

BUILDING COLLABORATIVE PARTNERSHIPS IN PRIMARY HEALTH CARE

by

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BGS Simon Fraser University, 2007

A THESIS SUBMITTED IN PARTIAL FULFILLEMENT OF THE REQUIREMENTS
FOR THE DEGREE OF

MASTER OF ARTS

in

The Faculty of Graduate Studies

(Educational Studies)

THE UNIVERSITY OF BRITISH COLUMBIA

(Vancouver)

April 2013

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Abstract

Collaboration is an increasingly adopted strategy for addressing many of society's most complex and pressing public challenges. The General Practice Services Committee's Divisions of Family Practice initiative offers a rich example of collaborative partnerships in action within the context of the primary health care system of British Columbia. Divisions of Family Practice are community-based nonprofit organizations consisting of family physician members. Division members work in partnership with health authority administrators and other community organization representatives with the goal of working at local and regional levels, through collaborative processes, to co-design locally feasible solutions for better delivery of primary health care services leading to improved provider and patient satisfaction. The research focuses on the question, "How can Divisions create and sustain effective collaborative practices"? This question is explored through a practitioner inquiry. The inquiry includes: a description of the General Practice Services Committee and the Divisions of Family Practice initiative; a review of the relevant literature; observations and reflections on the experience of collaborative process within the Divisions initiative from my perspective as an administrator supporting the initiative; and concludes by suggesting that further study in the areas of initiative sustainability, inclusive patient involvement, and a more culturally diverse leadership would be beneficial. The findings of the inquiry support the notion that educating about the processes of collaboration, the inherent obstacles and challenges, and the role of the behaviours of the participants, are instrumental in supporting effective collaborative partnerships. The inquiry has informed the second part of thesis, a participation guide and process handbook designed to share a model, processes and tools to foster the collaborative work of the Divisions and their partners.

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List of Abbreviations

BC - British Columbia

BCMA - British Columbia Medical Association

CSC - Collaborative Services Committee

DOI - Document of Intent

GPSC - General Practitioners Services Committee

HA - Health Authority

MOH - Ministry of Health

PDO - Provincial Divisions Office

PDSA – Plan Do Study Act

PEL - Physician Engagement Lead

Acknowledgements

I would like to acknowledge the contribution of the members of the Divisions of Family Practice and the GPSC. Your consistent and persistent commitment to your work and your full-hearted engagement with the collaborative process has informed the foundation of this study. I am indebted to my fabulous colleagues; your generosity in sharing your experiences, wisdom, encouragement and laughter are present on these pages.

I offer my sincere appreciation to my wonderful committee: Shauna Butterwick for guiding and directing this process so skillfully and for continually grounding my perspective; Tom Sork for your thoughtful insights and for introducing me to the 'NA' rule; and Brian Evoy for your constant encouragement and keen observations.

I am most grateful to my friends and family – each of you have shaped the person that I am and have made this journey possible. To Evelyn, Laurie Lee, Carolyn, and Tracy; when fog clears and consciousness awakens we begin to see our purpose in the world and our spirit is refreshed, a circle completes.

Chapter One: Introduction

Goals of the Study

Collaboration is an increasingly adopted strategy for addressing many of society's most complex and pressing public challenges. One reason for this is the growing understanding that in order to respond and reach positive outcomes to challenging social issues stakeholders across many organizations must work together to design solutions (Bryson, Crosby, & Middleton, 2006). I work with the General Practice Services Committee's Divisions of Family Practice initiative. Divisions of Family Practice are community-based nonprofit organizations consisting of family physician members. Division members work in partnership with health authority administrators and other community organization representatives with the goal of working at local and regional levels, through collaborative processes, to co-design locally feasible solutions for better delivery of primary health care services leading to improved provider and patient satisfaction.¹ This is an environment that offers a rich example of collaborative partnerships in action within the context of primary health care reform in British Columbia. Promoting and facilitating sustainable quality primary care, and based on a collaborative framework, the aim of the initiative is to "connect all citizens to physicians who are working with each other and their partners to build healthy communities" (*Divisions of Family Practice Strategic Action Plan*, 2013, p. 2).

