decreased number of admissions, improved symptoms and health outcomes, improved disability, improved activity and participation in management options, improved quality of life, prevention of problems, improved patient safety, improved client and family satisfaction, and patient empowerment. Similarly IPC contributed to provider satisfaction, effective team functioning, and integration of care outcomes, such as improved provider attitudes, improved role clarity and shared understanding, increased provider clinical confidence and satisfaction, decreased job demands, greater team decision-making power, flexibility and creativity, positive relationships, and improved communication. And finally, IPC contributed to effective organizational and system outcomes, such as decreased healthcare costs, decreased length of stay, decreased nurse turnover rates, reduced process-related delays and waiting times, improved quality care indicators, improved continuity of care, decreased use of medical resources, and improved access to care.

Table 1

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<th>Strategies to Enhance Interprofessional Care</th>
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<td>1. Interdisciplinary rounds</td>
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<td>2. Case conferences</td>
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<td>3. Team briefings and team meetings</td>
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<td>4. Multidisciplinary staff education</td>
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<td>5. Team-building training</td>
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<td>6. Multidisciplinary quality improvement</td>
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<td>7. Morbidity and mortality rounds</td>
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<td>8. Self-assessment audits</td>
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Recommendations

The overall goal of this guideline on Interprofessional care is to provide recommendations for systems, organizations, teams, and individuals, who are seeking to improve patient care by moving to a culture of IPC or who are seeking additional support for IPC teams.

Using a systematic process of reviewing the relevant research; holding consultations via focus groups, in-person, and teleconference style meetings; and stakeholder consultation, the Panel developed several recommendations for healthcare organizations, teams, individuals, and the healthcare system. The
meetings and discussions also led to the development of a conceptual model for Interprofessional care. The model that was adapted from the National Competency Framework for IPC and the Healthy Work Environment Framework to guide the development of a culture of IPC and assessment of interprofessional competencies. The core of the model provides six key domains that frame the recommendations for the effective implementation of IPC. These domains are:

1. Care Expertise
2. Shared Power
3. Collaborative Leadership
4. Optimizing Profession/Role/Scope
5. Shared Decision Making
6. Effective Group Functioning

These six domains have competent communication embedded in each and are supported by the three overarching tenets from the RNAO Healthy Work Environment (HWE) model:

1. Policy, Physical, Structural Components
2. Professional/Occupational Components
3. Cognitive/Psychosocial/Cultural Components

This guideline supports and aligns with the Ontario Ministry of Health and Long-Term Care direction of developing processes, and tools that will allow interprofessional care to be practiced and organized in a systematic way. This guideline also responds to the request of nurses who are seeking additional information regarding IPC to complement the BPG on collaborative nursing practice.
Conceptual Model for Developing and Sustaining Interprofessional Care

Healthy Work Environment

- Competent Communication
  - Is clear, focused, transparent and respectful
  - Constructively manages conflict
  - Maintains and enhances the relationship

- Cognitive/Psycho/Social/Cultural Components

- Shared Power
  - Creating balanced power relationships
  - Leveraging opportunities for all team members to contribute
  - Contributes to healthy work environment

- Policy/Physical/Structural Components

Care Expertise

- Patient/Client are full participants in their own care
- Encompasses specific, coordinated, and objective knowledge as dictated by the complexity of the patient/client need
- Greater complexity may dictate a need for coordination of specialized expertise

- Professional/Occupational Components

Effective Group Functioning

- Group members assess, practice and reflect upon effective group processes
- Collaborate together to formulate, implement and evaluate care
- Intentionally engage to formulate, implement and evaluate care

- Shared Decision Making
  - Developing structures and processes to support shared decision making
  - Reflect the priorities
  - Communicate and implement with respect of the context and the contributions of each team member within and across the team of care

- Optimizing Profession/Role/Scope
  - Demonstrate knowledge application of own profession/role/scope
  - Expanding and integrating roles of others
  - Optimizing interface to result in enhance care

- Quality & Safety Continuous Improvement/Enhancement

Goal:
Exemplary Interprofessional Care for Client/Patient and their Support Network

- Collaborative Leadership
  - Reflects shared accountability that addresses power and hierarchy
  - Utilizes structures and processes to advance exemplary care

*Adapted from the National Competency Framework and the RINAO Model for Healthy Work Environments for Nurses
Overview of Conceptual Model for Developing and Sustaining Interprofessional Care

The conceptual model for developing interprofessional health services presents exemplary interprofessional care for patients/clients delivered in a healthy work environment as a product of the synergy among healthcare teams who demonstrate expertise of the six key domains shown in the above model.

