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Enabling Collaboration in Primary & Mental Health Care & Addictions through Interprofessional Care & Education

Healthcare Provider's TOOLKIT

September 2010

Practice Toolkit

Collaboration

EnHANCE Project Partners

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Healthcare Provider's **Practice Toolkit**

September 2010

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Welcome

Welcome to the *Provider's Practice Toolkit.* This toolkit is designed to support healthcare providers as they work in interprofessional ***teams*** across primary care, mental health, and addiction organizations, to deliver services to individuals with mental health and/or addiction needs. It is a companion to the *Leader's Practice Toolkit*, a resource that supports healthcare leaders and administrators to initiate, foster and maintain inter-organizational ***partnerships***.

Background

Working separately, healthcare organizations develop activities in isolation – sometimes competing with each other and/or duplicating effort and wasting valuable resources. As well, working independently may lead to the development of a 'blame culture' in which chaos or neglect is all too frequently regarded as 'someone else's fault'. The impact experienced by clients is costly, as client safety issues are associated with poor interprofessional and inter-organizational communication.

Everyone benefits when the collaborative system operates effectively. Effective inter-organizational partnerships help to ensure that developmental initiatives, in all fields (not just healthcare), are imaginative, coherent and integrated in a way that addresses the toughest challenges experienced by each community. Partnerships provide new opportunities for managing client-care, by recognizing the qualities and competencies of each sector/organization and finding new ways of harnessing these for the common good (Tennyson, 2003).

Interprofessional collaboration (IPC) among healthcare providers has been identified as a key strategy to improve client outcomes. National efforts such as the Canadian Collaborative Mental Health Initiative (CCMHI), and provincially, the Collaborative Mental Health Network (established by the Ontario College of Family Physicians) have inspired collaboration among healthcare providers, consumers, families and caregivers. Ensuring that clients with mental health and/or addiction needs have access to the appropriate services they need, requires us to work better together – both within and across organizations.

About EnHANCE Ontario

"EnHANCE Ontario was a multi-partner project with a vision of leading the development of inter-organizational partnerships and enhancing capacity for the delivery of collaborative and interprofessional care for people seeking access to services across primary care, mental health and addiction organizations in Ontario."

Community of Practices

EnHANCE Ontario has an online *Community of Practice* to support collective learning, foster regular interaction among members and permit the exchange of suggestions and resources. The *Community* is open to any individual who has an interest in inter-organizational partnerships, interprofessional collaboration, and client-centred care.

Join the *Community of Practice* by emailing info@enhanceontario.ca or visiting www.enhanceontario.ca.

About EnHANCE Ontario

Completed in August 2010, EnHANCE Ontario bridged education and practice settings to engage healthcare leaders and providers in learning about inter-organizational relationships and helping to facilitate new ways of thinking and new ways of working together in Ontario. The project targeted Family Health Teams (FHTs), Community Health Centres (CHCs), and the Community Mental Health and Addictions (MH&A) organizations they work with.

Learn more about EnHANCE Ontario, access research reports, education materials and resources, and join the *Community of Practice* by visiting: www.enhanceontario.ca.

EnHANCE Ontario Education Program

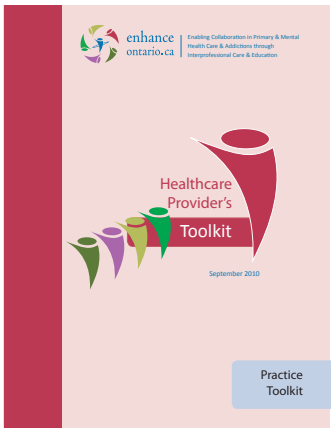
The content of the *Provider's* and *Leader's Practice Toolkits* are customized into educational learning opportunities for three target audiences, including healthcare leaders, providers and students. Intended to be easily adapted for your learning context, the ***interprofessional education*** (IPE) programs contain facilitator resources, participant resources, and practical learning exercises (e.g., case studies, client stories and reflective questions).

Community of Practice

EnHANCE Ontario has an online *Community of Practice* to support collective learning, foster regular interaction among members and permit the exchange of suggestions and resources. The *Community* is open to any individual who has an interest in inter-organizational partnerships, interprofessional collaboration, and ***client-centred care***. Join the *Community of Practice* by emailing info@enhanceontario.ca or visiting www.enhanceontario.ca.

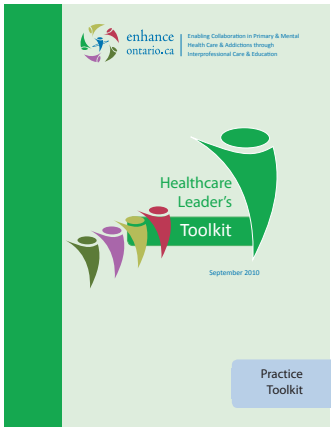
About the Toolkits

Are the toolkits right for you?



The *Provider's* and *Leader's Practice Toolkits* are designed to support inter-organizational relationships among healthcare leaders and providers. Said a different way, the toolkits are for people who work across FHTs, CHCs and MH&A organizations to either plan or deliver services to people with mental health and addiction needs. Both toolkits are specifically intended to bridge education and practice settings. While both toolkits spring from a similar body of knowledge, they each have their own focus.

The *Provider's Practice Toolkit* focuses on the competencies required by individual healthcare providers who practice and collaborate with colleagues in settings where inter-organizational partnerships (informal or formal) are in place.



The *Leader's Practice Toolkit* focuses on the specifics of partnering – that is, the process of creating, maintaining and continuously improving both informal and formal relationships between organizations using organizational agreements and structured monitoring processes. At the end of this toolkit, the *Inter-Organizational Partnership Framework* provides information, tools and templates for formalizing relationships among organizational partners.

How were the toolkits developed?

Review of the Literature

Prior to, and in preparation for, the development of the toolkits, a literature search was carried out to investigate the current state of scholarship related to ***inter-organizational collaboration***. Both peer-reviewed and 'grey' literature was considered. A search was done on the OVID; CINAHL; and PubMED databases for articles more recent than year 2000, and relating to Canada. The following search terms were used: inter-organization/organizational; inter-agency; collaboration; partnership; interprofessional collaboration; collaborative care; collaborative practice; network; service integration; and inter-organizational service agreements. Additional resources were discovered by investigating the bibliographies of the articles found by the search. Selection of articles focused primarily on literature reviews, but also included a variety of themes such as best practices, service level agreements, organization/partnership models, engaging community partners and evaluation. To help identify additional materials, a general search of the worldwide web was also undertaken, resulting primarily in the addition of toolkits, resources, and government reports to the literature under consideration.

Development and Review Process

The toolkits were developed using an iterative and collaborative process that reflected the vision of the EnHANCE Ontario Project. The project team and a working group guided the development and review process for the toolkits. Early drafts of the toolkits were piloted with focus groups, and shared at a number of meetings and academic conferences for feedback and revisions. Revised drafts were then shared with participants of the EnHANCE Ontario education workshops. An expert panel was created to guide the development of the *Inter-Organizational Partnership Framework*. This framework can help healthcare leaders decide if, when and how to foster both informal and formal inter-organizational partnerships. An invited group of experts from government, Local Health Integration Networks (LHINs), healthcare associations post-secondary education leaders, and researchers reviewed the final drafts of the toolkits. In total, nearly 300 individuals were exposed to the draft toolkits, representing healthcare leaders, providers, clients, policymakers, educators, and researchers. More than 50 individuals provided feedback on the format and content of the toolkits, helping to ensure these resources reflect the needs of the intended users.

What information will I find in this toolkit?

The main purpose of the *Provider's Practice Toolkit* is to answer the core question:

'How do I become a better interprofessional and inter-organizational collaborator?'

