COLLABORATION IN A PRIMARY CARE SETTING: STRATEGIES FOR A FAMILY NURSE PRACTITIONER CARING FOR THE FRAIL OLDER ADULT

by

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Abstract

Although many older adults live active and dynamic lives well into their late years, some become frail and increasingly dependent on the health care system, due to physical, cognitive, and social changes. In order to address these concerns in health care delivery, collaboration among health care providers has been a central focus for government in recent years. Collaboration among health care providers and community agencies are known to contribute to the continuation of support, by assisting the frail older adult person to achieve best health outcomes, as well as the most common goal: to remain in their homes. Nurse practitioners (NP) are one of the health care professionals, that provide quality primary health care to frail older adult patients in British Columbia (BC). The question for this project is: "when a NP is providing primary care for the frail older adult in the community setting, which practice strategies promote effective collaboration between health care providers?" Background knowledge about collaboration in health care, effective collaboration, the role of the NP as primary care provider, and the specific needs of the frail older adult, comprise the basis of this literature review. The 16 articles retained for analysis contained strategies themed into professional, organizational, patient and family foci. The research studies were then critiqued and themes emerged for professional, organizational, and building a therapeutic relationship with patient/family focused strategies. The results produced practice strategies for aiding in effective collaboration. The project concludes with implications for future research and education.

Keywords: nurse practitioner, frail older adult, primary care, community, collaboration, effective collaboration, strategies

Dedication

For my Baba, Palegia (Pauline) Hochachka, 1907- 1997,

my Grandpa, William H. Pike, 1910-1995,

and my Grandma, Mabel E. Pike, 1914-1997.

Who seeded into my youth the immeasurable value of older adults.

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Aging is not lost youth but a new stage of opportunity and strength.

-Betty Friedan

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Chapter One: Introduction

Imagine a fictitious patient, Mr. Brown; he is an active and healthy 81 year old man who has suffered a stroke. Mr. Brown has returned home to be cared for by his 80 year old wife because he cannot bear the thought of living in a senior's care facility. He can no longer speak clearly, has trouble chewing and swallowing many foods, has limited use of his right arm, and experiences substantial weakness in his right leg. Daily living tasks such as bathing, dressing, eating, and mobility are now difficult for him. Mr. Brown's primary care provider refers him to numerous medical specialists, home care nursing, physiotherapy, occupational therapy, social work, and a dietitian, in order to support his wish to remain at home.

His wife does her best to organize a multiple number of health care appointments made for Mr. Brown in different locations, at different times throughout the day, while juggling difficult transportation and mobilization issues. Health care providers prepare a variety of treatment plans and interventions; they do their best to help Mr. Brown and his wife manage a complex and difficult situation. However, every health care provider who comes into contact with Mr. Brown and his family asks the same questions, repeats suggestions, or even contradicts previous provider's directions. These inconsistencies confuse and frustrate Mr. Brown and he is convinced that the health providers continue to ask him the same things because they think he is lying. He stops answering questions, thereby making assessments very difficult and earning him the label of a difficult patient. Then, in an attempt to supplement the couple's limited budget, the social worker and the occupational therapist both apply for funding to obtain Mr. Brown a special shower chair for the bathroom. He receives two seats and a substantial deduction from his already very limited pension check that week for exceeding the allotted amount of funding permitted.

Mr. Brown's primary care provider is not aware of what other providers have planned or done, and Mr. Brown therefore has to spend much of his limited appointment time updating the provider about what he thinks has been done, but he really is not sure what had been decided upon. There is often confusion as to who will be doing what, who has already done what, and what needs to happen next. Mr. and Mrs. Brown feel overwhelmed, afraid, frustrated, and confused with the care and supports they receive.

A health care provider then changes one of Mr. Brown's medications; it is changed again by another and, consequently, he mistakenly takes both medications for four weeks, resulting in his admission to hospital because of adverse side effects and toxicity. While in hospital to organize his medications and normalize his blood levels, Mr. Brown tries to mobilize to the washroom during the night. He becomes disoriented, trips over a stool, and falls to the floor, breaking his fully functioning arm. Infection sets in after surgery to correct the fracture, depression follows, and, with his determination to live with his new challenges gone, he gives up. It becomes clear to everyone that Mrs. Brown can no longer care for her husband in their home, and he is moved to an extended care facility where he dies two days later.

Mr. and Mrs. Brown's story is not unique; they are not alone. Canada's population is aging. Over the next 20 years, older adults over the age of 65 will likely grow to comprise 25% of the Canadian population compared to 15.3% in 2013 (Statistics Canada, 2014). As a consequence of developments in science and advancing medical treatments, people are living longer and often into late life with chronic and fragile conditions (Reuben et al., 2013). Seventy-six percent of adults 65 and older report at least one chronic health condition such as hypertension, diabetes, and arthritis, while 24% report having three or more chronic conditions (Canadian Institute for Health Information [CIHI], 2011). Yet, over 90% of older

adults live in private households (CIHI, 2011; Statistics Canada, 2012) and, if current patterns continue, many older adults will continue to live in their own homes until an advanced age with at least one frail or chronic condition (CIHI, 2011).

Although many older adults live active and dynamic lives well into their late years, some, such as Mr. Brown, become frail and increasingly dependent on the health care system due to the physical, cognitive, and social changes that can occur as part of the aging process and the presence of chronic illness. Torpy, Lynm, and Glass (2006) consider a person to be "frail" if three of the five following characteristics are present: (a) low physical activity; (b) muscle weakness; (c) slow performance; (d) fatigue or poor endurance; and (e) unintentional weight loss. For the purposes of this project, a person is described as a frail older adult if they are experiencing a physical or cognitive impairment that causes challenges with activities of daily living that include problems with eating, personal care, and mobility (Torpy et al., 2006), and is aged 75-95 years old. This age range is specified because health care requirements tend to increase considerably in this age group (CIHI, 2014; Morley et al., 2013), as well as to provide a more focused population for this literature review.

Mr. Brown's situation is an example of the growing need for collaboration in health care for frail older adult persons. As I approach my transition into primary care NP practice, my wish is to be able to work efficiently with other health care professionals to improve patient care. Frail older adults such as Mr. Brown are at significant risk for hospital admission and morbidity, and consequently complex and multifaceted care is often required to provide quality care. Although the ultimate outcome of Mr. Brown's story might not have changed if there had been more effective collaboration, the literature suggests that collaboration between health care providers can contribute to better health outcomes for frail

older adults (Baxter & Markle-Reid, 2009; Emery, Lapidos, Eisenstein, Ivan, & Golden, 2012; Park, Miller, Tien, Sheppard, & Bernard, 2014).

Throughout the literature, there are numerous terms such as interdisciplinary collaboration, integrated care, and interprofessional working, used interchangeably with similar definitions to that of collaboration. To ensure consistency and avoid confusion, the term collaboration will be used in this project to address the process of bringing together health care providers from different professions to work towards a mutually identified goal or goals (College of Registered Nurses of British Columbia [CRNBC], 2015). In addition, the term health care provider will be used to address those who provide formal health care services, such as an occupational therapist, nurse, physician, physiotherapist, or nutritionist. Collaboration between health care providers, is a central component to the collaboration process. Although there has been much focus on collaboration facilitators and challenges, strategies to effectively achieve such collaboration has received considerably less attention in the literature.

In this paper, I will explore the question: "when a NP is providing primary care for the frail older adult in the community setting, which practice strategies promote effective collaboration between formal health care providers?" Due to the limited size and scope of this project, I will be focusing on collaboration between health care providers, but collaboration with the patient, families, and other informal care providers are also of great importance. I will show how specific collaboration strategies provide an increase likelihood of comprehensive care for the fragile older adult in order to achieve best health outcomes. These best outcomes include the stability of the older adult patient's frail condition, and to keep the patient in their individual private dwelling as long as possible. In the background section of this review, I will examine: (a) the specific needs of those frail older adults who

can benefit from a collaborative approach, (b) the NP's practice while providing care to the older adult population in the primary care setting, (c) best practice guidelines, (d) collaboration, and (e) collaborative facilitators and challenges in health care. The method section will detail the approach to the literature search that was completed and identify the way in which articles were selected. The findings section will provide an overview of the findings and analysis of the selected literature, followed by a description of the limitations of this review. Lastly, the discussion section will discuss evidence-based practice strategies followed by recommendations for future research and study.

Chapter Two: Background and Context

Caring for the frail older adult patient is often a complex endeavour, requiring input from multiple health care providers as well as the patient. Health Canada (2014) has promoted collaboration, through health care reform, for use in all areas of health care and between all health care providers to ensure the most effective use of resources, times, and better health outcomes. The goal of this review is to provide evidence for effective collaboration strategies that the NP can use with other formal health care providers while providing care in primary care practice, in order to achieve best health outcomes for the frail older adult patient, thereby assisting them to remain at home for as long as possible. This section provides background and context information on the specific needs of the frail older adult person, the NP as primary care provider in BC, best practice guidelines for managing the care of the frail older adult patient in primary care, collaboration in health care, and finally, challenges and elements to collaboration in health care.

The Frail Older Adult Person

Many older adults consider themselves to be successful agers despite debilitating illnesses and functional decline (Strawbridge, Wallhagen, & Cohen, 2002). Some people might view the positive aspects of aging as such characteristics as increased wisdom and confidence, increased coping skills, and increased motivation with an appreciation for the value of time (VanDyke, 2003). The frail older adult has stories of lived life to tell, and a rich history of experiences from which to learn. Many older people have grandchildren and great grandchildren to enjoy and are taking pleasure in the late years of their life.

Caring for the frail older adult person requires advanced skills and abilities for specialized needs that other populations do not necessarily require. Physically, the frail older adult person may experience gait or balance issues, functional decline of vision, hearing,

reflexes, and motor strength, and an increasing inability to complete daily tasks such as housework, meal preparation, and personal care. Changes in mental health may occur with the experience of loss of loved ones, change in social or economic status, and the response to the physical changes that accompany the aging process. General cognitive decline may include memory loss and language difficulties (Silva-Smith et al., 2011). These physical, mental and cognitive changes place the frail older adult person at greater risk for accidents or falls, abuse, depression, substance abuse, disability, hospitalization, and death (Metzelthin et al., 2013; Silva-Smith et al., 2011). Frail older adult patients often have additional health complications such as diabetes, arthritis, depression, kidney failure, respiratory disease, heart failure, incontinence, dementia, and cancers that tend to increase with age (Boeckxstaens & de Graaf, 2011; Reuben et al., 2013; Skultety & Zeiss, 2006). The primary care provider of the frail older adult patient, usually a physician or NP in BC, must consider all of the social, spiritual, physical, mental, occupational and emotional components for each unique individual and situation.

The BC provincial government has responded to the expected increase in the number of frail older adult persons by increasing home and community based programs and resources (Ministry of Health, 2012). Moreover, most frail older adults want to have a say in where they live their last years of life, and often choose to remain at home, often choosing to die there (Enhancing Interdisciplinary Collaboration in Primary Health Care in Canada Committee [EICP], 2005). Older adults want to be heard, make their own decisions, and be involved in the solution making process. They do not want to have their independence taken away from them despite any frailties, and they want to be taken seriously by health care providers (Metzelthin et al., 2012).

Despite considerable recent investments by the federal and provincial governments into community care for the older population (Ministry of Health, 2012), there are limited public resources available which are spread increasingly thinly amongst a growing number of people. The desire of the patient or family to avoid or delay facility care pushes family caregivers, or friends in the case of those who have no family available or willing to take on the responsibility, to fill the role of main support for the frail older adult person living at home. However, the family unit is smaller than in the past, and families are living farther apart, meaning fewer caregivers available to help with the needs of a frail loved one (Canadian Alliance for Sustainable Health Care [CASHC], 2013). Often, the main care provider is a spouse of the frail older adult and this caregiver may be frail themselves, or may be a grown child with childcare concerns, adding another layer of complexity to the situation. Caregiver illness or burnout often becomes problematic in these circumstances (CASHC, 2013; Park et al., 2014). Therefore, health care providers who provide care and support for the frail older adult patient also need to support any family caregivers. Without these caregivers, the frail older adult patient is less likely to be able to manage at home despite the best efforts of any community-based support personnel. Patients and family helpers may rely heavily on primary care providers, such as NPs, to assist them with complex and multidimensional issues of frailty, and to advocate for their best interests. This advocacy become more crucial when there is no extended family or caregivers to assist the older adult.

Nurse Practitioners as Primary Care Providers in BC

In response to health care sustainability concerns, a country-wide demand for health care delivery changes began in the mid-1990s (Donald et al., 2010). A focus developed on optimizing the NP profession as one potential important solution to provide accessible quality primary health care to more Canadians (Canadian Nurse Practitioner Initiative

[CNPI], 2006; Donald et al., 2010). Nurse practitioners have been a part of the Canadian health care system for over 40 years and have been regulated in BC for the last ten years.

In BC, NPs are health professionals with a minimum of two years registered nurse (RN) experience who have also completed a master's degree. The bachelor's degree obtained in order to become licenced as a RN includes education and practice experience with collaboration, leadership, and provision of holistic care, while putting the patient in the centre of their own health care. The master's degree adds to these skills, and includes additional education in health assessment, medical diagnosis reasoning, interpretation of medical investigations and tests, advanced treatment planning, and prescribing (British Columbia Nurse Practitioner Association [BCNPA], 2015; CRNBC, 2015). Nurse practitioners in BC are primarily educated as family NPs; that is, they are educated to provide primary care services for all ages. Primary care is the day to day first contact with a consistent health care provider, such as a family physician or family NP, who provides services that include health promotion, illness and injury prevention, and the diagnosis and treatment of illness and injury (Health Canada, 2014). As primary care providers, the NPs may work autonomously or collaboratively in a clinic or a primary care office in a wide range of possible geographic settings. These settings allow for the same continuity of care, or ongoing health management, that patients typically receive from other primary care providers.

Unlike other primary care providers in BC, the main funding model for NPs is salaried positions administered by the regional health authorities. These salaried positions often translate into additional flexibility in appointment times for service delivery. This flexibility may also translate into a more comprehensive planning of care for patients with multiple issues or illnesses.

The scope of practice, or the activities that NPs are licenced and educated to undertake, are dependent upon individual specialities and individual competencies (CRNBC, 2015). These competencies include personal responsibility and accountability to provide safe and ethical care to all patients. The increased education provides the NP more opportunities to develop into leadership roles given their advanced skills in communication, negotiation, coalition building, and conflict resolution (Canadian Nurses Association [CNA], 2010). This expanded training adds to the established nursing competencies to provide holistic care, taking into account psychological, economic, social, and physical determinants of health.

NPs collaborate in day to day practice with other health care providers, patients, families, and communities. The NP refers to, and consults with other health care providers, including medical specialities, to provide each patient with the most comprehensive care possible for their individual needs. Working together to achieve best health outcomes for patients, in this case maintain stable health care conditions and keep the frail older adult at home, is a key component of NP's professional standards (CRNBC, 2013). Added to this is the use of the best research and evidence-based management plans and best practice guidelines to make health diagnosis and management decisions (CRNBC, 2015).

BC Guidelines for Managing the Frail Older Adult Patient in Primary Care

BC Guidelines are distributed by the Ministry of Health, which is the government department responsible for BC's health care, and Doctors of BC, an organization representing BC physicians. These two organizations make up the province's Guidelines and Protocols Advisory Committee (GPAC). The guidelines provide primary care providers, such as NPs, with evidence-informed practice recommendations and protocols to use for a wide variety of health conditions and diagnosis. One of these guidelines focuses on older adult care, entitled Frailty in Older Adults - Early Identification and Management; it focuses on the

early identification and management of frailty in older adults (GPAC, 2012). The guidelines suggests that once the primary care provider suspects a patient to be frail, the Canadian Study on Health and Aging Clinical Frailty Scale (see Appendix A) can be utilized in order to assess the degree of frailty for that individual. The primary care provider is then expected to collaborate with other health care providers, the older adult patient, and their family, to investigate and assess the circumstances or conditions further, with the goal of creating a detailed care plan. A care plan is a written plan that is created by a patient, health care providers, and family and is a tool to facilitate communication between collaborating parties (Ontario Medical Association [OMA], 2014). This care plan should include care or health goals, a medication review, names and contact information of other providers, advanced care planning, advanced directives, co-morbidity management planning, level of intervention, identification of substitute decision makers, expected outcomes, and intended follow up (GPAC, 2012). The care plan contributors then monitor and re-evaluate the patient as required. Ideally, the frail older adult patient or the caregiver would bring the care plan document to all appointments as the patient moves between health care settings and providers (GPAC, 2012). As a facilitator to collaboration, care plans are discussed further in this project.

Collaboration in Health Care

Collaboration in health care is the process of bringing together health care providers from different professions to work towards a mutually identified goal (CRNBC, 2015). In 1978, the World Health Organization (WHO) published works introducing the importance of collaborative care and suggested that all countries strive for this health care delivery model. The publication was made in response to the inequality and health disparity experienced over much of the world. Results of the WHO research suggested that collaboration of health care

providers would enhance health care availability and affordability everywhere (WHO, 1978). This call for collaborative practice was shared again 30 years later as health systems continued to perform poorly (WHO, 2008). In response to the WHO's suggestion, Health Canada (2014) promoted the collaboration of health care providers. Such health care providers might include, but are not limited to, primary care providers such as NPs and physicians, and other providers such as physiotherapists, RNs, occupational therapists, and nutritionists who then provide high quality, comprehensive health care services. Also of high importance to the collaborating group are non-health care providers such as social workers, and mental health and life skills workers. Although the entire collaborating group of professionals are important in assisting the frail older adult patient, this project focuses on the collaboration between health care professionals. Health Canada (2014) expects that health providers who collaborate will be more innovative, cost-effective, and comprehensive with the care provided through joint communication and information-sharing with health care providers.

As a result of the collaboration between health care and other providers, positive outcomes have been documented for patients. Collaboration can prevent injury, exacerbations of chronic health issues, and acute care visits while providing effective support to move efficiently and smoothly between providers (de Stampa et al., 2013; Matthews & Brown, 2013; Ryan et al., 2013). Collaboration assists with monitoring, preventing, and treating the frail older adult's chronic and complex health issues, preventing or minimizing disability, preventing or delaying institutionalization, and promoting quality of life (CRNBC, 2015; Hendrix & Wojciechowski, 2005; Markle-Reid, Browne, & Gafni, 2013; Naylor & Kurtzman, 2010). Other benefits of collaborative practice include: improved quality of care, better access to health care services, reduced health care utilization and costs, enhanced

compliance, and improved health outcomes (Baxter & Markle-Reid, 2009; Burnett, Tucker, & Gagan, 2005; CASHC, 2013; Markle-Reid et al., 2013; Naylor & Kurtzman, 2010; Robben et al., 2012). It can ease family and patient frustrations as they become a part of the decision making process, prevent omitted or erroneous care, better utilize scarce resources, and ultimately help sustain our national health care system (CASHC, 2013; Keith & Askin, 2008; Markle-Reid et al, 2013; Naylor & Kurtzman, 2010; Weberg & Weberg, 2014). Collaboration among health care providers can contribute to the continuation of support in assisting patients to achieve best health outcomes as well as the most common goal for many frail older adults: to remain in their homes (EICP, 2005).

