Foreword

Réseau de collaboration sur les pratiques interprofessionnelles en santé et services sociaux (RCPI) was created in 2009 in the wake of the Le patient au cœur de nos actions : Mieux se former pour mieux collaborer project. Funded through Health Canada’s Interprofessional Education for Collaborative Patient-Centred Practice (IECPCP) program, the project was a joint venture between Université Laval’s faculties of medicine, nursing, and social work, in partnership with CSSS de la Vieille-Capitale* (now the CIUSSS de la Capitale-Nationale). It gave rise to an interprofessional collaboration (IPC) training curriculum for use in a continuum of activities at the undergraduate, graduate, and continuing education levels.

Université Laval and CSSS de la Vieille-Capitale* created RCPI to ensure continuity in the development of knowledge and practices related to interprofessional collaboration and to support health and social care facilities in the region served by Réseau universitaire intégré en santé de l’Université Laval (RUIS-UL).

RCPI’s mission is to develop and promote knowledge, skills, and attitudes in interprofessional collaboration practices centred on the patient, family, or community, both on the university campus and in RUIS-UL health and social care facilities. Along with its partners, RCPI is updating its mission by: 1) supporting the pedagogical development of interprofessional education in teaching environments, 2) supporting the development of interprofessional collaborative practice in RUIS-UL health and social care facilities, including through continuing education opportunities, and 3) contributing to research and knowledge translation in educational settings and health and social care facilities.

RCPI is committed to its mission and, since its founding, has worked with members of the university community (professors and researchers), facility workers (managers and practitioners), and persons and their close-ones in a spirit of exploration and coconstruction to develop a knowledge translation tool to convey the latest knowledge and research on the conceptualization of interprofessional collaboration. The Continuum of Interprofessional Collaborative Practice in Health and Social Care is the result of that approach. From 2009 to 2012, a formal process was followed to map the scientific literature in a meaningful way and put it through external validation. [2] Validation activities included three focus group sessions and one survey administered to partners across the province of Québec.

The Continuum of Interprofessional Collaborative Practice in Health and Social Care is a visual representation that will evolve in step with advances in knowledge and its use in the field. Email info-rcpi@cifss.ulaval.ca to share your feedback and experiences from applying it to your own work.

---

*The CSSS de la Vieille-Capitale was integrated with the CIUSSS de la Capitale-Nationale in 2015.

1 Actions taken by health and social care practitioners in partnership with the community on factors associated with social and health issues.
Table of Contents

Foreword ................................................................. 1

Introduction ............................................................. 5

Continuum of Interprofessional Collaborative Practice in Health and Social Care: Overview ......................................................... 7
  Situation ................................................................. 9
  Intention ................................................................. 9
  Interaction ............................................................. 10
  Disciplinary knowledge ............................................. 10

Forms of interprofessional collaborative practice .................................. 11
  Independent practice .................................................. 12
  Parallel practice ....................................................... 13
  Consultation/reference practice ...................................... 14
  Concerted practice ................................................... 15
  Shared healthcare practice ......................................... 16

Implications .............................................................. 17
  Contexts conducive to interprofessional collaboration ............... 17
  Developing the interprofessional collaboration reflex ............... 18
  Modes of collaboration ............................................. 19

Conclusion ............................................................... 21

Bibliography ............................................................. 23

Appendix ........................................................................ 25

Figure: Continuum of Interprofessional Collaborative Practice in Health and Social Care
Introduction

The burden on national healthcare systems has been increasing for many years due to population aging, the rising incidence of chronic disease, the increase in the number of patients with complex, multifaceted needs, and a serious shortage of human resources.\cite{3,4} One of the most promising strategies for addressing this is to adopt an organizational culture fostering the development of practices that motivate practitioners* from different health and social care disciplines to work together. This is what is known as “interprofessional collaboration” or IPC.\cite{3-7} The adjective “interprofessional” refers to any type of interaction involving at least two people from different disciplines.

