Collaborative Care Toolkit

Addiction & Mental Health in Primary Care

December 2020

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Citation

For citation purposes, use the following format:

Alberta Health Services. (2020). *Collaborative care for addiction & mental health in primary care: Toolkit*. Edmonton, AB: Author.

Acknowledgments

Development of this toolkit would have not have been possible without the support of community partners, staff, physicians, and leadership teams. We would particularly like to thank the collaborative teams who contributed all of the lessons learned contained in this document:

- The Bonnyville Child and Adolescent Mental Health Clinic
- The Cochrane Case Collaboration Program
- The West Bow Older Adult Case Collaboration

Their personal experiences provided valuable context, clarity, and understanding to the research evidence.

We would like to acknowledge our partners and colleagues at the Calgary Foothills Primary Care Network, Alberta Health Services – Addiction and Mental Health in the Calgary Zone, Alberta Health Services – Addiction and Mental Health in the North Zone, and the Bonnyville Primary Care Network. Your contributions throughout this process is valued and appreciated. We want to extend a special thank you to those who worked closely with us and provided information and support to the evaluation team.

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It is our sincere hope that this toolkit will provide practical guidance and will assist emerging collaboratives overcome the challenges that may arise while planning, delivering, and evaluating the success of a new team.

Introduction

The information in this toolkit is a combination of evidence from a literature review and findings from evaluation activities undertaken with three collaborative care teams in Alberta: the Bonnyville Child and Adolescent Mental Health Clinic, the Cochrane Case Collaboration Program, and the West Bow Older Adult Case Collaboration.

This toolkit is intended to provide:

a) a brief overview of collaborative care (refer to Appendix E for more information)
b) practical information to consider while developing a collaborative team
c) tools to assist with various processes

The format of the toolkit follows the steps outlined in a developmental logic model that was created by the evaluation team (Appendix A). The model was informed by a scan of the literature, as well as lessons learned developing teams in Alberta. Feedback on the model was also provided by representatives of the Calgary Foothills Primary Care Network (CFPCN) and Alberta Health Services – Addiction & Mental Health (AHS-AMH).

Each section provides an explanation of the developmental process, some guiding questions to assist with decision making, and some lessons learned that may help inform your process. A checklist is located in Appendix C to further assist your planning. As collaborative teams are interdisciplinary, the terms patient and client are used throughout the document.

Background

Rationale for Collaborative Care

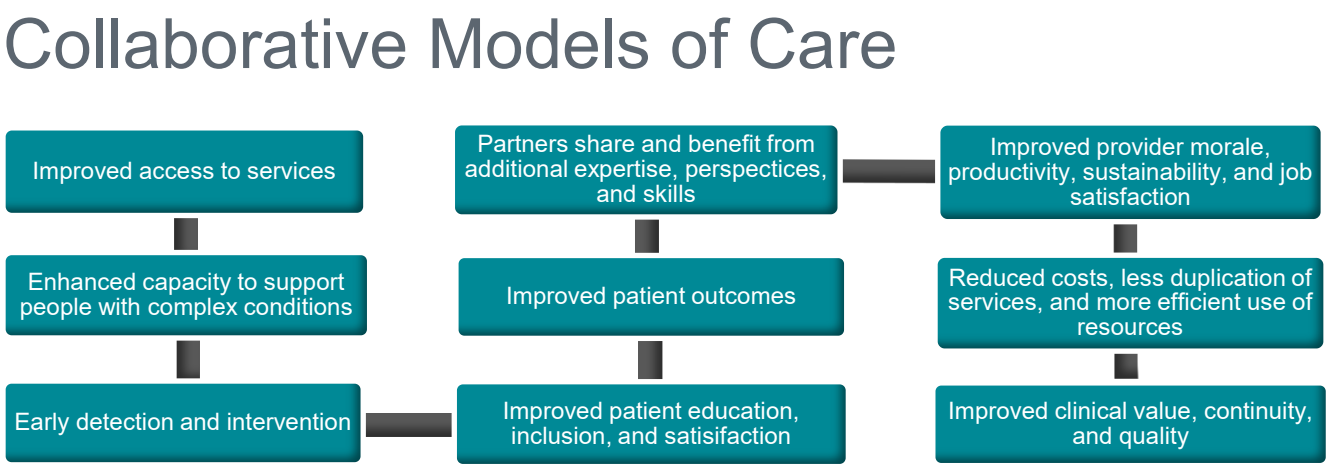
Approximately 20% of Canadians experience a mental illness or addiction issue in any given year.[1] Over half (57%) of Canadians who first seek professional care for their mental health do so by consulting with a family doctor.[2] Patients are also more likely to see a primary care physician over a mental health specialist each year, which makes primary care settings useful in recognizing and improving appropriate treatments over time.[3] Many patients today may visit multiple specialists, as well as providers of diagnostic, pharmacy, and other services over the course of a single year.[4]

The complexity of modern healthcare has forced providers to connect with one another to optimize patient care. Providers working in isolation face a difficult task by relying on solitary resources and opinions that may not be to the benefit of the patient.[5] Providers that work together can strive towards giving patients the best care possible by sharing their expertise and relying on one another for information.[5]

Evidence Supporting Collaborative Care Initiatives

Collaborative care is viewed as an effective approach to improving patient care.[6] The following are benefits that can be expected from collaboration (Figure 1).

Figure 1. Expected benefits of collaborative care



Source: [7, 8, 9]

Defining Collaborative Care

Collaborative care is a multi-professional, patient-centered approach to care that is team-driven, population-focused, measurement-guided, and evidence-based.[6] Collaborative care involves interdisciplinary professionals working in a coordinated, complementary and seamless fashion to ensure patients receive appropriate care.[10, 11, 12]

Collaborative care can also be seen as a continuum, whereby collaborative and integrative techniques of service delivery usually strengthen as the severity of AMH concerns increase.[13] Collaborative models set within primary care settings can be implemented in a variety of different ways depending on accessibility to tools and services, levels of service provider coordination, and the severity of patient or population needs.

Although collaborative care aims to connect fragmented knowledge and skills of interdisciplinary professionals, terminology around the model remains somewhat unclear. Because a wide range of terms are used among health professionals to describe different levels of collaborative care, words like 'integrated care' and 'collaborative care' have been used interchangeably in the literature, yet often reflect key differences in strategy or structure.[6, 7, 14, 15]

Collaborative Care Design

In order to clearly define collaborative care, the British Columbia Ministry of Health (2012) has described collaborative models linking primary care with AMH care through these three approaches: 1) **communicative**, 2) **co-located and collaborative**, and 3) **integrated**.[14]

Although collaborative care may be designed using these three approaches, collaborative models in practice do not have to be bound to a single approach. Depending on the needs of patients and the accessibility of staff, tools, and settings, collaborative care approaches can be individualized in a way that best serves patients and providers in their communities.

Communicative/Coordinated Model

Communicative or coordinated models represent more traditional linkages between primary care and AMH care providers and suit milder to moderate AMH needs (Table 1). These models can involve communication between practices in separate facilities, where physicians have informal access or involvement with mental health practitioners and contact is usually referral-based. They can also involve a process of medically-provided AMH care, where primary care services may be enhanced through physician training in AMH assessment and treatment.

Co-located/Collaborative Model

Co-located and team-based approaches to collaborative care connect providers in a way that supports individual and coordinated practice for all levels of AMH patient needs (Table 1). Providers using this model usually have independent services and care plans, but also align their work to provide more comprehensive treatment for patients, which suits mild to severe and/or complex needs. This approach can involve co-location, where providers work in the same facility but may not share the same work space. It can also involve shared care or reversed shared care, where aspects of mental health care (e.g., specialized consultation, assessment, self-management tools) are provided within a primary care setting, or primary health care is provided in an AMH setting.[12, 16] High levels of specialized assessment or treatment can also be provided in this model through multidisciplinary teams who provide education, consultation, or direct care planning for all providers included.

Integrated Model

Integrated team models address moderate to severe and/or complex AMH needs by creating one care plan to address the overall care of a patient (Table 1). Care can be unified, which includes total integration of services such as location, billing, and patient files. Care may also include primary care AMH teams who focus on at-risk individuals and solution-focused care independent of occupational specialties.[7] Unified care and primary AMH teams can also be combined to create a fully-integrated system of care, which encompass all aspects of primary and AMH care, while also encouraging the involvement of other organizations and providers, such as housing workers, occupational therapists, or school counsellors.

Table 1. Six levels of collaboration of primary care and addiction & mental health

Model	Six Levels of Collaboration	Setting	Severity of Need
Coordinated	**L1** Patients are referred to network providers at another site **L2** Providers periodically share communication about shared patients	In separate facilities	Mild to moderate
Co-located	**L3** PC and AMH providers share a facility but develop separate treatment plans for patients **L4** Providers share patient records and maintain some systems integration	In same facility, but not necessarily same space	Mild to severe and/or persistent/complex
Integrated	**L5** PC and AMH providers develop and implement collaborative treatment for shared patients but not for other patients **L6** PC and AMH providers develop and implement collaborative treatment for all patients	In same space within same facility	Moderate to severe and persistent/complex

PC= primary care
Source: [12, 14, 16]

Collaborative Care Components & Barriers

A number of studies have identified components of care that should be considered when implementing a collaborative care model.[17, 18, 19, 20] These components of collaborative care (Figure 2) include: patient-centered care, team-based driven care, population-focused care, measurement-guided care, evidence-based care, and quality improvement.[17, 19, 20, 21] Each of these components have associated best practices, which can help to ensure that collaborative care is implemented successfully, efficiently, and with a high standard of care.

