Toolkit to Support Effective Collaboration within an Integrated Care Team

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The Provincial Council for Maternal and Child Health (PCMCH): The PCMCH is accountable to the Ministry of Health and Long-Term Care (MOHLTC) and has two distinct roles. First, the PCMCH generates information to support the evolving needs of the maternal-child health care system in Ontario. Secondly, the PCMCH is a resource to the maternal-child health care system to support system improvement and to influence how services are delivered across all levels of care.

Why Children with Medical Complexity? The PCMCH has examined analyses completed by researchers affiliated with the Institute for Clinical and Evaluative Sciences (ICES) to identify children in Ontario with the greatest healthcare service use in any one year period as well as to identify children with the greatest healthcare service used over a multi-year period. These analyses consistently show that a small subset of children - children with medical complexity (CMC) - consume the majority of healthcare services and consume those services both in the community and in hospital. Data further illustrate that among all CMC, those who have multiple organ system complex chronic conditions, neurological impairment and/or are dependent on technology persistently require higher levels of health services and support from a greater number of health care providers and specialists. As such, CMC who are Medically Fragile and/or Technology Dependent (MFTD) have been identified as the first priority for targeted integrated medical care and coordination interventions.

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- Families with CMC
- Children's Treatment Centres
- Community Care Access Centres
- Primary care providers
- Home care providers
- Paediatric tertiary centre providers

PCMCH would also like to acknowledge and thank the Integrated Complex Care Advisory Committee to help inform and endorse this toolkit.

The development of this toolkit was led by a team from PCMCH including:

- Laura Visser, Lead, Integrated Family Centred Care for Children with Health Complexity
- Preeti Nigam, Sr. Project Manager

Introduction:

Over the last four years, PCMCH and its key stakeholders have had a major focus on advancing care for children with medical complexity (herein referred to as "CMC"). In 2014 PCMCH intensified its work related to care planning and coordination for this population. Building on the cumulative recommendations and work to date in Ontario, a Strategic Framework for province-wide integrated care and service coordination was developed and unanimously endorsed by participants of the 2014 PCMCH Provincial Symposium on Integrated Complex Care for Children and by the PCMCH Integrated Complex Care Advisory Committee.

The Strategic Framework represents our end-state vision for integrated care and service coordination. As a first step towards achieving this shared vision, our initial focus is advancing province-wide access to integrated medical care and coordination for CMC, starting with those who are medically fragile and/or technology dependent (MFTD). To support this journey, PCMCH committed to working with stakeholders in 2014/15 to develop three inter-related tools:

- A standard operational definition for CMC who are MFTD
- A toolkit to support effective collaboration within an integrated care team
- An paper-based care plan tool as a first step towards developing an province-wide integrated electronic care plan

A toolkit to support effective collaboration within an integrated care team

Integrated care teams* for children with medical complexity are unique from traditional care teams in that they consist of team members from various organizations and sectors who typically do not work collaboratively as one team. The goal of this toolkit is to help integrated care teams understand the shift required to overcome challenges and barriers to effective collaboration. Our intent is that, over time, these teams will develop practices and skills that enable:

- Family team members to effectively partner with providers and feel confident and comfortable advocating for their child
- Provider team members to work in true partnership with families – with an emphasis on listening and collaboration
- Family and provider team members to develop shared goals and implement practices that improve care and satisfaction for the entire team

Although the focus of the toolkit is on integrated care teams that support children with medical complexity and was developed by families and providers that support CMC, we recognize that this toolkit could be used by any integrated care team and would encourage others to use this toolkit where possible.

*Integrated care team members include: the family/child, inter-professional representation from the continuum of providers involved in supporting the child/family, at least one primary care provider who comprehensively understands the child's developmental and health status complexity and one point of contact for the family regarding clinical care coordination.

Background

Children with medical complexity (CMC) and their families are often faced with the challenge of navigating a very complex system, composed of different health care providers across various sectors/settings, located within and outside their communities. Generally these children do not have a unifying diagnosis; however, they are known to have multiple conditions that require specialized care that does not fit any existing program or the complexity of their condition is beyond what an existing program could manage. Both families and providers have indicated that there is an opportunity to improve integrated care coordination across the continuum of care for CMC.