The growth and maturing of the Division of Family Practice initiative offers a valuable opportunity to identify the significant learning that organizations partnering in collaboration must undertake in order to engage in a collaborative process. Once identified, the translation of this learning may enhance the potential for success through the introduction of proactive mechanisms for attending to challenges in areas such as: building relationships, managing expectations, setting priorities, solving problems, making decisions and resolving conflict. Adding knowledge in this area may enable partners to have more enthusiasm and insight into the potential/possibilities of their collaborative work ultimately leading to improvement in patient and health practitioner satisfaction. In addition, strengthening the work of the divisions and adding to the collaborative process literature may have broader application of informing researchers, practitioners and policy makers alike, influential in affirming existing understandings, while also contributing additional insights regarding the theory and practice

¹ The Divisions initiative is explained more fully in Chapter 2.

of collaboration. My interest at this stage is to write a thesis that will inform both practitioners and academics. I draw on the experience I have gained through my supporting role with the Division of Family Practice Initiative providing guidance, support, and strategic advice to assist each Division of Family Practice build their capacity, create effective partnerships, and promote inter-organizational networks and shared learning.

This thesis is organized in two parts. The first part is written in a traditional style and is comprised of four chapters. The second part of the thesis contains a collaborative process handbook and resource guide. This first chapter includes my research goals, research questions, positionality, conceptual framework, and methodology.

Research Questions

Recognizing that collaboration is a process utilized to help solve difficult problems both across and within organizations my main research question is: How can Divisions create and sustain effective collaborative practices? Sub-questions include:

- 1) What is meant by collaboration?
- 2) What are the benefits and value of collaborating?
- 3) What conditions make for successful collaboration?
- 4) What conditions make it problematic?
- 5) What does effective collaboration look like and how do we know when it is occurring?

Researcher Positionality

I work with the Provincial Divisions Office (PDO) in the role of Strategic Initiatives Lead. I work closely with the Executive Lead and the Physician Engagement Leads in guiding members of a Division of Family Practice through the process of becoming an incorporated self-sustaining nonprofit society. It is also my role to provide ongoing strategic support to both Divisions of Family Practices and the provincial division's team through the design, development and delivery of governance, operational (financial and administrative), information and technology, and strategic frameworks, resources, and trainings. It is our goal to ensure that members of each division have the flexibility to develop their organization according to their local community strengths and healthcare needs. When working with the physicians involved in the Divisions initiative I see my role as one of fostering a climate that encourages and supports learning. I do this in several ways. First, recognizing physicians as

adult learners who carry vast experience and who have much to contribute I facilitate a self-directed process allowing for their own knowledge, experience and interests to guide their learning. Second, by providing information and tools that may assist in accomplishing their goals. Third, by strengthening their capacity by showing how they can apply these tools in similar and/or differing scenarios; and finally, I support the physicians to be self-directed and to make their own decisions.

I bring to this work twenty-five years of experience as an adult educator, community developer and program designer. Several of these years I spent as a community health educator raising awareness of issues relating to HIV and AIDS. Much of this time I was frustrated by the inability of policy makers and funders to expand their contributions beyond technical responses to include solutions and policy changes that asserted the value of all human experience. Growing from this early work I continue to articulate public health policy as a social justice issue. Policy is more than a document - it encompasses both process and product. "It involves the production of the text, the text itself, ongoing modifications to the text and processes of implementation into practice" (Taylor, Rizvi, Lingard & Henry, 1997, p. 2). I strive to raise critical consciousness and propel social change through policy activism. I am comfortable aligning myself with Yeatman's (1998) descriptions of policy activists and policy activism: a policy activist being one who champions a "value orientation and pragmatic commitment" to the policy process and activism being "a publically declared and open contribution to political life. It is a commitment, a statement of vision, declaration of values and offering of strategic action, all of which are publically declared" (p. 34). Also, like Yeatman, 'as a policy activist and a policy intellectual I am prepared to be 'publically accountable for my ideas and locate them within processes of public learning" (p. 34). Further, I believe that engaging a reflective process is a valuable learning tool in my endeavors helping to highlight the ways my assumptions and behavior may impact my work (Watt, 2007). Guided by the traditions of emancipatory theories, I am comfortable emphasizing the significance of lived experience and theories that can be shared in everyday conversation over abstract and obscure theories that are not able to transform because they are not directed at daily life (hooks, 1994). Lather explains that when theory is embedded in everyday life, it "then becomes an expression and elaboration of politically progressive popular feelings rather than an abstract framework imposed by intellectuals on the