Figure 2. Components of collaborative care

Patient-centered care

- mutual respect and trust among the clients and team members
- involve clients and their family as partners in care planning and decision-making
- promote a respectful and comfortable care environment

Team-based driven care

- effective communication that is relevant, timely, understandable and reciprocal
- clear roles and responsibilities
- agreed upon and transparent leadership
- a communication method and frequency that is agreed upon and can be sustained
- agreed upon decision making process that links to the team's shared goals
- a conflict resolution process

Population-focused care

- proactively screen patients for highest needs to ensure resources are allocated accordingly
- use information technology, like shared electronic medical records (EMR), to share patient information

Measurement-guided care

- use standardized screening and assessment tools to inform clinical decisions and track progress
- self-reported tools should be brief, "multi-purpose (i.e., effective for screening, severity assessment, and monitoring treatment response)," and easy to score and interpret

Evidence-based care

- provide reliable, evidence-based treatments
- clinicians should have access to up-to-date treatment guidelines and training to support their decisions

Quality improvement

- establish a monitoring and evaluation plan in the beginning to ensure the success of the program

Barriers to Implementation

When implementing a collaborative practice, becoming aware of possible barriers and addressing them adequately can be important in the longevity and effectiveness of an initiative.[7] Sanchez (2017) has identified three categories of barriers to implementing collaborative care programs: clinical barriers, organizational barriers, and financial barriers (see Table 2).[22]

Table 2. Potential barriers to collaborative care implementation

Clinical Barriers	• absent or insufficient interprofessional knowledge and training • lack of access to services required for supporting a collaborative initiative • differing priorities among health professionals or priorities that do not align with the systematization of care or quality indicators • single mental health focus • lack of clarity regarding the care plan/process or target clientele • medico-legal liability and privacy concerns • patients unaware or confused by the service process
Organizational Barriers	• a lack of belief or confidence that collaboration can be valuable • hierarchical perceptions around the roles and relationships amongst team members and organizations • lack of governance structure or sustainable change management process • lack of trust, role clarity, openness to change among team members • stigma and discrimination towards those with mental health and addiction issues • inability or reluctance amongst the collaborative to work together as an interdisciplinary team • incompatible culture of some professionals and organizations • real or perceived time it takes to build relationships • too slow or too rapid growth of the collaborative
Financial Barriers	• sub-optimal funding models/structures and remuneration processes • initial start-up costs and possible time it takes for a return on investment • cost of technology (e.g., EMRs, systematic outcome tracking, computerized messaging systems, telehealth, etc.) to support collaboration • cost of required educational and technological training and updates associated • inadequate human resources to establish appropriate skill mix and team size • insufficient funding for space and treatment resources needed • lack of incentives or the presence or disincentives • lack of sufficient monitoring and evaluation to inform decisions

Source: [7, 11, 23, 24, 25, 26]

Collaborative Care Planning

A growing body of literature has begun to clarify specific components associated with effective care coordination. Commonalities among specific models and approaches for collaboration include:

- a need for effective linkages
- a high level of trust and reciprocity among participants
- a focus on a broad continuum of severity
- multi-sectorial involvement
- multiple levels of collaboration that align with different types of levels of severity
- and a distinction between service- and system-level initiatives

This section of the toolkit identifies and discusses the following steps to create a successful collaborative care team:

Although these steps have been identified as important in creating a successful and effective collaborative care initiative, they can be adapted to fit the needs, preferences, and local context of your initiative. A logic model displaying these steps can be found in Appendix A and the processes are explained in more detail in the following sections.

Defining the Collaborative

There are three main steps involved in defining your collaborative: identifying population health needs, securing providers and partners across organizations, and establishing and agreeing on goals and objectives.

Identify Population Health Needs

For a collaborative team to be effective and relevant to the clients and providers it is intended to serve, members must first identify specific population health needs, understand the level of capacity their community has for addressing those needs, and determine possible solutions.[23] These tasks can be accomplished through a health service gap analysis or a health needs assessment.

A health needs assessment is a systematic method for reviewing and identifying gaps (or problems) between current and desired results to inform plans, projects, or initiatives.[27, 28] For example, it may help describe the state of health of a population, establish major risk factors or causes of illness, and identify areas where action is needed or most urgently needed.[29] It can gather important information about population targets, patterns of health care utilization, gaps in existing services and barriers to service access, duplicated services, client and provider satisfaction, financial and human capacity and available resourcing, underlying assumptions about collaborative care, and providers' readiness for change.[30]

Lessons learned from local collaborative teams

It is critical to have access to people who have information about the services in the community.

Data was not enough to obtain a picture of all services within the community. It was important to speak directly with the managers of the services to gain an understanding of their functions.

Despite the benefits of conducting a heath needs assessment, there are a few barriers that may be encountered throughout the process. Specific barriers can include:

- accessing and analyzing relevant local data,
- accessing the target population,
- translating findings into effective planning and action,
- working across professional boundaries,
- and developing a shared language between providers and organizations[27]

In order to mediate or prevent these barriers, a work plan should established, information sources should be triangulated, health professional and other service providers should be included in the process, and the results of the need assessment should be produced in a timely manner and reported in a way that's useful. The project team and stakeholders should also adopt a shared language for key terms to ensure there is equal understanding of objectives and each other's contributions to possible solutions.[27, 31]

Additional information about conducting a needs assessment can be found in Appendix B.

Guiding Questions
Is a health needs assessment warranted (e.g., a recent assessment has not already been completed)?
Is there a committed and skilled project team that can be appointed?
How will the work plan be developed?
Which stakeholders need to be included?
What resources will you require (e.g., access to data, funding, staffing, etc.)?
What data is available? What data needs to be collected?
How will the data be analyzed?
What needs and/or strengths has the community or providers have expressed?
What are the needs or key issues for the population or community?
How will the needs assessment be reported? How will the report be distributed or presented and to whom?

Source: [9, 27]

Secure Providers and Partners across Organizations

Failure to secure and engage staff, especially physicians, makes it difficult for team members to share the vision, values, and goals of a collaborative initiative.[15, 32] Careful consideration of who needs to be involved within your collaborative care initiative will ensure that goals and priorities can be aligned, there are enough skills and resources to support the collaborative, and that stakeholders have a strong foundation for building relationships and championing the work.[33] Members should consider how to engage and keep stakeholders, as well as how to handle situations where there are stakeholders who are non-responsive or not committed to the delivery of collaborative care.[33]

Engagement strategies should consider:

- "expectations and or issues anticipated;
- level of interest, impact, and influence;
- appropriate level of engagement (inform, consult, involve, collaborate, empower);
- specific proactive activities and associated tools (e.g., stakeholder activity checklist)" (p. 33)[33]

Engagement strategies should also consider the key messages that will be shared to target stakeholders, whether messaging needs to be tailored for different groups, and how these key messages will be delivered. Visible sponsorship and communication by those in leadership positions can help add validity to your initiative and increase recruitment.

Lessons learned from local collaborative teams

Creating a new collaborative team may be made easier by leveraging existing partnerships.

One team reported they had existing partnerships in their community, which meant that they "didn't have to find partners" and were able to build from an initial core group.

The size and membership of a collaborative team can be influenced by:

- patient population characteristics (identified through your health needs assessment)
- the scope and goal of practice
- the locations(s) of practice,
- availability of service providers
- treatment and other health resources[26]

Although smaller teams may appear to be easier to manage, they may also reduce accessibility, continuity, and quality of care. Contrarily, too large of a team may reduce efficiency and clear communication pathways.[26] It is important that the approaches to human resources management are adequately considered so that an appropriate size and mix of skillsets among providers are incorporated and members of the collaborative are not over- or underrepresented, nor misused.[26]

Generally, core members of a collaborative mental health team include:

1) primary care providers (e.g., physician, nurse practitioner)
2) consulting psychiatrists
3) a care manager (e.g., nurse, clinical social worker, psychologist).[10, 11, 12, 17, 18]

Additional service providers, such as behavioral-health clinicians, substance-use treatment services, school counsellors, housing support workers, and other community providers may be included within the core team or incorporated on a case-by-case, or treatment phase basis.[17]

Lessons learned from local collaborative teams

It may be important to build in a redundancy plan for frontline collaborative team members.

A redundancy plan may be important to ensure that the work of the collaborative is sustainable. One team suggested that one or two additional members per partner organization would ensure continuity of attendance at team meetings during times of absences or turnover.

Evidence has stated that physician buy-in and support is an important facilitator to a successful collaborative; ongoing physician-specific engagement activities to solicit their support should be considered.[34, 35] Physician engagement should happen early in the development of a collaborative and their expertise should be utilized in the design, planning, implementation and sustainability for each element of collaborative care.[33] Communicating evidence that is in support of collaborative care can help to bring awareness of how changes to practice and process may positively impact their work and their client's health. Utilizing peer education amongst physicians, as well as data directly relevant to their practice, can greatly influence buy-in and engagement in collaborative care practice.[33]

Including patient and family advisors, or those with lived experience, may also be an important addition to your collaborative because of the experiences and perspectives they have. Additionally, some collaborations have stated that community involvement and support is important in facilitating and sustaining a collaborative.

Guiding Questions
How are/were members recruited and is/was enough time spent in the recruitment process?
What treatment values, priorities, and skills are needed from different providers?
Does the group have the right people and organizations at the table? How representative is the partnership membership?
How will new members be incorporated into the alliance as the collaborative moves forward?

Source: [36]

Establish and Agree on Goals and Objectives

For a collaborative initiative to be successful, it is essential for members of a collaborative care team to have a clear vision of the goals and objectives they want to achieve.[5, 15, 23, 37] Goals of the collaborative should be created as a team and embrace a shared commitment to patient care.[5] Goals should also:

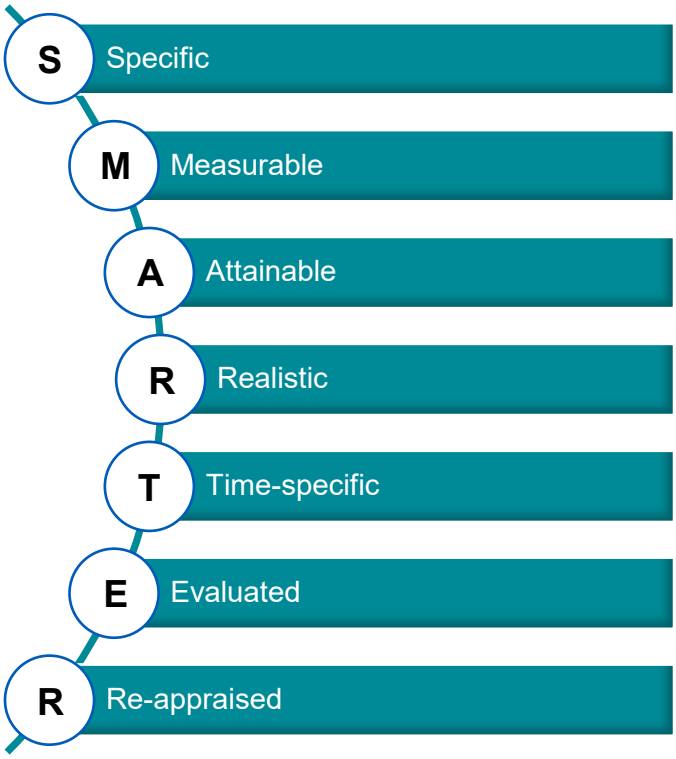
- reflect and support the strategic direction/vision of the initiative
- be clear, specific, and documented
- bound to a work plan with specific tasks and timelines
- link to a follow-up process to see if they are being met
- be celebrated when accomplished or when achievements are made[30]

Lessons learned from local collaborative teams

Create a shared focus between all partners involved.