Collaboration is not the sole way to provide health care of course, and may at times be a challenge to accomplish. By definition, collaboration is working toward a common goal, but if there is a value conflict and no common goal can be agreed upon, collaboration cannot happen. Using the frail older adult patient's values and goals to guide all clinical decisions may help bring health care providers, non-health care providers, patients and families together in some cases. The patient's individual situation, cultural beliefs, family situations and lifestyles, combined with complete unbiased health care options and education of benefits and risks, assist the collaborating group with direction that will lead to the realization of the frail older adult patient's wishes and goals. The health care providers must consider while in situations of crisis or when time is extremely limited, that collaboration amongst health care providers may not be the best course of action. Generally, collaboration is more time consuming than working alone, as the more people who contribute to the decision making process, the more that compromise and negotiation has to occur to accomplish the goal. The NP must use professional discretion to decide when it is and is not appropriate to consult and collaborate with other care providers and community sources. Acute care

services may be appropriate, or the frail older adult patient and the NP may be the sole collaborators in some instances. Not all situations require collaboration. Despite the benefits of collaborative care, it is important to understand and address the challenges, as this model of care has been criticized for being time consuming, expensive, and difficult to accomplish. These challenges will be discussed further in this paper.

When challenges are minimized or overcome, research has shown that collaboration between health care providers is effective in providing higher quality, reliable, and consistent health care (Health Canada, 2014; WHO, 2010). Researchers have shown collaboration to be positive and even necessary, to create best outcomes for the Canadian population as they age (Baxter & Markle-Reid, 2009; Emery et al., 2012; Park et al., 2014). Some of the best outcomes include timely implementation of care, stability of chronic frailty issues, and keeping the frail older adult in individual dwellings for as long as possible. Collaboration between health care providers continues to show gains for the complex specialty care required for the frail older adult person and are often considered core competencies of professional practice (Boult & Wieland, 2010; Emery et al., 2012; Ryan et al., 2013), in some instances without a significant increase in medical cost (Emery, Millheiser, Garcia, Marquine, & Golden, 2011). Considering the benefits, it is worth the time and energy to ensure that the collaboration occurring between providers is effective, and the process is producing positive results.

To ensure the longevity of these benefits, attention has been placed on the use of and sustainability of collaboration in the provision of health care. The government has invested considerable time and funding into ensuring collaborative practice is developed in a sustainable way through projects such as Enhancing Interdisciplinary Collaboration in Primary Health Care in Canada (EICP, 2005) and the Primary Health Care Charter (Ministry

of Health, 2008). The Primary Health Care Charter states that "legislation, governance, investment, media, human resources and research" (p. 36) facilitate sustainability of collaborative care, but that collaboration is ultimately up to each collaborator and organization to ensure sustainability (Ministry of Health, 2008).

"Effective" Collaboration

The word effective is defined as being successful in producing a desired or intended result ("Effective", 2015). Collaborator's perceptions or agendas in the joint process may determine the effectiveness of collaboration (Schroder et al., 2011), but collaborators usually consider collaboration to be successful when common goals have been realized (Keith & Askin, 2008; Markle-Reid et al., 2013; Ryan et al., 2013). The intended outcome for effective collaboration varies in specific goal setting, but generally is the stability of the frail older adult's condition in order to maintain quality of life and remain at home. However, it is important to consider effective collaboration as a process and not merely an end result. For instance, a NP and a registered psychiatric nurse might collaborate with the frail older adult patient and his daughter to resolve the patient's acute depression, with the mutual goal of controlling symptoms. The health care providers use the effective collaboration strategies they possess, communication between all parties happen to everyone's satisfaction, resources are utilized to maximum efficiency, but the patient enters a psychosis and hurts himself. The collaboration process was effective in joint decision making and care consistency, even though the health care goal was not achieved in the community and symptoms were not controlled. The collaborative process now shifts in order to achieve the goal, to control the patient's symptoms, by referral and consult with acute care services, adding more health care providers to the collaborative process.

Successful collaboration requires mutual respect and trust, shared decision making, openness to learning from the expertise of others, working towards a common goal, active listening, and regular dialogue between parties including the frail older adult patient and family (Clarin, 2007; CNA, 2010; O'Brien, Martin, Heyworth, & Meyer, 2009; Wilson, Coulon, Higgege, & Swann, 2005). These strategies will move the NP closer to the goals of care, such as maintaining stabilization of health care conditions and keeping the frail older adult patient in their own home, while contributing to effective collaboration in practice. In order to assess if these strategies are working, it is important to self-reflect and evaluate the process and its effectiveness to maintain the frail older adult patient's health conditions and treatment goals. Organizations may have an evaluation tool, or it may be up to the health care providers to find one for best practice outcomes. An effective collaboration tool is suggested in Chapter five.

Many examples of effective collaboration, including Burnett et al. (2005), are presented in the literature. In their (n=1) participant-observer case study, NPs Burnett and Tucker worked collaboratively to extend appropriate, timely and successful treatment for an older adult patient who traveled between summer and winter homes. They accomplished this through monthly email updates and connections, joint care planning, and keeping the older adult heavily involved with decision making and problem solving. Through each travel season, their efforts accomplished a smooth transition between providers in different locations and the continuation of health care goals. Effective collaboration saved time and resources through non-duplicated, consistent consultation. The patient felt included and heard while being involved in the collaborative process through emails and phone messaging. When an acute exacerbation of a chronic issue occurred, a care plan ensured that treatment started promptly. This example of effective collaboration highlighted continuity of care that

resulted in ongoing health maintenance for the patient. These health care providers recognised the value of collaboration for their patient. However, in day to day practice, it should be recognized that collaboration mainly exists in primary care through referrals and occasional consultations between health providers (Schadewaldt, McInnes, Hiller, & Gardner, 2013).

Facilitators and Challenges to Collaboration in Health Care

Despite the researched benefits of collaboration demonstrated in research, studies also show that collaboration in practice does not happen on a regular basis, and in some cases rarely happens (Bailey, Jones, & Way, 2006; de Stampa et al., 2013; Donald et al., 2009; Goldsmith, Wittenberg-Lyles, Rodriguez, & Sanchez-Reilly, 2010; Prada, Grimes, & Sklokin, 2014; Schadewaldt et al., 2013; Wilson et al., 2005). Both professional and organizational factors have an impact on effective collaboration.

As previously mentioned, working together as health care providers for the health care consumer can be difficult and requires the development of knowledge and skills honed through practice. Collaboration in health care provision involves the sharing of information and expertise among people in disciplines who have traditionally worked independently. Different health care providers evaluate health care situations on different levels and through different care foci (Emery et al., 2012; Korazim-Korosy, Mizrahi, Bayne-Smith, & Garcia, 2014). Although the different care foci may create some barriers to collaborative care, these ideological dissimilarities between providers may be the perfect combination to foster creative ideas, complementary care, and produce a stronger health care system.

Professional challenges.

The majority of collaboration challenges and facilitators occur at the professional level of health care delivery. One such challenge is that health care providers may be

uncertain about the roles of the different providers during collaboration (Emery et al., 2012; Mian, Koren, & Rukholm, 2012; Robben et al., 2012). This uncertainty of each other's roles can cause an avoidance of or a reluctance to collaborate with a professional or available resource because of lack of knowledge about what that service or provider can offer (Emery et al., 2012; Mian et al., 2012; Robben et al., 2012). A lack of knowledge may spill over into ambivalence between health care professions, thereby making working together effectively a challenge (Emery et al., 2012; Legault et al., 2012; Korazim-Korosy et al., 2014; Robben et al., 2012).

Furthermore, the overlapping roles between various formal health care professions have ignited issues with "territorialism" (de Stampa et al., 2013; DiCenso & Bryant-Lukosius, 2010; Korazim-Korosy et al., 2014) as providers try to determine who should be providing what service, at what time, and why. The desire for autonomy tends to foster individualism rather than collaborative practice (Elissen, van Raak, & Paulus, 2011). Without clear communication, services may be duplicated or missed altogether (Hubbard & Themessl-Huber, 2005; Palinkas, Ell, Hansen, Cabassa, & Wells, 2011). This confusion creates a greater collaborative challenge as health providers try to clarify roles and obligations while balancing an already heavy workload (Emery et al., 2012; Hellquist, Bradley, Grambart, Kapustin, & Loch, 2012).

Bailey et al. (2006) and DiCenso and Bryant-Lukosius (2010) noted that the concern of legal liability for those involved in collaborative decision making is often raised. The question arises as to who will ultimately be legally responsible for the decisions made in collaboration with other providers in licenced and unlicenced groups (DiCenso & Bryant-Lukosius, 2012; Hellquist et al., 2012). The nursing, midwifery, medical, and pharmaceutical associations have addressed some of the liability concerns in policy statements, attempting to

clarify this issue by stating that health care providers are legally responsible for their own actions and decisions (Canadian Medical Association, CNA, & Canadian Pharmacist Association, 2003; DiCenso & Bryant-Lukosius, 2010; The Canadian Medical Protective Association [CMPA] & The Canadian Nurses Protective Society, 2013; CMPA & The Healthcare Insurance Reciprocal of Canada, 2007). Individual practitioners are responsible to practice in accordance to professional scope of practice, personal abilities, and legislative allowances. For instance if a collaborative group suggests a specific medication would be in the best interest of a frail older adult patient, the NP may prescribe this medication based on best evidence and is then responsible for that decision. If the NP does not feel that this medication is appropriate, then the group must evaluate the issue again and obtain another way to solve the problem or the collaboration process is at risk of failing. If the NP prescribes the medication based on the group's wishes, the liability rests solely on the NP as the provider with prescription writing authority.

Along with liability concerns, privacy and consent issues may act as a further challenge to collaboration (Elissen et al., 2010; Emery et al., 2012; OMA, 2014). There is an assumption of consent for the health care provider to be able to share patient information with other care providers for the purposes of an individual's care and treatment (BC Freedom of Information and Privacy Association [BCFIPA], 2011). The group of professionals directly involved in a patient's medical care or treatment is often collectively referred to as the patient's "circle of care". It is ultimately up to the frail older adult patient or, if appropriate, their legal substitute decision-maker, to provide or decline consent for collaboration and information sharing between care providers. The "circle of care" requires specific permission to disclose personal information to those not directly involved in providing an individual's treatment or care (BCFIPA, 2011). In accordance with the BC

Health Care (Consent) and Care Facility (Admission) Act (1996) and the BC *Personal Information Protection Act* (2003), the frail older adult has the right to choose with whom their personal health information can be shared. To be in compliance with the law, the health care provider must obtain permission, whether written or verbal, to share personal information through professional collaboration practices. All care providers are expected to be aware of and abide by the privacy laws and requirements in their respective provinces.

Moreover, hierarchical leadership and the traditional hierarchical structure of the health care system pose a challenge to collaborative practice (de Stampa et al., 2013; Legault et al., 2012). Collaboration cannot be effective without full partnership in decision making between all relevant parties according to Matthews and Brown (2013). Leadership distribution should be shared and rotated depending on the need and expertise, with a focus on facilitating, rather than paternalizing, patient care (Chreim, Williams, Janz, & Dastmalchian, 2010; de Stampa et al., 2013; Legault et al., 2012; Weberg & Weberg, 2014). It should be based on knowledge and experience, with encouragement for all collaborators to contribute (EICP, 2005). Political differences and conflicting values (Chreim et al., 2010), inability to compromise (de Stampa et al., 2013; Lapidos & Rothschild, 2004; Legault et al, 2012; Mian et al., 2012), and lack of willingness to share information can also interrupt the collaborative process (EICP, 2005).

Collaboration can be accomplished if there is a common goal and all agree on both the goals and tasks to be completed (Baxter & Markle-Reid, 2009; Chreim et al., 2010; Emery et al., 2012; Hall, 2005; Legault et al., 2012; Palinkas et al., 2011; Weberg & Weberg, 2014). Knowledge of how to work together as a group, experience in problem solving, and an ability to create effective solutions, also help to move the process along effectively (de Stampa, Vedel, Bergman, Novella, & Lapointe, 2009; Hubbard & Themessl-Huber, 2005;

Lapidos & Rothschild, 2004; Legault et al., 2012). The process of how to achieve this common goal is the big challenge for collaborators.

It is helpful for all parties to be aware of the scope of practice and professional roles of each collaborator, as well as program limitations and policies, as this will help produce the trust and clarity needed for the team work ahead (Baxter & Markle-Reid, 2009; Robben et al., 2012). The programs included focused plans with a specific direction or end result, which are often limited by specific budgets, rules, time and space restrictions, or preferred guidelines. Efforts to sustain and maintain positive relationships between health care providers, departments, agencies, patients and families assist in the development of collaborative connections, as does having a common care philosophy (Baxter & Markle-Reid, 2009; Metzelthin et al., 2013; Legault et al., 2012). Commitment to working together with an understanding of the importance of continuity of care is a must, because group work is often a difficult process (Toscan, Mairs, Hinton, Stole, The InfoRehab Research Team, 2012; Tracy, Bell, Nickell, Charles, & Upshur, 2013). An environment (whether virtual or in-person), where all contributors feel able to share thoughts and disagreements freely, with perceived equal decision making power, may help to create success.

Clear communication has been identified as a critical factor in collaboration to ensure a positive outcome (Boeckxstaens & de Graff, 2011; Metzelthin et al., 2013; Park et al., 2014; Toscan et al., 2012). This clarity might be achieved through technological knowledge to facilitate connectivity or the physical space required to meet and to exchange ideas and updates. Furthermore, choosing language or "lingo" that all can understand, and listening with an open mind to the thoughts and opinions of others, will also encourage an effective collaboration process (Davey, Levin, Iliffe, & Kharicha, 2005).

A recurrent collaboration facilitator that appears throughout the literature is the use of care plans, such as the Frailty in Older Adults - Early Identification and Management (GPAC, 2012) plan presented earlier in this chapter. Care plans can be utilized to facilitate communication between health care providers, frail older adults and their families (OMA, 2014). An important component of the care planning process is involving the frail older adult patient and encouraging them to set goals. This often improves compliance and leads to better health outcomes (OMA, 2014), such as stability of a frail condition and the ability for the older adult patient to remain at home. Questions regarding the logistics of care planning involve issues such as who is responsible for creating, maintaining, monitoring, and distributing care plans. These concerns need to be addressed at the beginning of the collaboration process. The OMA (2014) suggests that it does not matter who is chosen, just that someone is specifically designated as the lead to coordinate and update the care plan. Care plans that are not updated, accessible, and usable are virtually ineffective. Hard copy care plans are difficult to update and distribute as frequently as may be required. Ensuring that electronic care plans are maintained in a standardized format is suggested to facilitate the use and following of these documents (Jones, Jamerson, & Suanne, 2012; OMA, 2014). The challenge is a lack of standardized technology and computer programs that are accessible to all collaborators. Regardless, once a care plan has been developed, the frail older adult patient should understand the purpose of the document and have it easily accessible to them. This might include mailing the care plan to the patient as changes are completed, or emailing the electronic version of the care plan if the patient is comfortable with this method of communication. In addition, formal health care providers should take the opportunity to use the care plan to sort and share information and responsibility among health care providers (OMA, 2014).

Finally, as with the difficulties in accessibility of the care plan, access to the frail older adult's medical records is another professional challenge to effective collaboration (EICP, 2005; Hubbard & Themessl-Huber, 2005; Palinkas et al., 2011). Unreliable and incompatible data systems, and denied access to electronic medical records (EMR) can result in duplicate diagnostic testing and redundant patient visits (Palinkas et al., 2011). Unfortunately, EMR programs are expensive, and require technical support and an investment in time and training to utilize (Lou et al., 2012). Despite these challenges, EMRs contribute to productivity through time and resource savings, patient safety, and more effective care coordination (Lou et al., 2012) through effective collaboration, all significant benefits for the frail older adult patient.

Organizational challenges

At an organizational level of health care delivery, resource scarcity and limitations can be a significant barrier to collaboration (Chreim et al., 2010; Emery et al., 2012; Hellquist et al., 2012; Palinkas et al., 2011; Robben et al., 2012). Such barriers may include staff changeover, competition for limited health care funds, and rigid organizational rules and policies (Elissen et al., 2011). Even the most experienced health care provider can find it difficult to locate services and resources currently available in the community in which they may have worked for years. Changes to government, public policy, and staffing can determine whether or not a resource remains available to the public; services may often come and go. Geography can create a particular collaborative challenge, especially in northern and isolated geographical regions of Canada because resources will be further stressed by increased distances between health care specialities and patients. The result of geographic isolation is an impact on availability of various elements of health care such as specialty equipment, medical devices, or services, and a reduction of specialists and other health care

providers with whom to collaborate (Elissen et al., 2011; Emery et al., 2012; Humbert et al., 2007).

Many hours invested in the collaborative process are not funded or reimbursed for many salaried and fee for service health care providers, and professionals sometimes choose to use uncharged time and after hours to complete work (Chreim et al., 2010; Emery et al., 2012; Hellquist et al., 2012, Legault et al., 2012; Mian et al., 2012). Where there is reimbursement available, often it is severely time limited (Medical Services Commission, 2013). This funding challenge is where the collaboration process may stop, the frail older adult patient may no longer have access to specialty services, and the sustainability of collaborative care may be at risk. Without proper funding and reimbursement, collaboration may not occur and it is therefore a substantial barrier. More needs to be done to advocate for changes to the funding model of health care delivery, starting from the governmental level.

Overlapping both the organizational and professional challenges is a lack of time to collaborate effectively (Chreim et al., 2010; Elissen et al., 2011; Hellquist et al., 2012). Time pressures and constraints from health care professional's full patient schedules make it difficult to organize meetings and collaborative exchanges (CASHC, 2012). Many health care providers feel there is a general lack of time for effective clinical practice (Oandasan et al., 2009). The way that clinical time is organized in managing the frail older adult patient, and the way in which an organization budgets time by limiting interagency collaboration, plays a vital role in how collaboration happens (CASHC, 2012; Elissen et al., 2011; Oandasan et al., 2009). Collaboration may be considered time *consuming*, in addition to being time *saving*, thereby leading to a decreased motivation to collaborate. Both health care and non-health care providers and organizations continue to look for the best balance of quantity and quality of time devoted to patient care and interprofessional collaboration.

Organizational support through collaboration policies, organized interprofessional education workshops, and scheduled evaluations on the collaboration product (de Stampa et al., 2013; Davey et al., 2005; Metzelthin et al., 2013) will offer health care providers an opportunity to learn and develop collaborative skills. It is worth noting that while researchers have examined challenges and have presented facilitators to collaborative care, research has provided less focus on the strategies to effectively achieve such collaboration. These strategies may offer a potential way to achieve stability of the older adult patient's frail condition and to keep the patient in individual private dwelling as long as possible, and are the focus of the literature search and review that follows.