This toolkit provides background information, best practices, tools and resources to guide your decision making, while recognizing that every ***team*** and organization is unique and has its own challenges. While our knowledge about IPC and organizational partnerships is growing, specific research about inter-organizational IPC as it occurs in teams of healthcare providers who work across organizations is still in its early stages.

Frequently Asked Questions

The information is presented in a 'how to' format, as a collection of frequently asked questions (FAQs). You will need to select information, processes, tools, and resources that apply to your situation.

The FAQs are organized by three main themes:

1. Interprofessional Collaboration (IPC)
2. Inter-Organizational Partnerships
3. Inter-Organizational Interprofessional Collaboration

We have also provided a series of *Making it Work* stories, which are examples to help demonstrate the various concepts presented in the toolkit.

Some aspects of IPC and the organizational partnering process discussed in this toolkit are already summarized in available resources. Rather than repeat content that you can access in other valuable materials, you will find a short overview, and highlights of any additional best practices that have emerged since the publication of the existing tools or resources.

Self-Reflection

A series of questions are provided to help you and your team members reflect on your experiences, knowledge and skills. This information can be used to determine any next steps that you might want to take, including planning, developing or implementing educational opportunities to support your practice experience.

Additional Resources

During the review process for the toolkits, numerous resource materials were identified as being able to supplement and augment the content in the toolkits. Visit the EnHANCE Ontario website to access a copy of the suggested resources, including books, toolkits/resources, courses, websites, and evaluation tools. The list is a compilation of resources that were recommended by the various reviewers of the toolkits. The resources are not meant to be exhaustive and we are not endorsing certain materials over others.

The Canadian Interprofessional Health Collaborative (CIHC) has an online library that provides free access to a range of resources related to interprofessional education (IPE), ***collaborative practice*** and patient-centred care (*https://www.cihc.ca/library*).

What are the key terms I should understand before starting?

At the end of this toolkit, you will find a *Glossary of Acronyms and Terms* to help orient you to the key terms used in the toolkit. For the purpose of this toolkit, four terms are helpful to distinguish before you begin:

- **Inter-organizational partnerships:** organizational relationships at the administrative or leadership level.
- **Inter-organizational IPC:** organizational relationships at the service delivery or healthcare provider level.
- **Inter-organizational relationships:** in this context, refers to both inter-organizational partnerships and inter-organizational IPC relationships that exist among people who work together across organizations.
- **Inter-organizational agreements:** signed, written agreements that are shared across two or more organizations, defining how they will work together.

FAQs: Interprofessional Collaboration

Interprofessional Collaboration (IPC)

What is IPC and why is it important?

Interprofessional collaboration (IPC) occurs when members of two or more health disciplines come together around the client – to work together to address issues and concerns. It is characterized by shared decision making and mutual accountability within appropriate an scope of practice roles. The client is the focus – the reason for the formation of the team.

In 2000, the Institute of Medicine released the comprehensive report, *To Err is Human: Building a Safer Health System*, which outlined the serious problem of healthcare associated error. In the US, these errors were equivalent to the number of deaths that would be caused by a 747 jet falling from the sky every day. In response to the report, Congress implemented laws to provide stricter control over the activities of care providers. Canada soon followed. In 2004, the *Canadian Adverse Events* study was released and indicated that 7.5% of all hospital admissions in Canada resulted in patient harm. This estimate did not extend to clients not admitted to hospitals and served in other care settings, so numbers may actually be higher. On further examination, it was determined that large numbers of these errors could be prevented by improvements in communication and collaboration between providers (Kohn et al, 2000).

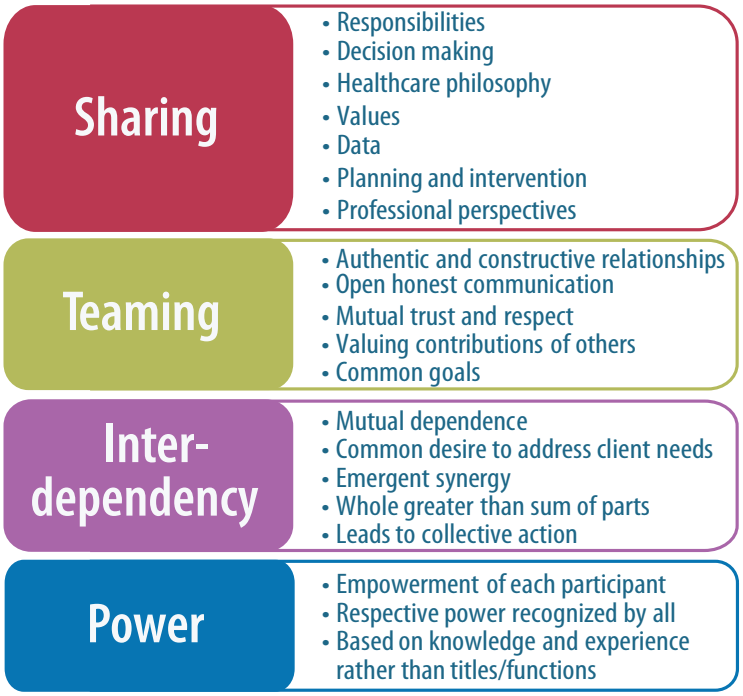
Health Canada has supported and implemented a number of initiatives aimed at improving client safety as they engage with the healthcare system. The Canadian Patient Safety Institute (CPSI) was established in 2003 as an independent not-for-profit corporation, operating collaboratively with healthcare providers and organizations, regulatory bodies and governments to build and advance a safer healthcare system for Canadians. Based on the *Safer Healthcare Now!* campaign, CPSI identified six safety domains within healthcare. All six domains can be clearly connected to the work of professionals within MH&As with the goal of keeping both clients and providers safe (CPSI, 2005):

- Domain 1: Contribute to a Culture of Patient Safety
- Domain 2: Work in Teams for Patient Safety
- Domain 3: Communicate Effectively for Patient Safety
- Domain 4: Manage Safety Risks
- Domain 5: Optimize Human and Environmental Factors
- Domain 6: Recognize, Respond to and Disclose Adverse Events

What are some of the core concepts related to IPC?

D'Amour et al., (2005) describe four core concepts that are commonly related to collaboration: sharing, partnership (teaming), interdependency, and power (see **Figure 1**).

Figure 1: IPC Model from Provider Perspective



The concept of **Sharing** includes the following: shared responsibilities, shared decision making, and a shared healthcare philosophy. Other effective strategies include shared values, data, planning and intervention, and professional perspectives.

Second to sharing, the notion of **Teaming** (called partnership by D'Amour et al., 2005) implies two or more individuals (or organizations) who share a common set of goals and responsibilities for specific outcomes. A team is characterized by a collegial-like relationship that is authentic and constructive. Team relationships demand open and honest communication. Members treat each other with mutual trust and respect. Members must also be aware of, and value, the contributions and perspectives of the other team members.

Interdependency implies mutual and reciprocal reliance and dependence among all members of the care team that is characterized by a common desire to address each client's needs. As client needs become more complex, expertise, contribution and participation is required from each member of the team. As a team works together and 'gels', the output of the whole becomes larger than the sum of the individual parts. The synergy then leads the team to collective action.

The fourth concept is **Power**. In an effective collaboration, power is shared among team members and characterized by "the simultaneous empowerment of each participant whose respective power is recognized by all...furthermore, such power is based on individual knowledge and experience rather than on functions or titles" (D'Amour et al., 2005, p. 119).

What are the competencies for IPC?