Getting all organizations and sectors to think in the same direction and have shared goals was a challenge for some team members; however, it was also viewed as a key factor to successful collaboration. It is important to ensure that all partners understand the value of the case collaborative, including the need to support efficient referral routes and building strong relationships.

Goals should be **SMARTER**, which includes evaluating and re-appraising the goals as the initiative proceeds.[30]



The goals and objectives should relate to the population health needs of the community and guide improvement. If goals and objectives are not aligned with resources, collaborators should consider whether the vision of the collaborative should be adjusted and if additional champions or partners can be recruited to advocate for the initiative or provide resources.

Guiding Questions
What is the purpose of this team?
Do leaders and members share a common understanding of the team's purpose?
Are policies and guidelines in place to achieve the group's purpose?
What are the primary activities?
What benefits and costs do each member expect to accrue as a result of participating in the team?
Does each member understand why they are there and what they are hoping to accomplish?
What outcomes does the group expect to reach?
What will indicate to the group that it is reaching its goals and outcomes?
Does the group have the appropriate agreements in place to govern its partnerships and activities?

Source: [9, 36]

Developing the Collaborative

Steps involved in developing a collaborative include: co-designing the care pathway, defining roles and responsibilities, and determining measures of success.

Co-Design the Care Pathway

Once the collaborative has been defined, the next step is to collectively agree how the collaborative team will function. To successfully implement a collaborative care initiative, partners should be given time to prepare and build necessary supportive structures (e.g., care process, working relationships, resources).

Lessons learned from local collaborative teams

The process of developing a collaborative team takes time.

There are several steps and processes that need to take place for a collaborative team to become operational (e.g., conducting population and service needs assessments; assembling partners; determining intake, consent, and discharge processes; determining communication, privacy, and information sharing processes), and many of them take time to complete. As one team member stated, "[They] need to be patient with the process. It takes time."

Policies and standardized procedures should be in writing and accessible by all members of the care team. These procedures should define how components of care are implemented within the initiative.[38] The American Academy of Child & Adolescent Psychiatry (2010) lists four types of consulting questions which may be helpful while designing a care pathway.[39] They include questions regarding:

- **Diagnostics:** how to screen and assess disorders
- **Management:** how to implement interventions, manage medications
- **Disposition:** when to refer to another collaborative member, when to refer to another service, how to coordinate services
- **Crisis and safety:** how to assess and respond to a crisis, how to ensure that patient safety is safeguarded

Considering these questions and discussing them with fellow team members can help the group develop a clear and mutually agreed upon pathway, which can reduce unnecessary referrals, duplicated assessments or treatment, and sub-optimal post-referral or hospital care.[40] Additionally, collaborative members can ensure that their care pathways are targeted, timely,

organized, equitable, safe, effective, and patient-centered, and that their roles and tasks are specific in nature.[42] An example of a client flow map is located in Appendix D.

Lessons learned from local collaborative teams

Develop clear processes for case collaborative team and advisory meetings.

Create a coordinated structure for case collaborative and advisory meetings, including template documentation, process maps, and agreed upon responsibilities. Leverage the expertise of your members in designing new processes and clarifying roles and responsibilities.

The checklist located in Appendix C was developed to assist teams with making decisions regarding the practical aspects of care delivery (e.g., meeting frequency, meeting location, virtual attendance, and administrative support).

Guiding Questions
Is there a sound policy and procedural framework in place to define and support the team function?
What are the procedures and criteria for routine, urgent, and emergency requests?
What will the formal enrollment process look like?
What are the days, hours, and staff available?
How will patients be screened? Will a specific staff member be assigned to conducting and interpreting screening measurements?
Who will be provided screening results? How?
How many patients will the practice serve and what are their health needs and challenges?
How will health care decisions be made? Who is responsible and therefore accountable for health-care delivery decisions?
How will the team manage patient expectations and respond to patient concerns?
Will referrals be made to community organizations, peer support or wellness agencies, groups, etc.? If so, will there be follow-up? By whom?
Who will make referrals? How will referrals be made and are patients consulted about the release of their information?
How and when will patient follow-up occur?

Source: [9, 41, 42]

Define Roles and Responsibilities

Members of a collaborative team, regardless of who is involved, often come from different backgrounds; have different knowledge levels, skills, and limitations; prefer different forms of communication; and are influenced by various organizational, cultural, and societal norms.[5, 43] An important factor of a successful collaborative team is understanding and respecting roles and responsibilities so that team members can maintain professional autonomy while being interdependent.[5, 32, 44, 45]

Members of the care team need to know whether their competencies are appropriate for the tasks assigned, as well as understand responsibilities and accountabilities. There should be a degree of flexibility in role allocation and the opportunity to negotiate roles as the team moves forward and develops. These factors are closely linked to team members' desire to feel involved and needed during the care process.[32, 46] It is important to ensure that members of the collaborative understand the roles and responsibilities of both themselves and other members, feel that they play a vital role within the group, and are able to identify and agree with a clear set of values set forth by the collective.

To be effective in team functioning and improving patient outcomes, team member roles in the planning and delivery of care must be clearly expressed and negotiated, and there should be a process for identifying/clarifying where roles may overlap, or where ethical and legal practices divide.[30, 47] All members of the collaborative team should become confident in the abilities of their fellow team members (as well as their own), be able to provide discipline-specific knowledge, and actively seek out the knowledge of others.[47] Creating a recruitment criteria and orientation package for new team members may also help ensure that responsibilities are understood and fulfilled.[30]

Lessons learned from local collaborative teams

Understanding of roles and responsibilities was considered to be one of the factors that mattered most to the success of the collaborative team.

In addition to relationship building and trust, one collaborative reported that an understanding of roles was critical in the initial stages of building their team.

Many of the roles and responsibilities of a collaborative team are specific to the individual's line of work (e.g., clinical assessment/diagnoses, psychotherapy, academic assessments); however, there are also shared responsibilities, such as treatment planning and participating in case

conferencing. At a program level, there is often involvement from many members in strategic planning.

Collaborative teams may be organized in a variety of ways depending on the model they choose and the clients the serve. As a consequence, the roles and responsibilities of the members will vary across teams. Table 3 provides a community example of roles and responsibilities within the Bonnyville Child and Adolescent Mental Health Clinic collaborative team. In their experience, the role of the mental health navigator was critical to the success of their collaborative.

Table 3. Bonnyville Child and Adolescent Mental Health Clinic team member roles and responsibilities

Team member	Roles and Responsibilities
Area Manager	• program alignment to zone priorities • program coordination • oversee budget and financials • strategic planning
Physician	• clinical assessment, diagnosis, treatment planning • follow-up assessments, medication reviews • case conferences • referrals, as needed • strategic planning
Mental Health Navigator	• program development (i.e., policies and procedures, client/family education, resource development) • clinic management (i.e., scheduling, documentation, client follow-ups) • assist with treatment planning • client/family navigation • clinic team coordination • coordinate information sharing • participate in case conferences • capacity building within community agencies and services • community advocacy and committee work • collaborate for and coordinate professional development opportunities for clinical staff, school teams, and frontline staff/first responders • coordinate community education sessions for parents • coordinate summer camp for clients/community youth • budgeting • strategic planning

Team member	Roles and Responsibilities
Nurse Practitioner	• clinical assessment, diagnosis, treatment planning • follow-up assessments, medication reviews • case conferences • referrals, as needed • clinic administration, budgeting • program planning • strategic planning
Mental Health Therapist	• clinical assessment, treatment planning • psychotherapy, as needed • treatment plan and clinical resource development • strategic planning
School Liaison	• referrals to the clinic • therapy as needed • scales, academic assessments, as required • attend weekly clinic, as needed • consultation for treatment planning • strategic planning

Source: [48]

Guiding Questions

Are leaders' and members' roles and responsibilities transparent and understood by all?
Are anticipated linkages between the members' parent organizations and the alliance clearly delineated?
How have roles and responsibilities shifted over time?
How successful have members been in prioritizing the goals of the alliance?
Are the roles and responsibilities of each team member clearly defined, based on their scopes of practice and each individual's knowledge, skills, and abilities?
Does every team member know their role and the role of the other team members?
Is there any ambiguity about roles between providers?
Will there be a designated care coordinator? What will their duties be?

Source: [9, 36, 41]

Determine Measures of Success

It is important for a collaborative to understand what success will look like for their team, and for their clients. Determining measures of success in the beginning and assessing their progress can validate their efforts and assist with ongoing improvement.

Lessons learned from local collaborative teams

Determining measures of success should involve all collaborative partners.

Collaborative decision making on key metrics and the evaluation framework will demonstrate the value of the case collaborative for all partners involved.

Collaborative teams in Alberta reported that it was important early in the team's development to discuss what the members think success will look like at a team level and a client level. As this was a new style of working together for many of the members, it was stated that they wanted to know if they were successful developing as a team, not just successful in meeting the needs of their clients.

Community Example

A collaborative team in the CFPCN identified several potential indicators of success for themselves and their clients during their team orientation session.

Team successes	Client successes

• Relationships are built between service providers
  ○ collaboration increases everyone's ability/comfort with managing clients at risk
• Care delivery is integrated
  ○ moving away from silos
• Interagency education
• There is increased communication
  ○ barrier-free information sharing
• There is increased knowledge of seniors' issues at a macro level
• There is improved access to the right services
  ○ knowledge of systems and resources
  ○ removal of barriers between services
	• Clients are engaged in services
	  ○ clients are connected to services, supports, community
	  ○ clients are engaged in treatment
	• Clients have increased self-management
	  ○ clients report increased function
	• Clients are socially connected
	• Clients have an increased sense of safety
	  ○ risk of harm is minimized
	• Basic needs are being met
	  ○ e.g., medical, housing, substance use
	• Client is allowed to live as they want
	  ○ self-determination
	• Client goals are achieved

Creating a logic model can be a process used by a collaborative team to help them link their activities with their outcomes (i.e., successes). Included within most logic models are the following components [49]:

- **Goal** – what the program is trying to accomplish
- **Target population** – who the program is being delivered to
- **Inputs** – the resources that go into a program (e.g., funding, staff, infrastructure).
- **Activities** – the processes, tools, events, and actions that take place as part of the program
- **Outputs** – the tangible, direct products of program activities. They can usually be measured or counted; for example, number of workshops, number of attendees
- **Outcomes** – the expected changes that result from program activities
    - Short-term outcomes refer to changes in individuals' knowledge or skills
    - Intermediate outcomes refer to changes in individuals' behaviours or attitudes
    - Long-term outcomes (impact) refer to changes in an organization, community, or client system
- **Assumptions** – what is needed to support continuation of the program

It may be helpful to use the developmental logic model in Appendix A for your team, along with a client-level logic model, to help determine the extent to which you are achieving success in both areas. AHS has created resources (Appendix F) that you can refer to that will assist with understanding and developing a client-level logic model.