The primary goal illustrated as the core of the model is the provision of exemplary interprofessional care for patient/clients and their support network.

The model consists of six key domains:

1. Care Expertise
2. Shared Power
3. Collaborative Leadership
4. Optimizing Profession/Role/Scope
5. Shared Decision Making
6. Effective Group Functioning

The outer circle is the expected beneficiaries for the healthcare team and the organization, a healthy work environment with enhanced quality and safety improvement.

These six domains are supported by Competent Communication and the three foundational components from the HWE model:

1. Policy, Physical, Structural Components
2. Professional/Occupational Components
3. Cognitive/Psychosocial/Cultural Components

These domains are fundamental to transforming work environments from interdisciplinary models to a collaborative interprofessional environment. The three pre-disposing foundational components support and influence each domain to achieve the goal of exemplary interprofessional care for client/patient and their support network.

When successfully implemented and sustained, quality and safety continuous improvement occurs on three levels. These three levels are: the client/patient level, the interprofessional provider level & the system/organizational level.

Care Expertise

Interprofessional collaboration requires a collaboration between patient, their circle of care and healthcare professionals. Effective interprofessional collaboration among all participants is warranted in order for care expertise to be identified and implemented. Seeking and engaging specific care expertise for some patients, depending on the unique needs and complexity. Successful care expertise can lead to collaborative decision-making and collaborative practice. Quality indicators that are impacted are improved financial and long term outcomes and improved quality of life.
Patient care needs are determined following interprofessional assessment. This identifies what local expertise will be required to best meet that patient’s unique needs. Assessment, treatment goals and strategies should be individualized according to each patient and their circle of care. Care expertise should be collaborative and coordinated to find the “best” expert for the right patient needs. Policies, practices and structures enable all health providers to optimize their scope of practice. In order to provide optimal care expertise, a novice professional may elicit the services of an expert in the same profession. This delineates the need for expertise versus the need for competence. Additionally, in some cases there may be an overlapping of scope of practice.

When care expertise is directed to Alzheimer patients, interprofessional collaborative care has resulted in a reduction of behavioral and psychological symptoms of dementia (BPSD) and decreased depression and distress for caregivers.

The degree of care expertise that is needed is dictated by the complexity of the client/patient needs. The greater the complexity, may dictate a need for coordination of specialized expertise. An example is a simple sprained ankle for a recreational soccer player in comparison to a World Cup soccer player with an upcoming game, may have two different interprofessional teams to meet their needs. The recreational player’s care expertise may require one or two professionals with a minimal impact on their life. In contrast, this sprained ankle may have a disruptive impact on the life of a World Cup soccer player, necessitating additional care expertise of a team (psychological support and rehabilitation professionals) in addition to the care expertise that the recreational player utilized. Geographical location and local setting will also impact on the extent of care expertise that is readily available.

Shared Power

Willingness to share power is defined as a commitment to create balanced power relationships through democratic practices of leadership, decision making, authority, and responsibility (D’Amour, Ferrada-Videla, San Martin, & Beaulieu, 2005). Shared power requires a willingness or desire from each team member to leverage opportunities for others to fulfill their needs toward influencing patient care regardless of educational or professional preparation (Orchard et al., 2005). Through their willingness to share power, team members can contribute to a healthy work environment where all team members including the patient feel engaged, empowered, respected and validated (SJHC, 2009).

Collaborative Leadership

Collaborative leadership is a new leadership paradigm that has also been called reciprocals or shared leadership. This people- and relationship-focused leadership approach is based on the premise that answers should be found in the collective or the team. It is a group-centred approach that views all team members as partners, co-leaders, and collaborators (Allen et al., 2010). Collaborative leadership is based on six principles:

- Reflects shared accountability that addresses power and hierarchy
- Utilizes structures and processes to advance exemplary care
1. **Promoting a collective leadership process** that is based on the belief that at different times and depending on the need, situation, and requirements, different people assume the leadership role and there are times when the nominal leader might not even be visible (Greenleaf, 1991).