Chapter Three: Literature Search

A thorough review of the literature was completed to gather current evidence related to collaborative practice in the primary care and community settings. In order to answer the question: "when a NP is providing primary care for the frail older adult in the community setting, which practice strategies promote effective collaboration between health care providers?", I completed a review in four stages to focus my results while still capturing the most up-to-date information.

A list of key terms, or significant words, were identified as relevant to collaboration, NPs, frail elderly and primary care, by reviewing related articles and the Medical Subject Headings (MeSH) browser from the National Library of Medicine. After the keywords and MeSH terms were collected, they were entered into academic databases including Cumulative Index to Nursing and Allied Health Literature (CINAHL), Cochrane Review, Medline, and PubMed. The databases were searched for articles pertaining to the review subject. These four databases cover a wide variety of information contained in peer reviewed articles, systematic reviews and theses within the nursing, medicine, health care, and behavioural and social science realms.

An internet search using Google Scholar was also completed, as well as reviews of the CRNBC, BCNPA, Ministry of Health, and the College of Family Physicians of Canada (CFPC) websites to search for grey literature and any practice guidelines that might already exist on the subject of collaboration in primary care in the community setting for the frail older adult. The BC Guidelines for The Management and Identification of Frailty in Older Adults (GPAC, 2012) was retrieved from this process and was included in the background information to my project.

Keywords

Numerous terms were utilized for the search in order to gather the greatest amount of literature possible that was still specific to the research topic. See Appendix B for search results. Key words and MeSH terms used:

Table 1: Keywords Used in Electronic Database Search

Inter-professional relations	Collaboration	Cooperative behaviour	Team work	Team building	Occupational therapist
Community health workers	Multi-disciplinary care	Pharmacist	Social work	Physiotherapist	Allied health personal
Registered nurse	Nurse	Mental health personal	Advance practice nurse	Primary health care provider	Nurse practitioner
Family or primary care physician	Gerontological care	Frail elderly	Aged adult 65-80+		

After the initial search hits, groups were combined using the Boolean operator 'or'. For example, primary care provider 'or' family physician 'or' primary care physician 'or' nurse practitioner 'or' advance practice nurse became one such grouping. After developing such groupings, the Boolean operator 'and' linked the groups together for each of the databases. Research dates were then limited to between the years of 2004 and 2014. This ten year span was chosen to ensure the most up to date and relevant articles were utilized, and to ensure any older or now commonplace collaborative strategies were not included in the results. Commonplace strategies were not deemed as useful to the data accumulation if the strategy was not evidence-based or was already established through literature citations as common primary care provider practice. Ongoing reference list reviews completed throughout the search process helped to ensure that no important and relevant articles were overlooked. Saturation was reached when duplicates and non-applicable materials became the sole results of the search.

Secondly, the database search was concluded and the 302 remaining articles saved to RefWorks after duplications were deleted. Only articles in English could be included to allow for my comprehension. Eligibility criteria were examined next.

Eligibility Criteria

Inclusion and exclusion criteria were developed to establish the articles that would be reviewed. Since the original search related to collaboration produced an overwhelming number of hits, the articles were then filtered in order to refine the search specifically to NPs, primary care in community settings, collaborative strategies, effective collaboration, and complex care or frail elderly patients. These criteria helped to provide a focus of information without being overwhelming in quantity or varying context. Titles and abstracts could then be reviewed, and 181of the 302 articles were left selected for further examination, based on eligibility criteria of the research question.

Table 2: Inclusion and Exclusion Criteria for Selection of Research Articles

Inclusion criteria:	**Exclusion criteria:**
Published between 2004 and June 2014	Collaboration as requirement by law (USA)
Articles with a community primary care focus to collaboration	Articles focused solely on collaborative practice in the acute care setting
Articles containing information on effective collaborative characteristics/approaches	Focus on role clarity in the collaboration process
Complex care or frail elderly patients	Publications based on educational and international collaboration
Published in English	Focus solely on the evidence to collaborate
Articles focused on collaborative strategies	Published in language other than English
Focus of establishing community health care professional collaboration practices without a formal arrangement	Strategies specific to NP and physician providing co-primary care
	No specific effective collaborative strategies offered

Looking deeper into the literature, I could see that numerous terms were being used interchangeably with each other. For example, integrated care, interdisciplinary,

multidisciplinary, transdisciplinary, inter/trans professional, integrated care collaboration, interprofessional working, and joint working, appear frequently in the literature with definitions very similar to the definition of collaboration and collaborative care used for this project. As stated in the introduction to this project, collaboration is the process of bringing together health care providers from different professions to work towards a mutually identified goal or goals (CRNBC, 2015). This overlap of definitions and terms was taken into account when selecting literature. Other interchangeable terms included complex care needs and frail older adults, chronic age related diseases, and seniors with multimorbidities. Chronic disease and disability would often overlap in descriptions of the frail older adult person for this project, but were not included in the selection process. If I located an article that was in close proximity to the definition of the terms presented for the frail older adult person, then the specific age range of 75-95 years for the target population was the deciding factor in selection.

Literature excluded for lack of specifics to the research question included those that focused solely on NP role clarity, NP and physician relationship dynamics, and academic interdisciplinary entwinement in post-secondary institutions. Literature retained for further analysis included those that focused on building collaborative teams in community or within primary settings. Collaboration strategies had to be offered in every selection for the resource to be retained in the review. After further analysis, utilizing the inclusion/exclusion criteria, 48 of the 181 articles remained.

Thirdly, to ensure that the purpose of this literature review would be met, the remaining 48 articles were read in their entirety for relevance to the research project. Of the 48 articles, 34 articles did not contain specific practice strategies useful in this context and could be eliminated. The remaining 14 articles contained enough relevant information to be

included as a finding. One additional publication, located from hand searching the grey literature, was retained for inclusion based on relevancy to my topic.

Table 3: Results of the Database Search

Database	Search results: 2004-2014 and in English	Results without duplicates	Articles selected from title/abstract	Results post eligibility criteria
CINAHL	112	112	71	28
Cochrane Review	76	69	23	2
Medline	152	110	85	18
PubMed	13	11	2	0
Total	368	302	181	48

The 15 selected articles were analyzed using a quality of data chart (see Appendix C). A review matrix was created to group relevant themes from the literature, including context, article outcomes and strategies offered. From this process, it became clear that I had become too narrowed on searching for collaborative strategies in the last stage of my search and had overlooked my population in many instances.

Going back to step two, I returned to the original 181 articles that had been selected from the literature abstract and titles and refocused my criteria to ensure that my population was better represented. The research question was referred to regularly throughout this process to ensure more complete relevance and context. Reviewing the original 181 articles, I was able to eliminate 101 based on eligibility criteria. The remaining 80 articles were then read in their entirety. Of these 80, 21 were eliminated for context, and 43 did not contain practice strategies. The selected 16 articles were analysed for data quality (see Appendix C) and then entered into a new review matrix (see Appendix D). From this process, common themes emerged as professional strategies, organizational strategies, and patient/family focused care strategies. The next section contains a critical review of the literature.

Chapter Four: The Findings

After a thorough review of the literature through the rigorous process outlined in the last chapter, 16 articles were selected that contained the most applicable information in the context of my research question. These articles revealed facilitators and strategies that can lead to effective collaboration for NPs and other health care providers who work with the frail older adult person. For the purposes of this project, the facilitators have been organized into three themes: professional, organizational, and patient/family focused. It is important to remember that these themes have overlapping components because the literature obtained addressed multiple challenges and elements to effective collaboration in primary care provision. The following is a critical review of the literature and descriptions of effective collaboration facilitators and strategies as they relate to providing care for the frail older adult patient. The chapter ends with an examination of some of the literature limitations and bias.

A literature review matrix can be found in Appendix D. The matrix provides an analysis of the Canadian, American, and European articles chosen for this project and contains information presented in this chapter. The matrix also contains additional information pertaining to the sample, setting and methods of the articles reviewed, as well as the collaboration strategies that were identified in the articles. These strategies were grouped into the three themes that were chosen based on the researched background information provided earlier this project. Further subthemes including role clarity, resources, communication, time and funding, were highlighted based on the level of prevalence and priority as presented in the literature. The strategies that did not fit into these categories and were less prevalent in the literature remain available for review in the matrix.

The research methods used in the articles for this literature review are further detailed in the matrix, and include seven qualitative reviews, one quantitative review, five mixed

method reviews, two systematic reviews, and one expert opinion piece. All were assessed for evidence levels based on LoBiondo-Wood, Haber, and Cameron's (2013) work, and ranked from one to seven. Further explanation in regards to the level of evidence ratings is available in the matrix. The quality of the studies will be discussed further in this chapter.

Professional Strategies

As presented in the background information, and confirmed in the sources reviewed for this project, challenges most common at a professional level involve a lack of role clarity, the ways in which resources are used, challenges with communication, and time issues. The literature analysed for this project presented facilitators and strategies in these three areas that may be useful for effective collaboration efforts aimed at working with the frail older adult patient, their families and other health care providers.

Role clarity.

In twelve of the sixteen sources reviewed, role clarity is presented as an important factor of effective collaboration (Baxter & Markle-Reid, 2009; de Stampa et al., 2009; de Stampa et al., 2013; Emery et al., 2012; Goodman et al., 2011; Hubbard & Themessl-Huber, 2005; Legault et al., 2012; Metzelthin et al., 2013; Park et al., 2014; Parmar et al., 2014; Skultety & Zeiss, 2006; Tracy et al., 2013). In this context, role clarity is defined as a mutual understanding of professional scope of practice and job descriptions, including one's own roles. Although important to consider informal caregiver roles and abilities, these are not specified in this project due to the specific focus of this paper.

Baxter and Markle-Reid (2009), Emery et al. (2012), Legare et al. (2013), Metzelthin et al. (2013), Park et al. (2014), and Toscan et al. (2012) all stated that role clarity can best be obtained through the sharing of common goals and visions. This statement resulted from these authors' qualitative and mixed method research on collaboration between health care

providers and patients. The goal of the collaborating team becomes evident when roles and tasks can be clarified and assigned. Tasks are organized so that correct assessments and data can be gathered without duplication, which would otherwise lead to a waste of resources and confusion. The authors of these six articles stated that many health care providers are not aware of certain professional roles, scope of practice or professional abilities. Without this knowledge, it is difficult for providers and patients alike to have confidence in the abilities of a contributor. The importance of role clarity was confirmed by Hubbard and Themessl-Huber (2005) in their qualitative study that involved semi-structured interviews of 34 health care providers working in a community primary care setting. The authors found that confidence and trust are facilitated by an understanding of professional abilities, scope of practice, and a shared vision of care. The research participants emphasized, based on their experiences and knowledge base as educated health care providers, how trust and confidence in other services and providers are formed. Researchers reminded collaborating health care providers that, in the service of role clarity, a shared vocabulary (Legare et al., 2013), shared professional philosophy (Legault et al., 2012; Metzelthin et al., 2013), and shared contributions, assist in establishing effective collaboration through an interconnectedness of common ground and understanding. de Stampa et al. (2013), Legault et al. (2012), and Parmar et al. (2014), suggest that role clarity can also be assisted by interdisciplinary education. This may include formalized education through workshops or presentations, or informally through networking and building relationships with other providers during meetings or a get-together. Building relationships and connections with other health care providers will assist with role clarity in the workplace. The frail older adult patient and their families need to understand their own roles and responsibilities in care provision, as well as the role and purpose of the involvement

for each health care provider participating in the collaboration. Having this list on a care plan or other treatment plan document will help keep this information organized for the patient.

Toscan et al.'s (2012) qualitative study using transcribed interviews and observations of collaboration events (n=44) between acute and community health care providers after patients' hip fractures, showed that patients, caregivers and health care providers, were unclear about their own roles and responsibilities. Toscan et al. (2012) suggested ensuring clear roles for all collaborators through effective communication, and keeping the frail older adult patient's needs and care goals at the centre of care. Toscan et al. (2012) also noted the frail older adult's concerns with the identification of different health care providers, and the need to make each person's role clear to the patient through ongoing communication. de Stampa et al.'s (2013) qualitative investigation, achieved through semi-structured interviews of 46 care providers (physicians, geriatricians, NPs, RNs and social workers) in France and Canada identified that once the collaborators understood the roles and abilities of each party, a true commitment and collaborative relationship began to develop. The study observed the relationship development between providers after months of working together. Prior to that, frustrations were high as many collaborators were providing fragmented care, which was confusing both the frail older adult patients and the providers themselves. The authors concluded, that once the collaborators became aware of the appropriate roles and abilities of one another, they then needed more knowledge of how to best utilize available resources.

Resources.

In addition to the importance of role clarity between collaborators, resource awareness also has an impact on patient care. This knowledge includes the awareness of valuable resources such as health care specialists, equipment, and community associations. According to Emery et al. (2012), Goodman et al. (2011), Legault et al. (2012), Park et al.

(2014), Parmar et al. (2014), Skultety and Zeiss (2006), Toscan et al. (2012), and Tracy et al. (2013), this knowledge of available resources is considered an important strategy for effective collaboration while working with the older adult patient, families and between health care providers in the community primary care setting. In order for the NP, as the primary care provider, to refer to and collaborate with services that will most benefit the frail older adult patient, they require the knowledge that a particular service exists. Once a provider is aware of a service, only then can referrals and collaborative contacts be made, as appropriate for each individual situation (Skultety & Zeiss, 2006)

Parmar et al.'s. (2010) retrospective chart review of 254 frail older adult Canadians with suspected dementia, showed a vast underuse of community supports, while Hubbard and Themessl-Huber's (2005) research concluded that providers continue to utilize the same familiar assets and services, and do not seek out other resources to collaborate. The authors of both studies concluded that the underuse of community supports had a debilitating effect on collaboration because providers failed to utilise the available community resources. This is where non health care providers such as social workers and life skills workers are key to the collaborative group. Avoiding the use of services because of lack of confidence or knowledge about them provides a disservice to the frail older adult patient who may be able to benefit from the service or consultation. The research states that the most effective collaborative strategy is to seek out and appropriately utilize as many unfamiliar services as possible. Again, the authors advise that health care providers seek out unknown resources through networking, while building and maintaining collaborative relationships with health care providers, and community service agencies. This search for resources requires the willingness to seek out new knowledge and the use of effective communication skills. In light of time and resource pressures in the primary care setting, this may be achieved on a smaller

scale for the primary care provider through a slow expanding and development of new professional relationships as feasible for the provider and the frail older adult patient.

Communication.

Baxter and Markle-Reid (2009), Boeckxstaens and de Graaf (2011), de Stampa et al. (2009), Emery et al. (2012), Legare et al. (2013), Metzelthin et al. (2013), Park et al. (2014), Parmar et al. (2014), and Toscan et al. (2012), all found that the key element in collaboration is effective communication. Communication, as presented in this project, is the exchange of information between health care providers, whether it is through different media, meetings, or information technology (Emery et al., 2012).

The literature reviewed varied in the media used to best communicate with other health care providers. Baxter and Markle-Reid's (2009) exploratory descriptive design study of 54 patients and 9 health care providers in Canada, and Davey et al.'s (2005) mixed method study of 79 health care providers in the United Kingdom, found that face to face and phone interaction worked best for effective communication, or at least was most common in their studies into effective collaboration between health care providers. Emery et al. (2012) found in their mixed methods review of 150 older adults with debilitating and complex health care conditions, that virtual communication with email to be very effective for communication, whereas Boeckxstaens and de Graaf (2011) and Metzelthin et al. (2013) (n=194), found a combination of telephone, email and in-person contact was most utilized in their articles. Legault et al. (2012) (n=241) found telephone and messaging systems to be most beneficial for communication in their survey, while Tracey et al. (2013) preferred face to face interactions in their review of a collaborative clinic. In contrast, Park et al. (2014) found in person and fax communication helpful in their qualitative study focused on health care providers, case managers, patients, and caregiver collaboration efforts, especially if having

difficulty reaching each other by phone. In addition, Goodman et al.'s (2011) research of collaboration activities between 292 primary and community care providers identified face to face meetings (39%-48%) were most used by participants to effectively communicate, then phone (32%-34%), and then email (9%-14%). The researchers did not find a pattern of contact between frail older adult patients and their health care providers, as all such contact occurred on an individual basis.

Table 4: Effective Communication Media

Source	Face to face interaction	Email	Phone/voice messaging	Regular meetings	Fax
Baxter & Markle-Reid	X		X	X	
Boeckxstaens & de Graaf	X	X	X		
Davey et al.	X		X		
Emery et al.		X			
Goodman et al.	X	X	X		
Legare et al.				X	
Legault et al.	X		X		
Metzelthin et al.	X	X	X	X	
Park et al.	X				X
Tracey et al.	X				

The research of Baxter and Markle-Reid (2009), Legare et al. (2012), and Metzelthin et al. (2013), revealed regular scheduled and face to face meetings as one strategy for effective collaboration. However, Baxter and Markle-Reid (2009) found meetings to be a barrier to effective collaboration, because participants in their study viewed it as increasing their workload. Table 4 shows that face to face interactions and meetings were the method of choice in the majority of studies reviewed. Unfortunately, poorly organized, time consuming, and frequent meetings with little outcomes or beneficial resolution are identified by Baxter and Markle-Reid (2009), Legare et al. (2013) and Metzelthin et al. (2013) to be common

occurrences. Regardless, meeting minutes need to be forwarded to all collaborators, as does changes to treatment plans and any situational developments (Emery et al., 2012).

The use of compatible information technology, such as computer programs or software and accessible electronic patient charts, was found to be a beneficial communication tool leading to effective collaboration between health care providers (Boeckxstaens & de Graaf, 2011; de Stampa et al., 2013; Goodman et al., 2011; Hubbard & Themessl-Huber, 2005; Parmar et al., 2014). It is suggested by Baxter and Markle-Reid (2009), Legault et al. (2012) and Boeckxstaens and de Graaf (2011) that these electronic systems and EMRs must contain up to date assessments, test results, medication lists, and care plans. Legault et al. (2012) conducted interviews and held focus groups of health care providers and medically complex older adult patients (n=241) in order to study the development of collaborative relationships between these parties. The authors suggested that health care providers create an electronic "To Do" system with secure access, to speed up and enhance communication. Boeckxstaens and de Graaf (2011) were the only researchers to express concern about the potential security and safety of information when creating a single EMR. The concern was confidentiality assurances and the security of private and personal information. In any case, Davey et al. (2005), Toscan et al. (2012), and Parmar et al. (2014), suggest that clear, useful and up to date documentation is necessary for effective collaboration to occur. This clear documentation might be in the form of a complete written referral document, assessment charting, or care plan updating.