In 2010, the CIHC released a framework outlining six specific competencies for IPC. Although these competencies are specific to individuals practicing in healthcare settings and the community, they can also be more broadly applied to organizations aiming to enhance collaborative processes. The six competency domains are (CIHC, 2010):

1. Interprofessional communication
2. Patient/client/family community-centred care
3. Role clarification
4. Team functioning
5. Collaborative leadership
6. Interprofessional conflict resolution

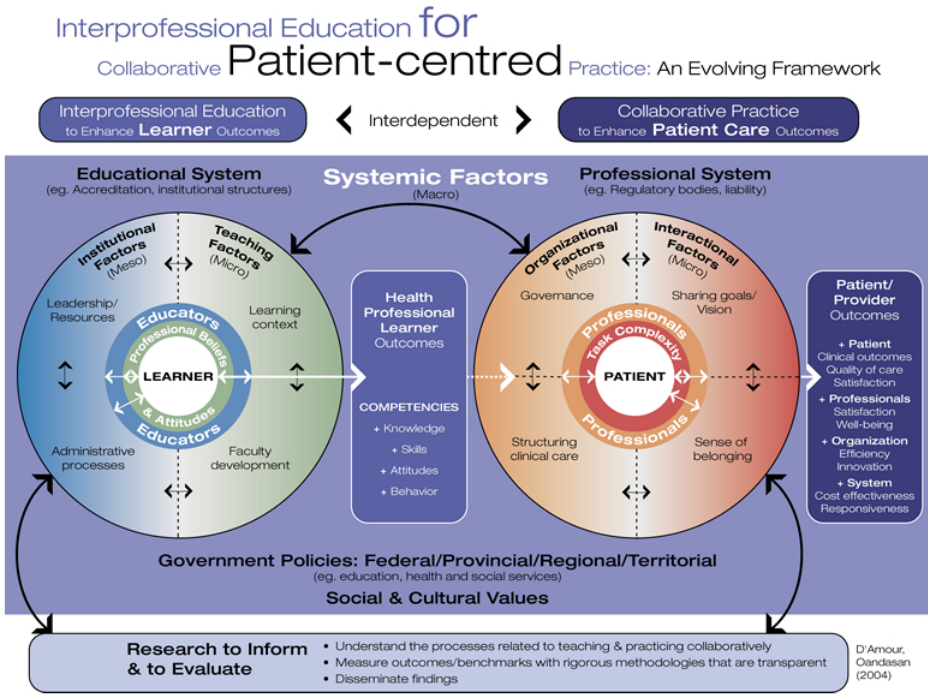
Context for Collaboration

Is there a framework that describes the context for IPC and IPE?

The Interprofessional Education for Collaborative Patient-Centred Practice (IECPCP) Framework helps us to gain a deeper understanding of IPC and IPE within the context of an over arching and concrete social system. The Framework was developed to describe the full social context of interprofessional practice (D'Amour & Oandasan, 2005; Oandasan et al., 2004). The success of IPC rests on three foundations (found at the bottom of the framework, **Figure 2**):

- Research to inform and to evaluate
- Social and cultural values
- Government policies at the Federal/Provincial/Regional and Territorial levels

Figure 2: IECPCP Model



How does the professional system side of the IECPCP Framework work?

The *Professional System* is the regulatory context in which healthcare providers function. This context comprises the regulatory bodies that both define the scope of practice, and deal with liability issues. Regulatory bodies can set and implement policies that positively influence how healthcare providers practice IPC.
Moving to the center of the right-hand circle:

- **Patients (Clients)** are central to ***collaborative client-centred*** practice. Clients and their families are autonomous consumers of healthcare services, who are part of the healthcare community and who are encouraged to work with the healthcare team to optimize services.
- **Professionals** is the term used for all healthcare providers (regulated and unregulated) who provide healthcare in a professional manner, regardless of where they are located in relation to each other.
- **Task Complexity** refers to the type of services the client requires and interactions among the healthcare team and its clients. These interactions are all dynamic in the collaborative client-centred care approach.

The outside circle represents the contextual factors that influence and support the client-healthcare provider relationships.

Interactional Factors influence the relationships between and among healthcare providers:

- **Sharing Goals/Vision** refers to the existence of common goals and the endorsement of these goals by the healthcare team.
- A **Sense of Belonging** reflects an awareness of interdependencies and relationships among healthcare team members.

The left side of the circle represents **Organizational Factors** that can significantly influence collaboration on three levels: within a team, within the context of an organization, and between organizations:

- **Governance** refers to the leadership functions that turn collaboration into a systemic requirement rather than a series of individual efforts.
- **Structuring Clinical Care** is the process of creating documented procedures to clarify each partners' responsibilities, and for ongoing re-negotiation of those responsibilities. One example would be the creation of formal inter-organizational agreements.

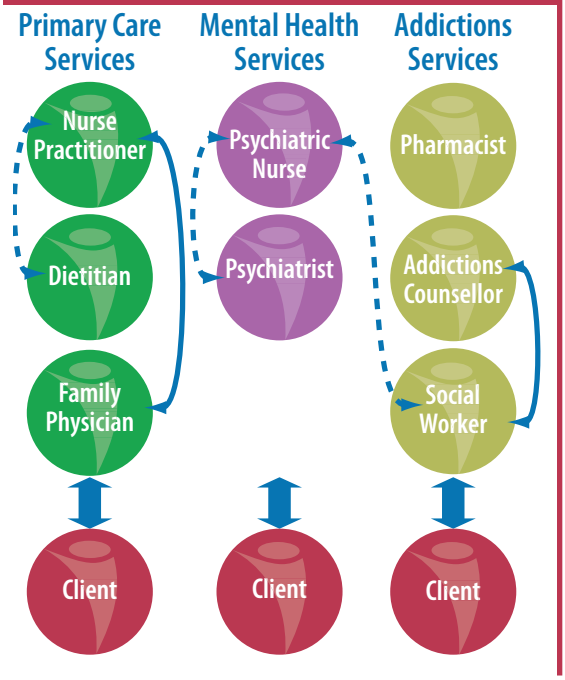
If you look carefully at the circles, you can see that the various circles and quadrants have arrows between them. These arrows represent the inter-relationship among the people, the organizations and the concepts they all support and receive support from.

At the extreme right of the model, **Patient/Provider Outcomes** such as positive clinical outcomes, quality of care, satisfaction, wellbeing, efficiency, innovation, cost effectiveness and responsiveness are the results expected in an environment or system where both clients and professionals participate together in a collaborative patient-centred practice (Oandasan et al., 2004).

Collaborating Across Organizations

The basic concept of IPC is the foundation for a discussion of inter-organizational IPC. Simply put, inter-organizational IPC happens when healthcare providers work together across organizational boundaries as well as professional role boundaries. This added complexity requires additional competencies.

Figure 3: Ad Hoc Collaboration



What is the goal of inter-organizational IPC?

As things currently stand, we have three separate systems spanning physical health, mental health and addictions, but we have not been able to bring these systems together to provide comprehensive care to Ontarians. With regionalization, integration, and other reform activities, there are both service gaps and there can be unnecessary duplications. Continuity of care is deficient, and clients fall through the cracks. This means that people have trouble accessing services when and where they need them, and they may not be able to access a health provider who has the adequate skills to serve them.

Figure 3 illustrates this idea in a more concrete way. The graphic shows the current situation. Within settings, there are varying amounts of collaboration between healthcare providers, and little collaboration between settings. The blue boxes represent individual settings. Solid lines depict open communication and interaction resulting from IPC, while broken lines depict inconsistent and/or ad hoc communication between settings and among healthcare providers and clients.

Although these and other examples refer to the *primary care services*, *mental health services* and *addictions services*, these examples are widely applicable to healthcare settings in general, and may have applicability to collaboration with other service systems such as corrections or social services.

