POLICYWISE FOR CHILDREN & FAMILIES

Continuum of Collaboration

The purpose of this paper is to summarize what we learned about the relationship between collaboration and implementation, and how this knowledge informed the importance of conceptualizing integration as a goal along a multidimensional continuum.

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CONTINUUM OF COLLABORATION

Key Messages

Through a developmental approach to the implementation of Youth Mental Health Hubs across 13 communities in Alberta, there were significant lessons learned about the relationship between collaboration and implementation, and how this knowledge informed the importance of conceptualizing integration as a goal along a multidimensional continuum. These lessons include:

- Communities can achieve early outcomes in the evaluation domains despite not being fully operational or integrated. At times, these early outcomes were overtaken by an emphasis on physical location which became an arbitrary goal and detracted from what integrated service delivery means in their local context.

- Recognition of changes to ways of working and signs that partners are moving toward integration is essential to maintain momentum and track progress in what is a multi-phased and multi-year process for many communities.

- A continuum that is reflective of organizational and practice interactions from parallel through integrated while incorporating contextual elements such as intention of engagement, complexity of needs and context, cross-disciplinary knowledge, and trust between all actors can help a community understand the changes they are experiencing.

- Incorporation of the domains of people and values, supportive structures, and operational processes provides nuanced identification and indicators of changes experienced across the continuum of collaborative practice.

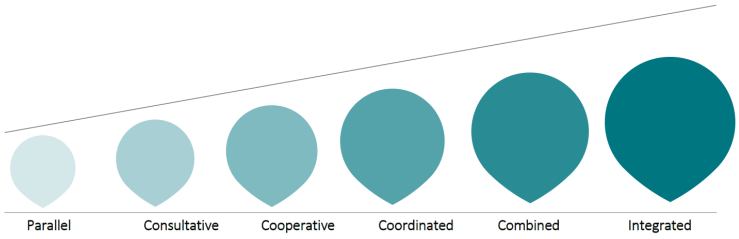
- Illustration of this continuum of collaborative practice promotes comprehensive understanding and can help communities recognize that progression towards organizational and practice integration and that provision of integrated care does not require moving immediately from current ways of working to fully integrated practices.

- The continuum of collaborative practice can provide communities, organizations, and relevant stakeholders with a concrete framework that captures the complexity of integrated service delivery and implementation.

CONTINUUM OF COLLABORATION

The Process

Based on the implementation approach and the findings from the developmental evaluations we learned how important it is to recognize different ways of working and signs that communities are moving toward integration. We initially used Boon et al.'s (2004) continuum of practice model to situate integration within the range of collaborative practice approaches. This continued to evolve based upon our review of related literature (Careau et al., 2018; Himmelman, 2002; Tamarack, 2017; Winer & Ray, 1994) and our knowledge of the integrated service delivery emerging in Alberta.

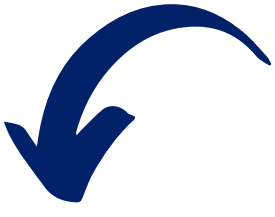


Our model defines a continuum of collaboration that identifies levels of organizational and practice interactions from parallel through to integrated. Second, our model includes significant contextual influences such as: trust, complexity, engagement, and cross-sectoral knowledge.

Implementation of an integrated initiative across the sectors of health, mental health, and community-based social services is a complex process. Once communities understood the incremental approach to achieving integrated service delivery, there was a need for support regarding how to navigate change and implementation considerations. Again, developmental evaluation provided data to inform what the implementation process looked like in each community. Using Evans et al. (2016) context and capabilities for integrated care as a guide, we were able to identify indicators of implementation along the continuum of collaborative practice.

CONTINUUM OF COLLABORATION

Continuum	*Supportive Structures*	*Operational Processes*	*People & Values*
Parallel	• Separate systems • No sharing of any resources	• Services work independently to support youth and families • Separate treatment plans • Communication driven by provider need but often siloed	• Have limited understanding of other service providers' roles • Little perceived need for collaboration
Consultative	• Separate systems • No sharing of financial resources	• Referrals made to other providers • Treatment plans might be shared • Communication driven by specific issues	• Frontline staff have contact information about other systems and know they can call with questions • Consultation based more on individual provider relationships, not by formal organizational relationships
Cooperative	• Separate systems • Human resources focus on building relationships, contacting practitioners, and connecting services • No formal information sharing	• Informal relationships across organizations • Facilitate appropriate service access on a case-by-case basis • Communication driven by specific needs	• Relationships across systems support connecting services to address specific needs for youth and families • Informal relationships among providers and organizations facilitate connecting people to services
Coordinated	• Financial or in-kind resources may be shared for certain initiatives • IT solutions may be required to confidentially share information	• Effort placed on understanding where, when, and how to connect with other services to address • Some knowledge of stepped care but not consistently practiced • Communicate about shared patients on a case-by-case basis	• Relationships across systems promote the use of case conferencing • Some provider buy-in and value placed on having needed information • Increased organizational commitment to working together



CONTINUUM OF COLLABORATION

Continuum	*Supportive Structures*	*Operational Processes*	*People & Values*
Combined	• Shared funding and resources including shared grants • Formalized communication structure to allow two or more systems to share information • Coordinator may be employed to facilitate communication and workflow across organizations and team members • Formal partnership agreements may be in place	• Shared intake processes • Meet to discuss cases • Shared decision-making to advance common vision • Each provider/system continues to make decision regarding their organizational resource allocations • Stepped care by organization • Warm handoffs are standard	• Some buy-in across systems allow for formation of a cross-organizational team • Service providers have improved understanding of each other's roles and recognize the value each service provider brings • Organization leaders supportive • Viewed as a project or program, not a long-term change in practice
Integrated	• Integrated funding, based on multiple sources of revenue • Resources shared across all practitioners • Full infrastructure required to support delivery modality (clinical, operational, and financial)	• One shared operating model • Stepped care inclusive across systems • All providers employed by same system • All patients have opportunity to be seen by a stepped care team who function effectively together	• Organization leaders strongly support integration and actively change practice • Learning culture where all Hub staff understand one another's roles, mandates, philosophies • Partnering organizations report increased willingness to work with one another, trust one another's competencies • Partnering organizations report sharing in decision making and responsibility • Integrated care and all components embraced by all providers and active involvement in practice change

Content adapted from Boon et al., 2004; Careau et al., 2018; Evans et al., 2016; Heath et al., 2013; and Tamarack 2017

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