The most common, and perhaps the most important, tool in communication between collaborating parties, is identified in the research as the care plan (Baxter & Markle-Reid, 2009; Boeckxstaens & de Graaf, 2011; Davey et al., 2005; de Stampa et al., 2013; Goodman et al., 2011; Legault et al., 2012; Toscan et al., 2012; Tracy et al., 2013). The analysis of

these eight articles identified the frail older adult's individual needs and health goals and development of a care plan, with input from health care providers and the patient, as an effective way to align services that will ultimately lead to effective collaboration. Such a care plan is created based on the patient's health care goals and in consultation with a single or multiple health care providers. It may be in the form of a written or electronic document. In either case, copies should be made and distributed to all collaborators, including the patient. It is not sufficient to only establish a care plan, as the plan need to be reviewed, monitored, and adapted as situations and circumstances change (Boeckxstaens & de Graaf, 2011; Davey et al., 2005; Toscan et al., 2012). Legault et al. (2012) found that care plans can be enhanced by prioritizing targeted areas, and assigning tasks to individual health care providers, or to the frail older adult patient themselves. Care plans are a simple, diverse tool, to be adjusted according to an individual person's situation and the treatment goals. The authors' suggest that care plans for the frail older adult is vital to effective collaborative care, and to assist in obtaining best health outcomes consistent with this project's outcome goals: to maintain stabilization of frailty issues and have the frail older adult remain at home as long as possible.

Time.

Ten of the sixteen articles reviewed identified time as a facilitator to effective collaboration (Baxter & Markle-Reid, 2009; de Stampa et al., 2009; Goodman et al., 2011; Legare et al., 2013; Legault et al., 2012; Metzelthin et al., 2013; Skultety & Zeiss, 2006; Toscan et al., 2012; Tracey et al., 2013). In this context, time is a resource that is often lacking in collaborative development and can result in workload issues for individual provider services on a professional level.

Time needs to be managed effectively and wastage avoided in health care delivery and collaborative practice in general. Some suggestions for time management cited in the literature included open access to medical records in order to avoid delays waiting for documents (Davey et al., 2005; de Stampa et al., 2013; Emery et al., 2012; Goodman et al., 2011; Hubbard & Themessl-Huber, 2005), clarity in intervention and treatment planning (Baxter & Markle-Reid, 2009; Metzelthin et al., 2013; Tracy et al., 2013), and prompt response to all messages and tasks assigned by the collaborating team (Davey et al., 2005, de Stampa et al., 2013; Park et al., 2014; Parmar, et al., 2014). Parmar et al. (2014) found that primary care providers might inadvertently cause delays in important interventions for their patients by not completing appropriate assessments and tasks in a timely manner. The issue may have involved a lack of time or increased workload for the health care providers, as the frail older adult patient and assessments required were referred to another health care provider. A lack of effective documentation also created issues for the researchers, as the data was incomplete since a retrospective documentation review is limited by the variability and thoroughness of what was documented. As Parmar et al. (2014) and Davey et al. (2005) identified, one cannot necessarily conclude, from a lack of documented care, that an issue was not actually addressed by the care provider.

Email communication has been presented as a strategy for communication, and it is worth noting that Emery et al. (2012) found that email maximized time efficiency as well. In contrast, Tracey et al. (2013) found that real time discussions or person to person, face to face or by telephone, was the most time saving method of communication.

Organizational Strategies

All 16 articles used in this review stress the importance of changes in organizational infrastructure and health care service delivery, to support and facilitate collaborative

activities. This alteration can be accomplished through policy changes, increased time permitted to collaborate with other providers, and increased dedicated funding, personnel, and resources. Challenges with time and funding can often create a disconnect between health care providers, patients and families, trying to effectively collaborate. Such issues are addressed at a provider and organizational level in the literature reviewed, rather than at a governmental level, the original source of funds. The analysis of the literature revealed a number of facilitators and strategies offered for the primary care provider in regards to time and funding.

Time.

As mentioned previously, ten of the sixteen articles reviewed offered time as a facilitator of effective collaboration (Baxter & Markle-Reid, 2009; de Stampa et al., 2009; Goodman et al., 2011; Legare et al., 2013; Legault et al., 2012; Metzelthin et al., 2013; Skultety & Zeiss, 2006; Toscan et al., 2012; Tracey et al., 2013). In this context, time is a resource that is lacking in collaborative development and support at an organizational level.

A valuable strategy to save time is to utilize evidence-based practice decision making tools (Boeckxstaens & de Graaf, 2011; de Stampa et al., 2013; Goodman et al., 2011; Metzelthin et al., 2013; Parmar et al., 2014), such as the best practice guideline for managing the frail older adult patient discussed previously. Tracy et al. (2013) suggest that the use of official organizational decision making tools may be difficult because clinical practice guidelines are severely limited in availability for the complex care requirements of the chronically ill and frail older adult patient. Regardless, these guidelines should be used for care consistency, and evidence-based care, saving the health care provider time in management of certain illness or care issues. Guidelines are to guide the health care provider, and allow flexibility to individualize patient care. Time is saved as the best practice

recommendations are provided and the provider can adapt them to fit individual situations without having to spend the time investigating the most recent research. The more providers utilize these guidelines, the more likely that further guidelines will be developed by organizations.

de Stampa et al. (2013) presented 46 semi-structured interviews with health care providers, and concluded that maintaining a close link between the NP and community geriatric speciality services would contribute to time saved, and thus effective communication; Skultety and Zeiss (2006) agreed. By developing and maintaining collaborative relationships with these geriatric specialists, methods of communication, role and scope of practice clarity, and specific practice preferences are likely already being utilized, resulting in a more effective collaborative relationship.

A signed informed consent may allow for quick and open information sharing between these speciality services (Emery et al., 2012). Consent should be addressed at the beginning of collaborative relationships, as some providers hesitate to share information because of liability concerns. Having a signed consent from the patient may avoid treatment delays, as providers wait for permission to share personal health information. This ability to quickly release and share information freely will benefit the health care provider's schedule, and ultimately the frail older adult patient.

With all of these effective collaboration strategies suggested in regards to provider time, the frail older adult patient who is in the centre of all the possible rush, perplexity, and confusion may also require more time. Skultety and Zeiss (2006) concluded from their literature review of eight randomized control trials in the treatment of depression in the complex care of the older adult that health care providers need to keep in mind that a frail older adult person may require more time to express concerns or needs, as well as longer

intervention or treatment time lines. In addition, Tracy et al. (2012) reviewed an interprofessional primary care clinic in Ontario, Canada, and found that consulting with specialised teams through referral and joint treatment planning provided the frail older adult person with sufficient time to express concerns and be heard. de Stampa et al. (2009) compiled the results of 61 questionnaires and 22 interviews of primary care providers of frail older adult patients, and found that the understanding and respect required for effective collaborative relationships are considerably enhanced over time, and cannot be rushed; Legault et al. (2012) and Tracey et al. (2013) agree. This means that building these relationships require time to be invested before time savings may be seen in NP practice. The amount of time to be invested will depend on individual situations, but the research confirms this time invested will be well worth the returns of time saved.

As referred to earlier in this chapter, the literature advises the NP as primary care provider to utilize predesigned, specialized teams to collaborate with, when these are available and deemed necessary, to promote effective collaboration (Emery et al., 2012; Goodman et al., 2011; Skultety & Zeiss, 2006; Tracy et al., 2013). It is no surprise then, that Skultety and Zeiss (2006) found in their research that the use of collaborative speciality care is more effective in patient health outcomes for the treatment of severe depression in the frail older adult population than single provider or fragmented assistance of numerous health care providers. A negative aspect to utilizing these special teams in de Stampa et al.'s (2009) research is the risk of relationship deterioration between the primary care provider and the patient. In this situation, other providers intervene in care provision and trusting relationship development with the frail older adult patient, perhaps leaving the primary healthcare provider less involved.

Having organizational support or policy to encourage the regular allotment of time in a day or week for collaboration was one suggested strategy to enhance collaboration efforts (Baxter & Markle-Reid, 2009); however, the research does not suggest just how much time should be set aside. Regardless, the amount of time required for collaboration in each individual health care provider's patient load will vary.

Sufficient time to measure collaborative effectiveness is identified as vital to effectively interpret collaborative research data and results (de Stampa et al., 2009; Goodman et al., 2011, Legault et al., 2012). Follow up to reflect and ensure effective collaboration is happening takes time away from patient care, although organizations can encourage practitioners by allocating time and tools to ensure this evaluation is happening with the least amount of interruptions to the clinical operations as possible. de Stampa et al. (2009), de Stampa et al. (2013) and Tracy et al. (2013) concluded that effective collaboration itself takes time to develop. Legault et al. (2012) highlighted that effective collaboration takes about six months to reach a functioning capacity. No other literature analysed produced a timeline for developing collaboration between all parties, and no research offered a timeline for collaboration development between health care providers and the frail older adult person and caregivers.

Funding.

Funding or allocation of funds is a facilitator for effective collaboration (Boeckxstaens & de Graff, 2011; de Stampa et al., 2009; Emery et al., 2012; Goodman et al., 2011; Hubbard & Themessl-Huber, 2005; Park et al., 2014; Parmar et al., 2014; Tracy et al., 2013). Scarcity of financial resources is always an issue in the provision of health care. There has not been an easy answer to this ongoing problem, and the majority of the literature analysed offered few suggestions on how to work with this challenge.

Goodman et al.'s (2011) review considered collaborative teams, and revealed joint funding strategies utilized in areas that also had joint personnel. Strategies offered in this article include aligned or pooled budgets, joint equipment services, and the use of specialized collaborative teams. For example, if a primary care provider feels that collaborating with a social worker would benefit the practice but cannot afford to pay one, hiring or applying for grants to pay for this resource with other primary health care providers may provide at least a partial answer for all involved. The practitioners may pool financial resources together to provide a service that no one could supply on their own. The idea of a pooled budget is riddled with issues of financial and information systems incompatibility, while being complicated by time consuming deliberations on agreements, responsibilities and other logistics. Examples of pooled budget successes exist in the literature and yet Goodman et al.'s (2011) research identified that separate budgets are the most common practice (71%) for collaborating teams. de Stampa et al. (2009) encourage health care providers to advocate for resolution of funding issues, but do not offer strategies on how to accomplish this.

Emery et al. (2012) recognized the importance of funding to successful collaboration efforts, and suggested taking full advantages of government grant funding for collaboration development, and then trying to sustain the work when the funding is over by using trainees or health care professional students. Park et al.'s (2014) observational review of collaborative care and joint efforts of case managers, primary care providers, caregivers and the frail older adult patient in BC, Canada, found that better use of funds through consolidation of some support services, freed up money to be reallocated to collaboration efforts. Solutions to funding issues at the organizational level encouraged creative problem solving solutions and ideas, but offered no specifics on what that creativity should resemble in practice. In the case of fee for service reimbursement, Parmar et al. (2014) views this type of payment for services

as problematic, but no strategies are offered in this regard. Again, a restructuring of health care delivery and infrastructure must be addressed at a governmental level in order to facilitate effective collaboration.

Therapeutic Relationship with the Patient/Family

As previously mentioned, the frail older adult person may experience a multitude of different physical, cognitive, and situational challenges resulting in an increase of required health care provision. Through logbooks, evaluation forms, four focus groups, and interviews of 194 frail older adult patients and 45 health care providers, Metzelthin et al. (2013) concluded that the complex and multidimensional needs of the frail older adult make the collaboration between providers more difficult; Hubbard and Themessl-Huber (2005) agreed. Contrary to these findings, Legault et al. (2012) stated in their study that the difficulties are not population specific, but that the issues instead lie within learning to be collaborative with each other. Regardless, nine of the sixteen articles reviewed for this project stress the importance of tailored health care for each frail older adult person, at the centre of all decision making and care planning, as a facilitator to providing effective collaborative care (Baxter & Markle-Reid, 2009; Boeckxstaens & de Graff, 2011; Davey et al., 2005; de Stampa et al., 2009; Emery et al., 2012; Hubbard & Themessl-Huber, 2005; Legault et al., 2010; Park et al., 2014; Skultety & Zeiss, 2006). Having patients at the centre of care should help with treatment or care planning issues, as the patient's wishes are sought after. The frail older adult patient's health becomes the central goal or aim of the collaborating group.

Boeckxstaens and de Graff (2011) and Metzelthin et al. (2013) suggest that the collaborative team concentrate on the frail older adult's capacity to maintain quality of life rather than eliminating disease. Eliminating the frailty or disease may be unlikely or impossible due to incurability or chronicity of some illnesses. This coincides with this

project's goal to maintain a stable level of disability or frailty for the frail older adult patient. To achieve this agenda, close collaboration with the frail older adult will facilitate these individualized health goals. Further knowledge is needed by the health care provider to ensure that important aspects of the patient's health are not being overlooked. Boeckxstaens and de Graff (2011) and de Stampa et al. (2013) stressed the importance of having a specialized body of knowledge directed at the specific needs of the frail older adult patient through education, use of geriatricians, or use of other speciality services. de Stampa et al. (2009) agrees with this concept, and encourages the close network and connection between primary health care and geriatric specialists as a facilitator to effective collaboration.

The frustrations of the frail older adult patient in having others making decisions for them has been previously mentioned. Toscan et al. (2012) found in their research of patient, caregivers and health care providers (n=44), that not only are the collaborating health care providers taking away choices pertaining to treatment options, but family members and caregivers are as well. This is important for the collaborative team to realize while providing care in these circumstances, to be sure that the plan of care is discussed in front of the patient, and all parties are involved in knowledge accumulation and discussion. Metzelthin et al. (2013) completed a study that included 194 frail older adult persons. The researchers found that frail older adults want to be taken more seriously by their health care providers, listened to, and have their wishes respected, even if this wish is not in line with what the providers see as best for a patient's health. With this in mind, flexibility and creative problem solving comes into play as a facilitator to effective collaboration, especially if the frail older adult is unable to make safe and competent decisions, while attempting to ensure respect and dignity is being considered in health care planning. Baxter and Markle-Reid (2009) give an example from their study of a frail older adult patient who was having difficulties with the number of

health care providers coming into the home and asking questions, not unlike Mr. Brown in the beginning story of this project. The team with different assigned tasks and foci collaborated yet again, and developed a patient friendly plan to have one professional perform the assessments for all providers with input from specialities. This idea of limiting providers is confirmed by Emery et al.'s (2012) research that found it helpful to only include those professionals who are required for achieving the treatment goals. Effective collaboration can help to best utilize personnel and limited resources while sharing information and assessments amongst all collaborators, possibly through a care plan or EMR. This kind of flexible problem solving in collaborative teams will help to decrease the confusion and frustrations that are common experiences during health care delivery for the complex frail older adult patient.

The building of strong relationships and connections between the frail older adult patient, their families, and the NP as primary health care provider, is an important strategy to effective collaboration (Emery et al., 2012; Parmar et al., 2014; Toscan et al., 2012). This connection is especially important in reducing confusion and the frequent overwhelming nature of a collaborative team approach to patient care. Legare et al. (2013) completed a survey (n=276) and focus group interviews (n=15) of health care providers who provided care for the frail older adult patient. Legare et al.'s (2013) study, along with Boeckxstaens and de Graaf (2011), Davey et al. (2005), Emery et al. (2012), and Metzelthin et al. (2013), all identified the importance of continuity of care, such as same health care providers, regular scheduling of appointments, regular follow up, and medication times and usage, for the frail older adult population, especially where cognitive impairment is an issue. Nevertheless, the reality in health care delivery involves high staff turnover and shortages (Emery et al., 2012). Researchers encourage health care providers to keep the continuity of the collaborating group

as part of the plan of care in day to day practice, since cognitive impairment is especially common for the frail older adult patient. It is suggested that a primary care provider can aid in continuity of care by providing clear and concise up to date documented and accessible patient information and care planning, while utilizing a consistent collaborative team. An example of the extent of cognitive issues was cited in Davey et al.'s (2005) research that found a substantial level of cognitive impairments in their research population (67%). The authors emphasized this issue of cognitive impairment to be a key variable as to whether or not the older adult would remain at home or be required to move to an advanced care facility. This finding by Davey et al. (2005) suggests that many frail older adults in primary care will have cognitive deficiencies. To address this challenge, continuity of care and the individual goal and collaborative care planning for every frail older adult person should be a priority for health care providers.

Families and unpaid caregivers cannot be forgotten while focusing on caring for their loved ones. Family involvement influences a frail older person's ability to achieve health care goals and to remain at home (Park et al., 2014). In a small portion of their study population, Davey et al. (2005) showed that 61% (n=16) of frail older adults remained at home with caregivers who *did not* want their loved one in facility placement, compared with 39% (n=8) of older adults who remained at home with caregivers who *did* want their loved ones to be placed. Even with assistance and education, caring for a frail loved one can be a highly stressful endeavour. As noted by Davey et al. (2005) and Toscan et al. (2012), it is important for the collaborative health care team to remember and appreciate, that without the caregivers or family members, it may be much more difficult for the frail older adult to be cared for in the community.

Toscan et al.'s (2012) qualitative study through semi-structured interviews identified some of the inappropriate tasks that a few informal caregivers have been assigned to do. Informal caregivers reported feelings of pressure by health care providers to perform care tasks for their loved ones, such a transfers or bathing, with which they were uncomfortable. Another family member reported her concerns that to obtain any information from the health care system, she had to be overly assertive and even aggressive. This study reminds the NP and all health care providers that, in order to facilitate effective collaboration, there needs to be communication regarding role clarity and responsibilities that are appropriate for the patient and caregiver, not only between the health care providers.

Limitations and bias

There are a number of limitations to this review. First, a lack of standardized language across the literature makes it difficult to determine the particular context that an article or research paper is referring to. As previously mentioned in this project, terms such as joint working, shared care, integrated care, interdisciplinary teamwork, multidisciplinary care, multidisciplinary cooperation, and interdisciplinary collaboration all have specific meanings but are frequently used interchangeably in literature. This overlap of definitions and use creates space for context interpretation for the reader, and made searching and choosing literature for this review more difficult. As a newer profession, NPs working in primary care were not considered in some research studies, where physicians were listed as the sole primary care providers. Today, in BC, this assumption that the physician is the sole primary care provider is incorrect and may have resulted in a limitation to the literature chosen for this review. Primary care practices, whether NPs or physicians, can be compared in the chosen literature based on a majority of scope of practice parallel and similar provision of care.

The quality of the research is another limitation of the literature, as small sample sizes in some of the presented research potentially introduce bias and may not be relevant to a larger group. The convenience and purposive sampling methods that were frequently utilized added concern as to whether or not the results of the study would remain the same if random participants had contributed more frequently. Some of the data discussed in this review did not arise out of qualitative or quantitative studies, but rather an opinion or report from expert committee; this may be seen as another potential limitation. This concern may be balanced however, by the authority of the sources, such as a committee comprised of local experts in the field of gerontology.

Lastly, one longitudinal study of four years was reviewed, while the duration of many other studies was limited to less than 18 months. Since collaboration takes time and is difficult to achieve, it would be preferable to carry on such a study for a considerable amount of time to ensure a more accurate results. This example of the study limitation, as well as the others listed in this section, contributed to the lack of strong evidence base to support NP collaborative practice strategies in the context of primary care and the frail older adult patient.

Chapter Five: Discussion

The goal of this review was to identify strategies that a NP in primary care community practice working with frail older adult patients can use to enhance effective collaboration with other health care providers. From the analysis of the literature, three main themes emerged: professional, organizational and building therapeutic relationships with patient and family focused strategies. This chapter synthesizes the evidence that was identified in these three areas and offers recommendations on ways that health care providers, including the NP, can utilize strategies (see Table 5) in order to maintain the stability of the older adult patient's frail condition, and to keep them at home as long as possible. The chapter concludes with recommendations for future research and education.