Figure 4: Inter-Organizational Collaboration

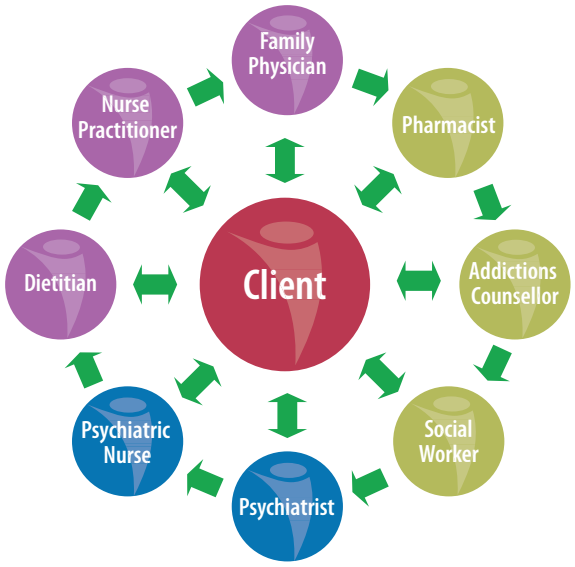


Figure 4 shows the 'goal' state, where all the providers on a client's service team work together on behalf of the client and with the client. In this case, there is regular and frequent dialogue between all health services providers within and between settings as necessary to serve client needs. Also, note that the client is a key participant in these dialogues.

Seamless care is only possible when there is an infrastructure that fully supports the links required among healthcare providers. This includes linkages at the policy, administrative, funding and information flow levels (Durbin et al., 2001).

What is the difference between inter-organizational partnerships and inter-organizational IPC?

In general, **inter-organizational partnerships** occur when two organizations agree to either formally or informally work together in some way to provide services to a client population. This working together at the organizational level is carried out by administrative and leadership staff, supported by the structures and processes that bring together two or more organizations to provide client services. **Networks** occur when three or more organizations agree to formally or informally work together to provide services to a shared client population. A **formal** inter-organizational partnership or network occurs when there is a shared inter-organizational agreement among the partners; otherwise, the relationships are considered **informal**.

The term **inter-organizational IPC** applies to the collaborative process at the healthcare provider level, when the providers are working together to deliver ***interprofessional care*** across organizations. For example, teams are only one way of collaborating. These relationships can also occur informally, or as a result of a formal inter-organizational agreement.

Making it Work: Client-Centred Service

Our community health centre consistently talks about and teaches client-centred care in terms of listening skills, advocacy, and soliciting the client's story and their understanding of their health. We wanted to deepen and develop inclusion of clients in our practice.

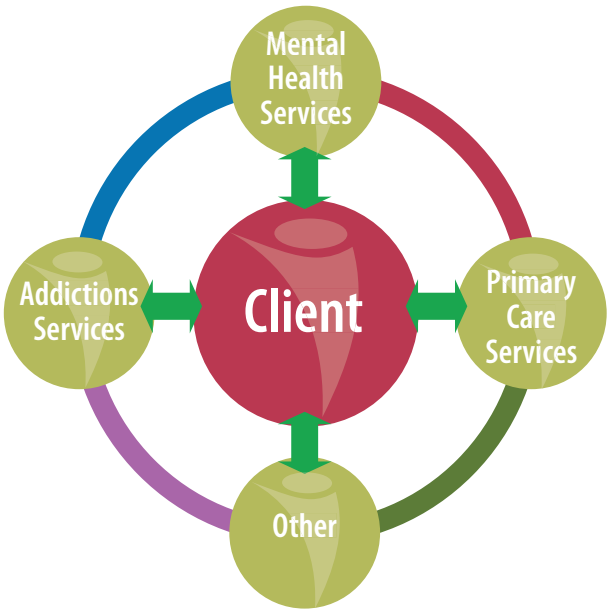
We (the healthcare providers) regularly meet with the program directors to plan for client inclusion. We suggested that we invite client representatives to join our program development committee. To make sure their participation is successful, the centre will cover costs of their involvement. We decided to include two client members and provide an orientation and buddy system.

Two client members joined the committee. We have been discussing whether to continue with a patient education program for older people with a new diabetes diagnosis. The program was not as successful as we had hoped it would be -- people were not attending. The client members made suggestions from the client perspective that allowed us to make real improvements in the way we market the diabetes group to clients. For example, they stressed the need for physicians and nurses to emphasize this group as part of the clients' treatment plan, and suggested the that group be structured as a 'fresh start', rather than just an opportunity to learn about a new disease. They encouraged giving pedometers to new participants. The interprofessional team became more involved in providing group facilitation. With these changes, the diabetes group became very successful and we ended up making it available in a second location.

What is client-centred service?

Client-centred service (practice) promotes participation of each healthcare provider in client care. It enhances client- and family-centred goals and values, provides a mechanism for continuous communication among caregivers, optimizes staff participation in clinical decision making within and across disciplines, and fosters respect for disciplinary contributions made by all healthcare providers. In client-centred service, all providers interact with the client, keeping the client's needs in mind. For IPC, if the service providers work in the same setting – for example, a primary care physician and an addictions specialist – these two providers would collaborate with the client to meet the client's needs. To extend this idea to a partnership context, the providers who are involved with the client would all communicate and collaborate with the client and each other, regardless of where they are physically located in relation to each other. They function as a service team for that single client (**Figure 5**).

Figure 5: Client-Centred Service



What is Knotworking?

Knotworking describes a type of collaboration that is specific to inter-organizational partnerships (or very large single organizations) (Warmington et al., 2004), and is the key difference between collaborating with other members of your own organization, and collaborating with members of other organizations. Knotworking teams form, based on the need of a specific client. When the needs of the client are met, the team disbands. At any given time, an individual provider could be involved with literally dozens of knotworking teams – at least one for each active client. For example, for one client a psychiatrist might collaborate with a primary care physician and a social worker, and for a second client a different primary care physician, an addictions counsellor and a dietitian might collaborate. Each of these providers is also collaborating on a variety of other teams providing care for other clients. In an inter-organizational partnership context, the members of these teams could be complete strangers, or they could be the provider in the office next door.

From the clients' perspective, their healthcare team changes over time. For example, a client with cancer would have an oncologist on their team. If the client later became clinically depressed, a psychiatrist might be added. When the client recovers from cancer, the oncologist is no longer part of the team. As the client ages, perhaps the psychiatrist is replaced with a different psychiatrist who specializes in geriatric clients.

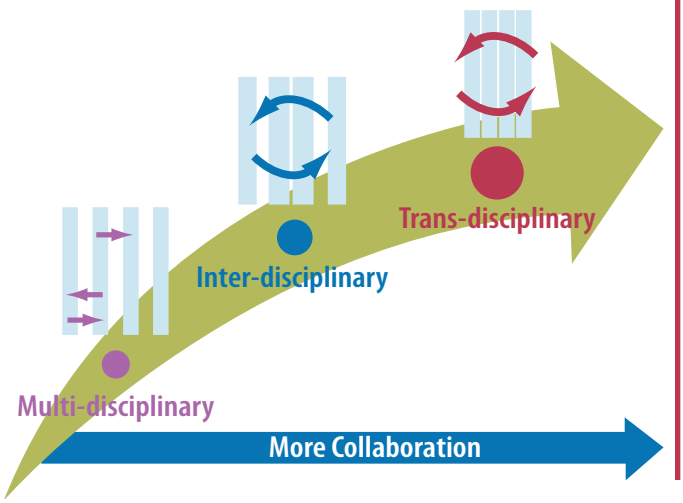
To an extent, knotworking does occur within small organizations, but it is structured slightly differently. In a smaller organization, all the providers are a 'team' with the potential for collaboration. In time, everyone gets to know one another. When the team forms up around a specific problem or client, the nurse practitioner on the team, for example, is going to be someone with whom you already have a relationship, or with whom you will eventually develop a long-term relationship. The number of collaborative relationships you will have to form is finite. In a partnership context, you will be expected to collaborate with providers whom you have never met, and may not meet again.

How closely do collaborative team members work together?