Guiding Questions
What will success look like for your clients? (e.g., improved ability to maintain living at home with supports, stabilization of symptoms, reduction use of acute care services, increased quality of life)
Are client outcomes SMART: specific, measurable, attainable, realistic, time-specific?
Are client outcomes achievable based on the activities that will be completed by the collaborative?
Are there resources and processes in place to measure outcomes?

Key Enablers

Consultations with collaborative teams and review of evidence have indicated that there are several factors that can contribute, to a great extent, to whether or not a collaborative team will be able to operate effectively, which we have termed key enablers. The five areas include: establishing leadership and accountability, determining infrastructure and financial requirements, facilitating training and core competencies, establishing methods of communication, and establishing methods of information sharing.

Establish Leadership and Accountability

Evidence shows that in team-based driven care, there should be an agreed upon and transparent leadership and decision-making process that links to the team's shared goals.[15] Strong leadership, extensive buy-in, and champions can facilitate cultural change and reduce practitioner resistance.[50, 51]

Some fundamental principles of an effective leader include:

- maintaining commitment to the collaborative,
- advocating for a high level of quality care for clients,
- being visible and available,
- communicating with team members clearly,
- keeping team members up-to-date and relaying information back to the group,
- encouraging the participation of the entire collaborative,
- developing a climate where leadership and collaborative practice can be shared,
- ensuring the principles of continuous quality improvement are promoted and incorporated to work processes and outcomes (including feedback on leadership),
- and providing meaningful and productive team member feedback.[9, 30]

Lessons learned from local collaborative teams

Supportive leadership was viewed as critical during the initiation of the collaborative team.

Support from leadership allowed members the freedom to have open conversations and to construct what they thought might work well. Leadership support also ensured the collaboratives had organizational endorsement of the work.

As the team develops, members are likely to work more collaboratively and become more willing to take on more responsibility for making and implementing decisions and changes. The collaborative should also have a culture of shared leadership, where the entire group is responsible for change, improvement, and shaping the collaborative initiative to meet the needs of the community and providers.[52]

Guiding Questions
How is/was the leadership identified?
Have informal leaders begun to emerge?
How are these leaders incorporated into the leadership group?
What is the leadership model for the practice? How will that affect patient care? How will it affect the collaborative team?
Who will coordinate care, manage the team, and ensure efficient and effective communication among team members and across teams?
How can non-leaders be engaged in team performance and decision-making?
What will be the decision-making process? Are clinical decisions shared among the group?
Will emerging champions or leaders of this work be encouraged?

Source: [9, 36, 41]

Determine Infrastructure and Financial Requirements

Historically, primary care and mental health care systems have operated in different service delivery, funding, and reimbursement sectors.[25] As such, funding and incentive models can be significant barriers to collaborative care.[53] The absence of a financial business model, financial costs for investing in collaborative care start-up and maintenance, inadequate space and staff, unbillable activities or a lack of payment codes, as well as a lack of stakeholder input are all factors that may amplify barriers associated to securing adequate infrastructure and finances.[54]

Lessons learned from local collaborative teams

It needs to be determined how physicians will be compensated for their time early in the planning process.

Physicians may be reluctant to attend collaborative team meetings if doing so will mean a loss of potential income. Determining physician billing for time spent on the collaborative will help to ensure their engagement and participation.

For funding of a collaborative to be effective, it should be linked to the activities associated to the whole team, rather than to the activities of specific providers or agencies.[9] Human resource

costs, operational costs, and one-time costs should all be considered, as the amount of resources available will determine team composition, training, information systems, and physical space available for providing care.[30, 50]

Doctors Nova Scotia (2013) has described the following as characteristics of effective funding:

- calculated per patient rather than per service,
- based on the needs and risk factors of the population served,
- clearly outlines and recognizes funding for members of interdisciplinary teams,
- is patient-centred rather than provider driven, and provide incentives for comprehensive care,
- and is dedicated to team development and supportive of collaborative practice.[9]

While considering infrastructure and funding, team members should identify possible funding sources, assess the type of providers, location/size of practices, and the interventions needed, develop a budget that encompass all costs, as well as consider sustainability and how the resources and funding available can be continued or maintained.[15, 30]

Guiding Questions
What are the overhead costs for my collaborative practice? Which payment model will best address them?
What funds are available to support the practice? Will resources be provided in kind? Does the team have sufficient resources to achieve the desired health outcomes?
What systems are in place for the budgeting and distribution of resources?
How are requirements for additional or different resources identified?
Which payment model best suits our philosophy of collaborative practice?
Are appropriate billing codes accessible to staff?
How will the other providers in my practice be compensated?
What are the physical space needs? What are the costs associated? How will it be funded?
What are the technology needs? What are the costs associated? How will it be funded?
Does the collaborative participate in activities that are not billable? If so, how are these services funded?

Source: [9, 36, 42]

Community Example

The Bonnyville Child and Adolescent Mental Health collaborative care program initially received pilot funding, which was re-approved for subsequent years. Additional sources of funding helped to provide professional development to the team and programming for the clients. The collaborative team also received in-kind funding and donated space; participating physicians were compensated with an approved billing code.

Facilitate Training and Core Competencies

Different educational, training, and procedural backgrounds can create challenges in decisions related to diagnosis, treatment, and how the care team functions as a whole.[54] Without appropriate education and training for collaborative practice, team effectiveness and quality of collaboration can be negatively impacted; therefore, it is essential that team members have the necessary skills to function effectively.[26, 30]

Creating a basic level of collaborative training for all team members helps to mitigate these differences and unites providers under a common understanding of interprofessional care.[15, 30] Interprofessional training can also create a more enjoyable experience in developing a collaborative initiative, allow providers to be able to implement collaborative care in a variety of settings, and improve the delivery of services.[55]

Training is most effective when it is brief, practical, taught interactively using case-based or problem-focused approaches, and directly relevant to provider's work.[23, 56]

Lessons learned from local collaborative teams

Training was viewed as very helpful in improving physician efficacy among members of the Bonnyville Child and Adolescent Mental Health collaborative.

CanREACH training was viewed as very helpful in improving physician efficacy, which meant that families accessing healthcare for some mental health concerns in their community may not need to pay for or wait to see a specialist (e.g., psychiatrist). The challenge, from one physician's perspective, was knowing how to integrate this work into their practice (i.e., "no one else knows what you can do").

It is also important for team members to share their expertise and learn from one another, which also helps members practice skills associated with working in teams. Team members with more experience working collaboratively with other specialties or disciplines may have an opportunity to educate those who do not. Likewise, professionals can share their expertise on other areas that some don't have as much experience with, such as standardized screening instruments, management and leadership guidelines, patient self-management resources and strategies, as well as information on community programs.[56]

Other examples of educational or training opportunities include:

- collaborative office/clinical rounds
- practice observations/case-based teaching
- case conferences
- professional development events, conferences, 'lunch and learns', and workshops
- educational handouts (including web-based resources)
- joint guidelines
- website resources and webinars[6, 54, 56]

Collaborative initiatives may also be interested in other targeted training on topics such as signs and symptoms, risk factors, treatments, or screening and monitoring tests and assessments.[38] Skill development may also target specific mental health problems, substance use, preventative health, patient self-management, or change management.[38]

Guiding Questions
What is the baseline level of knowledge and skills needed among the collaborative?
Are there training and supports that are required?
What are the costs associated to training? Who is responsible for them?
Are there experienced users who can share insights about each system?
What opportunities are there for team members or other collaborative teams to share their expertise?

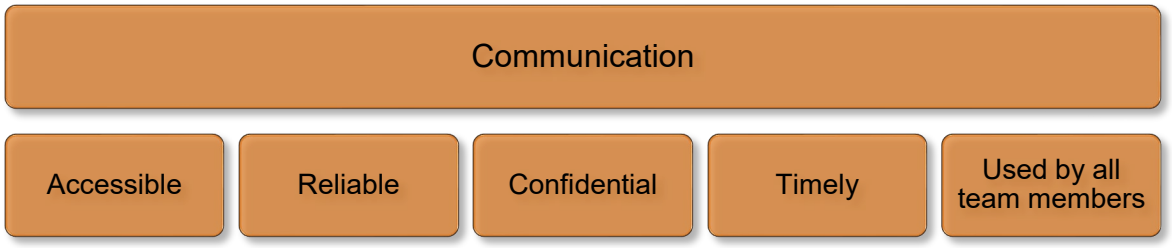
Source: [9]

Establish Methods of Communication and Information Sharing

Communication

Most studies identified communication as the principal facilitator of successful collaborative care teams.[5, 8, 15, 44, 46] Formal communication processes, such as regular meetings, as well as frequent, informal shared communication, are vital factors in achieving and sustaining interprofessional collaboration.[15, 45, 57] Clear lines of communication between team members facilitates knowledge creation, development of shared goals, and clinical decision making.[5, 59] Effective communication practices also help teams to discuss and resolve conflict, as well as improve care coordination.[45, 46, 53]

Case Western Reserve University (2010) indicates that modes of communication should be accessible, reliable, confidential, timely, and used by all members of the collaborative.[38]



Part of effective communication involves having an agreement on the preferred mode of communication and frequency that is sustainable.[12] A number of team-based programs usually start well in terms of communication, but then taper off as time goes on.[12] It is therefore important that teams establish a strong communication and engagement plan to ensure sustainability and consistency; communication must be maintained across settings and over time.[47]

Lessons learned from local collaborative teams

Communication should be organized, timely, and regular.

Communication was viewed as successful amongst members of the teams because it was organized, timely, and regular, and methods used to communicate were both formal and informal.

Building a communication plan that identifies key stakeholders, the communication approach that is most appropriate, and what activities must be done to meet the objectives of the initiative ensures that the right information is provided at the right time, in the right manner.