Working in an integrated manner requires both families and providers to play an equal role in shifting practice and behavior to establish an effective integrated team approach. Several promising models of care targeting CMC have been developed and tested across the province, and have shown to improve outcomes for these children and increase family and provider satisfaction with care delivery. Similar initiatives to improve care and coordination for medically complex populations have also found that simple shifts in practice and behavior, where each team member plays an active role in the client's care plan, can help bring out the best in the team.

(*For purposes of this document, the term "family" includes the broad spectrum of potential caregivers for children who are MFTD, including legal guardian(s) or a legal entity, such as the Children's Aid Society)*

Tips for Working Effectively Within An Integrated Care Team

Introduction:

The purpose of this section is to provide real-life experiences along the journey of care for CMC and suggested approaches to work effectively as an integrated care team. Each tip also contains helpful resources that integrated care teams can access for more information.

Overview of Tips for Working Effectively as an Integrated Care Team:

Tip	Opportunity
1. Sustain senior level leadership	Successful integrated care planning requires joint senior level leadership to: a) articulate the vision and strategy of the integrated care team model and b) help remove barriers to ensure sustainability of the team.
2. Establish a One Team Approach	To maximize each team member's role and create more seamless transitions throughout the journey of care, identify ways in which team members can collaborate effectively and proactively as one team.
3. Focus on Relationship Building	To create a culture of trust and collaboration between all team members, invest in relationship building.
4. Use Effective Communication and Information Sharing Techniques	To ensure effective team communication and sharing of information pertaining to the child's care plan, recognize that each team member may have a different communication style and identify communication and information sharing techniques that work for the team.
5. Optimize Child and Family Functioning	To ensure optimal child and family functioning, work together as a team to create a supportive environment that can respond to family needs while respecting provider roles within the team.
6. Develop an Effective Decision-Making Process	To have an effectively functioning team, develop a transparent and constructive approach for decision- making that ensures diverse viewpoints are heard and appreciated.

Sustain Senior Level Leadership

The Opportunity

#1. To support cross-organizational and cross-sectoral collaboration, joint leadership is required for integrated care team success and sustainability.

Description: Successful integrated care planning requires joint senior level leadership to: a) articulate the vision and strategy of the integrated care team model and b) help remove barriers to ensure sustainability of the team.

Expected Outcomes and Benefits

- ☑ Sustainability of the integrated care team
- ☑ Equal accountability across all partner organizations
- ☑ Clearly defined outcomes and goals for the integrated care team with leadership oversight
- ☑ Quick and effective resolution of challenges that the team may encounter
- ☑ Change management processes in place to facilitate cross-organization and cross-sector collaboration

Tips to Achieve Sustained Senior Level Leadership

1. Identify all members of the leadership group. The leadership group should consist of leaders from each of the partner organizations participating in the integrated care team. Determine whether this leadership group should be an advisory committee (e.g. appointed to provide advice) or steering committee (e.g. appointed to provide direction).
2. Establish an appropriate management structure to execute the leadership team's vision of the integrated care team. Consider the appropriate mix of administrative and clinical representatives across each of the partner organizations for this management structure and project management resources, if required.

3. Identify appropriate change management tools and resources required to facilitate collaboration across partner organizations and help execute the leadership team's vision for integrated care planning.

Helpful Resources

- A "terms of reference" document could help describe the purpose and structure of the leadership advisory/steering committee and what they have agreed to contribute to accomplish their shared goals
- Change management tools to help execute the leadership's vision include:
  - Appendix 1 - Roles and Responsibilities for integrated care team members
  - Information sharing agreement (e.g. to document the terms and conditions of information exchange between partner organizations)
  - Stakeholder engagement templates (e.g. identify all stakeholders involved in the integrated care team and how to engage and communicate with each stakeholder group)
  - Communication strategy templates (e.g. for consistent messaging to stakeholders about the integrated care team)

Establish a One Team Approach

The Opportunity

#2. To maximize each team member's role and create more seamless transitions throughout the journey of care, identify ways in which team members can collaborate effectively and proactively as one team.

Description: The integrated care team consists of families and providers across different organizations, sectors and locations. Integrated care teams must make extra effort to break through real and perceived barriers and silos in order to get to know each other and their scope of practice to work as a cohesive team with a shared goal. Having a one team approach can enable team members to empower each other in their individual role and set teams up for success.