complexity of lived experience” (1991, p. 267). Practitioners need accessible language and tools to translate general theories into practical knowledge and skills.

The Divisions initiative is a unique opportunity, where the stars have aligned to bring policy makers and practitioners together to work to reform the delivery of primary health care in our province. I am eager to support and help grow this work in a manner that attends to critical inquiry and joins the “hidden contexts that undergird human organizational systems in order to confront resistance and conflict” (Mullen, 2004, p. 48) to form a socially just response during this time that policy makers and funders have the political will to embed a shift in the system.

Conceptual Framework

This work draws on several distinct, yet overlapping orienting frameworks. Critical theory with its aim of social justice and transforming the social context (Bensimon & Marshall, 1997; Alvesson & Skoldberg, 2009), and feminists theories which “shift the focus of teaching for a critical consciousness from an emphasis on rationality to one that emphasizes learning through relationships and affective ways of knowing” (Taylor et al., 1997). Key to both critical and feminist theories is the utilization of reflexivity as a practice for assisting the researcher to inform and build upon current work and to maintain values and integrity in scholarly work by moving back and forth between past and present experiences and insights. Further, to ground this framework I will draw on the adult learning praxis of Paulo Freire which stresses action and subsequent reflection in the learning process as well as the principles of collaborative working to solve problems of local importance, continuous capacity building, and investment in relationship and trust building embedded in community development theory (Frank & Smith, 1999).

I embed this work within an empowerment framework as it helps us understand the process of gaining influence over conditions that matter to people who share experiences or concerns (Fawcett, Paine-Andrews, Francisco, Schultz, Richter, Lewis, ... & Lopez, 1995). Israel, Checkoway, Schulz, and Zimmerman (1994) construct empowerment at three levels of practice. The first level of individual empowerment “refers to an individual’s ability to make decisions and have control over his or her personal life which “incorporates the development of critical or analytical understanding of the social and political context and the cultivation of both individual and collective resources and skills for social action” (p. 152). The second

level is organizational empowerment. Drawing largely on democratic management principles this level explores where members of empowered organizations “share information and power” and how this, consequently, leads to empowering “individuals as part of the organizational process” thus increasing both the individuals’ control within the organization and the organization’s ability to influence policies and decisions in the larger community (p. 152). The third level is community, where individuals and organizations make collective efforts to gain increased influence and control over decisions and changes in the larger social system – creating capacity to solve problems and equity in gaining a fair share of resources (p. 152).

For the three levels to be successful requires the framework above to be expanded to incorporate the concept of reflexivity in direct relation to the professionals participating in empowerment practice. Lather (1991) explains, “empowerment is a process one undertakes for oneself; it is not something done ‘to’ or ‘for’ someone” (p. 4). Simon (1990) expands on this notion when he states that empowerment is a “reflexive activity, a process capable of being initiated and sustained only by the agent or subject who seeks power or self-determination. Others can only aid and abet . . . by providing a climate, a relationship, resources, and procedural means through which people can enhance their own lives” (as cited in Starkey, 2003, p. 278). I am interested in how we can engage our experiences of empowerment or disempowerment in our processes of empowering others. I work to identify strategies to assist in empowering and also to stop disempowering actions in order that we may learn to work more effectively within systems and start to unmask and respond to systemic problems and answer how empowerment is central to collaboration?