To be able to build an interprofessional practice framework, we must all be working from a clear, precise definition of what interprofessional collaboration is, yet there is no real conceptual consensus within the scientific community. The terms used to discuss interprofessional collaboration—whether in practice settings or the scientific literature—are often confusing or used interchangeably.\cite{8,9} Leathard raised this issue as early as 1994 and, nearly a decade later, observed that with the increased interest in interprofessional collaboration around the world, an even broader range of terms were being used.\cite{10,11} Conceptual confusion surrounding interprofessional collaboration appeared to still be an issue in 2012.\cite{8,12} There are a number of terms that are related to interprofessional collaboration, including interdisciplinarity, multidisciplinarity, teamwork, collaboration, consultation, and cooperation. Definitions evolve over time, so there is no single, agreed-upon definition of interprofessional collaboration.

The Continuum of Interprofessional Collaborative Practice in Health and Social Care developed by RCPI provides an overview of collaborative practice and makes connections between the various concepts related to this phenomenon. It draws on theoretical knowledge in the scientific literature and the experiential knowledge of stakeholders interested in collaborative practice.\cite{13} This guide introduces readers to the Continuum of Interprofessional Collaborative Practice in Health and Social Care and describes the relationship between the different terms and concepts used. It is specifically aimed at practitioners and managers in health and social care organizations but may also be of use to anyone interested in exploring the issues involved in interprofessional collaboration.

* For the purposes of this guide, the generic term “practitioner” is used to designate individuals who, as part of their role or duties, deliver, coordinate, or administer person/close-ones/community-centred care and services.
Continuum of Interprofessional Collaborative Practice in Health and Social Care: Overview

The definition on which this continuum is based is taken from the “Interprofessional Education for Collaborative Patient-Centred Practice” conceptual model. Regularly used in academic settings and by Canadian government authorities, this model defines interprofessional collaboration as a process whereby practitioners from various disciplines work together to develop modes of practice enabling them to deliver consistent, integrated care that meets the needs of patients, families, caregivers, and communities.

The Continuum of Interprofessional Collaborative Practice in Health and Social Care is a visual representation comprising four components: the situation, the intention, the interaction, and disciplinary knowledge. The components are closely related in a logical, meaningful way. Aside from establishing a partnership with the individual(s), which transcends the entire continuum, the degree of complexity of the biopsychosocial needs of the person and close-ones (the situation component) influences the other three (intention, interaction, and disciplinary knowledge). The intention to collaborate and the need to combine knowledge across disciplines to meet the individual needs of the person/close-ones/community depend on the complexity of the situation, which also helps determine which interactions are most appropriate, i.e., the degree of interdependence required in that specific case. The continuum encourages practitioners to tailor their collaborative interaction processes to the situation experienced by the person/close-ones/community.
To that end, interprofessional collaboration interactions are divided into four types of collaborative practice: parallel practice, consultation/reference practice, concerted practice, and shared healthcare practice. Independent practice appears on the far left side of the continuum, in the interaction component (Figure 1). Unlike the other four other practices, independent practice does not involve two practitioners working with one person/close-ones/community (C).

Figure 1. Continuum of Interprofessional Collaborative Practice in Health and Social Care
Independent practice, therefore, is characterized by unidisciplinary knowledge, whereas increased interdependence between practitioners involves a combination of disciplinary knowledge leading to interdisciplinarity. All of these practices require practitioners to apply their disciplinary knowledge.

The overall logic between the four components, which evolve along a continuum, can be explained as follows: the scope of collaboration between professionals depends on the complexity of the situation of the person/close-ones/community. Practitioners identify the intention that motivates them to collaborate, which in turn determines the interactions required between them, and the intensity of their interdependence. This interaction and interdependence requires practitioners to combine disciplinary knowledge to better meet the needs of the person/close-ones/community.

The individual components of the Continuum of Interprofessional Collaborative Practice in Health and Social Care are described in detail below.

**Situation**

The Continuum of Interprofessional Collaborative Practice in Health and Social Care suggests that interprofessional collaboration practice must be based on a desire to suitably meet the biopsychosocial needs and expectations of the person/close-ones/community and, consequently, must begin by means of an authentic partnership with them. In this theoretical view, persons/close-ones-communities are considered as partners in their own right. Multiple authors emphasize that leadership in interprofessional collaboration relationships is shared based on the expertise each practitioner brings to a given situation. [8, 15,19-22] Yet, drawing on their own experience, persons/close-ones-communities are clearly experts when it comes to their own needs and the expectations they have of health and social care practitioners as a result. Unlike other models that focus more on how work is divided among individuals, the proposed continuum posits that client-centred practice is integral to the conceptualization of interprofessional collaboration interactional factors and that the underlying principles must be taken into account to assess the quality of collaborative practice.