Messaging should be consistent and align with the design of the initiative, updates should be provided regularly, communication approaches should be made in consultation with those who receive messages, and key messages should be clearly outlined for each stakeholder group.[33]

Other facilitators of effective communication:

- meetings are held regularly (e.g., team meetings, quality improvement meetings)
- communication amongst the team happens openly and remains effective during stressful situations
- members are free to express their opinions, advocate for decisions, and they have an influence on decisions
- language used is understood by all involved in care and discipline-specific terminology is explained
- there are strategies in place to communicate information regarding client care
- team members work together rather than in silos to find ways to support clients
- methods of communication are evaluated and modified accordingly
- information systems and technology are used to exchange relevant information among the team[14, 30]

Guiding Questions
What type of communication will work best for this unique team, without creating a burden on team members?
Is technology needed to facilitate effective communication and meetings?
What can ensure that the collaborative is safe environment where different opinions and perspectives can be shared openly and heard respectfully by others?
Has the group established systems and norms for managing consensus and conflict?
Have potential situations that may lead to conflict been considered (e.g., role overload, goal differences, etc.)?
How can language and discipline-specific jargon be simplified and understood by other members and clients?
How effective and timely is communication between different providers?

Source: [9, 36, 41]

Information Sharing

Members of a collaborative team must be able to jointly and effectively share information amongst themselves and their partners using a clear, and agreed upon, communication process. Sharing individually identifying health information across organizations; however, is regulated by the *Health Information Act* and may require consultation with organizations' privacy departments.

Lessons learned from local collaborative teams

Several different stakeholder groups may need to be consulted, and you may need to work with various departments within an organization, to ensure clients' privacy is protected and enable information sharing.

It is the responsibility of everyone who is part of the collaborative team to ensure clients' privacy. How that privacy is protected during information sharing may require input, and decision making, at both the team and organizational levels (e.g., allied health professionals, partner organizations). Initiating and implementing the method chosen for information sharing may require advice and support from various internal departments (e.g., privacy departments, IT departments), as well as support from senior operational leadership.

Before a method for information sharing can be implemented, consultation should take place with privacy departments to determine if a privacy impact assessment (PIA) is required. If one of the partnering organizations has completed a PIA, it may not be necessary to repeat the process; however, this scenario would be under the advisement of the privacy department.

Evidence shows that using integrated information technology, such as a shared electronic medical record (EMR), is key to implementing effective collaborative care programs.[7, 58] An EMR allows care providers to share client information and serves as a useful tool to keep providers up-to-date on a client's health status. It also lets the care manager monitor client progress and follow-up accordingly.[17]

Other potential benefits of using an EMR within a collaborative care team include:

- ensuring that patient information remains private and confidential through the use of secure logins and auditing abilities
- streamlining and aggregating interoffice communication and reporting
- maintaining consistent, real-time records that are legible, reliable, and accessible
- monitoring medication lists and current prescriptions
- delivering chronic disease management and care of complex patients
- minimizing the risk of missing or forgetting details
- generating decision support and reminders for physicians and staff
- simplifying and optimizing billing information[9]

Lessons learned from local collaborative teams

An EMR may not be accessible by all members of a collaborative team. A secondary, secure platform may be required to share common documents and tools.

All documents and tools that will be used by the collaborative team during their consultations will need to be easily accessible by all members (e.g., intake forms, consent forms, information about the case collaboration). Two collaborative teams in Alberta chose SharePoint as the collaborative platform they would use to share non-confidential information. Having a means for sharing information electronically was reported to be one of the main factors that lead to communication being successful during the past year.

Regardless of the methods used or the technologies chosen to share information, it may take some time for members of the collaborative team to learn new skills and adjust to new ways of working.

Lessons learned from local collaborative teams

Allow time for learning among collaborative team members involved in implementing and using a new information sharing process.

Coordinating implementation of new processes for information sharing may be outside of the usual scope of work for the person responsible and therefore, completing steps in the process may take longer than anticipated. A new process (e.g., sending an encrypted email) may also require some training and practice amongst the team members.

Providing a clear understanding of what is legally permitted regarding information sharing may alleviate apprehension among collaborative team members.

Lessons learned from local collaborative teams

Brief documents, or clinical practice notices, may be useful in ensuring frontline staff understand what is permitted legally, and within their professional associations, regarding information sharing.

Although health professionals may have a clear understanding of Alberta's privacy legislation, and efforts are made to ensure that there is understanding (e.g., webinars and FAQs), there may be some apprehension based on how they perceive direction from their professional associations. Having documentation from these associations may help to enable information sharing across all members of the collaborative team. AHS Provincial Addiction and Mental Health staff worked with Professional Practice Consultation Services to develop practice notices for social workers and psychologists.

Guiding Questions
How is information disseminated to members?
What information is relevant to whom?
Is a privacy impact assessment required?
How can technology assist information exchange between team members and with patients?
Does an electronic medical record meet the team's needs or is a new technology required?
Who will be responsible for sharing information with clients and their families?
Who will be responsible for relaying outside information to the team? Who will be responsible for relaying information from the team to others?

Source: [9, 36]

Determine Data Requirements, Collection, and Storage

Providing care to patients through a collaborative team will require accessing, collecting, and storing data related to health status, diagnoses, and care needs. Determining the process for obtaining client consent is an important step in this process.

Lessons learned from local collaborative teams

Policies and procedures may vary by partner organization within a collaborative team.

Varying policies led to some initial challenges with documentation of client consent. It was noted that physicians in the Bonnyville Child and Adolescent Mental Health Clinic wanted “things to be simple and not be more work.” The collaborative was able to work together to develop a flexible process that still met legal requirements.

The team will need to decide the data points that will be collected from all patients (e.g., minimum data set) to ensure they can accurately report on the activities of the team (e.g., demographics, referral source, presenting issues). Other data may also be collected through their interaction with the collaborative team (e.g., previous diagnoses, assessment scores, referrals from the team to other services), which will also need to be recorded and stored in a secure location. Team members who will have ongoing access to this data will also need to be determined.

Data related to quality improvement and evaluation activities will also need to be stored securely. Retention and disposition schedules will need to be established, as schedules may vary by organization. Team members who will be responsible for recording, retrieving, and disposing of data will also need to be determined.

Delivering the Collaborative

Health care providers that work together can strive towards giving patients the best care possible by sharing their expertise and relying on one another for information. Effectively providing collaborative care involves both co-delivering the care pathway (i.e., seeing clients) and fostering team functioning.

Co-deliver the Care Pathway

When planning a care pathway, collaborators must clearly:

- determine the needs of the client
- identify eligible client care options
- determine which evidence-based treatment options are best
- discuss care and care options with the client and/or family
- discuss how care can be modified when desired results are not produced
- produce a transitional care plan for clients upon discharge or for those who need to access other services or levels of service
- evaluate the course of care and the care pathway by using client, collateral, and objective measures of process and outcome variables[7]

Admission, triage, response to request for care, care hours, scheduling, coordination of visits, protocols for warm hand-off or appointment reminders, patient portals, transition between levels of care, and communication methods should all be considered when developing a care plan.[38] Providers should have mechanisms in place to identify the immediate, short-term, and long-term needs and goals of the patient. To identify the needs of patients, providers should consider the following:

- patient history
- current and past mental health, substance use, and physical health status
- demographics
- family characteristics
- behavioural risks
- dates of most recent medical visits
- a list of all medications and allergies
- any barriers to communication
- needed tests and assessments
- basic needs (e.g., housing, psychosocial, religious/spiritual)
- advanced care plan[38]

The care plan created should be responsive and respectful to these individual characteristics and needs. Specific treatment and levels of care should also be based on ongoing assessment of these factors.

Lessons learned from local collaborative teams

Not all complex cases will accept assistance from a collaborative team.

Even if members feel the client would benefit from support from a collaborative team, there are times when a client will choose to live at risk and there must be respect for that client's decision.

Patient Referral, Screening, and Diagnosis

Shared patient referral, screening, and diagnostic protocols must be made to coordinate team members and patient care in a useful and effective way.[7] Protocols regarding further assessment, treatment and treatment support, follow-up consultations, crisis intervention, and external referrals should also be developed and standardized in order to avoid barriers regarding differences in practice, poor coordination among members, changing workflow, and competing work demands.[54]

Protocols should address where, when, and how referral, screening and diagnosis will be gathered or determined, as well as how the information collected will be conveyed to clients or used to guide treatment.[39] By developing protocols for your care pathway, intake procedures, inclusion/exclusion criteria, changes to treatment, and discharge planning can all be simplified.[23]

Case Review and Consultation

Each provider must be clear about their role from the beginning to the end of the care pathway so that role ambiguity, duplication of services, and unmanageable workloads are absent, and clients are able to get what they need from the most appropriate resource(s) in a timely manner.

Procedures should be simple enough to be understood and worked with between providers and their agencies, but thorough enough that they can be routinely followed.[56] Likewise, regular communication about the care pathway and specific care plans should remain open so that if problems arise, they can be reevaluated and discussed.

Evidence-Based Treatment

As mentioned previously, evidence-based care is one of the main components of collaborative care and serves to identify and utilize treatment options that are supported by research. Collaborative care teams should strive towards introducing clinical guidelines or pathways based on current literature and best practice.[23] Changes or adjustments in treatment or medications should be (re)discussed amongst the care team if patients do not meet treatment targets or issues arise.[21]

Lessons learned from local collaborative teams

Complex clients may require numerous services, which can be time consuming and difficult to address.

The nature of collaborative teams trying to address the needs of complex clients can often mean that they require coordinated assistance from multiple service providers (e.g., home care, mental health support). It was reported that it may be difficult to "know where to start."

Patient Involvement

Involving people with lived experience and drawing from client and family feedback and experiences, when appropriate, and can make collaborative care more responsive and tailored to specific client needs and goals.[7] The care team should consider how they may engage clients in setting treatment goals and communicate with one another about medication compliance, level of functioning, and changes to diagnosis, treatment, or recovery.

Providing options to clients about how they may want to receive information or share their thoughts can help to ensure that difference in language, reading levels, and preferences are respected and accounted for. Providers should also consider patient preferences for the type, duration and frequency of services; what their needs, strengths, and readiness for change is; and what accessible and convenient care looks like from their perspective.[38] Encouraging clients to ask questions and communicate with providers can help to ensure that treatment is individually tailored and education about symptoms, treatments, and self-management can be shared.[21] "Warm handoffs", or an in-person transfer of care between the health care team in front of the patient and/or family, also allows for real-time communication between providers and facilitates an immediate, whole-person care plan.[59]

Community Example

The needs and feelings of the clients and their families may change depending on the stage they are in during the collaborative process.