Methodology

In this practitioner inquiry I have engaged in a careful and considered reflection of my practice combined with a review of the concepts and processes of collaboration as found in the literature. As a scholar practitioner I use theory to inform my practice and allow my reflections upon my practice to inform theory (Horn, 2002, p. 101, as cited in Mullen, 2004, p. 47). I strive to “inquire in a disciplined manner” (Mullen, p. 49) in order to contribute a balanced and pragmatic view between scholar and practitioner and to integrate insights from both theory and practice into this work. As Patti Lather (2006) counsels “layering complexity, foregrounding problems, thinking outside easy intelligibility and transparent

understanding, the goal is to move educational research in many different directions in the hope that more interesting and useful ways of knowing will emerge” (p. 53). I'm interested in the nature of social structures and the role of agency in the production of meaning in changing social systems.

The research undertaken aligns with an identified gap in my professional work and my academic learning goals. This study assists my work and the work of those I support as collaboration is a new way of working for the partners and they have minimal resources to draw on to design collaborative processes to guide their work. The goal of my project is to provide a framework and identify tools that can support the partners in gaining practical knowledge and skills in order to improve the quality of their collaborative experience. My methods are both analytical and generative. For the analytical portion of my project chapter 3 documents a thorough review of the relevant literature in several parts culminating in the following:

- a review of the definitions of collaboration
- an examination of models of collaboration and how they are used in cross organization environments
- an analysis of the value and complexity of employing collaborative processes and determining what the experience would look like at its best
- an exploration into building collaborative relationships and processes

The generative portion of my study is informed by the literature review and also my lived experience working within the Divisions of Family of Practice initiative. I draw on my observations and reflections recorded in my journal notes from meetings with Divisions and team members in addition to conversations with colleagues. Peer debriefing and corroboration have been embedded through the process by having peers respond to my interpretations and conceptual thinking throughout this project (Morse, Barrett, Mayan, Olson, & Spiers, 2008).

The thesis is comprised of two parts; the first is traditional in style. In the next chapter I provide detail on the origin of the General Practice Services Committee, its role in the effort to reform primary health care delivery in British Columbia, and describe the context of the Division of Family Practice Initiative. The third chapter is a review of the relevant

collaborative theory and practice literature predominantly in the areas of inter-organizational collaboration between public and nonprofit organizations with specific attention given to the fields of healthcare, organizational studies and community development. The final chapter draws on particular observations and reflections of my work with the many Divisions of Family Practices and their engagement in the collaborative process; I identify common challenges and offer strategies to address them. The second part of the thesis is a collaborative process handbook and resource guide that is informed by both the literature and my practice and presented in order to share a model, processes and tools to foster the collaborative work of the Divisions. It is formatted in the style of a resource guide and is intended to be distributed to those interested in learning more about collaborative processes.

Chapter Two: Background and Context

Background

The morale of family physician's working in full service family practice in British Columbia was in significant decline in the mid 1990's (Mazowita & Cavers, 2011, p. 3). This situation was precipitated by major public-sector reforms undertaken by provincial and federal governments. Of these reforms the "health-care sector was one of the more visible and contested areas" (Church & Smith, 2008, p. 218). Key changes, such as the rapid adoption of regional health authorities in most provinces, were undertaken with relatively limited input from physicians. For example, Church and Smith state that the regionalization of the health system in Alberta "eliminated existing local physician governance structures involving decisions about hospital privileges" and that without these "structures in place, local physicians felt out of the decision-making loop" (p. 232). Mazowita and Cavers identify additional reasons for the decline in morale. Some examples are higher compensation for specialists than for general practitioners, an increasingly complex workload, and cost restraints affecting health care services in general (p. 3). Consequences of family physician disconnection and low morale was being evidenced by fewer medical residents choosing to enter family medicine practice and increasing numbers of family physicians limiting or leaving full-service family practice completely (Mazowita & Cavers). The increasing number of family physicians retiring or nearing retirement age intensified this problem. These factors have resulted in fewer primary care physicians working in full service family practice than are required to meet the needs of the province's patient population. According to a 2003 Statistics Canada Survey 2.9% of British Columbians (101,700 people) had not been able to find a family physician (*Primary Health Care Charter: A Collaborative Approach*, 2007 p. 5).