Expected Outcomes and Benefits

- ☑ Active family and provider engagement and contribution to the care planning process
- ☑ Effective use of all team member's time and skills
- ☑ Appreciation and understanding of each member's unique role, scope of practice and perspective
- ☑ Each team member recognizes themselves as part of a team
- ☑ Appropriate expectation setting for team members
- ☑ Seamless transitions throughout the journey of care
- ☑ The team recognizes the relationship between team functioning and quality of care

Tips to Achieve a One Team Approach

1. Know your partners and understand each other's role within the integrated care team. This will help you carry out your own roles and responsibilities more effectively and engage other team members appropriately. Understanding each other's roles also helps to reduce unnecessary duplication of effort and set realistic expectations of what each team member can accomplish towards the development, implementation and monitoring of the child's integrated care plan.
    - Families and community providers carry a wealth of information of resources that are available in the community. This information can help teams set appropriate care planning expectations in the community when the child is discharged from hospital to home.

2. Formal partnership agreements between team member organizations can help facilitate cross-organization collaboration and establish clarity in roles and responsibilities within the team.

3. Proactively identify key transition points in the client's care plan that would warrant an integrated care team meeting. Hosting a case conference prior to major transitions can help address confusion between team members in a timely and effective manner. It can also facilitate a smoother transition for the child and family.
    - Sometimes, team member roles in the development, implementation or monitoring of the child's care plan are determined with no consultation to confirm the contribution they are able to make. Instead, plan team responsibilities as a group so each team member has an opportunity to discuss what is feasible within their role.

4. Develop an orientation plan for all new team members to help them understand each team member's roles and responsibilities within the child's care plan, the goals of the team and how the team operates.
    - It is helpful to discuss how team member roles may change over time, based on the family's needs and circumstances (e.g. greater reliance on tertiary level coordination vs. community level coordination).

5. Create an evaluation process for continuous improvement. For example:
    - Conduct short surveys with team members to obtain feedback about their experience working within the team.
    - Share feedback with the team to brainstorm ideas for improvement.

6. Establish a family-representative advisory committee to provide input into the design and operations of the integrated care team.
    - For example, the family-representative advisory committee can be involved in reviewing team materials and documents shared with families to ensure they are appropriate and user friendly.

7. Get to know all providers involved in the child's care, including those beyond the integrated care team, to have a broader view of the services the family is receiving.

Helpful Resources

- Ontario Telemedicine Network (OTN) is a useful meeting tool to bring together team members in different locations. It can be used for group or one-on-one meetings using a personal computer or mobile device (see link: http://otn.ca/en/services)
- Refer to Appendix 2 for sample team satisfaction surveys
- The University of Kansas – Beach Centre on Disability provides resources to help teams measure their satisfaction with programs and partnerships http://www.beachcenter.org/families/family_research_toolkit.aspx

Focus on Relationship Building

The Opportunity

#3. To create a culture of trust and collaboration between all team members, invest in relationship building.

Description: Building effective relationships can help establish a positive environment for collaboration, shared decision-making and shared responsibility between team members. Upfront investment of time and energy to build relationships can improve team satisfaction, improve team productivity and improve the child and family experience.

Expected Outcomes and Benefits

- ☑ Families have increased trust and comfort in their child's care plan
- ☑ Team member's roles and responsibilities are well understood and are regularly updated as required
- ☑ Increased team productivity and satisfaction
- ☑ Increased trust within the team
- ☑ Team members will feel more empowered in their role within the team

Tips for Effective Relationship Building

1. Proactively get to know your team. There are several ways to build rapport with other team members, such as:
    - Attending meetings/case-conferences/rounds in person
    - Active team participation, such as providing input and asking purposeful questions in meetings
    - Informal coffee/lunch with other team members

2. Encourage team building and interaction through non-client related activities. Simply bringing team members into one space for joint training or information sessions can help build relationships.
    - Examples include seminars to share lessons learned, brainstorm solutions for common challenges or discuss topics related to care planning for CMC.

3. Don't let paperwork and process get in the way of meaningful engagement, particularly between families and providers. When family and provider team members engage in two-way dialogue beyond documentation, they can have a more productive conversation about the child's care plan.
    - For example, sometimes information about what has not worked well in the past is not documented or is simply overlooked. However, simply asking the family and/or other providers about what has and has not worked in the past can help teams develop a better understanding of the immediate child and family needs.