The intensity of interprofessional collaboration depends on the situation experienced by the person/close-ones/community. [18,19] A relatively straightforward situation that can easily be resolved through parallel practice does not require mobilization of multiple professionals working in an integrated manner. But when a client’s biopsychosocial needs are complex, practitioners should adopt more intense collaborative practices. Note that we are not referring here to the complexity of the underlying pathology or problem, but the complexity of the needs of the person/close-ones/community and the biopsychosocial context in which these needs are to be met. The challenge for health and social care teams, programs, and departments is to avoid a one-size-fits-all approach. Practitioners must be able to move easily in both directions along the collaboration continuum and adjust their collaborative practices based on the complexity of the situation experienced by the person/close-ones/community. Practitioners must therefore develop their ability to determine the best type of collaborative practice based on the specific case at hand. Moreover, situations may change over time and require a different interprofessional collaborative practice. Stakeholders must therefore remain flexible throughout the intervention.

**Intention**

Among the innovations proposed by the Continuum of Interprofessional Collaborative Practice in Health and Social Care, the intention component is decidedly one of the most important concepts. While the question of common goals and objectives is addressed in the most frequently cited definitions and conceptualizations, the specific nature of these goals has yet to be clearly defined. A number of authors argue that a common goal serves to get practitioners working together, usually in the aim of delivering quality health and social care, but we think this view is too imprecise to anchor a genuine shared vision capable of underpinning the various forms that person/close-ones/community-centred interprofessional collaboration can take. Interprofessional collaboration quality assessments must make it possible to determine whether practitioners are using the best practices.
in relation to their intention. A partnership based on the intention to inform, for example, will not be the same as one whose intention is to share decisions regarding a common objective. It is essential to clarify the relationship between intentions and the way in which practitioners should interact.

In a completely independent practice, the objective is to collaborate only with persons/close-ones/communities, while a complex situation will require more intense interaction between practitioners and persons/close-ones/communities, who will agree together, among other things, on the need to make shared decisions so as to best address the needs at hand.

**Interaction**

Circles illustrated in this component represent the person/close-ones/community (C) and the other practitioners involved in meeting their biopsychosocial needs. As collaboration between practitioners intensifies, the circles move closer together and eventually overlap—illustrating the partners’ increasing interdependence. Clearly then, interprofessional collaboration is vital to offering quality health and social care to persons/close-ones/communities based on the underlying intention.\(^{19,20}\) Practitioners may work in different units or departments, with different programs and clienteles, or for entirely different organizations. Interdependence can be seen in decision-making processes but also in the sharing of responsibility.\(^{8}\) These forms of interaction correspond to different interprofessional collaboration practices, which are described in the next section.

**Disciplinary knowledge**

In the Continuum of Interprofessional Collaborative Practice in Health and Social Care, the combining of knowledge results in two different forms of interprofessional collaboration: multidisciplinarity and interdisciplinarity. The terms are rooted in the word “discipline,” meaning “branch of knowledge.” Disciplinary knowledge is a body of knowledge organized within frameworks that allow us to comprehend some of the biopsychosocial needs of persons/close-ones/communities. In some cases, the disciplinary knowledge of a single practitioner may be enough to assess and meet the needs of the person/close-ones/community. In that case, we would say that their partnership requires unidisciplinary knowledge. But in other situations, a practitioner’s unidisciplinary knowledge may fall short and multiple practitioners will have to share their respective knowledge to build a common understanding of the needs of the person/close-ones/community and work together to deliver quality care and services that are coherent and complementary. This is known as multidisciplinarity. And finally, in the most complex situations, practitioners are asked to exchange knowledge to build a shared body of knowledge and coconstruct a shared understanding of the biopsychosocial needs of the person/close-ones/community in order to share in decisionmaking and decide what actions are required to reach their objectives. In this scenario, the interactions and interdependence between practitioners are more intense, and interprofessional collaboration takes the form of interdisciplinarity.
Different forms of interprofessional collaborative practice