Collaborative team members work together with different degrees of closeness, depending on their situations. Oandasan et al. (2004) and D'Amour et al. (2005) suggest a continuum ranging from multi-disciplinary, through inter-disciplinary to trans-disciplinary.

A **multi-disciplinary team** is one where several different healthcare providers work side-by-side, but do so in a way that is independent or in parallel. They each make their own decisions and apply those decisions to their respective duties. Although they work on the same project, they do not work together – or if they do work together, it is on a limited and transient basis. They may never meet, but the infrastructure of the system where they work supports them to work in a sufficiently co-ordinated fashion (**Figure 6 & Table 1**).

Figure 6: Continuum of Autonomy



An **inter-disciplinary team** shows a greater degree of collaboration between team members. The team makes an effort to integrate and translate themes and activities shared by several professions. An inter-disciplinary team is usually formally structured and generally has a common goal and a common decision-making process. Inter-disciplinary teams draw on the knowledge and expertise of each team member, to solve complex problems proposed in a flexible and open-minded way. One of the major challenges facing interprofessional practice is how 'professional territories' are carved out and distributed within a complex system. Brought into interdependent relationships so client needs can be met, members of inter-disciplinary teams have to gain flexibility in the sharing of professional roles and boundaries within an appropriate scope of practice roles.

The most collaborative form, the **trans-disciplinary team,** is a form of professional practice where consensus seeking and the broadening of professional boundaries play a major role. In the trans-disciplinary team, there is a deliberate exchange of knowledge, skills, expertise and decision making that transcends the usual discipline boundaries. These teams address client involvement in a team's collaborative dynamic with the client taking a role as a participant in decision-making processes. Clients often act as external entities or as third party guarantors to whom the responsibility of co-ordinating interprofessional work is delegated (D'Amour et al., 2005; Oandasan et al., 2004).

Table 1: Continuum of Autonomy: Summary of Characteristics of Collaborative Teams

	Multi-disciplinary	Inter-disciplinary	Trans-disciplinary
Working Style	Independent working	Team working	Collaborative working
Knowledge Exchange	Parallel working	Some effort to integrate and translate themes and activities shared by several professions	Deliberate exchange of knowledge, skills and expertise
Interaction Type	Limited	Common space, some shared ownership, elements of cohesion. Integration of knowledge and expertise to find solutions to complex problems.	Consensus seeking
Co-ordination	Ad hoc	Managed	Collective
Boundaries	Strong	Partially open	Open
Client Role	Client as subject	Client as subject	Client as participant

*This table was created based on D'Amour & Oandasan (2005) and Oandasan et al., (2004).

FAQs: Inter-Organizational Partnerships

What do inter-organizational partnerships look like?

Inter-organizational partnerships look different depending on a variety of characteristics, including:

- Types of services performed by each of the partnering organizations
- Professional and organizational cultures of the partnering organizations
- Degree of autonomy versus team collaboration practiced by the healthcare providers
- Size and complexity of the partnering organizations
- Number of partners
- Amount of funding available to support inter-organizational relationships
- Physical distance between the partnering organizations
- Number of each type of provider within each partnering organization
- Whether or not there is an inter-organizational agreement

Partnership between organizations provides a context and infrastructure that can either support or inhibit inter-organizational IPC. In this section, we will have a brief look at some partnership models and concepts. The *Leader's Practice Toolkit* provides a more detailed discussion.

What are some characteristics of successful partnerships?

Despite the many possible variations, effective relationships across partnership may have the following characteristics in common (Kodner, 2006):

1. **'Umbrella' organizational structures:** these guide the integration of service delivery, ensure efficient operations, provide a structure for overall accountability and support collaborative practice.
2. **Inter-disciplinary case management:** to plan for client needs, to set up appropriately co-ordinated services, to allow clients to enter the system in a consistent fashion regardless of their entry point and to evaluate overall outcomes.
3. **Organized provider networks:** such networks have common protocols, training and information systems, may be formalized by service agreements, and may share facilities and materials to provide clients with a seamless care experience.

Making it Work: Partnership Between a Mental Health Clinic and a Supportive Housing Agency

The mental health clinic where I work had a new client who was also a client of our local supportive housing agency. The client is deaf and uses American Sign Language (ASL). The last time we needed to work with a deaf client that was referred to us from the housing agency, they worked with us to provide support for the client. In particular, they provided me with training to learn ASL.

Once the client was housed and I started to work with her, I started spending more time talking to the workers at the supportive housing agency. I found out that there are a number of clients they are working with who are homeless and dealing with mental health challenges.

I also found out that my client is talking about past trauma and could benefit from the narrative therapy group that my agency runs.

I spoke to my program manager and director and we decided that we would like to pursue a possible partnership with the supportive housing agency. They were very receptive and the partnership resulted in a block of supportive housing apartments being reserved for deaf and hard of hearing clients. As well, several other mental health agency staff at my clinic are learning ASL and the supportive housing agency is working with us directly to co-facilitate a narrative therapy group using ASL.

Providers in both agencies are very positive about the benefits for our clients such as an increased sense of community, access to group therapy, and shared support in a crisis. We also see benefits for ourselves such as opportunities to acquire advanced skill sets, specialized learning, and co-facilitated programming.

What do formal partnerships look like?

Inter-organizational partnerships take a variety of forms, depending on the needs of the individual organizations. Many organizations work informally together, and do not have a signed written agreement or other formal structures that link the partnering organizations. There are five formal types of inter-organizational relationships.

1. **Partnership:** A formal, typically long-term relationship between organizations, where each has defined obligations and contributions to meet a common goal.

2. **Affiliation:** A formal relationship that comprises co-operative efforts between universities, colleges and/or service providers to affect the academic interchange of faculty, and students, and academic and research information.

3. **Service Agreement:** A formal relationship between a customer or client and the provider of a service or product. A service level agreement can cover a straight forward provision of a service or the provision of a complete function.

4. **Secondment:** A formal arrangement to temporarily transfer or 'loan' an employee to another part of an organization or to a completely different organization without any change in the employment relationship.

5. **Strategic Alliance:** A formal relationship where organizations come together to plan, operate or evaluate services that involve the sharing, exchange and co-development of services, procedures, processes, skills and resources.

What principles form the foundation for successful partnerships?

For partnerships to successfully support inter-organizational IPC, they must be intrinsically oriented toward doing so. The partnership should define a set of operating principles to create a positive climate for collaborative working and learning. Operating principles are also sometimes called "core values", and answer the question: "How do we want to act, consistent with our mission [purpose], along the path to achieving our vision [for the future]?" (Senge, 1990, p. 224). Senge writes:

> "Core values are necessary to help people with day-to-day decision making. . . . People need 'guiding stars' to navigate and make decisions day to day. But core values are only helpful if they can be translated into concrete behaviours" (Senge, 1990, p. 225).

Operating principles of an individual organization and the partnership need to be articulated and understood by all members of the healthcare team – including the client; although they often embody complex ideas, and should be stated simply. Operating principles will vary between partnerships. They should form the basis of decision making at all levels of the partnership and within each partner organization.

Sample organization level principles

Tennyson (2003) provides three guiding principles for partnerships.

1. **Equity:** "Equity is not the same as 'equality'. Equity implies an equal right to be 'at the table' and a validation of those contributions that are not measurable simply in terms of cash value or public profile" (Tennyson, 2003, p. 6-7).
2. **Transparency:** "Openness and honesty in working relationships are pre-conditions of trust – seen by many as an important ingredient of successful partnerships. Only with transparency will a partnership be truly accountable to its partners, clients and the general public" (Tennyson, 2003, p. 6-7).
3. **Mutual Benefit:** "If all partners are expected to contribute to the partnership they should also be entitled to benefit from the partnership. A healthy partnership works towards achieving specific benefits for each partner over and above the common benefits to all partners. Only in this way will the partnership ensure the continuing commitment of partners and therefore be sustainable" (Tennyson, 2003, p. 6-7).