4. Use meeting time effectively. Experience shows that team members are more likely to participate in meetings when they feel a sense of accomplishment and direction as an outcome.
    - For example, standard meeting agendas with effective facilitation can help drive meetings forward. The agenda should clearly articulate the goal of the meeting and who is responsible for action items that come out of the meeting.

Helpful Resources

- Refer to Appendix 1 – "Roles and Responsibilities for integrated care team members" for a sample document of suggested roles and responsibilities for team members. Be sure to tailor it for your needs and seek endorsement from all team members.
- The CanChild website has relevant links to help team members with relationship building. (http://www.canchild.ca/en/childrenfamilies/fcs_sheet.asp
    - FCS Sheet #9 – Respectful behaviours and language in family-centred services
    - FCS Sheet #10 – Working together in family-centred services

Use Effective Communication and Information Sharing Techniques

The Opportunity

#4. To ensure effective team communication and sharing of information pertaining to the child's care plan, recognize that each team member may have a different communication style and identify communication and information sharing techniques that work for the team.

Description: Communication and reporting styles can vary between people, disciplines and settings, which can create a challenge in urgent situations. Be cognizant of different reporting and communication styles between team members and use appropriate modes of communication, based on the circumstance or situation. In addition, sometimes information is not properly communicated between team members to support care planning. Be sure to integrate and share information to the team using appropriate information sharing tools.

Expected Outcomes and Benefits

- ☑ Reduced family stress related to miscommunication and misunderstanding
- ☑ Increased understanding and trust between team members
- ☑ Increased team productivity
- ☑ Team members consistently have access to information shared by other team members that is useful for care planning
- ☑ Team members consistently integrate all information when planning and providing care

Tips for Effective Communication

1. Identify appropriate communication tools to facilitate a standard approach to communicating between team members.
    - The Situation-Background-Assessment-Recommendation (SBAR) tool is an effective debriefing tool for team members. It promotes structured communication using a short and concise format.

2. Accurate and up-to-date information can help ensure consistent messaging from provider to family team members. Create a culture of using and maintaining the single coordinated medical care plan as the primary source of client information. When using the single coordinated medical care plan:
    - Regularly review the care plan to ensure information is up-to-date and includes contributions from all team members.
    - Ensure family team members have the most up-to-date copy.
    - Maintain a one-page summary of critical information about the child's medical conditions and their care plan.
    - Ensure information from all team members is consistently integrated into the care plan.

3. Create a standard process for communicating client information between different organizations or across unprotected electronic platforms. Ensure that appropriate approvals are in place when information is shared.
    - For example, team members within the same organization may be able to communicate openly if they are using a secure platform, however, they may need to change their communication style to ensure privacy when communicating outside their organization.
    - Ensure families have access to their child's information and provide consent before information is shared between other team members.

4. Determine how technology can be used to facilitate communication between team members in different locations.
    - Teleconferencing and videoconferencing are effective ways of bringing team members together for case conferencing, rounds, etc.

Helpful Resources

- Refer to Appendix 3 for a Situation-Background-Assessment-Recommendation (SBAR) template.
- In Ontario, many health care organizations have access to ONE Mail, which allows secure inter-organization email communication. Work with your team members to see how you can use it more frequently in cross-organization communication.
- Ontario Telemedicine Network (OTN) is a useful meeting tool to bring together team members in different locations. It can be used for group or one-on-one meetings using a personal computer or mobile device (see link: http://otn.ca/en/services).

Optimize Child and Family Functioning

The Opportunity

#5. To ensure optimal child and family functioning, work together as a team to create a supportive environment that can respond to family needs while respecting provider roles within the team.

Description: Optimal child and family functioning depends on several factors, including the overall health of the family unit and the level of support they require from other team members. Recognize that the level of support required from the team can change depending on family's circumstances. Teams must work together in a timely way to provide the right level of support to families while respecting the level of support providers can deliver to meet family needs.