The interactions component of the Continuum of Interprofessional Collaborative Practice in Health and Social Care illustrates four non-linear and non-hierarchical types of collaborative practices—i.e., practices that are not ranked according to importance or employed in any particular sequence. These practices are chosen on the basis of the situation. For practitioners engaged in interprofessional collaboration, the challenge is to be able to move easily in both directions along the continuum. The level of interaction between practitioners depends on the complexity of the biopsychosocial needs of the person and close-ones. Each practitioner must have the skills to assess the complexity of the situation in order to determine the motivation for partnership and adjust the intensity of interprofessional collaboration interaction so the needs of the person/close-ones/community can be effectively addressed. The more complex the situation, the more intense the interaction.

Before we examine each type of interprofessional collaboration practice in detail, it is worth mentioning that interaction can take various forms. Interaction for the purposes of interprofessional collaboration does not necessarily involve regular formal meetings. Different arrangements can be used depending on the context and the practitioners involved.

The level of interaction between professionals depends on the complexity of the biopsychosocial needs of the person and close-ones.
Independent practice

On the far left of the continuum we have independent practice, which is used in situations that are relatively straightforward. This practice is characterized by the presence of a single practitioner in partnership with the person/close-ones/community [C]. In such cases, interaction between individuals is based on the practitioner/client(s) dyad [Figure 2] and does not incorporate the disciplinary knowledge of other practitioners. This approach is not an interprofessional collaborative practice because it is a form of unidisciplinarity.

Figure 2. Independent practice
Parallel practice

In parallel practice, the practitioner partners with at least one other practitioner from a different discipline to obtain information on the kinds of interventions employed by the other professional with the same person/close-ones/community (C). This is represented on the continuum by a unidirectional dotted arrow (Figure 3). Interaction is minimal, even absent (e.g., when information is acquired via reports and progress notes in the client’s file). Interdependence is therefore almost nonexistent in this type of collaborative practice, and disciplinary knowledge is organized in silos (unidisciplinarity). Parallel practice sometimes leads to more intense forms of collaboration, especially if there is interaction between practitioners, since it allows them to explore potential areas for collaboration.
Consultation/reference practice

This practice stems from the intention to exchange information with at least one other practitioner. It usually involves consulting another practitioner directly to clarify, add to, or guide one’s interventions. Or this collaborative practice may take the form of a referral to another practitioner with a request to contribute in a specific way (e.g., a request for assessment or treatment) to improve the care or services offered to the person/close-ones/community (C). In all cases, this interprofessional collaborative practice requires practitioners to acknowledge the scope and limits of their expertise and call on another practitioner with specific expertise or from a different discipline entirely. There is little, if any, interaction in consultation/reference practice; it is represented by circles that are closer together but connected by a unidirectional dotted arrow, representing a lesser degree of interdependence between the people involved (Figure 4).

Practitioners who consult a colleague have sole responsibility for deciding whether to let the advice they receive guide their interventions and then inform the person/close-ones/community (C) of their decision. If the referral is to a practitioner from another discipline, that practitioner will be the one to decide what type of follow-up is required. In this context, the disciplinary knowledge of the practitioners—while still parallel—will ideally come together in a coherent way to meet the needs of the person/close-ones/community, an initial step toward multidisciplinarity. [23]
**Concerted practice**

Concerted practice stems from an intention to plan and, especially, organize care and services to meet the biopsychosocial needs of the person/close-ones/community in a way that ensures that interventions are coherent and complementary. There is moderate, bidirectional interaction in this practice. The circles touch but do not overlap and are connected by a solid bidirectional arrow (Figure 5). The disciplinary fields are closely related and complementary but still independent. There is, however, a certain amount of interdependence between the practitioners (indicated by a solid rather than a dotted arrow), since their actions are intended to promote consistency in addressing the needs of the person/close-ones/community. The collaborative intention implies interdependence in coordinating actions to meet disciplinary objectives. For that reason, this practice falls more within the multidisciplinary category, since disciplinary knowledge remains parallel. The formal concerted approach ensures that knowledge is complementary and coherent, based on the objectives of the practitioners and the person/close-ones/community.