2. **Structuring a learning environment** that supports continuous self-development and reflection. The team members are encouraged to learn together and from each other, and to cultivate practices of open-mindedness, mutual trust, seeking constructive feedback, and viewing conflict as an opportunity for growth (Allen et al., 2010).

3. **Supporting relationships and interconnectedness** that value honesty, mutual respect, expecting the best from others, and the ability to exercise personal choice. Collaborative leadership focuses on facilitating the ability of the team to live those values towards a shared vision that allows people to set common goals and direction (Allen et al., 2010).

4. **Fostering shared power** that implies a shared responsibility and accountability for decision making and for learning. Power is found at the centre of the team rather than at the top of the hierarchy (McCallin, 2003).

5. **Practicing stewardship and service** focuses on ensuring that the interests and needs of others are being served rather than focusing on personal power and control (Block, 1993; Greenleaf, 1991).

6. **Valuing diversity and inclusiveness** implies respect for individual differences which will result in freedom to learn together and for the exercise of collective ownership (Allen et al., 2010; Rost, 1994).

### Optimizing Profession/Role/Scope

The Council of Federations (2012) identified team based models of health care as one of the three main priority areas for the Health Care Innovation Working Group. As part of their descriptor they identified the need for all health care professionals to work to their full scope of professional capacity. The National Interprofessional Competency Framework (CIHC, 2010) have identified that all practitioners must not only understand their roles but also understand the roles of other practitioners on the team. This competency also identifies the requirement for practitioners to articulate their roles, knowledge and skills and use effective listening skills with other members of the teams. The British Columbia Competency Framework for Interprofessional Collaboration (2008) additionally discussed the need for all practitioners’ to respect each other’s professional culture and values.

Overlapping scopes and roles need to be embraced and optimized as an opportunity to collaborate and advance the role of exemplary care for the client/patient and their support network.

### Shared Decision Making

Shared decision making is based on the premise that all team members, including the patient/client, has the opportunity to contribute his/her knowledge and expertise in order to collaboratively arrive at an optimal goal (Orchard et al., 2005; Mariano 1998)

Shared decision making requires respectful and trusting relationships among the health care providers, including with the client/patient. It necessitates that we acknowledge and respect the knowledge and expertise of all healthcare professionals, regardless of occupation and formal position. [Grinspun]. It requires acceptance that each team member “has both the right and ultimate responsibility to share knowledge in order to contribute toward a patient/client’s plan of care. (Orchard et al., 2005). Thus
shared decision making means that each member must be willing to accept responsibility for decision making.

Shared decision making is not appropriate in every situation. For example, in crisis or emergency situation such as during a “Code Blue,” a patient’s life depends on the person running the code to make unilateral decisions and direct the Code Blue Team quickly and decisively. However, in a shared decision making approach, all team members can participate in a review /debrief after the emergency situation is over to influence future decisions. There are also other situations in health care in which some team members are not provided with an opportunity for input. In these situations, what is most important is the transparency around decision making. Team members will feel valued and respected if they understand which decisions are shared and which decisions are not. Collaboration exists on a continuum, from least collaborative, in which team members may be told what decisions have been made without any opportunity for input, to most collaborative, in which teams can expect to co-create outcomes with maximum opportunity for input (The Fifth Discipline (1990), Peter Senge).

In shared decision making, health care decisions need not be made unanimously. Decisions may be made by one or more individuals, or by team consensus. What is important is that each member of the team, including the patient/client, is given an appropriate opportunity to influence the plan of care (Mariano, 1998).

Effective Group Function

The definition for effective group functioning in IPC is adapted from that provided by Oandasan et al. (2007): the successful interaction or relationship of an interprofessional health care team who work interdependently to provide care for patients/clients.

A healthcare system that supports effective teamwork can improve the quality of patient care, enhance patient safety, and reduce workload issues that cause burnout among healthcare professionals (Oandasan, et al., 2007). Effective team functioning is outlined in the CIHI National Interprofessional Competency Framework (2010) as an element of interprofessional collaboration, and is one of the six competency domains. In the Framework, the key competency for team functioning is that “learners/practitioners understand the principles of team dynamics and group processes to enable effective interprofessional team collaboration” (p.11). In this HWE model, the term “team” is replaced by “group” to draw attention to the notion of group process development and maintenance.