Expected Outcomes and Benefits

- ☑ Family team members feel empowered and supported by other team members within the team
- ☑ Providers are understanding, rather than judgmental, when the needs and circumstances of the child and family warrant a high level of care and services
- ☑ There are processes in place to support all team members when there are changes to the level of support to families
- ☑ All team members respect and support each other's service level decisions and commitment

Tips to Help Teams Optimize Child and Family Functioning

1. Recognize that some family team members may wish to be more involved within the integrated care team than others. Clarify the level of involvement family team members wish to have within the team and recognize that it may change over time, depending on their circumstances.
    - Where possible, use tools to help assess child and family needs and make decisions regarding associated levels of service (e.g. Child and Adolescent Needs and Strengths (CANS) assessment)

2. Work together as a team to determine the level of support each team member can provide and how changes in family circumstances may impact each team member.
    - For example, the team may expect some provider team members to increase their level of support to a point that might not be feasible (due to service level agreements or organizational policy). Ensure each team member has an equal voice when discussing service levels and feasibility of making suggested changes to service levels possible.

3. Proactively address questions or concerns family team members may have regarding their child's care plan by:
    - Having family team members decide who should be part of care planning meetings.
    - Ensuring family team members are aware of their right to ask about their child's care plan or ask about alternative approaches if they do not feel comfortable with a proposed plan of action for their child.

4. Identify ways in which family team members can have direct access to provider team members via tele- or videoconference to avoid unnecessary trips to the hospital/clinic and navigate urgent situations.
    - Identify ways to streamline the number of clinical appointments and trips to a tertiary centre to reduce the burden on families (e.g. schedule appointments over 1-2 days rather over multiple weeks, eliminate unnecessary in person appointments where possible)

5. Identify family networks and peer support groups for family team members. Families appreciate the opportunity to connect with other families who have undergone similar experiences for information and support.

Helpful Resources

- Regional family networks and some service providers support families by linking them with other families who have undergone similar experiences.
- Visit the "The Health Line" http://www.thehealthline.ca/ for a list of available services in your region. Integrated care teams can work with their local CCACs to generate a list of resources relevant to children with medical complexity.
- The Child and Adolescent Needs and Strengths (CANS) tool can be found on this website: http://www.praedfoundation.org/About%20the%20CANS.html#Here
- The CanChild website has relevant links to help families advocate for their child (http://www.canchild.ca/en/childrenfamilies/fcs_sheet.asp):
  - FCS Sheet #6 – Building on parent & family strengths and resources
  - FCS Sheet #7 – Parent to parent support
  - FCS Sheet #14 – Advocacy: Getting the best for your child

Develop an Effective Decision-Making Process

The Opportunity

#6. To have an effectively functioning team, develop a transparent and constructive approach for decision- making that ensures diverse viewpoints are heard and appreciated.

Description: Decision-making is a critical component of team functioning. Sometimes during decision making, different viewpoints have the potential to create conflict between team members. Differences make diverse teams more effective, therefore treat different viewpoints as an opportunity to work better as a team, while not letting it disrupt team functioning.

Expected Outcomes and Benefits

- ☑ Families have an active role in decision-making regarding their child's care plan
- ☑ The team uses appropriate conflict resolution strategies to manage and/or resolve conflict
- ☑ The team consistently seeks the perspectives and opinions of others
- ☑ Each voice and viewpoint is considered in the team decision making process

Tips for Effective Decision-Making

1. Ensure that the decision-making process links back to team's shared goals. The team goals articulate what is important to the family and providers and can help ensure the family's needs are the primary focus of resolving issues.

2. Develop a conflict resolution process for team members. Identify team member(s) who could be involved in managing conflict resolution (depending on the circumstances).
    - One of the key tactics in conflict resolution is having a dedicated meeting to discuss the issue and understand each perspective. Active listening and effective communication are important during conflict resolution.

3. Incorporate conflict resolution training in the orientation plan for new team members.

Helpful Resources

- The CanChild website has relevant links to help teams with effective decision making and conflict resolution (http://www.canchild.ca/en/childrenfamilies/fcs_sheet.asp):
    - FCS Sheet #9 – Respectful behaviours in family-centred service
    - FCS Sheet #10 – Working together in family-centred service
    - FCS Sheet #11 – Effective negotiation for family-centred service
    - FCS Sheet #14 – Advocacy – getting the best for your child

Appendix 1 – Roles and Responsibilities for Integrated Care Teams

The following table provides a suggested starting point to help define the roles and responsibilities for each member of the integrated care and service coordination team. Each team should modify it based on the needs of their group.