![Figure 5. Concerted practice](image-url)
Shared healthcare practice

The final practice is at the far right of the continuum. Decision-making is shared between the practitioners and the person/close-ones/community (C) regarding a common objective and the actions that should be taken to achieve it. This practice is used in situations where the degree of complexity requires participants to harmonize their points of view to establish a shared vision of the situation and a common action plan. Interaction between collaborators is necessarily more intense in this type of practice, and there is a real partnership between disciplines (indicated by the overlapping circles). This situation requires interdependence characterized by a formal commitment to develop a common action plan and share responsibility when it comes to team decisions. Practitioners must work together as a cohesive unit and combine their disciplinary knowledge; this type of collaborative practice is known as interdisciplinarity.\cite{18,19}
Implications

For practitioners in a team, program, or department, the challenge is to avoid a one-size-fits-all approach to their interprofessional collaborative practice. They must be able to adjust their interprofessional collaborative practices according to the complexity of the biopsychosocial needs of the person/close-ones/community. Not only must they develop their ability to use each form of practice, but also their understanding of the factors that create situations conducive or inconducive to interprofessional collaboration. These factors are interconnected. Some are related to our healthcare, education, and labour systems, while others have more to do with the processes in place in health and social care facilities and the attitudes of their members.

Contexts conducive to interprofessional collaboration

At the systemic level, the scientific literature shows relatively clearly that a non-hierarchical social environment and a professional system that values contribution from all disciplines help foster interprofessional collaboration. When certain socially constructed and culturally shared representations of one or more professions are widespread within a given environment, they may either hinder or facilitate interprofessional collaboration. Representations are formed of knowledge, beliefs, perceptions of reference values, and the understanding of what interprofessional collaboration actually is.

In environments with a strong collaborative culture, the principles and values associated with interprofessional collaboration are nurtured. This encourages managers to promote interprofessional collaboration, and practitioners to adopt it as a best practice for delivering quality healthcare and services.
practitioners to adopt it as a best practice for delivering quality healthcare and services.\textsuperscript{[21, 25, 26]} With that in mind, there is a benefit to basing internal recognition policies on group performance.\textsuperscript{[21, 25, 26]} Resources allocated in terms of time, space, and training opportunities, physical proximity, prompt and effective conflict management, and support for innovation are all conditions conducive to interprofessional collaboration.\textsuperscript{[25-27]}

Developing the interprofessional collaboration reflex

Although the usefulness of interprofessional collaboration in health and social care has been well-documented, implementing the practice is not necessarily self-evident.\textsuperscript{[4, 19, 20, 28, 29]} Practitioners require special competencies to engage effectively in collaborative practice.

In 2010 the Canadian Interprofessional Health Collaborative (CIHC) developed the National Interprofessional Competency Framework to describe the minimal knowledge, skills, attitudes, and values a practitioner must acquire or master to succeed at interprofessional collaborative practice. It includes two domains (interprofessional communication and patient/person/close-ones/community-centered care) that support the other four key competency domains (role clarification, team functioning, collaborative leadership, and interprofessional conflict resolution). A description of each competency is provided in Figure 7.\textsuperscript{[30]}

\begin{figure}[h]
\centering
\includegraphics[width=\textwidth]{figure7.png}
\caption{The six competency domains in the Canadian Interprofessional Health Collaborative’s (CIHC) national framework}
\end{figure}

Source: Adaptation of the National Interprofessional Competency Framework\textsuperscript{[30]}
These competencies must be acquired and put into action—no matter which form of interprofessional collaborative practice is being used—to meet the biopsychosocial needs of the person/close-ones/community. But the degree of interaction and interdependence is important: the more intense and complex the collaboration, the more important it is to master these competencies. Unfortunately, people tend to overestimate their collaborative skills. So it is essential that practitioners further their understanding of the Continuum of Interprofessional Collaborative Practice in Health and Social Care and the related competencies.

**Modes of collaboration**

A mode can be defined as “a particular form or variety of something.” In terms of interprofessional collaboration, it refers to the specific way practitioners work together to deliver quality care and services to the person/close-ones/community.