To support effective IPC group functioning, it is expected that group members assess, practice and reflect upon effective group processes. They are also expected to intentionally collaboratively engage to formulate, implement and evaluate care (CIHI, 2010; Oandasan, et al., 2007).

NB: Although we are defining this domain on an individual level: “Effective teamwork can only be achieved when all levels of the healthcare system work together” (Oandasan et al., 2007, p. iv).
Competent Communication

Competent communication encompasses all domains of interprofessional practice within the context of health care, reflecting openness, honesty, respect for each other’s opinions and effective communication skills (Humphreys & Pountney, 2006). Team goals of communication are achieved through effective sharing and responding to information in a timely manner, actively listening to other points of view, communicating clearly and succinctly, (Shaw, 2005) utilizing established communication processes and tools necessary for interprofessional collaboration (Mulkins et al., 2005). Effective communication enhances interprofessional relationships in the provision of patient/client care and other work related activities. Competent communication supports developing and sustaining leadership, actively and constructively engages members of the health care team while demonstrating respect and professionalism (RNAO HWE BPG).

Summary of Recommendations

The following recommendations were organized using the key concepts of the Healthy Work Environments Framework and therefore identify:

• System-based recommendations
• Organizational recommendations
• Individual/Team recommendations

System-based recommendations*

1.0 System-wide Partnerships across Organizational Boundaries/Sectors

1.1 Leaders of key agencies (e.g., governments, academic institutions, regulatory bodies, professional associations, and practice based organizations) within the broader system should purposefully collaborate to make IPC a collective strategic priority

1.2 Various agencies within the broader system should strategically align IPC with other initiatives pertaining to healthy work environments

1.3 IPC partnerships across organizations should commit to an evidence-based approach to planning, implementation, and evaluation for joint IPC activities

2.0 Power & Hierarchy

2.1 Willingness to acknowledge and share power across organizational boundaries by:
   a. Purposefully talking about power: be open to constructive and courageous conversations that examine inequities, privilege, and power differentials
   b. Building a collaborative inter-organizational environment through recognition of and understanding your power and its influence on others around you
   c. Creating balanced power relationships through democratic practices of shared leadership, decision making, authority, and responsibility.
   d. Including diverse voices in decision making within the context of your collaboration
   e. Sharing knowledge with each other and avoiding withholding or guarding information
   f. Creating safe collaborative spaces where everyone feels welcome
3.0 Academic Setting Recommendations

3.1 Academic settings build IPC knowledge and competencies into curriculum design

3.2 Special attention to accreditation standards that focus in particular on IPC

3.3 Academic settings support the culture required for IPC education by:
   a. Instilling the beginning values, skills and professional role socialization necessary for IPC
   b. Developing, implementing, and evaluating new education models that foster interprofessional values and skills within the professional education curricula
   c. Designing specific methods to enhance educational and clinical opportunities for joint learning of the health professions

4.0 Research Recommendations

4.1 Researchers partner with decision makers to conduct research that examines the impact of IPC on patient/client outcomes and on the impact on health care teams

4.2 Major health research granting agencies should develop and maintain a focus on IPC research priority areas

4.3 Use effective knowledge translation strategies, researchers support evidence-based practice by reporting research findings and outcomes back to funders, study participants, system-based decision maker partners (e.g., governments, professional associations, regulatory bodies, unions, health care organizations), and educational institutions.

4.4 Researchers use evidenced informed knowledge translation strategies to mobilize research findings to broad based stakeholders

5.0 Professional Associations/Regulatory Bodies/Unions

5.1 Professional Associations/Regulatory Bodies/Unions support IPC by:
   a. Specifically considering IPC when developing legislation and policies for their members
   b. Working together to develop joint competencies and standards for IPC
   c. Working together to add principles of IPC practice to their respective approval standards for educational programs
   d. Including IPC as a competency in licensure requirements
   e. Supporting IPC as a strategic priority
   f. Advocating for human and fiscal resources to empower their members to participate fully in IPC

6.0 Accreditation Organizations

6.1 Accreditation bodies for health care organizations and professional academic educational programs develop and integrate standards and specific performance indicators of IPC in their accreditation processes
7.0 Government

7.1 Governments support the culture required for IPC by:
   a. Developing, implementing and evaluating a strategic priority that focuses on IPC
   b. Allocating financial resources for health care organizations to develop, implement and evaluate IPC
   c. Developing structures to support IPC, including alternative funding mechanisms (e.g., staff and physician replacement to engage in IPC activities)
   d. Reviewing and developing legislation and regulations that break down professional silos in education and practice, promote full scope of practice, and discourage underutilization of health human resources.