Ungar and Jarmain (2000) identified three principles that are specific to collaborative relationships between psychiatrists and family physicians. These principles also inform collaboration and partnership between partners in general.

A mutually understood set of operating principles provides a framework for all healthcare providers within a multi-organizational setting to use in their decision making – especially decisions related to relationships with co-workers.

1. **Stance:** a position of receptive open-mindedness that considers other ways of understanding without being personally threatened (Trussler & Marchand, 1997). It involves looking after one's self while simultaneously attempting to meet the needs of the other. It is the ability to maintain an empathic position, to be a participant and an observer simultaneously, and to allow for variability rather than demanding uniformity.
2. **Cultural Competence:** Cultural competence is actively striving to understand the culture and context of the primary care physician (or other healthcare providers). This requires participation in the primary care physician's world, and awareness of their unique language, customs, beliefs, and ways of interacting.
3. **Integrative Systemic View:** An integrative systemic view is the ability to hold different representations and viewpoints all at once. This requires acknowledging the limitation of one's paradigm, and the curiosity to search for alternative ways of thought. This requires tolerance for complexity, uncertainty, as well as flexibility and fluidity. It is also the ability to synthesize these views and apply them in a practical manner.

Sample healthcare provider level principles

The Enhancing Interdisciplinary Collaboration in Primary Health Care (EICP) Initiative developed six principles to guide healthcare providers working in primary care. The purpose of these principles was to create shared values and a foundation for professional and system-wide approaches to policies, programs and services. The six principles build upon each other in the following order (EICP Steering Committee, 2006):

1. Client centeredness
2. Population health approach
3. Best possible care and services
4. Access
5. Trust and respect
6. Effective communication

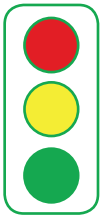
What information does the Inter-Organizational Partnership Framework provide?

Inter-organizational relationships develop when two or more individuals identify a common issue that could be managed or addressed better collaboratively. In some cases, a relationship already exists between two or more individuals, but a new common issue is identified and further explored. Relationships across organizations occur at a variety of levels within an organization (e.g., among administrators/leaders, among healthcare providers, and among mixed groups). Similarly, these relationships exist on a continuum of informal to formal relationships. The EnHANCE Ontario Project defines **formal** partnerships as those organizations that have an inter-organizational agreement, and **informal** partnerships as those that do not have a written agreement. Not all relationships that begin as informal relationships will or need to evolve to formal relationships. Further, a formal relationship may exist, and through this relationship, additional informal relationships may emerge.

There is little information available in the literature to guide the negotiation of inter-organizational agreements. Recognizing this gap, EnHANCE Ontario brought together an expert panel to develop a draft framework to guide the development of inter-organizational relationships among FHTs, CHCs and MH&A organizations. The *Inter-Organizational Partnership Framework* is a companion resource to this toolkit. A brief overview of the framework's key steps is provided in the *Leader's Practice Toolkit;* you are directed to the full framework for more detailed information.

The framework will help guide your decision making about whether to partner formally or informally, and negotiate and develop a contract, while recognizing that every team and organization is unique and has its own challenges. The framework describes a continuum of inter-organizational partnerships:

- Green light (informal partnerships)
- Yellow light (informal, with the potential to become a formal partnership)
- Red light (formal partnerships)



The framework answers the following questions:

- What are the characteristics of green, yellow and red light partnerships?
- What are some examples of green, yellow and red light activities?
- How do we know when we are moving from a green to a yellow light partnership?
- How do we know when we are moving from a yellow to a red light partnership?

FAQs: Inter-Organizational Interprofessional Collaboration

What's different about working in an inter-organizational team?

In a traditional team, the team membership is relatively static. In a single organization, even a large one, there are a finite number of people to interact with, and, since you see them regularly, it is possible to develop relationships over time with the key people with whom you work. In an inter-organizational team, there are many more people involved and you may never meet them in person. Further, in a client-centred model, the team forms up around the client, depending on their needs, so you may end up working on many teams, all of which have different members. In a single organization these might be described as 'sub-teams' of people you have already bonded with. In a client-centred inter-organizational setting, these are **knotworking** teams and require a number of special accommodations (see **Figure 7**).

Figure 7: Traditional Versus Knotworking Teams (adapted from Warmington et al., 2004)

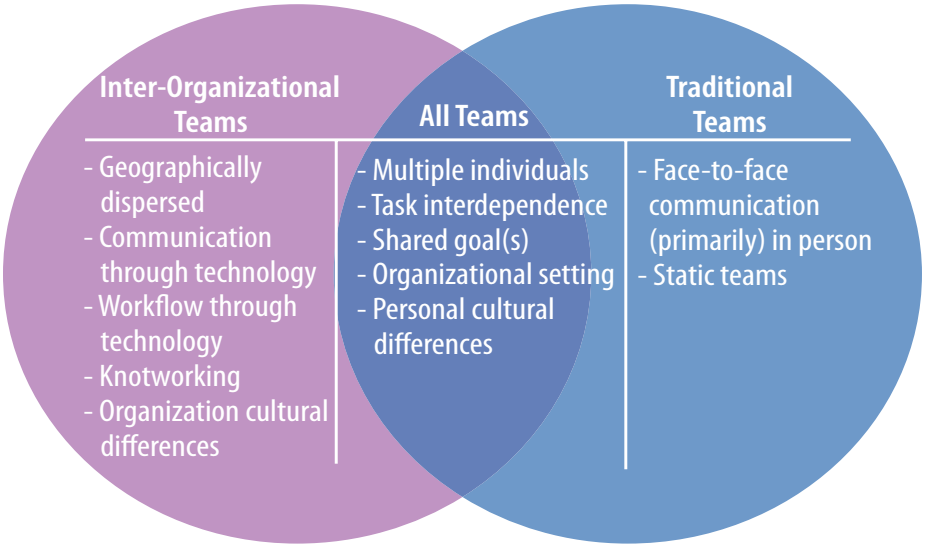
Traditional Teams	Knotworking Teams
• Teams take time to 'gel'	• Team must be effective from the first moment
• Driven by people and relationships	• Process and role driven
• Members trust each other personally	• Members may not have met before
	• Culture of organizational trust (e.g., if the person came from X, they must be good)
• Formed based on organizational structure/needs	• Teams constantly form, reform and disperse based on client needs
• Team is team- or system-centred	• Team is patient-centred
• Consider conflict a 'barrier' to effective team functioning	• Expect conflict and use it constructively to improve learning and development of better process

You might say, "I work with other healthcare providers all the time - what's different?" Working in an interprofessional team is not the same as 'working autonomously, but with other people'. It has a different dynamic, different rhythms and requires a different set of interpersonal and communication skills.

Some characteristics are specific to practicing inter-organizational IPC. Modified from Horvath and Tobin (2001), **Figure 8,** shows the characteristics of inter-organizational teams on the left, traditional teams on the right, and the characteristics that apply to both types of teams in the intersection point in the middle. The implication is that working in an inter-organizational team requires that you be good at everything needed for working in a face-to-face team and that you have the skills to cope in a professional environment that is geographically dispersed, where:

- communication and workflow may be carried out by technology rather than face to face;
- teams are knotworking; and
- there are differences in organizational culture.

Figure 8: Differences Between Inter-Organizational and Traditional Teams (modified from Horvath and Tobin, 2001)



What is the impact of being geographically dispersed?

Your colleagues and teammates might be in the next building, the next town, or even further away. The result is that you have to team up with others without the advantages of day-to-day, face-to-face interaction. This may challenge your existing teaming skills and require you to acquire some new ones. You may need to learn how to use communications technology in place of face-to-face conversation, and how to manage workflow using technology. Finally, you may have to work with people you have never met in person.

What communication technology do I need to learn?