The state of the family physician profession and patient access to primary care physicians are not the only elements stressing the healthcare system. Additional stressors include a rapidly aging population and the rising demand for appropriate services to meet the unique needs of this population, alongside the rising burden of managing chronic diseases (i.e. diabetes, depression, hypertension, congestive heart failure) common in older populations (*Government of British Columbia Ministry of Health 2010/11 – 2011/12 Service*

Plan, 2010). These current and future challenges demand a vibrant and sustainable primary care system. Starfield, Shi, and MacInko (2005) explain that evidence not only illustrates that primary care helps prevent illness and death but also “shows that primary care (in contrast to specialty care) is associated with a more equitable distribution of health in populations” (p. 457). To prepare for the increasing demand of eldercare and chronic health needs numerous government policy documents have begun to recognize the essential role of primary care in creating a viable and sustainable health system. For example: “The Ministry of Health’s Service Plan, the Medical Services Division’s Strategic Plan, health authority plans, and the B.C. Government/British Columbia Medical Association negotiated agreement have all underscored the need to shift the system from an acute/episodic orientation towards planned/proactive care” (*Primary Health Care Charter: A Collaborative Approach*, p. 1, 2007).

The British Columbia Ministry of Health’s (MOH) strategic direction, as set out in the 2010/11 – 2011/12 Service Plan, concentrates on the “great potential in primary health care to improve the health of the population and contribute to the sustainability of the health system” (2010). The 2007 British Columbia Primary Health Care Charter: A Collaborative Approach (the Charter) also outlines this new direction. The Charter asserts that Primary health care is considered a key strategy of the MOH to meet the service plan goals of improved health and wellness, high quality patient care and a sustainable, affordable, publicly funded health system. The Charter also outlines the objectives and guiding principles of the health system reform model as follows: “to improve individual and population health outcomes: to increase value for patients; to focus on priority populations; to transform clinical, practice, system, and information and technology practices; to support the active involvement of many in stakeholder coalitions, negotiations and provider relationships” (2007, p.14).

To reform health care strategy from ‘acute/episodic’ to primary care the MOH has embraced an approach outlined in the *Primary Health Care Charter* (PHCC) “founded on evidence-based best practices for quality improvement in primary health care” (2007, p. 15). It employs a patient-focused methodology where analysis of the population’s needs is paired with an evidence review to determine care gaps and opportunities for improvement to inform system transformation and increase the strength and sustainability of the provincial health

care system. Further, “this “approach provides an adaptable, evolutionary, and collaborative model involving top-down (system redesign) and bottom-up (practice redesign) components” (PHCC, p. 15). The system redesign focuses on the “realignment of health care services, strategy, legislation and policy, provincially and regionally, to better support better primary health care” (PHCC, p. 15). Practice redesign focuses on “supporting family physicians, their practice staff and other health professionals to innovate, improve practice changes that result in better professional satisfaction and improved patient health outcomes” (PHCC, p. 15). Necessary for both system and practice redesign is the existence of strong relationships between family physicians and health system managers.

Two important organizations in enabling system and practice redesign are the British Columbia Ministry of Health (MOH) and the British Columbia Medical Association (BCMA). The MOH “provides direction, support, and funding; creates legislation; negotiates fees and wages; and sets province-wide goals, standards, and expectations for service delivery” (Mazowita & Cavers, 2011, p. 4). The BCMA is the professional organization of physicians in BC and negotiates on behalf of physicians for fees and benefits paid by the provincial health insurance program in addition to promoting “adequate physician compensation, solutions to increasing job stress and complexity and the best patient care”(Mazowita and Cavers, p. 4). These sometimes competing positions have often led to the BCMA and BC government relations being characterized by “animosity and confrontation” (Mazowita and Cavers, p. 4). In 2009 an initiative, outlined below, sought to transform this relationship and facilitate a new policy direction in health system redesign.