A mode can be considered as having been planned when its location, timing, and objective are agreed upon in advance by all participants. Unplanned modes are more spontaneous in nature and are often a product of the initiative of a single participant. A direct mode involves synchronized collaboration, i.e., participants interacting at the same time. An indirect mode involves unsynchronized collaboration, with participants giving and receiving information at different times. Organizing these qualifiers in a matrix offers a more formal categorization of the various modes of collaboration. Table 1 shows examples of modes used in health and social services for each category. It is important to understand that the same mode may be used very differently from one setting to another, affecting the expected outcomes in different ways.

<table>
<thead>
<tr>
<th>Mode</th>
<th>Direct</th>
<th>Indirect</th>
</tr>
</thead>
<tbody>
<tr>
<td>Planned</td>
<td>Evaluation and joint intervention</td>
<td>Meeting report</td>
</tr>
<tr>
<td></td>
<td>Formal team meeting</td>
<td>Consultation request form</td>
</tr>
<tr>
<td></td>
<td>Conference call</td>
<td>Referral request form</td>
</tr>
<tr>
<td></td>
<td>Videoconference</td>
<td>Notes in health record</td>
</tr>
<tr>
<td>Unplanned</td>
<td>Spontaneous phone call</td>
<td>Email</td>
</tr>
<tr>
<td></td>
<td>Spontaneous meeting</td>
<td>Note and memo</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Via a third party</td>
</tr>
</tbody>
</table>

To our knowledge, the modes listed here are the ones most commonly used in health and social care settings. In addition, there are the direct, planned modes of the action plan, intervention plan, (IP), and individualized service plan (ISP)—the last two being governed by the Act respecting health services and social services (ARHSSSS). However, the legislative framework allows facilities to adapt the procedures and mechanisms for developing these two types of plans based on the practice setting and the situation of the person and close-ones. Intervention and service plans are tools for organizing care and services in keeping with the needs and expectations of persons and close-ones. Therefore the form of interprofessional collaborative practice used to meet those needs (unidisciplinarity, multidisciplinarity, or interdisciplinary) should be reflected in the intervention plan. The mechanisms put in place to develop the plans should also be appropriate to the level of interaction between individuals. Sometimes resources may be allocated to develop an interdisciplinary intervention plan when the situation of the person and close-ones does not require interprofessional collaboration of such intensity—for instance, formal meetings where participants set disciplinary objectives that are documented in what is termed an interdisciplinary intervention plan.
Conclusion

The *Continuum of Interprofessional Collaborative Practice in Health and Social Care* is a tool that integrates current scientific knowledge and clinical experience regarding interprofessionalism. It demonstrates that collaborative practice should be person/close-ones/community-centred. This means that the underlying goal of any interprofessional collaborative practice is to build a partnership with the person/close-ones/community. The continuum aims to help readers develop a deeper understanding of the factors at play in interprofessional collaboration and the way in which they can be combined to meet the biopsychosocial needs of persons/close-ones/communities. It emphasizes the need for practitioners to adopt reflexive practice in order to determine the best intention for collaboration based on those needs. Moreover, practitioners should be able to judge whether their interactions are optimal based on the intention underlying their collaboration. Managers can also use the *Continuum of Interprofessional Collaborative Practice in Health and Social Care* to support the continuous quality improvement process in their organization. Ultimately, the continuum is a tool to support practitioners and managers in their efforts to optimize interprofessional collaboration within their organization.
Bibliography


Continuum of Interprofessional Collaborative Practice in Health and Social Care

Authors: Careau, E.; Brière, N.; Houle, N.; Dumont, S.; Mazlade, J.; Paré, L.; Desaulniers, M.; Museux, A.-C.

Situating the Complex
- Biopsychosocial needs of the person, close-ones and community
+ Complex

Intention
To establish a partnership with the person and close-ones
- To inform
- To exchange information
- To agree on disciplinary objectives
- To share decisions and actions regarding a common objective

Interaction
Independent practice
Parallel practice
Consultation/reference practice
Concerted practice
Shared healthcare practice
Increased interdependence

Disciplinary knowledge
Unidisciplinarity
Multidisciplinarity
Interdisciplinarity

* C: Person/close-ones/community
RCPI
2601, chemin de la Canardière
Bureau G 3208
Québec (Québec) G1J 2G3
Phone: 418 663-5000 ext. 5026
www.rcpi.ulaval.ca
info-rcpi@cifss.ulaval.ca

July 2018 edition