Professional Practice Strategies

Collaboration challenges are well researched and documented in the literature as examined earlier in this project. The most prominent challenges to collaboration are related to the professional level of health care delivery. The literature review offered practice elements and strategies to address these challenges and were centred on role clarity, resources, and communication.

In obtaining role clarity for health care providers, including the NP in primary care practice, all scopes of practice and roles need clarification for all professionals in the collaborating group. Health care providers can ensure role clarity by actively promoting their roles in clinical settings, interdisciplinary meetings, and by providing health care services to their full scopes of practice. Health care providers need to be aware of all scope of practice and legislative changes immediately, and share such information with the collaborative practice group (Bailey et al., 2006; DiCenso et al., 2010). In order to provide a better understanding of the different roles, Clarin (2007) suggests that care providers, such as the

NP, should be involved in exposing other health care provider students through interprofessional education. No matter how each collaborator decides to promote their profession's job descriptions, skills, and abilities, there is a connection between the ways in which health care providers build confidence and trust in each other and their understanding of one another's professional abilities (Hubbard & Themessl-Huber, 2005).

Obtaining knowledge about community resources can be accomplished by the collaborating group through networking, relationship building, and by asking questions of patients, families and other health care providers. The NP and other collaborators may learn about special forms, paper work, or cost for the service, as many older adults are on a strict budget and are unable to afford many extras.

As discussed in the findings for this project, communication is cited as an important collaboration facilitator between health care providers. The use of communications through fax, email, telephone, and voice messaging systems can be considered critical tools to move the collaborative process forward (Elissen et al., 2010; Emery et al., 2012; Lapidos & Rothschild, 2004). The collaborating group can work with others more effectively by promptly replying to all messages and completing all tasks on time. Adding these tasks to a day schedule or having reminder lists may help with this.

It is important for health care providers to communicate effectively by using specific language and being clear on what is required from a collaborative relationship. Resolving issues as quickly as possible and not avoiding conflict may help the providers to communicate more effectively. A primary health care provider, such as the NP, often acts as the synthesizer of information on behalf of the patient, and when able, face to face meetings to build rapport with patients and other health care providers can aid in better connections, and a clearer understanding of roles and goals of care.

As addressed previously in this report, another way to ensure effective communication is to create a care plan based on feedback from all collaborating parties, including the patient and family. Individual collaborators can contribute to effective collaboration by facilitating the development of group goals, individual tasks, and treatment plans, and ensuring these goals are well laid out in a care plan. All parties should agree on the care plan goal or goals and the document should be distributed to all collaborators, including the frail older adult and caregiver. Most importantly, once an agreed upon care plan is created it should be followed and adhered to. Prioritizing tasks from the care plan, holding all collaborating parties accountable for their assigned responsibilities, and following up on meetings or electronic connections with outcome reports, may help accomplish this goal.

In Mr. and Mrs. Brown's situation presented at the beginning of this project, the primary care provider might have facilitated a care plan for Mr. Brown seeking speciality contributors such as the social worker, occupational therapist, or physiotherapist to add to a joint plan of care. Keeping each provider informed of changes and interventions through email, phone, or fax, would have avoided the double funding application issue, and the missed medication changes. Such media options could have been used to communicate assessments between all professionals, resulting in less repeated questions, and, in such circumstances, Mr. Brown might have never become unwilling to be part of the collaborative process. A reference card of listed professionals, roles, and goals for Mr. and Mrs. Brown might have been helpful in informing the couple of who was doing what tasks, especially when the professionals were unable to coordinate visits at the same time, and share their assessment information verbally. These small changes may have assisted Mr. and Mrs. Brown to feel as though they were a valuable part of the plan of care, and perhaps less fearful and confused.

Organizational Policy and Systems Strategies

There is a call for organizational infrastructure and health care service delivery to support and facilitate collaborative activities through policy changes, time allowances, and increases in funding, personnel, and resources. The literature identifies a lack of time and funding as challenges to effective collaboration, and offers strategies for collaborative practice on a provider and organization level.

In order to effectively collaborate in primary care practice, the provider needs to maximize organizational strategies to utilize time and funding provisions well. One of the ways that the primary care provider can accomplish this goal is by being familiar with recent technology, and using it to advance connections between health care providers and the frail older adult patient. Whether it is email, fax, phone messaging, texting, or video conferencing, all health care providers need to be proactive in learning what is available to the organization and community of employment by consulting with the information-technology department or online resources. The NP working as a primary care provider can use the organization's technology to bring professionals and the frail older adult person together despite geographic proximity (Lapidos & Rothschild, 2004). Lapidos and Rothschild (2004) studied the use of Virtual Integrated Practice, a process that joins health care professionals willing to collaborate, to assist in managing the complex chronic disease of patients, such as the frail older adult person, through technology. The study concluded that online teams offer a practical, time-saving, and more resource-efficient way, to provide focused interdisciplinary care in the primary care setting. This suggestion is congruent with this literature review in recommending that primary care providers utilize other specialized teams with a focus on the complex issues of the frail older adult person (Emery et al., 2012; Goodman et al., 2011; Skultety & Zeiss, 2006; Tracy et al., 2013). In BC, the rapid access consultative expertise

(RACE) telephone advice line, connects a primary care provider with a specialist for collaboration and shared care. Specialists include geriatricians and geriatric psychiatrists who can be reached at regular scheduled hours (Providence Health Care, 2015).

The literature review suggests the use of EMRs to connect all collaborators with up to date information about the frail older adult patient. When all collaborating participants have access to the EMR, valuable knowledge and information about the patient can be shared more effectively (de Stampa et al., 2013; Hubbard & Themessl-Huber, 2005; Legault et al., 2012). Having the health care information and history accessible as issues arise saves everyone time and the health care system money (Hubbard & Themessl-Huber, 2005). The choice of EMR may or may not be something that a NP can control as many are provided by the organization or employer, but the NP can advocate for an EMR that will connect with other agencies in the community.

For time saving measures, the use of evidence-based practice guidelines is suggested in the literature. BC Guidelines are published in order for primary care providers, such as the NP, to have up to date evidence-based practice recommendations to use for a wide variety of health situations or illnesses. Most of these are adaptable to meet unique situations, such as the one reviewed earlier in this project for managing the frail older adult patient. The literature suggests that the NP advocate at the organizational level for more evidence-based guidelines to assist in providing up to date care, and to create a focus point when collaborating with other health care providers.

Evaluating and reflecting on the collaborative practice is important to ensure effective collaboration is happening. In order to assess if these strategies are working, the collaborative practice assessment tool (CPAT) can be used by the NP and fellow collaborators, to assess if true collaboration is happening and where weaknesses in processes may be occurring

(Schroder et al., 2011). The evaluation tool may be used in a variety of care settings with an array of health care specialities, and is helpful in measuring effective collaboration (see Appendix E).

Funding and reimbursement issues remain substantial as relayed by the literature. Resolutions might include pooled resources of personnel or equipment, and organizational budgets that prioritize spending for collaborative related usage (de Stampa et al., 2009; Emery et al., 2012; Goodman et al., 2011; Legare et al., 2013). Health care providers may feel advocacy and governmentally aimed pressure is required in order to encourage funding issue resolutions.

In Mr. and Mrs. Brown's situation, the primary care provider may have utilized the BC Guidelines for managing the frail older adult patient, but did not follow through with the remainder of the process, such as the collaborative care planning. Following the guidelines fully would have contributed to Mr. Brown's care through a more structured and organized plan of care for the multiple health care providers involved. Another option for the primary care provider could have been referring to, and collaborating with, the Geriatric Assessment and Treatment (GAT) unit in an attempt to work with all care specialities at once. The GAT unit is a coordinated, comprehensive, multidisciplinary care program specializing in the care of the frail older adult. Mr. Brown might have had better alignment of complementary services and fewer appointments for which Mrs. Brown needed to arrange attendance. Access to an EMR might have assisted the health care professionals in reviewing medication and up to date evaluations about Mr. Brown's health and situation, resulting in less repetition, duplicate assessments, and medication administration confusion.

Therapeutic Relationship with the Patient/Family Strategies

Research indicates that having a strong level of patient participation in the provision of care is a strategy to achieve effective collaboration. The frail older adult person may experience many physical, cognitive and situational challenges, but many also consider themselves to be successful agers. The extra care requirements and challenges that natural aging brings are unique to all individuals, and the NP in primary care practice must be ready to provide individual care for any combination of issues or illness.

One of the most important aspects in the research is the building of relationships between the health care provider, patient, and family. A health care provider can help to create a positive relationship with the frail older adult patient and their family by speaking to them with words appropriate for their level of understanding, respecting their wishes, listening to their concerns, and working within the patient's care plan goals. The patient may be considered medical complex and frail but they may not actually view themselves that way; therefore, the goal may not be to heal or cure, but rather to maintain independence and stabilize an already limited mobility or physical ailment. Studies revealed that care providers need to be kept informed of the frail older adult's health care status and not be required to complete inappropriate tasks in caring for their loved one.

As the literature review highlighted, clarity of all health care provider's roles must be shared with the frail older adult patient and their families to decrease confusion. One way that this clarity can be accomplished is through information sharing. One suggestion is to have a printed card for the frail older adult patient with the names, titles and job descriptions of each health care provider who is to be involved with the patient's care. Not only can the patient refer to this card for a reminder about who they are seeing, but it may also provide the professional with an overview of who the patient has already seen and for what service. The

use of a reference card has already proven helpful with medication administration and organization for people on multiple drugs (Mahtani, Heneghan, Glasziou & Perera, 2011). It is necessary for the collaborating group to ensure the patient and family have a copy of the care plan, as well as access to the document as it changes and is updated by the health care providers.

Findings from this project are further supported by the wider research literature indicating that the NP in primary care has the unique position to share perspective and expertise in a holistic fashion. Furthermore, the NP has much to offer to problem solving and decision making bridging between health care providers, frail older patients and their families (CRNBC, 2015; DiCenso et al., 2010; Dierick-van Daele et al., 2010; Donald et al., 2010). The health care provider needs to critically analyze and problem solve the collaborative barriers and obstacles which are unique to each frail older person's contextual care. For example, if the frail older adult is uncomfortable with seeing another health care specialist, the NP as primary care provider may choose to consult with specialists away from the patient and bring the information back for discussion. Such an approach can reflect 'outside the box' creative solutions and create a more flexible, patient-centred solution to the problem. NPs have the advanced knowledge and abilities to assist the frail older adult person in accessing more seamless care between health care services through effective collaboration strategies.

One of the important missing pieces of Mr. Brown's care was a lack of his and Mrs. Brown's involvement and contribution. A care plan should have been developed that specifically addressed the couple's health goals, and the emphasis on what *they* felt was required for Mr. Brown to successfully remain at home. Mrs. Brown's challenges with transportation and Mr. Brown's mobility issues were never considered in appointment times, whereas a care plan that noted transportation challenges would have more easily highlighted

this as an important issue for the couple. Rather than labeling Mr. Brown as a difficult patient for his reluctance to connect during assessments and care, the health care providers might have sought to address why Mr. Brown was disengaging in the process and attempted to correct the problem. Mr. and Mrs. Brown could have been better assisted through a more patient-centred care process. Mrs. Brown's responsibility as her husband's caregiver was a large undertaking for her. Assistance and appropriate tasks for her and her abilities needed to be addressed and considered when planning Mr. Brown's care at home, possibly through a caregiver needs assessment. This assessment may have assisted the primary care provider in ensuring Mrs. Brown's ability to continue to care for her husband at home, and for as long as possible.

Table 5: Summary of Practice Recommendations

Theme	Recommendations	Actions
Professional Organizational Therapeutic relationships with patients and families	Establish role clarity	1. Share own scope of practice and promote own roles with other health care providers, while seeking out the same from other providers. 2. Goal for all providers to practice to full scope. 3. Interprofessional education by working with other health care provider students in different specialities. 4. Clear task assignments so everyone knows who is responsible, for what and by when. 5. Provide the patient with a reference card with names, titles and job descriptions of each care provider that is collaborating 6. Assign a health care provider to facilitate the updating and follow up of care plan.
Professional	Utilize available community resources	1. Seek out and learn about other resources available through networking, relationship building and asking questions. 2. Utilize the care professional that has the most knowledge of these services to share with the rest of the group.
Professional Therapeutic relationships with patients	Effective communication	1. Build rapport and relationships with other providers, patients and their families. 2. Use specific language and clear requests of individuals in the collaborating group.

Theme	Recommendations	Actions
and families		3. Prompt reply to all communications 4. Resolve issues quickly and directly; do not avoid conflict. 5. Use a care plan with shared goal or goals, ensuring it is adhered to, updated and followed up, ensure the patient has a copy.
Professional Organizational	Utilization of time	1. Be familiar with up to date technology for data entry and communication. 2. Utilize and share an up to date EMR. 3. Utilize practice guidelines to guide care as appropriate. 4. Set up work flow to allow completion of tasks on time. 5. Utilized specialized geriatric care teams when available. 6. Reflecting on and evaluate the collaborative process by utilizing tools such as the CPAT (see Appendix E).
Professional Organizational	Utilization of funding	1. Pool resources of personnel or equipment. 2. Prioritize spending for collaborative related usage. 3. Advocate at a governmental level for adequate funding.
Professional Therapeutic relationships with patients and families	Be patient focused	1. Respect patient and family wishes and care goals; active listening to concerns 2. Be flexible through problem solving and decision making unique to each contextual care situation 3. Keep family informed of health care status 4. Ensure family is not unnecessarily burdened with inappropriate care tasks or internal issues within care team

Recommendations for Education

Part of the CRNBC (2015) NP licensing requirements involves continuing education. The NP and health care providers in general should be educated on collaboration strategies in health care provision, and well-versed in the complexity of group and team work. This education occurs in university, but needs to continue throughout the nurse's career. The NP may find useful workshops or classes through the local university or technical school,

CRNBC, and online continuing education websites. Much of this knowledge comes with experience, but workshops and continuing education seminars, where available, will provide further leverage to the NP to enhance this necessary skill.

Knowledge of the special care requirements for the frail older adult person is becoming increasingly important. Although the adult and family trained NP have a foundational education in geriatric care, more may be required depending on individual scope of practice, job placement and age of patients regularly seen. As the population ages, the NP will see an increasing number of older adult patients in primary care practice. It is advised that the primary care NP seek further continuing education programs or skill training in geriatric and geriatric psychiatric conditions in order to feel confident and comfortable with the complex needs of this age group.

Recommendations for Research

The limitations of literature in the research context of NP providing primary care, frail older adult patients, and effective collaboration, show areas in which research could be more focused. Further investigation and focus on effective collaborative strategies, would be beneficial for practice, as would a review of the ways in which collaborative team members successfully resolve differences when caring for the frail older adult patient. The literature repeatedly asks for more research on collaborative outcomes, specific to the user of the services. Another area of interest, is the research into the frail older adult patient's outcomes when collaboration is seen as effective vs. not effective, and how this can be measured. Consideration of the value placed on the frail older adult population, and how this impacts health care provider's willingness to collaborative, could shed some light onto further enhancements towards effective collaboration. Much emphasis is placed on the value of

collaboration in health care; therefore, more research in this area would strengthen this new health care delivery model.

There is a clear need for research into better funding models that promote collaborative care and information about how to best achieve this goal. This research could include optimal provision of preventative services, funding approaches that optimize service delivery (Boeckxstaens & de Graff, 2011), and further research into the provision of specialities in urban versus rural areas.

Lastly, the literature points to the fact that more research is needed regarding best practice guidelines for the geriatric population, specifically for complex chronic disease patients who do not easily fit into any one category of illness. With the increasing numbers of frail older people with overlapping chronic and debilitating issues, more information and direction would benefit both the patient, and their health care providers.

Summary and Conclusion

There is a significant increase of frail older adults expected to be living in community over the next 20 years. As science and technology increases, so does the life expectancy of Canadians. As we age, we require an increasing amount of health care services to meet changing health care needs. Health Canada (2014) wishes to create a health care environment that promotes an effective use of health care resources and dollars through the use of collaboration between health care providers. The NP needs to be up to date on the complex and often challenging care needs of all patients, in particular the frail older adult person who requires special consideration. Health care providers are encouraged and expected to work together to provide complete and holistic care. Research has shown that the benefits of collaborative care include improved quality of care, reduced time and resources wastage, enhanced compliance, and improved health outcomes (Burnett et al., 2005; CASHC, 2013; Markle-Reid et al., 2013; Naylor & Kurtzman, 2010; Robben et al., 2012). Despite this research, collaboration is not occurring as it should be in primary practice (Bailey et al., 2006; de Stampa et al., 2012; Donald et al., 2009; Goldsmith et al., 2010; Prada et al., 2014; Schadewaldt et al., 2013; Wilson et al., 2005).

The purpose of this project was to supply effective collaboration strategies for an NP, providing primary care for the frail older adult patient in the community setting. A thorough literature search was completed that focused on the context of NPs, community primary care, and the frail older adult patient. Of the 302 possible articles identified, 16 were retained for in-depth analysis based on context and specific inclusion and exclusion criteria. The research studies were then critiqued and thematically analyzed for professional, organizational and building therapeutic relationship with patient/family focused strategies. The results produced

practice strategies for aiding in effective collaboration, and the project concluded with a discussion about the implications for future research and education.

NPs possess the skills, education, and ability to move collaboration forward in their professional practice and work environments. These practice strategies as well as future research in this context, hold an opportunity for the NP to improve the collaboration between community health care providers, patients and families, and to benefit the health outcomes of the frail older adult patient.

References

Bailey, P., Jones, L., & Way, D. (2006). Family physician/nurse practitioner: Stories of collaboration. *Journal of Advanced Nursing, 53*(4), 381-391. doi:10.1111/j.1365-2648.2006.03734.x

Baxter, P., & Markle-Reid, M. (2009). An interprofessional team approach to fall prevention for older home care clients 'at risk' of falling: Health care providers share their experiences. *International Journal of Integrated Care, 9*(2), e1-e12. Retrieved from http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2691945/pdf/ijic2009-200915.pdf

Boult, C., & Wieland, G. D. (2010). Comprehensive primary care for older patients with multiple chronic conditions: "Nobody rushes you through". *Journal of the American Medical Association, 304*(17), 1936-1943. doi:10.1001/jama.2010.1623

Boeckxstaens, P., & de Graaf, P. (2011). Primary care and care for older persons: Position paper of the European forum for primary care. *Quality in Primary Care, 19*(6), 369-389.