The GPSC: Reviving/Revitalizing the Family Practice Profession

The General Practice Service Committee (GPSC) was established in response to the escalating challenges facing the primary health care system in British Columbia and is responsible for leading primary health care reform. Formed in 2003 as a partnership between the British Columbia Ministry of Health (MOH) and the British Columbia Medical Association (BCMA) the GPSC aims to “improve the existing system through gradual but transformative change from within, largely based on what primary care doctors said they needed in order to better serve their patients” (Mazowita & Cavers, 2011, p. 4). Further, “at the heart of such reform was a conviction that the doctor – patient dyad – a long-term relationship built on trust and forged over time – is the critical attribute of successful primary

care” (Mazowita & Cavers, p. 5). The work of the GPSC is undertaken by family physicians and government representatives meeting together to determine primary health care priorities and to distribute resources to primary care providers with the mandate of “finding solutions to support and sustain full-service family practice” (*GPSC Annual Report*, 2010, p. 2).

Based on partnership and collaboration the GPSC models a new way of working together for its member organizations. The philosophy of the GPSC is focused on solutions designed with an emphasis on the patient experience. GPSC Co-Chair Dr. William Cavers explains that when “we started talking about what worked from the patient’s perspective, not the doctors’ or the government’s, but what actions would lead to better patient care and experiences, that is when the work of the GP Services Committee truly came together and we started to make a difference” (as quoted by Mullens, 2010, p. 19). Building on the partnership and collaboration model, health authority officials and other stakeholder representatives, participate as guests in GPSC meetings. The decisions of the GPSC are informed by the perspectives and contributions of all members and guests; significantly, all decisions of the GPSC are made by consensus. Guiding the work of the GPSC and utilized as a lens to measure existing and new programs are several evidence-based initiatives of the Institute for Health Improvement. First is the Triple Aim initiative. The impetus of the Triple Aim is to ensure that the design of any new health delivery program accomplishes three goals: improves patient and provider experience, improves population health, and contributes to the financial sustainability of the health care system (*GPSC Annual Report*, 2010, p. 4). Second is the Model for Improvement (Langley, Moen, Nolan, Nolan, Norman, & Provost, 2009). This model is a tool for accelerating improvement by setting aims, establishing measures, selecting changes and then testing the changes on a small scale using the Plan Do Study Act² (PDSA) cycles. The third and final initiative is the Framework for Spread. The aim of this initiative is to “implement a system for accelerating improvement by spreading change ideas within and between organizations” (Massoud, Neilson, Nolan, Schall & Sevin, 2006, p. 1). In addition, the GPSC requires external evaluations of all its initiatives. The

² The Plan-Do-Study-Act (PDSA) cycle was originally developed by Walter A. Shewhart as the Plan-Do-Check-Act (PDCA) cycle. W. Edwards Deming modified Shewhart's cycle to PDSA, replacing "Check" with "Study." Deming, (2000), explores the benefits of cooperation rather competition in management styles. The Plan Do Study Act cycle is similar to Kolb’s Learning Cycle found in adult education learning theory.

desire to advance these initiatives along with the creation of the new partnership between government and family physicians endorse the development of collaborative strategy.

In the spirit of cultivating this new way of working in collaborative partnership and with the mandate to improve the morale within the family physician profession, the GPSC sought out the voices of British Columbia's family physicians. The Professional Quality Improvement Days (PQIDs) of 2004 and 2005 is one example of the GPSC attaining the benefits of physician inclusion in policy planning. The PQIDs involved consultation with over 1000 BC family physicians concerning patient care and physician professional satisfaction. Through this process the GPSC learned that family physicians felt isolated, undervalued, underpaid, and poorly supported. In response, the GPSC developed several initiatives designed to align with each other and improve the experience of full service family physicians³. These include the Full Service Family Practice (FSFP) initiative which makes available financial incentive payments for full service family practice coverage providing, for example, chronic disease management, complex and maternity care; and the Practice Support Program (PSP) an initiative that provides clinical training programs to enhance skills and to promote practice redesign. The goal is to reward physicians and to help them provide continuous comprehensive care particularly to patients who are chronically ill or have other complex health conditions (Mazowita & Cavers, 2011).