Organizational recommendations

8.0 Shared Vision
Provider organizations commit to a shared vision that will enable the culture shift required for Interprofessional education, care and practice.

8.1 Organizations create a culture which enables practice-based Interprofessional care by:
   a. Ensuring that the goals and principles of interprofessional collaborative care (IPC) are aligned with the organization's values and that the IPC goals are a strategic priority that is fully integrated into corporate and service specific goals
   b. Ensuring structures and processes are in place to enable all health-care professionals to have shared roles in organizational and clinical decision making
   c. Ensuring the availability of required resources and infrastructures to facilitate staff training and development, effective and ongoing communication, and the development of relevant policies and guidelines
   d. Developing, implementing, and monitoring IPC-specific hiring and performance management measures and processes for ongoing evaluation/feedback
   e. Adopting, promoting and evaluating evidence-based patient/family/relationship-centred care models to improve patient satisfaction and health outcomes
   f. Introducing strategies to promote respect and build healthy work environments for all members of the health-care team, patients/clients and other stakeholders
   g. Creating safe shared Interprofessional physical and virtual environments which intentionally foster communication and innovation.
   h. Reviewing and responding to recommendations from accreditation bodies regarding IPC.

8.2 Acknowledging and Transforming Power & Hierarchy
The intentional surfacing of power and hierarchy is essential to realizing a shared vision and enabling practice-based Interprofessional care.

Organizations can do so by:
   a. Identifying situations where there is imbalance of power in health care related to for example; profession, role, status, reimbursement, meritocracy, working conditions, social bias, health status or need; and ensuring structural changes to equalize power bases to support mutually supportive and clinically safe IPC work environments
b. Ensuring that any disruptive individual behaviour is addressed in a timely manner through ensuring performance improvement processes that include attention to IPC competencies

c. Promoting best practice guidelines and related team education related to preventing and managing disrespect and violence, facilitating respectful communication and embracing diversity.

8.3 Development of Leaders and leadership throughout the system
The active engagement and development of leaders throughout the health care organization and of health professionals as leaders at the point of care is essential to the success of IPC.

Strategies which promote and deepen IPC leadership include:
   a. Developing IPC Champions within each profession, program and across programs to promote awareness, encourage involvement, address structural issues and guide implementation
   b. Providing in-house leadership courses and access to academic courses which introduce IPC concepts and strategies and employ IPE learning modalities to facilitate IPC competencies in care and management
   c. Engaging corporate and operations leaders in reforming compensation and fee structures, resource alignment and support for innovative models of care.
   d. Developing and enhancing academic partnerships to strengthen collaborative academic (education and research) leadership at the point of care.

9.0 Development of enabling corporate operational supports
Organizations develop and support policies and processes that promote IPC by ensuring dedicated time, space, adequate compensation, a plan to address power and hierarchy, a competency development program and expectation of collaboration.

Corporate and operations leaders and teams can promote and support IPC by:
   a. Establishing a human resources plan to allow for dedicated time and staff coverage/replacement for IPC activities.
   b. Committing educational and leadership development resources to develop, promote and evaluate IPC teams
   c. Specifically targeting a variety of external funding and learning opportunities to support IPC, establish best practices and evaluate models of care
   d. Considering co-location of professions as an option when developing buildings, spaces and care pathways.
   e. Considering interactive patient and team spaces to enhance opportunities for communication and innovation.
   f. Supporting virtual teams and teams across agency boundaries to promote integrated patient-centered care and care across distances (geographically dispersed team members utilizing technology).
   g. Adopting policies that support full scope of practice, and discourage underutilization of health human resources.
10.0 Interprofessional Education in a Life-Long Learning Organization

Organizations wishing to promote an Interprofessional care vision and culture need to provide Interprofessional Education (IPE) opportunities for staff and students throughout the organization and throughout their careers within the organization.