British Columbia Freedom of Information and Privacy Association. (2011). *Your privacy and your personal health information*. Retrieved from http://www.healthinfoprivacybc.ca/files/forms/privacy_faq_brochure.pdf

British Columbia Nurse Practitioner Association. (2015). *B.C. nurse practitioners meet the highest educational standards*. Retrieved from http://bcnpa.org/index.php/npsinbc/education/

Burnett, B. L., Tucker, B. A., & Gagan, M. J. (2005). Fellows column. Collaboration, continuity, compliance: Two fellows "share" their experiences. *Journal of the American Academy of Nurse Practitioners, 17*(2), 45-46. doi:10.1111/j.1041-2972.2005.00009.x

Canadian Alliance for Sustainable Health Care. (2012*). Improving primary health care through collaboration. Briefing 2: Barriers to successful interprofessional teams.* Retrieved from http://www.conferenceboard.ca/temp/1794617a-2e4d-4d22-8d91-cdfaff027bf6/13-146_primaryhealthcare-briefing-2.pdf

Canadian Alliance for Sustainable Health Care. (2013). *Future care for Canadian seniors: Why it matters.* Retrieved from http://www.conferenceboard.ca/temp/36e5ea32-de28-4d62-ac2f-7fd5474015f1/14-125_futurecareseniors.pdf

Canadian Institute for Health Information. (2011). *Health care in Canada, 2011: A focus on seniors and aging*. Retrieved from https://secure.cihi.ca/free_products/HCIC_2011_seniors_report_en.pdf

Canadian Institute for Health Information. (2014). *National health expenditure trends: 1975 to 2014*. Retrieved from http://www.cihi.ca/web/resource/en/nhex_2014_chartbook_pdf_en.pdf

Canadian Medical Association, Canadian Nurses Association, & Canadian Pharmacist Association. (2003). *Scopes of practice*. Retrieved from http://www.pharmacists.ca/cpha-ca/assets/File/cpha-on-the-issues/PPScopesOfPracticeEN.pdf

Canadian Nurses Association. (2010). *Canadian nurse practitioner: Core competency framework.* Retrieved from http://www.cno.org/Global/for/rnec/pdf/CompetencyFramework_en.pdf

Canadian Nurse Practitioner Initiative. (2006). *Nurse practitioners: The time is now - A solution to improving access and reducing wait times in Canada*. Retrieved from http://www.npnow.ca/docs/tech-report/section1/01_Integrated_Report.pdf

Chreim, S., Williams, B. E., Janz, L., & Dastmalchian, A. (2010). Change agency in a primary health care context: The case of distributed leadership. *Health Care Management Review, 35*(2), 187-199. doi:10.1097/HMR.0b013e3181c8b1f8

Clarin, O. A. (2007). Strategies to overcome barriers to effective nurse practitioner and physician collaboration. *Journal for Nurse Practitioners, 3*(8), 538-548. doi:10.1016/j.nurpra.2007.05.019

College of Registered Nurses of British Columbia. (2013). *Professional standards for registered nurses and nurse practitioners: Accountability, knowledge, competence, ethics, service, self-regulation.* Retrieved from https://www.crnbc.ca/Standards/Lists/StandardResources/128Providerstandards.pdf

College of Registered Nurses of British Columbia. (2015). *Scope of practice for nurse practitioners: Standards, limits and conditions (revised).* Retrieved from https://www.crnbc.ca/Standards/Lists/StandardResources/688ScopeforNPs.pdf

Davey, B., Levin, E., Iliffe, S., & Kharicha, K. (2005). Integrating health and social care: Implications for joint working and community care outcomes for older people. *Journal of Interprofessional Care, 19*(1), 22-34. doi:10.1080/1356182040021734

de Stampa, M., Vedel, I., Bergman, H., Novella, J. L., Lapointe, L. (2009). Fostering participation of general practitioners in integrated health services networks: Incentives, barriers, and guidelines. *BioMed Central Health Services Research, 9*(1), 48-58. doi:10.1186/1472-6963-9-48

de Stampa, M., Vedel, I., Bergman, H., Novella, J. L., Lechowski, L., Ankri, J., & Lapointe, L. (2013). Opening the black box of clinical collaboration in integrated care models for frail, elderly patients. *The Gerontologist, 53*(2), 313-325. doi:10.1093/geront/gns081

DiCenso, A., Bourgeault, I., Abelson, J., Martin-Misener, R., Kaasalainen, S., Carter, N., . . . Kilpatrick, K. (2010). Utilization of nurse practitioners to increase patient access to primary healthcare in Canada – thinking outside the box. *Journal of Nursing Leadership, 23*(Special Issues), 239-259. doi: 10.12927/cjnl.2010.22281

DiCenso, A., & Bryant-Lukosius, D. (2010). *Clinical nurse specialists and nurse practitioners in Canada: A decision support synthesis.* Ottawa, ON: Canadian Health

Services Research Foundation. Retrieved from http://www.cfhi-fcass.ca/sf-docs /default-source/commissioned-research-reports/Dicenso_EN_Final.pdf?sfvrsn=0

Donald, F., Mohide, E. A., DiCenso, A., Brazil, K., Stephenson, M., & Akhtar-Danesh, N. (2009). Nurse practitioner and physician collaboration in long-term care homes: Survey results. *Canadian Journal on Aging, 28*(1), 77-87. doi:10.1017 /S0714980809090060

Donald, F., Martin-Misener, R., Bryant-Lukosius, D., Kilpatrick, K., Kaasalainen S., Carter, N. . . DiCenso, A. (2010). The primary healthcare nurse practitioner role in Canada. *Canadian Journal of Nursing Leadership, 23*(Special Issue), 88-113. doi:10.12927 /cjnl.2013.22271

Effective. (2015). In *Oxford dictionaries: Language matters*. Retrieved from http://www .oxforddictionaries.com/us/definition/american_english/effective?searchDictCode=all

Elissen, A. M., van Raak, A, J., & Paulus, A. T. (2011). Can we make sense of multidisciplinary co-operation in primary care by considering routines and rules? *Health and Social Care in the Community, 19*(1), 33-42. doi:10.1111/j.1365-2524 .2010.00946.x

Emery, E. E., Lapidos, S., Eisenstein, A. R., Ivan, I. I., & Golden, R. L. (2012). The BRIGHTEN program: Implementation and evaluation of a program to bridge resources of an interdisciplinary geriatric health team via electronic networking. *The Gerontologist, 52*(6), 857-865. doi:10.1093/geront/gns034

Emery, E. E., Millheiser, A., Garcia, C. M., Marquine, J. J., & Golden, R. L. (2011). Community long-term care teams: Assessing team fitness. *Clinical Gerontologist, 34*(5), 355-366. doi:10.1080/07317115.2011.588538

Enhancing Interdisciplinary Collaboration in Primary Health Care in Canada Committee. (2005). *Enhancing interdisciplinary collaboration in primary health care in Canada.* Retrieved from http://www.eicp.ca/en/resources/pdfs/Enhancing-Interdisciplinary -Collaboration-in-Primary-Health-Care-in-Canada.pdf

Goldsmith, J., Wittenberg-Lyles, E., Rodriguez, D., & Sanchez-Reilly, S. (2010). Interdisciplinary geriatric and palliative care team narratives: Collaboration practices and barriers. *Qualitative Health Research, 20*(1), 93-104. doi:10.1177 /1049732309355287

Goodman, C., Drennan, V., Scheibl, F., Shah, D., Manthorpe, J., Gage, H., & Iliffe, S. (2011). Models of inter professional working for older people living at home: A survey and review of the local strategies of English health and social care statutory organizations. *BioMed Health Services Research, 11*(1), 337. doi: 10.1186/1472 -6963-11-337

Guidelines and Protocols Advisory Committee. (2012). *Frailty in older adults: Early identification and management*. Retrieved from http://www.bcguidelines.ca/guideline _frailty.html

Hall, P. (2005). Interprofessional teamwork: Professional cultures as barriers. *Journal of Interprofessional Care, 19*(s1), 188-196. doi:10.1080/13561820500081745

Health Canada. (2014). *Primary health care.* Retrieved from http://www.hc-sc.gc.ca/hcs-sss /prim/about-apropos-eng.php

Health Care (Consent) and Care Facility (Admission) Act, RSBC 1996, c 181. Retrieved from http://www.bclaws.ca/EPLibraries/bclaws_new/document/ID/freeside/00_96181 _01

Hellquist, K., Bradley, R., Grambart, S., Kapustin, J., & Loch, J. (2012). Collaborative practice benefits patients: An examination of interprofessional approaches to diabetes care. *Integrative Medicine, 11*(4), 43-48.

Hendrix, C. C., & Wojciechowski, C. W. (2005). Chronic care management for the elderly: An opportunity for gerontological nurse practitioners. *Journal of the American Academy of Nurse Practitioners, 17*(7), 263–267. doi:10.1111/j.1745-7599.2005 .0044.x

Hubbard, G., & Themessl-Huber, M. (2005). Professional perceptions of joint working in primary care and social care services for older people in Scotland. *Journal of Interprofessional Care, 19*(4), 371-385. doi:10.1080/13561820500165167

Humbert, J., Legault, F., Dahrouge, S., Halabisky, B., Boyce, G., Hogg, W., & Amos, S. (2007). Integration of nurse practitioners into a family health network. *Canadian Nurse, 103*(9), 30-34.

Jones, K., Jamerson, C., & Brown, S. (2012). The journey to electronic interdisciplinary care plans. *Nursing Management, 43*(12), 9-12. doi:10.1097/01.NUMA.0000422896 .29829.03

Keith, K. M., & Askin, D. F. (2008). Effective collaboration: The key to better healthcare. *Nursing Leadership, 21*(2), 51-61. doi:10.12927/cjnl.2008.19875

Korazim-Korosy, Y., Mizrahi, T., Bayne-Smith, M., & Garcia, M. L. (2014). Professional determinants in community collaborations: Interdisciplinary comparative perspectives on roles and experiences among six disciplines. *Journal of Community Practice, 22*(1-2), 229-255. doi:10.1080/10705422.2014.901267

Lapidos, S., & Rothschild, S. K. (2004). Interdisciplinary management of chronic disease in primary practice. *Managed Care Interface, 17*(7), 50-53.

Lau, F., Price, M., Boyd, J., Partridge, C., Bell, H., & Raworth, R. (2012). Impact of electronic medical record on physician practice in office settings: A systematic review. *BMC Medical Informatics & Decision Making, 12*(1), 10-19. doi:10.1186 /1472-6947-12-10

Legare, F., Stacey, D., Briere, N., Fraser, K., Desroches, S., Dumont, S., . . . Aube, D. (2013). Healthcare providers' intentions to engage in an interprofessional approach to shared

decision-making in home care programs: A mixed methods study. *Journal of Interprofessional Care, 27*(3), 214-222. doi:10.3109/13561820.2013.763777

Legault, F., Humbert, J., Amos, S., Hogg, W., Ward, N., Dahrouge, S., & Ziebell, L. (2012). Difficulties encountered in collaborative care: Logistics trumps desire. *Journal of the American Board of Family Medicine, 25*(2), 168-176. doi:10.3122/jabfm.2012.02 .110153

LoBiondo-Wood, G., Haber, J, & Cameron, C. (2013). Chapter 3. Critical reading strategies: Overview of the research process. In C. Cameron & M. D. Singh (Eds.), *Nursing research in Canada: Methods, critical appraisal, and utilization* (pp. 48-64). Toronto, ON: Elsevier Canada.

Mahtani, K. R., Heneghan, C. J., Glasziou, P. P., & Perera, R. (2011). Reminder packaging for improving adherence to self-administered - medications. *Cochrane Database for Systematic Reviews, 9*. doi:10.1002/14651858.CD005025.pub3

Markle-Reid, M., Browne, G., & Gafni, A. (2013). Nurse-led health promotion interventions improve quality of life in frail older home care clients: Lessons learned from three randomized trials in Ontario, Canada. *Journal of Evaluation in Clinical Practice, 19*(1), 118-131. doi:10.1111/j.1365-2753.2011.01782.x

Matthews, S. W., & Brown, M. A. (2013). APRN expertise: The collaborative health management model. *The Nurse Practitioner, 38*(1), 43-48. doi:10.1097/01.NPR .0000423382.33822.ab

Medical Services Commission. (2013). *Payment schedule: General practice*. Retrieved from http://www.health.gov.bc.ca/msp/infoprac/physbilling/payschedule/pdf/7-general -practice.pdf

Metzelthin, S. F., Daniels, R., van Rossum, E., Cox, K., Habets, H., de Witte, L. P., & Kempen, G. I. (2013). A nurse-led interdisciplinary primary care approach to prevent disability among community-dwelling frail older people: A large-scale process evaluation. *International Journal of Nursing Studies, 50*(9), 1184-1196. doi:10.1016 /j.ijnurstu.2012.12.016

Mian, O., Koren, I., & Rukholm, E. (2012). Nurse practitioners in Ontario primary healthcare: Referral patterns and collaboration with other healthcare providers. *Journal of Interprofessional Care, 26*(3), 232-239. doi:10.3109/13561820.2011 .650300

Ministry of Health. (2008). *Primary health care charter: A collaborative approach.* Retrieved from http://www.health.gov.bc.ca/library/publications/year/2007/phc _charter.pdf

Ministry of Health. (2012). *Improving care for B.C. seniors: An action plan.* Retrieved from http://www2.gov.bc.ca/gov/DownloadAsset?assetId =3776A87BFF2445F391A133FD564AFA68&filename=seniorsactionplan.pdf

Morley, J. E., Vellas, B., van Kan, G. A., Anker, S. D., Bauer, J. M., Bernabei, R., . . . Walston, J. (2013). Frailty consensus: A call to action. *Journal of the American Medical Directors Association, 14*(6), 392-397. doi:10.1016/j.jamda.2013.03.022

Naylor, M. D., & Kurtzman, E. T. (2010). The role of nurse practitioners in reinventing primary care. *Health Affairs, 29*(5), 893-899. doi:10.1377/hlthaff.2010.0440

O'Brien, J. L., Martin, D. R., Heyworth, J. A., & Meyer, N. R. (2009). A phenomenological perspective on advanced practice nurse-physician collaboration within an interdisciplinary healthcare team. *Journal of the American Academy of Nurse Practitioners, 21*(8), 444-453. doi:10.1111/j.1745-7599.2009.00428.x

Oandasan, I. F., Gotlib-Conn, L., Lingard, L., Karim, A., Jakubovicz, D., Whitehead, C., . . . Reeves, S. (2009). The impact of space and time on interprofessional teamwork in Canadian primary health care settings: Implications for health care reform. *Primary Health Care Research & Development, 10*(2), 151-165. doi:10.1017 /S1463423609001091

Ontario Medical Association. (2014). *Key elements to include in a coordinated care plan.* Retrieved from https://www.oma.org/Resources/Documents/CoordinatedCarePlan _June2014.pdf

Palinkas, L. A., Ell, K., Hansen, M., Cabassa, L., & Wells, A. (2011). Sustainability of collaborative care interventions in primary care settings. *Journal of Social Work, 11*(1), 99-117. doi:10.1177/1468017310381310

Park, G., Miller, D., Tien, G., Sheppard, I., & Bernard, M. (2014). Supporting frail seniors through a family physician and home health integrated care model. *International Journal of Integrated Care, 14*(e001). doi: http://www.ncbi.nlm.nih.gov/pmc/articles /PMC3956084/pdf/IJIC-14-2014001.pdf

Parmar, J., Dobbs, B., McKay, R., Kirwan, C., Cooper, T., Marin, A., Gupta, N. (2014). Diagnosis and management of dementia in primary care. *Canadian Family Physician, 60*(5), 457-465.

Personal Information Protection Act, SBC 2003, c 63. Retrieved from http://www.bclaws.ca /EPLibraries/bclaws_new/document/ID/freeside/00_03063_01#section17

Prada, G., Grimes, K., & Sklokin, I. (2014). *Defining health and health care sustainability.* Ottawa, ON: The Conference Board of Canada. Retrieved from http://www .conferenceboard.ca/temp/274ed208-1359-4639-90e0-cd4d96750a62/6269 _defininghealth_cashc_rpt.pdf

Providence Health Care. (2015). *Rapid access to consultative expertise*. Retrieved from http://medstaff.providencehealthcare.org/shared-care/rapid-access-to-consultative -expertise/

Reuben, D. B., Ganz, D. A., Roth, C. P., McCreath, H. E., Ramirez, K. D., & Wenger, N. S. (2013). Effect of nurse practitioner comanagement on the care of geriatric conditions. *Journal of American Geriatrics Society, 61*(6), 857-867. doi:10.1111/jgs.12268

Robben, S., Perry, M., van Nieuwenhuijzen, L., van Achterberg, T., Rikkert, M. O., Schers, H., . . . Melis, R. (2012). Impact of interprofessional education on collaboration attitudes, skills, and behavior among primary care providers. *Journal of Continuing Education in the Health Professions, 32*(3), 196-204. doi:10.1002/chp.21145

Ryan, D., Barnett, R., Cott, C., Dalziel, W., Gutmanis, I., Jewell, D., . . . Puxty, J. (2013). Geriatrics, interprofessional practice, and interorganizational collaboration: A knowledge-to-practice intervention for primary care teams. *Journal of Continuing Education in the Health Professions, 33*(3), 180-189. doi:10.1002/chp.21183

Schadewaldt, V., McInnes, E., Hiller, J. E., & Gardner, A. (2013). Views and experiences of nurse practitioners and medical practitioners with collaborative practice in primary health care – an integrative review. *BioMed Central Family Practice, 14*(1), 132-142. doi:10.1186/1471-2296-14-132.

Schroder, C., Medves, J., Paterson, M., Byrnes, V., Chapman, C., O'Riordan, A., . . . Kelly, C. (2011). Development and pilot testing of the collaborative practice assessment tool. *Journal of Interprofessional Care, 25*(3), 189-195. doi:10.3109/13561820.2010 .532620

Silva-Smith, A. L., Feliciano, L., Kluge, M. A., Yochim, B. P., Anderson, L. N., Hiroto, K. E., & Qualls, S. H. (2011). The Palisades: An interdisciplinary wellness model in senior housing. *The Gerontologist, 51*(3), 406-416. doi:10.1093/geront/gnq117

Skultety, K. M., & Zeiss, A. (2006). The treatment of depression in older adults in the primary care setting: An evidence-based review. *Health Psychology, 25*(6), 665-674. doi:10.1037/0278-6133.25.6.665

Statistics Canada. (2012). *Living arrangements of seniors: Families, households and marital status. Structural type of dwelling and collectives, 2011 census of population.* Retrieved from http://www12.statcan.gc.ca/census-recensement/2011/as-sa/98-312 -x/98-312-x2011003_4-eng.pdf

Statistics Canada. (2014). *Population projections: Canada, the provinces and territories, 2013 to 2063.* Retrieved from http://www.statcan.gc.ca/daily-quotidien/140917 /dq140917a-eng.pdf

Strawbridge, W. J., Wallhagen, M. I., Cohen, R. D. (2002). Successful aging and well-being: Self-rated compared with Rowe and Kahn. *The Gerontologist, 42*(6), 727-733. doi:10 .1093/geront/42.6.727

The Canadian Medical Protective Association & The Canadian Nurses Protective Society. (2013). *CMPA/CNPS joint statement on liability protection for nurse practitioners and physicians in collaborative practice*. Retrieved from http://www.cnps.ca/upload -files/pdf_english/CMPA_CNPS_Joint_Statement_Nov_2013.pdf

The Canadian Medical Protective Association & The Healthcare Insurance Reciprocal of Canada. (2007). Joint statement on liability protection for midwives and physicians.