The Calgary Zone undertook a patient journey mapping exercise with family advisors who had participated in collaborative care. Clients and families reported they wanted to feel informed and prepared about the process during initial conversations. In addition to feeling overwhelmed, exhausted, and relieved, they also experienced feelings of nervousness and anxiousness. They reported that they wanted a clear description of what to do (e.g., checklist of things to bring with them) and what to expect (e.g., is it therapy? what are the ground rules?) during their case conference.

During the case consultation, some clients and families reported feeling stressed, anxious, and overwhelmed, but also hopeful and supported. They reported that they wanted to feel welcome, to feel comfortable, to be understood, and to be seen as an equal partner in the process. They wanted to leave the meeting with a written plan.

After the meeting, some clients and families continued to report feeling anxious, but also hopeful, grateful, and less alone. During this stage, they reported wanting to feel supported, which could be facilitated through having a "point person" to contact, having their plan reviewed regularly, and having someone ask them for their feedback about the process.

Treatment Adjustment, and Relapse Prevention

Proactively, the care team should designate who and how they will reach out to patients who do not follow up, are not improving, or who may be having complications. A crisis or relapse prevention plan should also be created and specialty behavioural services should be well coordinated in the event that patients need immediate or advanced care. A set process that notifies the collaborative when their clients visit or are discharged from the emergency department may be a helpful tool to consider. Using screening results and other patient data can also help providers characterize patient risk, complexity of needs, and deteriorated functioning.[59]

Proactive planning for transitions, such as transfer or discharge, should begin upon client admittance into the program.[33] Likewise, a follow-up procedure should be established for community referrals.[54]

Guiding Questions
How will new clients be recruited/referred into the collaborative?
Who will be responsible for coordinating activities for the team (e.g., sending meeting requests, recording meeting minutes)? Is administrative support needed?
Will client input be used to inform the collaborative process?
How will clients be made to feel informed, welcomed, and engaged during the process?
Will standardized screening and assessment tools be used and if so, when? (e.g., intake, during the case consultation, during follow-up)

Foster Team Functioning

Evidence shows that there are factors that can help sustain a collaborative initiative which include:

- having a sense of team culture and responsibility
- treating others/being treated by others with trust, respect, and honesty
- being open and flexible to new ideas or approaches to doing the work
- acquiring and acknowledging skill mix
- acknowledging the successes of individuals and the collaborative as a whole

Team Culture and Responsibility

Team functioning cannot be productive until individual and organizational perspectives shift from what each person's 'level of clinical responsibility is' to 'how their role, knowledge, and services can be incorporated into collaborative client care'. Individuals with addiction, mental health issues, or physical health issues have historically existed with separate structures, processes, infrastructure, and staff.[7] Collaborative teams must share responsibility for team actions and agree to work together across partner organizations to facilitate a culture that supports the development and implementation of integrated care.[15, 35] Professional and personal culture and values should be shared and respected, and the collaborative should be an inviting space for new team members.[30, 47]

Lessons learned from local collaborative teams

Learning to work as a collaborative team was viewed as a challenge.

It was reported that although organizations work in the same sector and seem to be similar, they are more different than they initially understood (e.g., different systems and policies). It can also take some time to understanding how to work as a team when everyone has different roles and different skills.

Trust, Respect, and Honesty

Research indicates that team members are more likely to be able to identify and define their role on a team and recognize the strengths of others if there is an environment of mutual trust, respect, honesty.[5, 15, 23, 30, 32, 45, 47, 56] The Canadian Medical Association (2008) also lists mutual respect and trust as one of the critical success factors for interdisciplinary teamwork regarding patient-centered collaborative care.[8]

Team members must demonstrate sensitivity to one another's feelings, problems and needs, as well as be transparent about their opinions, decisions, uncertainty, and mistakes.[5, 30, 47] Disrespect and inequality within the team must be diplomatically addressed.[47] Additionally, time dedicated towards the collaborative and scheduling processes should be fair and respected.

Lessons learned from local collaborative teams

Relationship building was considered to be one of the aspects that mattered most to the success of the collaborative team.

One collaborative team reported that relationship building and trust were two of the aspects that mattered most to getting their collaborative team up and running. Being supportive, having a positive attitude, and having trust and respect for each other were seen as critical to successful collaboration during their past year of operating as a team. Other factors mentioned included valuing others' perspectives, having empathy, and listening to each other.

Flexibility

Collaborative team members should ensure that they have the willingness to be flexible to be able to respond to the demands of the collaborative or to reach consensus.[15, 23, 39, 47] Additionally, team members should be curious to reflect upon the lessons they learn throughout their daily activities and be open to continuously improving both their own work, as well as how the team is functioning.[5] At the same time, team members should also ensure that they are disciplined in adhering to their standards and protocols.[5]

Lessons learned from local collaborative teams

Working as a collaborative team means working differently and breaking down silos.

There may be structures or processes in place in within the systems or organizations that do not allow for collaborative care. Although willing, partners at the collaborative table may be unsure how to make changes happen to allow for collaboration. Working collaboratively often means "looking at things from different lenses, being creative and thinking outside the box."

Appropriate Skill Mix

Team composition depends on the resources and skills needed to address the health needs of the population a collaborative initiative is trying to reach. Therefore, it is important for personal and professional differences amongst team members to be valued for the group to move forward cohesively.[15, 30] Team members must recognize their differences in training and opinion; however, they mustn't believe that one type of training or perspective is superior to others.[5]

Acknowledgement and Reward

Team cohesion can also be developed by acknowledging the contributions of all members, celebrating successes, providing individual opportunities based on specific interests, creating opportunities for staff to meet socially or informally, and supporting others during times of difficulty or crisis.[15, 30, 47]

Guiding Questions
Do leaders and members acknowledge and address progress and setbacks?
What practices (such as education/rounds, regular staff meetings or huddles, using technology and co-locating team members) can the team establish to create a community that is encouraging, trusting, transparent and respectful?
Do team members show a strong commitment to the team? How can commitment be increased or sustained?
Are team members willing to put in an equal effort to have the collaborative succeed?
Is team functioning something the team wants to measure and monitor over time?

Source: [9, 36, 41]

Tools have been developed to assess how well a collaborative team is functioning (e.g., the *Wilder Collaboration Factors Inventory* was used by the collaborative teams in the Calgary Zone). Refer to Appendix H for more information.

Quality Improvement and Evaluation

Undertake quality improvement and evaluation activities

An important component of an effective collaborative care team is systematically collecting and evaluating data at multiple collection points, and from various sources, to continuously improve collaboration between providers and patients and to strengthen the initiative overall. With regular quality improvement and evaluation activities, providers can understand what is working well, where there are potential areas for improvement, and whether the practice is meeting its expected outcomes.

Quality Improvement

"Quality improvement is the framework used to systematically improve care. Quality improvement seeks to standardize processes and structure to reduce variation, achieve predictable results, and improve outcomes for patients, healthcare systems, and organizations."[60]

Quality can be measured in a variety of ways. The Health Quality Council of Alberta (2005) has identified the following six dimensions of quality to consider determining if high-quality health care is being provided[61]:

Acceptability	Are services respectful and responsive to user needs, preferences, and expectations?
Accessibility	Are services obtained in the most suitable setting and within a reasonable time and distance?
Appropriateness	Are services relevant to user needs and are they based on accepted or evidence-based practice?
Effectiveness	Are services achieving desired outcomes?
Efficiency	Are resources being used optimally?
Safety	Is the program able to mitigate risks to avoid harmful results?

Quality improvement data can be used to improve health care delivery by generating performance reporting, allowing for the results to be compared to the goals of the initiative or to other initiatives, giving providers and patients a voice to express their feedback, and informing action plans that can be developed as next steps.[38]

Lessons learned from local collaborative teams

Focus quality improvement activities on the improvement of coordinated care.

It is common for partners to work independently of one another prior to belonging to a collaborative team and as such, working together to meet the needs of their clients can be a new experience. It was recommended that quality improvement activities focus on the improvement of coordinated care between specialized, primary, and community organizations.

One of the ways in which quality improvement can occur, particularly in the early stages of implementing a new practice, is through PDSA (i.e., plan, do, study, act) cycles. The Institute for Healthcare Improvement (2020) states that "the PDSA cycle is shorthand for testing a change by developing a plan to test the change (Plan), carrying out the test (Do), observing and learning from the consequences (Study), and determining what modifications should be made to the test (Act)."[62] Guiding questions used by collaborative teams in the Calgary Zone during their PDSA cycles can be found in Appendix G.

Lessons learned from local collaborative teams

Develop processes using PDSA (i.e., plan, do, study, act) cycles.

It was reported that there is value in going slow initially; starting with one case discussion with parties involved and spending time working through the challenges, process development and completing PDSA cycles to evaluate the process.

Evaluation

A written evaluation plan should be developed in consultation with the members or representatives from the collaborative team to ensure that their needs for data and quality improvement information will be met. The plan should include the questions you want answered, and clearly articulated measures and data collection strategies.[7]

An evaluation plan describes the overall approach that answers the following questions:

- Why is the evaluation being conducted?
- What will be done?
- Who will do it?
- When will it be done?
- How will evaluation findings likely be used?[63]

An evaluation plan needs to be flexible enough that it can be tailored as issues or opportunities emerge. An evaluation plan often includes the following sections:

- **Program background** – describes the program that is being evaluated and its goals and objectives
- **Goals and objectives** – describes the purpose of the evaluation, goals, objectives, and the intended audience/stakeholders
- **Scope** – describes what will be undertaken as part of the evaluation, and what is considered to be out-of-scope
- **Evaluation questions, outcomes, and indicators** – evaluation questions, outcomes, and indicators are often included in an evaluation framework
- **Methods** – describes how evaluation data will be collected
- **Budget** – describes what financial resources are available for the evaluation
- **Reporting** – describes the strategy for sharing results and developing recommendations
- **Roles and responsibilities** – describes who will be involved in the evaluation and how
- **Timeline** – outlines a schedule for developing the evaluation plan, data collection, data analysis, and reporting of results

Specific measures such as scales, questionnaires, tools, lab results, supervision records, client tracking, and stakeholder feedback are all viable methods in evaluating how efficient and effective the collaborative initiative is, what the strengths and challenges are, and what can be improved or continued.[38] It is important to keep in mind that the information you collect, regardless of which data collection tools are selected, must be necessary for the evaluation.[30]