Interprofessional education promotion may include:

a. Providing dedicated time and resources for teambuilding and teamwork training for Interprofessional groups of healthcare providers
b. Supporting activities that promote understanding of professional roles

10.1 Communication Processes

10.2 Building effective communication within and across healthcare organizations by:

a. Establishing effective communication processes and tools to support opportunities for collaboration and communication among team members, within and across professions, with patients and across teams, programs and organizations
b. Adopting proactive strategies to address relational issues such as turf protection and disrespectful communication
c. Creating environments that promote regular formal and informal communication among team members such as team rounds, care conferences, etc.
d. Implementing strategies to promote IPE (strong evidence shows that IPE addresses barriers to collaborative practice and promotes competent communication)

11.0 Documentation

Organizations support shared standardized documentation systems that promote interprofessional communication, documentation, transparent decision-making and care planning that is evidence-base, transparent and accessible.

12.0 Model Adoption and Evaluation

- Systematically evaluating both the financial and patient outcomes of these specialized care environments to ensure goals and targets are met
- Service and academic organizations develop and implement a process to evaluate IPC models and impacts

Individual/Team recommendations

13.0 Commitment to IPC Teams & Care Delivery

13.1 Team members develop knowledge about the values and behaviours that impact of IPC on patient/client outcomes and support IPC. The IPC team establishes processes to:

a. Develop common goals and outcomes and measures for evaluation of team performance
b. Create a quality work environment that validates all contributions from team members
c. Support continuity of care for better patient outcomes and increased staff satisfaction
d. Clarify team members’ understanding of the unique and shared roles within the team and create common tools (e.g., integrated care pathways)
e. Implement individualized or “tailored” interprofessional care plans to improve coordination and communication of care between team members
13.2 All health care professionals (volunteers and students as appropriate) demonstrate principles and commitment to effective IPC Interactions by:

a. Practice and collaborate with team members and patients and families in a manner that fosters respect, trust and understanding and trust
b. Practice to their full scope and understand and demonstrate respect for the unique and shared competencies of other team members
c. Have a clear understanding of their own role and expertise, be confident in their own abilities, must recognize the boundaries of their scope of practice, be committed to the values and ethics of their own profession, and be knowledgeable of their own practice standards
d. Acquire the knowledge and competencies to effectively practice within an interprofessional environment
e. Engage in self-reflective practice and examine how one's behaviour, culture, and ethnic background impacts others and how others’ behaviours, cultures, and ethnic backgrounds impacts them
f. Engage in self-reflective practice that considers the historical and political rootsof power imbalances among health professionals
g. Contribute to the development of organizational strategies to support interprofessional practice models
h. Teams / individuals implement an individualized or “tailored” interprofessional care plan to improve coordination and communication of care between team members

14.0 Supporting the Development of IPC Culture

14.1 Individuals contribute to a culture that supports effective IPC by:

a. Initiating collaborative processes within the team that address “turf” issues and improve patient / client outcomes
b. Refraining from disruptive behaviour (i.e. actions such as gossiping, bullying, harassment, or socially isolating others)
c. Contributing to the development of organizational strategies to prevent, identify and respond to disruptive practitioner behaviour

15.0 Accountability

15.1 Individuals have accountability for maintaining effective communications with other members of the interprofessional health care team to promote team problem-solving, decision-making, conflict resolution and collaboration.

15.2 Individuals working in an interdependent relationship with other team members have a responsibility to manage conflicts in a constructive manner in order to produce a positive outcome
16.0 **Power & Hierarchy**

16.1 Team members demonstrate a willingness to acknowledge and share power among team members by:
   a. Purposefully talking about power: be open to constructive and courageous conversations that examine inequities, privilege, and power differentials
   b. Building a collaborative team environment through recognition of and understanding of power and its influence on everyone involved
   c. Create balanced power relationships through shared leadership, decision-making, authority, and responsibility.
   d. Inclusion of diverse voices for decision making
   e. Sharing knowledge with each other, openly
   f. Creating a welcoming space and environment that extends to all team members

16.2 Team members demonstrate a willingness to share power with patient and family by working collaboratively with the patient and circle of care in the planning and implementation of their health care plan.

17.0 **Interprofessional Education**

17.1 Individuals need to develop skill and competency in preceptorship, mentorship and facilitation of interprofessional learning opportunities

17.2 Individuals need to support the ongoing education needs of students