Retrieved from http://www.canadianmidwives.org/DATA/DOCUMENT/JSLiability_ENG200706.pdf

Torpy, J. M., Lynm, C., & Glass, R. M. (2006). Frailty in older adults. *The Journal of the American Medical Association, 296*(18), 2280. doi:10.1001/jama.296.18.2280

Toscan, J., Mairs, K., Hinton, S., Stolee, P., & The InfoRehab Research Team. (2012). Integrated transitional care: Patient, informal caregiver and health care provider perspectives on care transitions for older persons with hip fracture. *International Journal of Integrated Care, 12*(2), e1-e14. Retrieved from http://www.ijic.org/index.php/ijic/article/viewArticle/797/1530

Tracy, C. S., Bell, S. H., Nickell, L.A., Charles, J., & Upshur, R. E. (2013). The IMPACT clinic: Innovative model of interprofessional primary care for elderly patient with complex health care needs. *Canadian Family Physician, 53*(3), e148-e155.

VanDyke, S. (2003). *Senior series: Positive aspects of aging*. Retrieved from http://ohioline.osu.edu/ss-fact/pdf/0209.pdf

Weberg, D., & Weberg, K. (2014). Seven behaviors to advance teamwork: Findings from a study of innovation leadership in a simulation centre. *Nursing Administration Quarterly, 38*(3), 230-237. doi:10.1097/NAQ.0000000000000041

Wilson, K., Coulon, L., Hillege, S., & Swann, W. (2005). Nurse practitioners' experiences of working collaboratively with general practitioners and allied health providers in New South Wales, Australia. *The Australian Journal of Advanced Nursing, 23*(2), 22-27.

World Health Organization. (1978). *Declaration of Alma-Ata. International conference on primary health care*. Alma-Ata, USSR: World Health Organization. Retrieved from http://www.who.int/publications/almaata_declaration_en.pdf

World Health Organization. (2008). *The world health report 2008. Primary health care: Now more than ever*. Geneva, Switzerland: World Health Organization. Retrieved from http://www.who.int/whr/2008/whr08_en.pdf

World Health Organization. (2010). *Framework for action on interprofessional education & collaborative practice.* Geneva, Switzerland: World Health Organization. Retrieved from http://whqlibdoc.who.int/hq/2010/WHO_HRH_HPN_10.3_eng.pdf?ua=1

Appendix A

Box 1: The CSHA Clinical Frailty Scale

1 *Very fit* — robust, active, energetic, well motivated and fit; these people commonly exercise regularly and are in the most fit group for their age

2 *Well* — without active disease, but less fit than people in category 1

3 *Well, with treated comorbid disease* — disease symptoms are well controlled compared with those in category 4

4 *Apparently vulnerable* — although not frankly dependent, these people commonly complain of being "slowed up" or have disease symptoms

5 *Mildly frail* — with limited dependence on others for instrumental activities of daily living

6 *Moderately frail* — help is needed with both instrumental and non-instrumental activities of daily living

7 *Severely frail* — completely dependent on others for the activities of daily living, or terminally ill

Note: CSHA = Canadian Study of Health and Aging.

Note. From "A global clinical measure of fitness and frailty in elderly people", by K. Rockwood, X. Song, C. MacKnight, H. Bergman, D. B. Hogan, I. McDowell and A. Mitnitski, 2005, *Canadian Medical Association Journal, 173*, 490.

Appendix B

Preliminary Search Terms and Results

Search Words	CINAHL	Cochrane Review	Medline	PubMed
Nurse practitioner	14,464	354	15,135	21,585
Collaboration	20,616	5,647	0	28,992
Cooperative behaviour	2,944	614	28,070	1,937
Team work	7,675	29	0	14,200
Team building	1,038	24	362	2,488
Interprofessional relations	15,935	231	53,898	54,067
Multidisciplinary care	21,750	496	65	25, 396
Pharmacist	4,453	1,311	10,484	6,476
Social work	10,643	471	14,990	71,061
Physiotherapist	6,165	3,840	317	6,476
Occupational therapist	4,642	1,146	0	1,705
Registered Nurse	21,709	167	0	9,162
Nurse	40,577	6,735	54,668	288,294
Mental Health Personal	4,539	1	0	8,872
Community Health Workers	1,050	296	3,109	13,537
Allied health personal	68,834	0	41,050	662
Advanced Practice Nurse	24,573	53	750	5,333
Family or Primary Care Physicians	4,142	706	10,577	44,364
Primary Health Care (provider)	17,462	12	98,902	12,976
Gerontological care	9,075	0	0	10,137
Frail elderly	2,171	763	4,471	8,597
Aged adult 65-80+	1,492	303,406	2,590,805	312,027
Totals	305,949	326,302	2,927,653	948,344

Appendix C

Quality of Data Chart

	Yes	Cannot tell	No
1. Did the review address a clearly focussed issue? Was there enough information on: · The population studied · The intervention given · The outcomes considered			
2. Did the authors look for the appropriate sort of papers? The 'best sort of studies' would · Address the review's question · Have an appropriate study design			
3. Do you think the important, relevant studies were included? Look for · Which bibliographic databases were used · Follow up from reference lists · Personal contact with experts · Search for unpublished as well as published studies · Search for non-English language studies			
4. Did the review's authors do enough to assess the quality of the included studies? The authors need to consider the rigour of the studies they have identified. Lack of rigour may affect the study's results.			
5. If the results of the review have been combined, was it reasonable to do so? Consider whether · The results were similar from study to study · The results of all the included studies are clearly displayed · The results of the different studies are similar · The reasons for any variations are discussed			
6. What is the overall result of the review? Consider · If you are clear about the reviews 'bottom line' results · What these are (numerically if appropriate) · How were the results expressed (NNT, odds ratio, etc)			
7. How precise are the results? Are the results presented with confidence intervals?			
8. Can the results be applied to the local population? Consider whether · The patients covered by the review could be sufficiently different from your population to cause concern · Your local setting is likely to differ much from that of the review			
9. Were all important outcomes considered?			
10. Are the benefits worth the harms and costs? Even if this is not addressed by the review, what do you think?			

Note. Adapted from "*Critical appraisal checklist for a systematic review*", by The Department of General Medicine, University of Glasgow. 2013. Retrieved from http://www.gla.ac.uk/media/media_64047_en.pdf

Appendix D
Level of Evidence/Literature Review Matrix

Level 1: Evidence for a systematic review or meta-analysis of randomized controlled trials (RCTs) or Evidence informed clinical practice guidelines based on systematic reviews.

Level 2: Evidence from a well-designed RCT.

Level 3: Evidence from a controlled trial without randomization (quasi-experimental study)

Level 4: Evidence from single non-experimental studies – case-control, correlational, cohort studies.

Level 5: Evidence from systematic reviews of descriptive and qualitative studies

Level 6: Evidence from single descriptive or qualitative study

Level 7: Evidence from the opinion of authorities and/or reports of experts committees

Note. Adapted from "Chapter 3: Critical reading strategies: Overview of the research process," by G. LoBiondo-Wood., J. Haber., and C. Cameron, 2013, In Nursing research in Canada: Methods, critical appraisal, and utilization, p. 48-64.

Author, Date, & Location	Purpose, Context and Population	Level of Evidence, Sample, Setting, and Method	Key Findings and Conclusions	Implications for Future Research	Effective Collaboration Facilitators	Collaborative Practice Strategies
Baxter & Markle-Reid (2009) Ontario, Canada	To describe the experiences of 5 different care providers as they participated in an inter-professional team approach to care for elderly with fall risk Community care Collaboration Complex, frail older adults	Level 6 Exploratory descriptive 9 months Case manager, physio-therapist (PT), occupational therapist (OT), registered nurse (RN), registered dietitian nutritionist (RDN) N = 9 Then PT, OT, RDN, medicine, pharmacy, nursing	Themes in the literature include barriers in: communication, role clarity, and power differentials in collaborative groupings. Early interventions with variety of providers approaches and strategies has the greatest impact on prevention of falls Collaboration a benefit for providers, patients and families Clear communication to frail older adults on who you are, what your role is. Appreciate the older adult's unique personal characteristics and wants, and work collaboration around those needs Adjust focus on falls to not cause anxiety and over focus.	How teams engage with each other when planning and implementing an inter-professional approach to complex patient care in community. What are the perceived outcomes of engaging in a team approach? The effect of gender on collaboration. How much time should collaborators allocate for various inter-professional collaboration to be effective?	Role clarity Climate promoting development of personal relationships Clear communication Common goal Team discussions on conflicts Time Same perceived levels of power	Be flexible in problem solving. Positive attitude Mutual respect Clear roles as to not duplicate assessments and care Creative problem solving Do not shy away from conflict, reconcile it Follow up/re-evaluate decisions and interventions Face to face meetings. Build a rapport. Email, phone, voice-mails. Know all collaborator by name and role Share common assessments and charts: EMR or chart in patient's home Weekly meetings (also can be barrier) Scheduled time for collaboration Share a common goal and vision: health care providers, patient, family Share your ideas, share your stress

Author, Date, & Location	Purpose, Context and Population	Level of Evidence, Sample, Setting, and Method	Key Findings and Conclusions	Implications for Future Research	Effective Collaboration Facilitators	Collaborative Practice Strategies
						Be patient centred Written plans, goals, health care providers for the patient to keep Re-evaluate that the collaboration is effective
Boeckxstaens & de Graaf (2011) Contributors from Netherlands, Spain, Slovenia, Germany, Canada, Belgium, Italy and UK	To explore how to address the needs of older patients in PC practice Older persons: over 65 years with multi-morbidities and complex care requirements , including frail and very frail older adults Primary care in community	Level 7 Opinion paper from the European Forum for Primary Care Joint working between primary care provider, groups or teams of providers and specialists 'across health and social care system', older adult patient and caregivers	Coordination of care and health care system navigation is centre of primary care Primary care providers still to be proactive in prevention and health promotion Aging is an individual experience requiring individual responses Insufficient information transferred between health care providers or primary and secondary care services is a large issue Frailties may limit access to services, there is a huge lack of service flexibility Polypharmacy issues	Develop multi-morbidity clinical practice guidelines for primary care Optimal provision of preventative services Evidence-based practice (EBP) guidelines for 'seamless care' with regard to medications Funding approaches and regulations that optimize	Shared funding between health care providers Two way communication technology All parties are felt heard. Concerns are taken seriously Organizational policy on working together Clear communication Continuity Flexibility Mutual respect and trust Proactive attitude Caregiver open to	Utilize EBP guidelines Have a thorough understanding of the impact of ageing. "Untangling" the multi-dimensions of the older adult to know what services are required; best fit and utilization of resources Consider quality of life (QOL) and autonomy, individual patient goals, before deciding on treatment plans/goals Centre collaborative plans/goals or strategies around what the patient and caregivers want. Common collaborative goal and needs assessment Access: telephone, internet, in person. Clear communication of individualized care plans with regular review, monitoring and adaption

Author, Date, & Location	Purpose, Context and Population	Level of Evidence, Sample, Setting, and Method	Key Findings and Conclusions	Implications for Future Research	Effective Collaboration Facilitators	Collaborative Practice Strategies
			need strategies. Medication adherence is complex issue. Older adult specific education, content and communication required Need to connect with caregivers to provide support Collaboration is foundation to care	comprehend-sive care	collaboration	Consider 1 party as the single coordinator of care to help patient prioritize the demands from the co morbidities Continuity of relationships Focus on health and independence, not falls and injuries Face to face, personalized and flexible appointments Access to electronic med lists Clear medication list and history with pharm and consulting specialists. Consistent med teaching from practitioner and pharmacist Follow up on new treatment plans, medications, etc. Follow up and re-evaluation of the collaboration process, observe for effectiveness
Davey et al. (2005) UK	Compares two models of joint working and the impact of personal characteristics, service use	Level 6 Mixed 6 month study	Primary care providers under document collaboration Co-location of collaborators do not alter overall type or	Need more research to prove that effective collaboration leads to more effective user	Two-way collaboration Clear, useful, up to date documentation Flexibility	Reply to all messages as soon as possible Sharing of up to date medical records Prompt response to task requests and clarifications

Author, Date, & Location	Purpose, Context and Population	Level of Evidence, Sample, Setting, and Method	Key Findings and Conclusions	Implications for Future Research	Effective Collaboration Facilitators	Collaborative Practice Strategies
	and collocation on the likelihood of older people to remain in the community Older adults aged 76-101 with complex needs Primary care Community services	N = 79 Interviews Collaboration between SW, primary care provider, home care nursing, home care workers, meal services, respite care	amount of collaboration Effective communication may be determined by the quality, skills and knowledge of individual collaborators Factors effecting outcomes: level of cognitive impairment, extent of home care services provided, older adult living alone Outcomes of collaboration have to take into account cognitive impairment, circumstances and services received Most required services: home care, home nursing, meals Telephone main communication medium even in co-located areas Co-location increases face to face exchanges	outcomes Future studies on outcomes for older adults need a wide context due to unique circumstances and varying levels of cognitive impairment	Willingness to collaborate No cognitive impairment Caregiver open to collaboration	Joint care planning with all involved. Refer to more services as required Follow up and re-evaluate care plan, other health care professional concerns

Author, Date, & Location	Purpose, Context and Population	Level of Evidence, Sample, Setting, and Method	Key Findings and Conclusions	Implications for Future Research	Effective Collaboration Facilitators	Collaborative Practice Strategies
			No substantial changes to patient outcome in either model of joint working			
de Stampa et al. (2009) France and Canada	A look at incentives and barriers to primary care provider's participation in integrated health services networks Primary care Frail elderly persons Community Integrated care	Level 6 Mixed method Mail survey Semi-structured face to face interviews N = 61 question-naire N = 22 interviewed Primary care providers $100 incentive 23 months Team: case	Incentives to participation: 1.Provider characteristics: has elderly patients, previous integrated care patients, has collaborative practice 2. Perceived consequences: concerns 3. Team implementation: selection of frail elderly patients, influence of peers 4. Relationship with team members: good 5. Professional consequences: efficacy and quality of team care, funding, improved professional practice	Verify data on other populations	Funding available Amicable relationships Good outcomes Understanding or previous experience in collaborative experiences Time Mutual trust and respect Health care provider has a lot to gain by joint working HCP has many older adult patients to coordinate Connections with patients	Take the time to build relationships with collaborators Utilize already established collaborative teams Build solid relationship with patient and families Decision making based on what patient wants, goals, needs Role clarifications clear Communicate with other health care providers, patients and families clearly, precisely Close connection with geriatrician Advocate for resolution of funding issues

Author, Date, & Location	Purpose, Context and Population	Level of Evidence, Sample, Setting, and Method	Key Findings and Conclusions	Implications for Future Research	Effective Collaboration Facilitators	Collaborative Practice Strategies
		manager, community nurse, SW, OT, PT, home care workers, geriatrician, mangers of care, pharmacist				
de Stampa et al. (2013) France and Canada	Looking at the collaboration process among primary care physicians, case managers (NPs) and geriatricians N=46 Data analyzed using grounded theory Primary care in community Frail elderly patients	Level 6 Qualitative Semi structured interviews with physicians, geriatricians, NPs, RNs, social workers	Three phases to collaboration: initiating relationships, developing two way collaboration and developing interdisciplinary teamwork Collaboration develops at the same time as trust. Need to be proactive in working with providers that do not normally collaborate.	Need to assess the impact of collaboration on professional practices, patients and family caregivers	Joint decision making Integrated care Organizational support and facilitator Objective in practice Training in interdisciplinary collaboration Openness and willingness to compromise Be available to the team Mutual understanding of all roles and job descriptions	Group decided upon care plans shared between all collaborative parties: care providers, patients, families Access to consult notes, test results, EMR Meet face to face to establish report Establish and maintain collaborative relationships: networking, follow up Keep a close link between primary care provider and geriatric services Follow through re: plans and recommendations Answer messages and requests promptly; be available

Author, Date, & Location	Purpose, Context and Population	Level of Evidence, Sample, Setting, and Method	Key Findings and Conclusions	Implications for Future Research	Effective Collaboration Facilitators	Collaborative Practice Strategies
Emery et al. (2012) USA	Screening for geriatric depression in outpatient primary care clinic: using electronic networking for interdisciplinary team members BRIGHTEN program evaluation Collaboration Community setting Older adults over 65 years with depression as debilitating chronic health care condition	Level 4 Mixed method Program evaluated by RE-AIM 9 Medical centres 2 Community clinics Screened + N = 859 Enrolled N = 150 3 years Collaboration between PT, OT, RDN, psychotherapy, psychiatric medication management, neuropsychological	Interdisciplinary team linked to primary care provider: seamless, nonthreatening, effective approach Time and resources consuming program Solution for isolated primary care providers without access to medical and care specialities to collaborate with. Potential access for specialized teams in all health areas Most used collaborators: Psychotherapy, nutritionist, chaplain	Research on the program for more cognitively imparted patients: can add a neuropsychologist , speech pathologist	Good communication Clear goals Provider trust and respect Openness to new ideas Technology awareness Government funded collaborative programs No reimbursement issues Time With necessary collaborators only Professional role awareness Resources availability	Informed consent to allow for information sharing Follow up with patient/provider Collaboration evaluation/reflection Utilize virtual communication and email Meetings with only those required: minutes forwarded to others involved Care plan Set up clear goals and treatment plans with patient Choose words like 'stress and frustration' rather than depression and anger to patients Be available to engage with the collaborative team Referral to predesigned teams when possible Minimize time wasting

Author, Date, & Location	Purpose, Context and Population	Level of Evidence, Sample, Setting, and Method	Key Findings and Conclusions	Implications for Future Research	Effective Collaboration Facilitators	Collaborative Practice Strategies
		testing and strategy development, chaplain, care management				
Goodman et al. (2011) UK	Investigate how interprofess-ional working for older people living at home is delivered, enacted and evaluated 'Interprofess-ional working' Chronic disease management for frail older adults and their caregivers Community setting	Level 5 Online survey Systematic review of 50 papers N = 292 Health and social care managers	Language differences re: collaboration but term may be not important Organizations recognize value in collaboration A need for shared outcomes form health care providers and patients to understand what model of collaboration achieves what outcomes No consensus about the best indicators of collaboration Large complex mix of contexts of care that influence collaboration and how it is achieved	More research on collaborative outcomes needed and what collaboration models are best More research on how collaborative effectiveness is evaluated. (for resource use and patient expectations) Investigate the range of services reliant on collaboration More guidelines on	Joint funding Networks of care Co-location Less co-morbidity complications Joint funding and pooled budgets Clear frameworks about what collaboration is and looks like	May need to define the language of collaboration Sharing of resources or resources knowledge Electronic records all can access Utilize predesigned specialty teams: stroke rehab, fall prevention, palliative, etc. whenever possible Organize collaboration around the older adult (not the disease or frailty) Express what effective collaboration will look like in each situation, ensure consensus on measures Advocate for funding resolutions