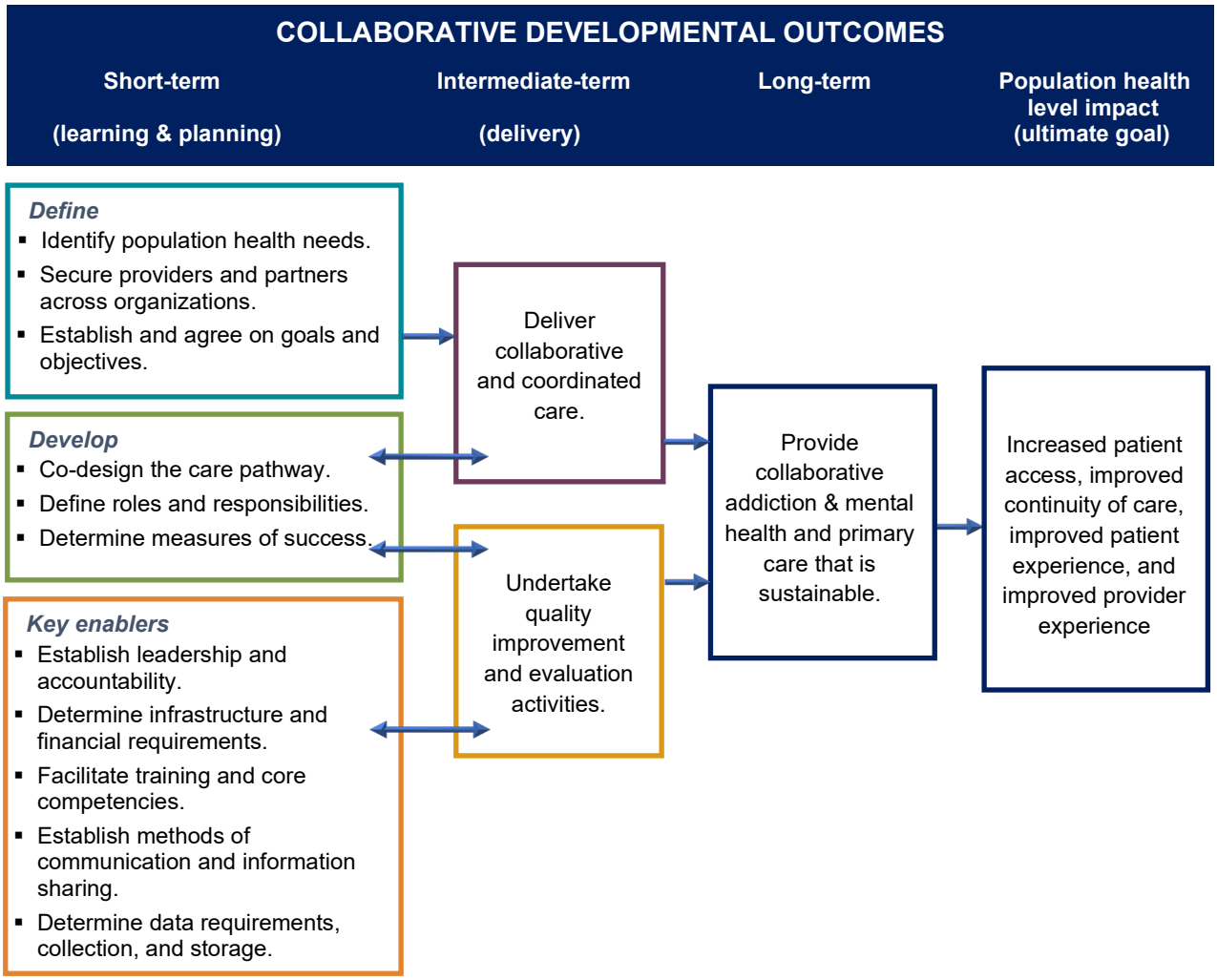
Tools and resources related to understanding evaluations and evaluation planning can be found in Appendix F.

Guiding Questions
How will you know if the team is functioning effectively?
Are there mechanisms in place to monitor health outcomes? Are they linked to a logic model?
What patient, provider, and organizational measures will be tracked? How?
What activities have been carried out, and how satisfied is the group with them?
What goals have been accomplished and how satisfied is the group with its performance?
To what extent does each member/partner believe the purpose of the collaborative has been fulfilled?
What events (both foreseen and unintended) have had an impact on the group's performance?
Is the collaborative evolving or transforming? What factors are precipitating the transformation?
How is data being used to inform decision-making and to make mid-course corrections?
Are lessons learned going to be used to inform changes to the collaborative, leadership, or processes?

Source: [9, 36]

Appendix A: Collaborative Developmental Logic Model

The following excerpt is from a larger model developed with the Calgary Foothills Primary Care Network. The model describes the learning and planning that needs to occur in the short term to move to the delivery of services in the intermediate term. Quality improvement and evaluation activities contribute to further refining the development of the collaborative, as well as some key enablers, to ensure that the collaborative is achieving results and becomes sustainable in the long-term. Ultimately, the work of the collaborative will contribute to increased patient access, improved continuity of care, improved patient experience, and improved provider experience, which are based on the four components of Quadruple Aim.



Appendix B: Conducting Needs Assessments

By conducting a needs assessment, the information gathered can help to support the development of a collaborative and allow it to:

- address gaps and opportunities for current services to become more effective
- determine priorities and where resources are most needed and/or will have the greatest impact
- fit the needs of clients and providers
- align with existing infrastructure, resources, and services
- serve as a foundation in determining specific goals, priorities, and strategies for the initiative
- correctly identify the amount of additional resources that may be required
- prepare for the monitoring of implementation and impact
- enable continuous improvement activities by identifying changes/where changes are needed, what practices or approaches are/are not working, and what strategies offer the greatest success[30, 64]

Interviews, focus groups, observations, surveys, and community forums or public meetings may be helpful in understanding provider, community, and patient experiences, knowledge, and concerns, as well the unique characteristics and opinions of a community. Other common sources of data that may be utilized in the creation of a needs assessment includes clinical, service or census data, document analysis, program evaluations, environmental scans, proposals, and research reports.[64]

The **Assessment, Analysis, Design, Development, Implementation, and Evaluation** (AADDIE) model, showcased below in Table 4, displays a general performance improvement process that may be applied to a needs assessment.

Table 4. AADIE Model[28, 65]

Assessment	- identify gaps - prioritize gaps based on need, consequences, and cost
Analysis	- identify causes for gaps - identify possible solutions - create a goal to match the form and circumstances of the issue(s)
Design	- select/derive solutions/means based on specified needs and identified goals
Development	- produce solutions/means based on design specifications - evaluate and modify solutions/means
Implementation	- prepare for change - implement solutions - manage response to change
Evaluation & Continual Improvement	- evaluate progress and revise as required - evaluate impact and revise as required

Additional Resources:

Centers for Disease Control and Prevention (CDC): Community Needs Assessment

The World Bank: A Guide to Assessing Needs

Appendix C: Collaborative Care Checklist

A collaborative care checklist was designed to help teams to determine their level of progress in areas that could help them develop their addiction and mental health collaborative team. The checklist should be updated periodically as development of the team progresses.

Sample page

Collaborative Care Checklist
Collaborative Care for Addiction & Mental Health in Primary Care

This collaborative care checklist provides new addiction and mental health collaborative teams with steps to consider as they progress through the various phases of developing their team. The development of this checklist was informed in part from lessons learned while evaluating collaborative care teams in Alberta and is intended to be used in combination with the information provided in the *Collaborative Care Toolkit*.

The checklist was created with the understanding that collaborative teams often differ in the way that they function and provide care. As such, the checklist was designed to be as inclusive as possible and teams may choose "not applicable" for items that do not apply or are not relevant to them. The checklist should be updated periodically to reflect the current state of the team's development.

Defining the collaborative

Identify Population Health Needs

	Not started	In progress	Not applicable/ Deferred	Achieved/ Completed
Resources to complete the assessment are secured.	☐	☐	☐	☐
Data needs and data availability have been determined.	☐	☐	☐	☐
A work plan for the assessment has been developed and there is a set process for data collection, analysis, and dissemination.	☐	☐	☐	☐
Applicable stakeholders (e.g., providers, organizations, communities, and patients) have been included or considered.	☐	☐	☐	☐
The needs assessment/gap analysis is conducted.	☐	☐	☐	☐
Gaps/needs have been identified (i.e., target population is identified) and prioritized based on need, consequences, and cost.	☐	☐	☐	☐
Causes for gaps/needs and possible solutions have been identified and evaluated.	☐	☐	☐	☐
Results of the needs assessment/gap analysis are shared with the project team and stakeholders in a timely manner.	☐	☐	☐	☐
Results of the needs assessment/gap analysis have led to goals being set and resources secured; contributions from the collaborative team and stakeholders are agreed upon.	☐	☐	☐	☐