Because team members may not all be working side by side in the same location, they may not be able to discuss things face to face. To communicate effectively and efficiently with colleagues at other locations, you may have to master **communication technologies**. This includes phone, of course, but you may have to learn how to use your phone for conference calls. It also includes email, fax, video-conferencing, web-conferencing, and electronic client record systems. You may need to participate in online forums and use and/or contribute to a knowledge base. In addition to the technology itself, each type of technology has its own rules of etiquette and norms. Your organization should be able to provide training on how to use the technologies selected by your partnership.

How does technology affect workflow?

Technology is not only used for discussions, but may also be used within your partnership to **manage workflow**. By workflow, we mean the administrative processes in which clients engage as they interact with and move between healthcare providers across organizations. An appropriate amount of the clients' personal and health information (depending on the circumstances, this might amount to their entire health record, or just the record of the current set of interactions) has to travel with them so that each healthcare provider has access to the information being used to make decisions about the client. There are stringent ethical, policy and legal factors associated with gathering and sharing client information within and across organizations. It is crucial that every member of the team be familiar with these guidelines and your organizations' policies and procedures. As a member of the care team, you may have to learn how to access, create and update electronic client records.

Making it Work: Using Technology to Involve Everyone in Decision Making about Community Buildings

Our new family health team covers a large, mostly rural area. We've started off with a very diverse team of providers: by profession, age, experience, ethnicity, and interests. We wanted to keep in touch with each other, build relationships and programs and keep in touch and with other GPs and community agencies across our region.

We decided to use an online communication and polling tool called Rypple which allows us to pose a question that everyone on staff can respond to anonymously. It automatically compiles summaries and charts to record answers. The question is sent to everybody through regular email and the process is very easy and quick to use.

Every two weeks we decide on a question regarding patient care, team communication, best practices, education interests ... and poll the whole group. The last agenda item at our bi-weekly staff meeting will be review of answers and deciding what question to ask the group next.

This process has allowed our whole team to be engaged, responsive and innovative while we build our interprofessional and inter-agency partnerships. 'Taking the pulse' of health interests and needs, allows us to implement programs that are genuinely needed. For example, we are now hosting a community forum once a month for providers and community members.

We are currently raising funds to install a computer in our offices that patients can use. We will use it to pose online questions regarding patient needs and service evaluation using the same feedback tool and process for evaluations.

An example of technology in the workplace

Your practice may be a member of the electronic Child Health Network (eCHN). The eCHN portal is a system that "allows healthcare providers access to accurate and current patient information that may have been collected from a variety of geographically-dispersed sources" (eCHN Services). The eCHN portal allows providers to access a patient's "web-chart" as well make e-referrals for ambulatory patients to Sick Kids in Toronto. Providers log in to the portal, where they are able to instantly see and update materials such as lab reports, notes from clinics, radiology reports and surgical reports. Since patients who are children often receive treatment in different locations (e.g., hospitals, clinics, doctors offices), this system allows providers to participate in each child's care with full knowledge of their complete health-related information. For more information about eCHN, see *www.echn.ca*.

What is the difference between a traditional team versus a knotworking team?

Warmington et al., (2004) describes a **knotworking** team as one that forms in response to a specific client need. One of the key challenges of being in a knotworking style team is that you often have no time to 'gel' as a team before you have to be effective. To do this, two of the basic team competencies have to be in place: understanding roles and responsibilities, and team functioning.

Not only do you have to be aware of the roles, responsibilities, and processes of other team members, you have to have integrated that understanding so deeply that you can work seamlessly with any healthcare provider regardless of how well you know them personally. This is a kind of depersonalization of your teammates, where you see them as a role and put your professional trust in the role, rather than in the person as an individual.

However, at exactly the same time, to be effective your team functioning skills must also operate at a very high level, particularly those related to fostering mutual trust and respect and celebrating success, acknowledging contributions and supporting others during times of difficulty and crisis. This may sound like a bit of a logical contradiction – work with the role not the person; respect and support the person as an individual. In practice, the contradiction disappears because it is possible for humans to interact on more than one level at the same time and to relate to each other in dynamic and flexible ways. **Figure 8** provides a summary of the key characteristics that differentiate traditional teams from knotworking teams.

What can I do to support my organization's partnerships?

Providers should reflect on, and pass on to their managers and directors, their clinical observations, clients' stories, and community liaison experiences. Likewise, their challenges in providing care are very relevant. Your day-to-day experiences of different relationships reflect reality in a way that no summary or report can provide. Further, your experiences may indicate a need to form or formalize existing or new organizational and interprofessional relationships. For existing partnerships, your observations may indicate whether the partnership is meeting or not meeting its goals.

How does organizational culture affect inter-organizational IPC?

In inter-organizational teams, challenges related to **culture** are exacerbated by the addition of another 'layer of difference'. In a single setting team, ethnicity, gender, ability, sexual orientation, and social-economic differences are often addressed by formal 'diversity' programs and by simply getting to know people as individuals by working together. In inter-organizational teams, the **institutional** or **corporate culture** of each participating organization can also affect how individuals function within the inter-organizational team.

There is rarely any formal training or even explicit acknowledgement or discussion of cultural differences between organizations. Therefore, it is helpful to actively try to understand the special characteristics of the culture of another organization, and to be able to describe your own organizational culture. Factors that may be impacted by organizational culture may include (but are not limited to):

- Level of energy and enthusiasm
- Negative versus positive general attitudes about work, clients, or administration
- Power dynamics and decision-making autonomy
- Promptness of responses to email and phone messages
- Role flexibility (willing to pitch in versus 'it's not my job')
- Role of client in the decision-making process
- Terminology, acronyms and use of initials/short-forms
- Willingness to learn new skills
- Willingness to share information

Making it Work: Recognizing Dysfunction

Things have not been going well since we partnered with a community hospital. I work for a community mental health team focusing on elder care. About half of us are of the same profession and we have a broad scope of practice, are very experienced and are essential to service provision.

But the staff at the hospital treats us like 'assistants'. Rather than using our names, they call us by our role – we aren't even individuals to them. The staff however,call each other by their given names no matter what job they do.

As well, we are almost always excluded from inter-organizational team meetings because our work schedules don't work with the usual meeting time. Everyone else thinks that it is sufficient to let us know what is talked about in the meeting. We think the time should be rotated so we can attend sometimes.

The lack of respect is starting to alienate people on our team. Our turnover rate has increased, and so has our absenteeism.

We talk among ourselves about how the leaders of both organizations don't seem to be stepping up to the plate. We aren't included in communications and our input isn't sought – even for things that affect us directly. We think that the other team needs to be educated about our roles and what we bring to the table. Maybe if the other team had a better idea of what we do, and what our qualifications are, they would be more willing to listen to our ideas.

I heard through the grapevine that their last partnership with elder care service providers didn't go well, and they ended up with a lawsuit, but what does that have to do with us? I'm tired of being treated as if I don't matter and my own agency isn't doing anything about it. I'm sorry to be leaving, but I deserve better. It's time to dust off the résumé.

It is important to separate factors that are due to organizational culture, rather than "not caring". Recognizing the differences in values and appreciating the differences in organizational cultures can help mitigate conflict, provide a neutral starting point and provide a shared language for necessary discussions about what team members need from each other to be effective.

How do dysfunctional power dynamics affect inter-organizational IPC?

As a team becomes more and more collaborative and trans-disciplinary, the power dynamic between the members of the team changes as well. This can be challenging and disconcerting for some team members. In some cases, team members have to give up autonomy and put their trust in others instead of just trusting themselves. In other cases, team members whose knowledge and experience warrants a greater role, but who have a lesser title or function, may hesitate to put themselves forward or accept responsibility for decisions. Power dynamics have been identified as an area of potential conflict and disruption among collaborating team members. Anticipating that conflicts may arise, partnerships may wish to develop and put into place dispute resolution procedures. It is important that members of the partnership are fully committed to being members of collaborative teams and are prepared to consciously work together to address power dynamics.