Author, Date, & Location	Purpose, Context and Population	Level of Evidence, Sample, Setting, and Method	Key Findings and Conclusions	Implications for Future Research	Effective Collaboration Facilitators	Collaborative Practice Strategies
				care for complex elderly patients and their specific needs Need to develop more outcome measures		
Hubbard & Themessl-Huber (2005) Scotland	Health and social care providers perception on joint working together for the care of older people 'Joint working' Primary care Community setting	Level 6 Qualitative, semi-structured interviews N=34 Health and social care providers (manage-ment and frontline staff)	Two areas determine the progress of joint working: 1) Only successful if part of a professional's identity 2) Environmental and organizational infrastructure open to working together	More research on the older adult's perceptions of collaboration in health care Research different impacts of different collaboration models	Time Small groups of collaborators Experience with collaborating National policies on collaboration Organizational support and organizational policies Information technology Direct referrals/consultations Informal to formal meetings	Prioritize collaboration in your day Same EMR in health care Facilitate not dictate Evaluate own attitudes and ways of working Face to face meetings when able Phone contact ad hoc Share patient information with patient, collaborators, families Electronic links between care providers Shared databases Be willing to work together

Author, Date, & Location	Purpose, Context and Population	Level of Evidence, Sample, Setting, and Method	Key Findings and Conclusions	Implications for Future Research	Effective Collaboration Facilitators	Collaborative Practice Strategies
					Knowledge of resources Limited geographical zone Established confidence, trust and rapport between providers Common model of care Use unfamiliar services	Have collaboration be a part of your professional identity Creative solutions: how can we keep the older adult out of hospital? Be accessible and approachable to patients and the collaborative team Advocate for national level policy changes (ie. funding) Build rapport with patients, families, collaborators
Legare et al. (2013) Quebec, Canada	To examine health care providers' intentions to engage in shared decision making in home care programs Frail elderly over 65 with functional impairments Community setting	Level 6 Mixed method Survey N = 276 Focus group interview N = 7 GP, RN, SW, OT, PT, RDN, home support worker Manager interviews,	Behavioural intention: Cognitive attitude 0.30 Affective attitude 0.13 Subjective norm 0.45 Perceived behavioural control 0.39 Positive intentions to engage in interprofessional shared decision making Team members more likely to participate in shared decision making with varying motivations Behavioural control	To develop standardized evaluation and tools such as decision aids to help with the group process	Time and workload Resources Involving all providers in case management Team meetings Balance of power amongst collaborators	Use a common vocabulary Regular face to face meetings Standard evaluation tools Common charting and technology available to all Bringing forth decision aids to help Clear communication Know the roles of all collaborators Be accessible Commit. Continuity of care for patients, families and fellow collaborators

Author, Date, & Location	Purpose, Context and Population	Level of Evidence, Sample, Setting, and Method	Key Findings and Conclusions	Implications for Future Research	Effective Collaboration Facilitators	Collaborative Practice Strategies
	Interprofess-ional team collaboration Shared decision making model for primary care	N = 8 11 months Nurses, SW, OT, PT, activity coordinators, RDN, other	most closely associated with intention to engage in shared decision making, the perceptions of a high level of control			Before brining options to patient, get information accurate and consistent Patient preference is centre to treatment plan. Common goal Everyone gets a voice and is heard
Legault et al. (2012) Ontario, Canada	To study the development of collaborative relationships between care providers of medically complex patients at risk for negative health outcomes Development of collaborative relationships Primary care Complex care, at risk patients older adults	Level 6 Qualitative Interviews and focus groups with physicians, NPs, pharmacists and patients N=241 18 months	Difficulties of collaboration has nothing to do with patient population being cared for Developing relationships and learning to work collaboratively is difficult and time consuming Health care providers need support and education on how to make collaboration work.		Understanding of professional roles Knowledge of available resources Time and experience collaborating Shared philosophies Openness and willingness to compromise	Attempt direct interaction as able Establish and maintain Significant advance notice for meetings Care plans with targeted areas Phone messaging system Create an electronic To Do system with secure access Involve families and patients in planning: copies of care plan, consults, BW, etc. Coordinate patient care Follow up on consults/referrals and with patient Reflect on self-practice and attitude Seek out interdisciplinary workshops or

Author, Date, & Location	Purpose, Context and Population	Level of Evidence, Sample, Setting, and Method	Key Findings and Conclusions	Implications for Future Research	Effective Collaboration Facilitators	Collaborative Practice Strategies
	over age 50 (mean 71.35 years) Community setting					education
Metzelthin et al. (2013) Netherlands	To examine the extent to which the interdisciplin-ary care approach (called preventive care approach) is implemented as planned and to gain insight into benefits, burdens, stimulating factors and barriers Frail older adults over (mean 77.7 years) Primary care Community	Level 6 Mixed method Logbooks, evaluation forms Semi-structured interviews 4 focus groups N = 194 Frail older people GP (N = 12) RN (N = 7) OT (N = 6) PT (N = 20) 22 months	Preventative care approach was a useful structure of primary care and preventative treatment. Patient's felt acknowledged and listened to by health care providers Substantial improvement in interprofessional cooperation in actually working together Frail older people want to be taken seriously healthcare providers. Look deeper into anger, frustration, treatment refusal or loss of motivation regarding care Frailty is easily	More research on prevention of care in client centred interdisciplin-ary care, behavioural change and engagement in meaningful activities What interventions can be successfully used in daily practice? Identification of and participation in "meaningful activities" for this population	Have a common care philosophy Clearly defined roles Open and clear communication Regular meetings Shared decision making Organizational skills Up to date technology Team size (smaller the better)	Have patient sets the goal. Common ground Utilize care protocols and guidelines Meaningful activities are whatever the patient says it is. Goal for patient to self-manage Attend team meetings Education re: how to work together Utilize practice tools Evaluation and reassessment of the collaborative process Must share information, active participant Communication by telephone, email, face to face Be aware of professional roles and abilities Patient at centre of care

Author, Date, & Location	Purpose, Context and Population	Level of Evidence, Sample, Setting, and Method	Key Findings and Conclusions	Implications for Future Research	Effective Collaboration Facilitators	Collaborative Practice Strategies
			overlooked and multidimensional Focus on maintaining function and quality of life			Follow up and feedback on interventions, treatment plans, collaborative processes
Park et al. (2014) BC, Canada	Review of using the integrated care model for frail seniors in Fraser Health Authority Primary care Community care Frail seniors	Level 6 Qualitative Focus on primary care providers, case managers, patients and caregivers as collaborators May include pharmacy, mental health, OT, etc.	Longitudinal primary care results in cost reduction and better health outcomes Children/spouses may be burning out from heavy care. Restructuring of Fraser Health is underway, introduction of home care and primary care partnerships Personalizes joint care Integrated care model providing faster response time, more informed assessments, recognizable emerging patient issues.	More research to assess the longevity and sustainability of the collaboration as the population ages.	Communication Financial compensation for time spent Role clarity Trust	Be available and reachable Answer messages asap Perform tasks quickly, follow up on requests Faxed messages Attend regular case conferences, have regular contact Face to face consultation when able Develop close relationships with collaborating partners Know your available resources and availability in the community Have a mutual goal for a patient
Parmar et al. (2014)	To assess current identification and	Level 6 Retrospec-tive chart	Biggest referral form PCP for memory decline, medication review, behaviour	Research on collaboration research efforts needed	Specialized training Time Funding	Follow EB guidelines and protocols for dementia Utilize screen and assessment tools

Author, Date, & Location	Purpose, Context and Population	Level of Evidence, Sample, Setting, and Method	Key Findings and Conclusions	Implications for Future Research	Effective Collaboration Facilitators	Collaborative Practice Strategies
Alberta, Canada	management of patients with dementia. Primary care Community Older adult aged 56-96 (mean 81.4 years)	review, exploratory study N = 254 Charts form the geriatric assessment team, primary care network, and community care (system dementia care is delivered)	disturbances, and safety Utilize the Third Canadian Consensus Conference's indicators of quality of care Address the uncomfortable areas: medicolegal issues, public safety (driving) Not completing assessment tasks may delay important interventions for the patient Duplication of assessments wastes time and confusing patients and families. Family/caregivers need support Inconsistencies of assessment of dementia in primary care	to facilitate primary and community care	Resources available	Complete the necessary assessments, not refer them off to another provider Detailed charting, be thorough Access to EMR including history, assessment, medications, etc. Check if service has already been completed. Ask or check EMR Distribute tasks Clear communication When referring/collaborating, ensure all necessary documents, tests, history is included Include family and caregivers in the collaboration process, treatment plans and reviews Assess for caregiver burnout regularly
Skultety & Zeiss (2006)	An evidence-based review of recent psychosocial	Level 1 Literature review of 8	Eight studies and 2 treatment models were evident. Improvement and	More research into depression for the older adult	Openness to collaborate Knowledge on roles	Have up to date specialty knowledge on diagnosing, treating and monitoring depression in the older adult

Author, Date, & Location	Purpose, Context and Population	Level of Evidence, Sample, Setting, and Method	Key Findings and Conclusions	Implications for Future Research	Effective Collaboration Facilitators	Collaborative Practice Strategies
USA	treatments for depression Older adults, 55 and older with high likelihood of comorbidity and complex chronic problems (mean 72.7 years) Primary care community	RCT	better outcomes found for each model. Findings varied by depression severity Treatment was individualized and difficult to compare Interdisciplinary teams recommended. More psychosocial treatment has shown to be effective. Some providers don't treat because of age Integrated care models with a multidisciplinary approach have some outcomes than provider alone, but biggest effects of positive outcomes used a fully interdisciplinary treatment approach. Medication not older adults' treatment choice and does not treat depression to full	needed for the primary care setting Need more empirically supported psychosocial treatments for depression in older adults in primary care Efficiencies of psychosocial therapy as first line treatment for the older adult	Resources available Time	Appropriate referrals Involve geriatricians and psychiatrists as required Establish trusting relationships Coordinate plans of care, who is doing what Adhere to joint treatment plans Refer to specialty teams as required

Author, Date, & Location	Purpose, Context and Population	Level of Evidence, Sample, Setting, and Method	Key Findings and Conclusions	Implications for Future Research	Effective Collaboration Facilitators	Collaborative Practice Strategies
			remission…you need therapy Older adults need more sessions to respond			
Toscan et al. (2012) Ontario, Canada	Investigate care coordination for older hip fracture patients from multiple perspectives to determine core factors related to poorly integrated care when patients transition from one care setting to another Discharge from acute care Primary care Community care Older adult	Level 6 Qualitative Semi-structured interview Observations N = 44 Patients, caregivers, health care providers	Four factors related to poor transitional care: 1.confusion with communication about care 2.unclear roles and responsibilities 3.ownershipo of care 4.role limitations due to system constraints Frustration evident waiting form pertinent information for all involved Patient not feeling centre of own care…others making decisions for them Recognize appropriate roles for caregivers. Make sure the tasks are wanted and doable. Avoid heavy reliance on their assistance.	Development of more patient centred care primary care level interventions What is the appropriate role of informal caregivers?	Honest, clear communication Responsibility Appropriate tasks are given Time Resources	Ensure patient goal focused Include family/caregivers Keep documentation up to date and thorough Make time to collaborate in the day Ensure roles and responsibilities are clear in the group and to the patient and family Present options clearly to patients, family Take ownership of errors Go over discharge plan, medication lists and follow up on ensuring patients and families understand

Author, Date, & Location	Purpose, Context and Population	Level of Evidence, Sample, Setting, and Method	Key Findings and Conclusions	Implications for Future Research	Effective Collaboration Facilitators	Collaborative Practice Strategies
	71-94 (mean 83 years)					
Tracy et al. (2013) Ontario, Canada	A review of the IMPACT clinic: a new model of interprofess-ional primary care Community Older adults over age 65 with complex health care needs, 3 or more chronic conditions or 2 is 1 is unstable, polypharmacy, (mean 83.9 years) Complexity score 19.74 (5.56)	Level 4 Quantitative review of IMPACT clinic	All members of the interprofessional team complete patient assessments and together develop an individualized care plan, and follow up plan for the health care provider Collaboration is enhanced over time The older adult wants to be heard and listened to Objectives: assist seniors in independence and healthy living to reduce health care costs and inpatient pressures	Develop clinical guidelines in primary care for patients with comorbidities Research on what the frail elderly thinks of this model. More research and innovation needed into primary care reform	Time Funding Community support resources	Utilize specialized teams whenever possible Have real time discussions whenever possible Develop detailed patient specific care plan with collaborators, patient and family members Be patient Flexible appointment times Know what is available in your community for supports specific to frail elderly population

Appendix E

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Collaborative Practice Assessment Tool

Introduction:

Collaboration is a key factor in better patient and provider outcomes. Collaborative practice has been described as a: "process for communication and decision making that enables the separate and shared knowledge and skills of care providers to synergistically influence the client/patient care provided." (Way, Jones & Busing, 2000)

Instructions:

Please respond to the following statements ***from the perspective of being a member of a specific patient care team.*** If you work on more than one team, provide answers based on the team you work with most often and/or hope to develop into a more collaborative team. Those practitioners who are considered to be members of the team will vary depending on the service provided, but any person involved in the day-to-day care of patients should be considered a member of the team for the purpose of answering the survey. For example, this may also include clerks, volunteers, consultants, etc.

There are no right or wrong responses. Honest responses are the most helpful. If there are any questions that you feel are not applicable to your team you may skip them, but please try to answer each question to the best of your ability. Your responses are confidential and the results will be aggregated and used to understand your team functioning.

Thank you for your time and thoughtful consideration.

Print Name:

_____

Sign Name:

_____

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Collaborative Practice Assessment Tool

The content in the following statements contain items relevant to collaborative practice. Please respond to each statement from the perspective of the specific patient care team you work with most often.

Mission , Meaningful Purpose, Goals	Strongly Disagree	Mostly Disagree	Somewhat Disagree	Neither Agree nor Disagree	Somewhat Agree	Mostly Agree	Strongly Agree
1. Our team mission embodies an interprofessional collaborative approach to patient/client care.							
2. Our team's primary purpose is to assist patients/clients in achieving treatment goals.							
3. Our team's goals are clear, useful and appropriate to my practice.							
4. Our team's mission and goals are supported by sufficient resources (skills, funding, time, space).							
5. All team members are committed to collaborative practice.							
6. Members of our team have a good understanding of patient/client care plans and treatment goals.							
7. Patient/client care plans and treatment goals incorporate best practice guidelines from multiple professions.							
8. There is a real desire among team members to work collaboratively.							
General Relationships							
9. Respect among team members improves with our ability to work together.							
10. Team members care about one another's personal well being.							
11. Socializing together enhances team work effectiveness.							
12. It is enjoyable to work with other team members.							
13. Team members respect each other's roles and expertise.							
14. Working collaboratively keeps most team members enthusiastic and interested in their job.							
15. Team members trust each other's work and contributions related to patient/client care.							
16. Our team's level of respect for each other enhances our ability to work together.							

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Team Leadership	Strongly Disagree	Mostly Disagree	Somewhat Disagree	Neither Agree nor Disagree	Somewhat Agree	Mostly Agree	Strongly Agree
17. Procedures are in place to identify who will take the lead role in coordinating patient/client care.							
18. Team leadership ensures all professionals needing to participate have a role on the team.							
19. Team leadership assures that roles and responsibilities for patient/client care are clearly defined.							
20. Team leadership discourages professionals from taking the initiative to support patient/client care goals.							
21. Team leadership supports interprofessional development opportunities.							
22. Our team leader models, demonstrates and advocates for patient/client-centered best practice.							
23. Our team leader is out of touch with team members' concerns and perceptions.							
24. Our team leader encourages members to practice within their full professional scope.							
25. Our team has a process for peer review.							
General Role Responsibilities, Autonomy							
26. Team members acknowledge the aspects of care where members of my profession have more skills and expertise.							
27. Physicians assume the ultimate responsibility for team decisions and outcomes.							
28. Team members negotiate the role they want to take in developing and implementing the patient/client care plan.							
29. Team members are held accountable for their work.							
30. It is clear who is responsible for aspects of the patient/client care plan.							
31. Physicians usually ask other team members for opinions about patient/client care.							
32. Team members feel comfortable advocating for the patient/client.							
33. Each team member shares accountability for team decisions and outcomes.							
34. Team members have the responsibility to communicate and provide their expertise in an assertive manner.							
35. Team members feel limited in the degree of autonomy in patient/client care that they can assume.							

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Communication and Information Exchange	Strongly Disagree	Mostly Disagree	Somewhat Disagree	Neither Agree nor Disagree	Somewhat Agree	Mostly Agree	Strongly Agree
36. Patients/clients concerns are addressed effectively through regular team meetings and discussion.							
37. Our team has developed effective communication strategies to share patient/client treatment goals and outcomes of care.							
38. Relevant information relating to changes in patient/client status or care plan is reported to the appropriate team member in a timely manner.							
39. I trust the accuracy of information reported among team members.							
40. Our team meetings provide an open, comfortable, safe place to discuss concerns.							
41. The patient/client health record is used effectively by all team members as a communication tool.							
Community Linkages and Coordination of Care							
42. Our team has established partnerships with community organizations to support better patient/client outcomes.							
43. Members of our team share information relating to community resources.							
44. Our team has a process to optimize the coordination of patient/client care with community service agencies.							
45. Patient/client appointments are coordinated so they can see multiple providers in a single visit.							

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Decision-making and Conflict Management	Strongly Disagree	Mostly Disagree	Somewhat Disagree	Neither Agree nor Disagree	Somewhat Agree	Mostly Agree	Strongly Agree
46. Processes are in place to quickly identify and respond to a problem.							
47. When team members disagree, all points of view are considered before deciding on a solution.							
48. Disagreements among team members are ignored or avoided.							
49. On our team, the final decision in patient/client care rests with the physician.							
50. In our team, there are problems that regularly need to be solved by someone higher up.							
51. Our team has an established process for conflict management.							
Patient Involvement							
52. Team members encourage patients/clients to be active participants in care decisions.							
53. Team members meet face-to-face with patients/clients cared for by the team.							
54. Information relevant to health care planning is shared with the patient/client.							
55. The patient/client is considered a member of their health care team.							
56. The patient's/client's family and supports are included in care planning, at the patient's request.							

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Please complete the following questions to help us gain further understanding of your collaborative practice.

What does your team do well with regards to collaborative practice?

_____

_____

_____

_____

In your practice, what are the most difficult challenges to collaboration?

_____

_____

_____

_____

What does your team need help with to improve collaborative practice?

_____

_____

_____

_____

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CPAT Scoring

"To score the CPAT, simply average the items within each domain, with the one caveat that questions 20, 23, 35, 48, 49, and 50, should all be reverse coded for scoring purposes (ie. 1-7, 2=6, ...7=1)."

Note. From "Development and pilot testing of the collaborative practice assessment tool", by C. Schroder, J. Medves, M. Paterson, V. Byrnes, C. Chapman, A. O'Riordan, A., . . . and C. Kelly, 2011, *Journal of Interprofessional Care, 25*, p. 189-195.