For more information, contact
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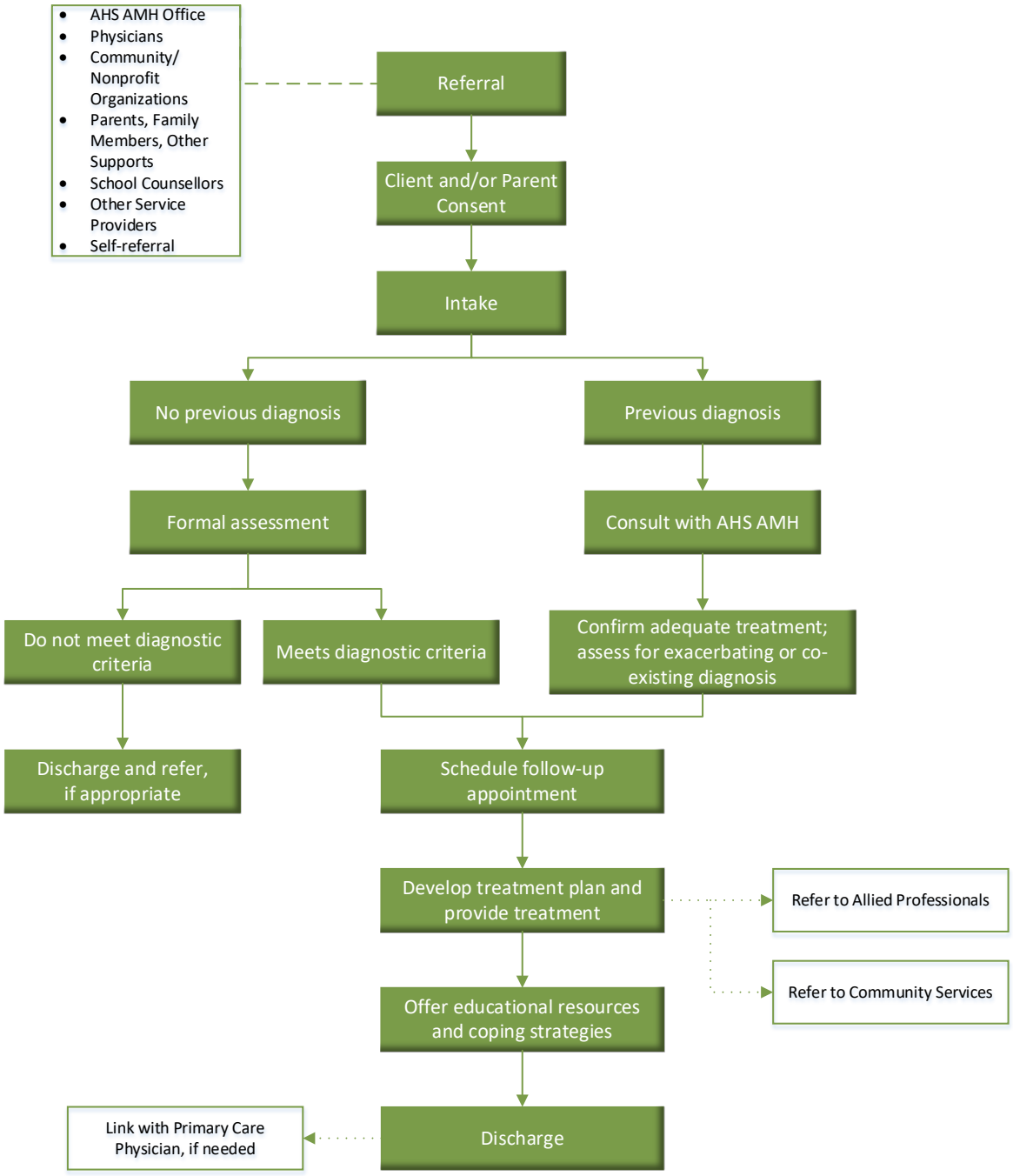
Updated August 2021

Alberta Health Services

Appendix D: Example Client Flow Map



Source: [48]

Appendix E: Collaborative Care Information & Training

The following links provide additional information about collaborative care and CanREACH training.

Collaborative Care

Collaborative Care Literature Review

- A comprehensive literature review that addressed the following questions about collaborative care for addiction and mental health in primary care:
    - What is collaborative care?
    - What are collaborative care best practices?
    - What contributes to the effectiveness of collaborative care teams?
    - What is the impact of collaborative care on patient outcomes?
    - What is the impact of collaborative care on organizational outcomes?
    - How can Telehealth be used to support collaborative care teams?

Collaborative Care Infographics

- The following five summary infographics were developed based on the collaborative care for addiction and mental health literature review above:
    - Introduction to Collaborative Care
    - Collaborative Care Best Practices
    - Effective Collaborative Care Teams
    - Collaborative Care Patient Outcomes
    - Collaborative Care via Telehealth

American Psychiatric Association Learning Center

Applying the Integrated Care Approach: Core

- A free online course that provides an introduction to collaborative care.

Applying the Integrated Care Approach: Advanced

- A free online course that provides a deeper exploration of collaborative care topics that are discussed in the "Applying the Integrated Care Approach: Core" course.

CanREACH

CanREACH

- three-day, 15-hour interactive course focused on building skills and confidence in diagnosing and treating pediatric behavioral health problems.
- six-month, case-based distance-learning program to learn how to manage pediatric mental health issues in daily practice
- enrollment includes custom-designed toolkits with guides, assessment instruments, dosing and side effect charts, medication comparison tables, and handouts for patients and parents
- Participants learn to:
    - correctly identify and differentiate among pediatric behavioral health problems such as childhood depression, ADHD, bipolar disorder, anxiety states (including PTSD), oppositional and conduct disorders, and psychosis
    - effectively manage psychopharmacology: selecting medications, initiating and tapering dosages, monitoring improvements, and identifying and minimizing medication side effects
    - create and implement a treatment plan by mobilizing existing resources like family members, school personnel, and other professional caregiver

Appendix F: Evaluation Planning

The following links provide additional information that may be helpful while planning a health care evaluation.

Evaluation Dictionary

- This infographic provides an overview of key evaluation terms and concepts.

Introduction to Evaluation

- This document defines evaluation, showcases when they are most appropriate, what they can achieve, what they should consider, as well as describes some of their limitations.

Evaluability Assessment

- This infographic provides additional information on evaluability assessments and what they can determine about a program and whether it is ready for an evaluation

Research and Evaluation Methods

- This document describes different research and evaluation methodologies, when they may be most appropriately used, and how data is collected and analyzed within each.

Evaluation Planning

- This document:
    - defines and describes logic models, how they may be used, and provides a basic template for logic model creation
    - describes evaluation plans, what is typically included in them, and tips on how to develop one
    - describes evaluation frameworks
    - defines evaluability assessments, provides steps to conducting them, and lists questions to consider throughout the process

Steps to Developing an Evaluation Plan

- This infographic provides nine steps to developing an evaluation plan.

Tips for Planning an Evaluation

- This infographic provides seven tips for planning an evaluation, as well as provides some additional evaluation resources.

Data Collection and Analysis

- This document:
  - describes what data collection in evaluation looks like and provides information on sampling, recruitment, instrument design, pilot testing, and ethical considerations
  - describes what data analysis in evaluation looks like and provides information on basic quantitative and qualitative analysis techniques.

Ethics in Research and Evaluation

- This document discusses some key considerations regarding ethics in research and evaluation, such as privacy and confidentiality, consent, and strategies for risk management.
- A pRojects Ethics Community Consensus Initiative (ARECCI): ARECCI is a network of practitioners, agencies and organizations dedicated to the evaluation and implementations of the ARECCI framework and tools to fill a gap in ethics reviews. ARECCI has created tools and resources for organizations and other contexts to build their own capacity (knowledge and skill) to effectively and consistently manage risk in quality improvement and evaluation (non-research projects). This page features decision support tools.

Additional Resources:

- The Alberta Quality Matrix for Health: User Guide: provides a tool for understanding how quality in the health system can be measured across six dimensions.
- University of Calgary Program Evaluation Toolkit: this toolkit provides guides for planning an evaluation, collecting and analyzing data, and using findings.

Appendix G: PDSA Cycle Guide

The following questions may be used to help guide discussions during a PDSA cycle.

Meeting Date: _____

We are inviting everyone to participate in a brief discussion about how you perceived today's meeting as part of the PDSA approach we are taking to develop this program. The information you provide will be used to make immediate improvements and adjustments to collaboration and care planning until we are satisfied as a group that this aspect of the program is working well. The notes we take from today's meeting will also be sent to the evaluation team to summarize on our behalf. Your participation in this discussion is voluntary and your comments will remain anonymous in any reporting that results from this work.

Based on today's meeting, as well as any activities or connections that happened leading up to today's meeting, please respond to the following. Be brief, but provide enough context so that someone who was not at today's meeting can understand the situation.

1. In your own words, describe the collaboration that happened with the group (what did it look and feel like to you?)
    - *Please note that collaboration can mean a variety of different aspects of working together, including communication, information exchange, working environment, roles & responsibilities, process for decision making, leadership, etc.*

2. In your opinion, what worked well, and why?

- *It may be helpful to think about what should be continued or replicated in future meetings, and some of the conditions that made success possible.*

First, let's focus on what everyone thought worked well today.

Any other ideas about what made those aspects work well so that we can make effort to continue doing them or even integrate it as part of a more formal process?

3. In your opinion, were there any issues or problems? Based on this, is there anything you would do differently next time?

To begin, let's focus on what seemed to be an issue or a challenge related to the group collaborating today.

Are there other ideas about what we can do as a group to prevent some of these challenges in our next meeting?

Appendix H: Measuring Collaboration

Incorporating global, validated collaboration measurement tools is one way of consistently and reliably assessing the effectiveness of a collaborative. The table below provides some basic information on five measurement tools that were reviewed by the AHS – AMH Knowledge Exchange team for use within the CFPCN. The team scanned literature for factors that could contribute to successful collaborative team functioning and listed them in the table below. Other factors that may influence whether a team may choose to use one of the tools (e.g., standardization, cost, number of questions, permission to adapt) were also considered. Please note that this table does represent an exhaustive list of tools available.

Name	The Wilder Collaboration Factors Inventory	Collaborative Practice Assessment Tool (CPAT)	Collaboration Assessment Guide and Tool	TeamSTEPPS 2.0: Team Assessment Questionnaire	Conceptualizing and Measuring Collaboration Tool
Standardized (y/n)	Yes	Yes	No	Yes	Yes
# of questions	40	53 + 3 open-ended	78	55	17
Cost	Free	Free (permission needed)	Free	Free (permission needed)	Free (permission needed)
Scale(s)	5-pt likert	7-pt likert; open-ended	6-pt likert (4-pt in scale + N/A and Don't Know	5-pt likert	7-pt likert
Information exchange	1	1	1	1	1
Leadership	1	1	1	1	

Name	The Wilder Collaboration Factors Inventory	Collaborative Practice Assessment Tool (CPAT)	Collaboration Assessment Guide and Tool	TeamSTEPPS 2.0: Team Assessment Questionnaire	Conceptualizing and Measuring Collaboration Tool
Positive team climate	1	1		1	1
Trust	1	1	1	1	1
Relationship building		1	1	1	1
Respect	1	1	1		1
Defined roles and responsibilities	1	1	1	1	1
Shared accountability		1	1	1	1
Clear mission/mandate	1	1	1	1	1
Sense of team identity					1
Decision making/conflict management	1	1	1	1	1
Team effectiveness			1	1	1

Name	The Wilder Collaboration Factors Inventory	Collaborative Practice Assessment Tool (CPAT)	Collaboration Assessment Guide and Tool	TeamSTEPPS 2.0: Team Assessment Questionnaire	Conceptualizing and Measuring Collaboration Tool
Establish/manage community relationships	1	1			
Program sustainability	1		1		
Standard processes/screening tools					
Patient/family involvement in care		1		1	
Staff professional development/ mentorship		1		1	
# of criteria (out of 17)	10	13	11	12	11

More information on these tools can be found here:

- The Wilder Collaboration Factors Inventory
- Collaboration Assessment Guide and Tool
- TeamSTEPPS 2.0: Team Assessment Questionnaire
- Conceptualizing and Measuring Collaboration Tool

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