Task	Family	Primary Point of Contact for Medical Coordination	Most Responsible Physician/Provider*	Other Integrated Care Team Members
Coordinating the Team				
Identify who should be involved in the integrated care team.	X	X		
Contacts team members to inform them of a new client in the integrated care team program. Explains integrated care team process and involvement with all team members.		X		
Calls initial team meeting and schedules regularly occurring team meetings.		X		
Facilitates discussion re: team roles/assignments: chair, minute taker, time keeper and team challenges.		X		
Initiates team meetings to proactively plan for and facilitate transitions, including to adult services.		X	X	

Primary Point of Contact for the Family				
Acts as the primary point of contact for the family regarding clinical care coordination and triage for medical emergencies in consultation with the most relevant clinical team member(s).		X		
Comprehensively understands the child's developmental and health status complexity and needs and is capable of monitoring and addressing ongoing needs and changes.			X	
Managing the Single Coordinated Care Plan				
Responsible for the development of a single coordinated care plan.	X	X	X	X
Ensures the child and family's single coordinated care plan is comprehensively completed, monitored and communicated with all integrated care team members.	X	X	X	
Ensures implementation and execution of the single coordinated care plan and keeping the primary point of contact for clinical coordination informed of progress, challenges and opportunities.	X	X	X	X
For team members not "connected" to the shared care plan electronically, acts as a conduit of information and ensure that all team members have an up-to-date copy of the plan.		X	X	

Monitors changes in the child's health status, circumstances or needs and communicates with the team if a change in the level of care coordination is required.	X	X	X	
Ensures information in the single coordinated care plan is accessible, accurate and timely.	X	X	X	
Ensures single coordinated care plan is regularly monitored.	X	X	X	X

Source: Children's Treatment Network – Single Plan of Care Coordination

*Note that the primary care provider and tertiary care provider may trade the role of most responsible physician/provider depending on where the child is receiving care (e.g. in hospital or in community)

Appendix 2 – Integrated Care Team Sample Satisfaction Survey

The following survey can be used by integrated care teams to assess Integrated Care Team functioning. Consider other dimensions to include in your team's satisfaction survey. Key categories to consider include:

- Roles and responsibilities
- Family-Centred Approach
- Communication
- Collaboration
- Team Functioning
- Conflict management / Resolution

Dimensions	Minimal – Score of 1	Developing – Score of 2	Competent – Score of 3	Mastery – Score of 4
Roles and Responsibilities	☑ Team member's roles and responsibilities are not understood by the team.	☑ Team member's roles and responsibilities are somewhat understood by the team.	☑ Team member's roles and responsibilities are well understood by the team.	☑ Team member's roles and responsibilities are well understood and are regularly updated as required.
Integration of Patient/Client Beliefs and Values	☑ Does not integrate family's circumstances, beliefs and values into care plans.	☑ Occasionally integrates the family's circumstances, beliefs and values into care plans.	☑ Frequently integrates family's circumstances, beliefs and values into care plans.	☑ Consistently promotes and integrates family's circumstances, beliefs and values into care plans.

Information Sharing with Patient/Client	☑ Does not share options and health care information with family team members.	☑ Occasionally shares options and health care information with family team members.	☑ Frequently shares options and health care information with family team members.	☑ Consistently shares options and health care information with family team members.
Patient Advocacy in Decision-Making	☑ Does not advocate for family as partners in decision making processes.	☑ Occasionally the team advocates for family as partners in decision making processes.	☑ Team frequently advocates for family as partners in decision-making processes.	☑ Team consistently advocates for family as partners in decision-making processes.
Collaborative Relationship	☑ Does not establish collaborative relationships with others.	☑ Occasionally establishes collaborative relationships with others.	☑ Frequently establishes collaborative relationships with others.	☑ Consistently establishes collaborative relationships with others.
Integration of Information from others	☑ Does not integrate information from others in planning and providing client care.	☑ Occasionally integrates information from others in planning and providing client care.	☑ Frequently integrates information and perspectives from others in planning and providing client care.	☑ Consistently integrates information and perspectives from others in planning and providing client care.