What competencies need to be in place to avoid failure?

Weems-Landingham (2004) carried out an organizational behaviour study that looked at characteristic behaviours of team members and correlated those behaviours with the teams' success in meeting their objectives. The study looked at many of the behaviours and competencies that are typically

presented as part of IPC frameworks or competencies. The study found that while these typically identified characteristics were present in successful teams, a lack of any of them did not necessarily cause the team to fail. There were only two behaviours whose absence was directly correlated with failing teams – responsiveness and facilitation.

Responsiveness: "Responsiveness refers to the perception that team members are willing and able to follow up on requests and needs posed by other members of the teams" (Weems-Landingham, 2004, p. 59). Team members perceived as unresponsive to requests for assistance or information contributed most to inter-organizational team failure by decreasing the likelihood that members could work interdependently in terms of communicating, setting goals, managing performances, and planning and co-ordinating tasks.

Facilitation: "Facilitation refers to the ability of team members to direct work, problems and concerns through proper channels to ensure appropriate completion or resolution" (Weems-Landingham, 2004, p. 57). Through reliance on open and supportive communications, teams co-ordinate and synchronize activities, and information and tasks, which ensure that team performance objectives are achieved. Without this facilitation, work is not completed, problems are not solved, and clients do not get the service they need.

So even if your IPC skills are still developing, focusing on these two simple things will provide you with a place to start. First, be responsive: frequently check and respond to your phone messages and email, show up on time to where you are supposed to be, and keep the commitments you make to your team members – even the small commitments. Second, make sure you know what you are supposed to be doing with whom and when, and then do it. When your piece is complete, pass the task on to the proper person. If you are not sure, find out. Keep in touch with the team and make sure you know in advance when you are going to be called upon to do your part.

Self-Reflection

You can reflect on your own experience with IPC, inter-organizational partnerships and inter-organizational IPC by reviewing the questions below. The questions can be answered individually, or in a group. There are no right or wrong answers. Everyone's experience is unique!

*These questions are also found in the *Leader's Practice Toolkit*.

Interprofessional Collaboration

*1. How collaborative are your relationships with the other healthcare providers who practice within your organization?
2. Do you have relationships with healthcare providers from different professions outside your organization? What about within your discipline?
*3. How often do you interact with your clients' other healthcare providers?
*4. How skilled are you in the competency domains for collaborative practice described in the CIHC framework? How might you go about working on those skills that need attention?
*5. How do you value and facilitate client-centred practice?
6. As a healthcare provider, what are your guiding principles?
7. What different teams do you work in? Do they change from client to client, or do you usually work with the same people? Are the teams knotworking?
8. If you apply the right side of the IECPCP model, what parts of your own practice are described by the various elements? What organizational and interactional factors impact your ability to collaborate? Does the model express the relationships with which you are familiar?
9. Are the teams you work on multi-disciplinary, inter-disciplinary or trans-disciplinary? If they aren't trans-disciplinary, what actions could you take to move them in that direction?

Inter-Organizational Interprofessional Collaboration

*1. If your organization is on the verge of partnership, what will you have to learn to be an effective collaborator with healthcare providers from other organizations?
*2. Are you well versed with the communication technology used by your team? If not, how will you find out how to master it?
*3. There are practical differences between working in an intra-organizational team and an inter-organizational team, but not all apply to every situation. Which ones apply to you?
*4. In your organization, what are the barriers or challenges to inter-organizational IPC? What are the facilitators?

5. Two competencies routinely contribute to collaboration failure in partnership settings when they are lacking. What are they? Would improving your competence in either of those two areas improve your success regarding challenges?

Inter-Organizational Partnerships

*1. Does your organization partner with other organizations?
*2. What are your organization's guiding principles? Are they set up to support IPC?
*3. How would you describe the culture of your organization?
*4. What are the barriers or challenges to inter-organizational partnerships? What are the facilitators?
5. There are four characteristics of partnership structures that are generally found to be successful in supporting IPC. Do your organization's partnerships have these characteristics?
6. With whom do you collaborate? In the IECPCP model, which elements of Sharing do you regularly practice? What about Teaming? Interdependency? Power? If you collaborate with providers from other organizations, how do your interactions with them differ from those within your own organization?

What's Next?

Developing healthy inter-organizational relationships takes time, energy and practice! It is easy to be wrapped up in our day-to-day work. We end up working 'in' relationships, and not 'on' them. Interprofessional education is a critical strategy that brings together learners to share their experiences and learn about other interprofessional team members' roles, responsibilities, and scopes of practice. The overarching goal of IPE is collaborative patient-centred practice. IPE has gained momentum in health professions curricula over the last decade and is becoming a mandatory component of the pre- and post-licensure educational experience.

In addition, taking the time to learn about the services provided by organizations in your community is just as critical as knowing that you have a colleague that you can call when you have a question or need access to services for your clients. Do not under estimate the power of connection – the foundation for collaboration and partnerships across organizations is the personal relationships that develop between people. If you are curious to learn more about the concepts presented in this *Toolkit*, whether you are a healthcare leader, provider or student, you may be interested in the *EnHANCE Education Program*.

Glossary of Acronyms and Terms

Acronyms

ASL	American Sign Language
CCMHI	Canadian Collaborative Mental Health Initiative
CHCs	Community Health Centres
CIHC	Canadian Interprofessional Health Collaborative
CPSI	Canadian Patient Safety Institute
EICP	Enhancing Interdisciplinary Collaboration in Primary Healthcare
FAQs	Frequently Asked Questions
FHTs	Family Health Teams
ICEF	Interprofessional Care Education Fund
IECPCP	Interprofessional Education for Collaborative Patient-Centred Practice
IPC	Interprofessional Collaboration
IPE	Interprofessional Education
LHIN	Local Health Integration Network
MH&A	Mental Health and Addictions
MOU	Memorandum of Understanding
WSIB	Workplace Safety and Insurance Board

Terms

Client-centric care: quality healthcare achieved when "providers partner with patients and their family members to identify and satisfy the full range of patient needs and preferences" (Planetree, 2010).

Collaborative client-centred practice: 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 (Lamarche et al., 2003).

Collaborative practice: defined as "an interprofessional process for communication and decision making that enables the knowledge and skills of care providers to synergistically influence the client/patient care provided" (Way, Jones & Busing, 2000, p. 3).

Inter-organizational collaboration: applies to collaboration between professionals at the provider level, when the service providers are working together across organizations.

Interprofessional care: the provision of comprehensive health services to clients by multiple health caregivers who work collaboratively to deliver quality care within and across settings (HealthForceOntario, 2006).

Interprofessional education: the process by which "two or more [health] professions learn with, from and about each other to improve collaboration and quality of care" (CAIPE, 2010).

Knotworking: "rapidly changing, partially improvised collaborations of performance between otherwise loosely connected professionals" (Warmington et al., 2004, p. 2).

Partnership: a situation where two or more organizations agree to formally or informally work together in some way to provide services to a population of individuals. This working together at the organizational level is carried out by administrative and leadership staff, supported by the structures and processes that bring together two or more organizations to provide client services.

Team: a "collection of individuals who are interdependent in their tasks, who share responsibility for outcomes and who see themselves and who are seen by others as an intact social entity embedded in one or more larger social systems (for example business unit or corporation) and who manage their relationships across organizational boundaries" (Cohen & Bailey, 1997, p. 241).

Teamwork: describes an interdependent relationship that exists between members of a team. It is an application of collaboration. "Collaboration" deals with the type of relationships and interactions that take place between coworkers. Effective healthcare teamwork applies to caregivers who practice collaboration within their work settings (Interprofessional Care Steering Committee, 2007, p. 44).

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