Information Sharing	☑ Does not share information with other team members.	☑ Occasionally share information with other team members that is useful for the delivery of client care.	☑ Frequently share information with other team members that is useful for the delivery of client care.	☑ Consistently share information with other team members that is useful for the delivery of client care
	☑ Does not seek approval of client when information is shared.	☑ Occasionally seeks approval of the client when information is shared.	☑ Frequently seeks approval of the client when information is shared.	☑ Consistently seeks approval of the client when information is shared.
Team Functioning and Dynamics	☑ Does not recognize the relationship between team functioning and quality of care.	☑ Occasionally demonstrates recognition of the relationship between team functioning and quality of care.	☑ Frequently demonstrates recognition of the relationship between team functioning and quality of care.	☑ Consistently demonstrates recognition of the relationship between team functioning and quality of care.
Team Discussion	☑ Does not view themselves as part of the team.	☑ Occasionally demonstrates recognition of themselves as part of a team.	☑ Frequently demonstrates recognition of themselves as part of a team.	☑ Consistently demonstrates recognition of themselves as part of a team.
Respect for different perspectives	☑ Does not consider the perspectives and opinions of others.	☑ Occasionally seeks the perspectives and opinions of others.	☑ Frequently seeks the perspectives and opinions of others.	☑ Consistently seeks the perspectives and opinions of others.
Conflict management	☑ Does not manage or resolve conflict with others.	☑ Occasionally uses ☑ appropriate conflict resolution strategies to manage and/or resolve conflict.	☑ Frequently uses appropriate conflict resolution strategies to manage and/or resolve conflict.	☑ Consistently uses appropriate conflict resolution strategies to manage and/or resolve conflict.

Source: Curran, V. Interprofessional Collaborator Assessment Rubric. *Academic Health Council.* Retrieved from: http://www.med.mun.ca/CCHPE/Faculty-Resources/Interprofessional-Collaborator-Assessment-Rubric.aspx

Appendix 3: SBAR Situation-Background-Assessment-Recommendation

The following table provides an overview of how to use the Situation-Background-Assessment-Recommendation (SBAR) tool to communicate information between team members.

Description	Sample Script
S – Situation *A concise statement of the problem* *Overview*: • Identify yourself and the site/organization you are calling from • Identify the client by name and the reason for your report • Describe your concern	My name is_____ and I work _____ (*your role/responsibility and organization*) I need to talk to you about: ▪ An urgent issue regarding ____ (*name of client*) ▪ A quality of care issue regarding ____ (*name of client*) I need ____(*minutes*) to talk to you, if not now, when can we talk? I need you to know about _____ (*describe situation – e.g. changes to a patient status, treatment plan, procedures or protocols or environmental / organizational issues related to client care*)
B – Background *Pertinent and brief information related to the situation* *Overview*: • Describe the client's current circumstances • Explain relevant information about the client's history	Are you aware of ____ (*specific problem*) The client is ____(*age)* and has a diagnosis of ____(*list the diagnoses*) His/her treatment plans related to this issue to date include ____(*treatment*) He/she is being monitored by ____(*name*) and has appointments for ____(*procedures*) The client/staff is requesting that____(*describe the requests*)
A – Assessment *Analysis and considerations of options – what you found/think* *Overview*:	I think the key underlying problem/concern is____(*describe*) The key changes since the last assessment related to the specific concern are:____(*describe*)

Description	Sample Script
• Clinical impressions, concerns	
R – Recommendation *Action requested/ recommendation – what you want* *Overview:* • Explain what you need – be specific about request and time frame • Make suggestions • Clarify expectations	Based on this assessment, I request that: ____(*describe*) To be clear, we have agreed to____ (*describe*). Are you ok with this plan? ▪ I would like to hear back from you by ____(*date/time*) ▪ I will be in contact with you about this issue by____(*date/time*)

Relevant resources include:

- ***Longwoods*** – The adopted SBAR tool: http://www.longwoods.com/articles/images/HQ_vol13_SP_AndreoliF1.jpg
- ***The Institute for Healthcare Improvement*** – SBAR toolkit: http://www.ihi.org/resources/Pages/Tools/SBARToolkit.aspx
- ***National Health Service*** – Institute for Innovation and Improvement – SBAR: http://www.institute.nhs.uk/quality_and_service_improvement_tools/quality_and_service_improvement_tools/sbar_-_situation_-_background_-_assessment_-_recommendation.html