In addition to implementing the financial and training incentives, the GPSC investigated related responses to similar health system challenges experienced nationally and abroad. Through this process they learned of several innovative formulations of family physician member organizations in the UK, Australia and New Zealand founded to promote the strengthening of physician professional satisfaction and improving primary care. Drawing on these models and joining with inspirational local primary health care projects developing in several BC communities, the GPSC created the BC Divisions of Family Practice (Divisions) initiative. The following figure shows the organizational structure of the GPSC and relationships of several of the initiatives. The focus of my study is limited to the Divisions of Family Practice initiative.

³ Full service family physicians are "general practitioners who provide primary care throughout patients' life span. They coordinate care and maintain longitudinal, comprehensive patient records." (Mazowita & Cavers, 2011, p. 3)

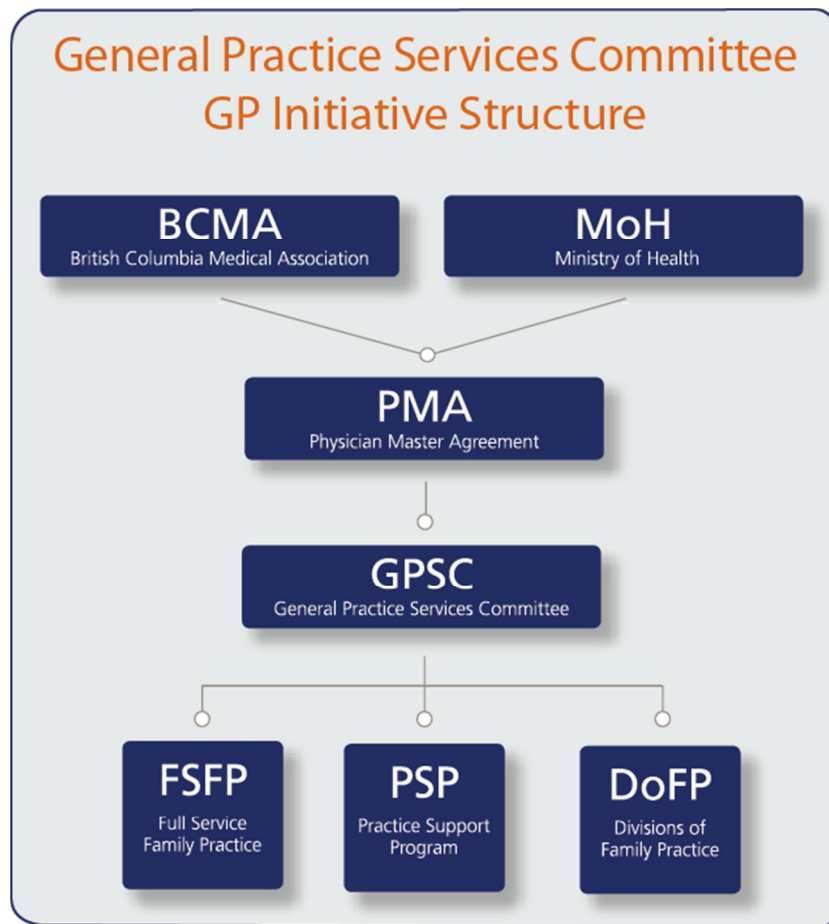


Figure 1. Organizational Structure of the GPSC

Divisions of Family Practice

A Division of Family Practice is a GPSC funded geographically bound nonprofit society created at local and regional levels, whose membership consists of family physicians. Divisions “provide a collective voice and network for isolated family doctors. This increases their influence on health care delivery and policy in their community, and makes them better able to work together to address gaps in patient care” (Mazowita & Cavers, 2011, p. 5). Divisions exist with the understanding that successful change strategies need to recognize the interdependent nature of primary health care, whereby strategies are best generated and sustained by policymakers and practitioners working in partnership. The process of forming, developing and supporting Divisions, and their relationship to their partners, is critical to their uptake and success. “Divisions are voluntary and based in mutual agreement rather than imposed on physicians in a top-down manner. Decisions are made by consensus rather than

by majority vote or resort to third-party arbitration. This reflects community development principles and ensures maximum levels of ownership, buy-in and support” (Brian Evoy, personal communication, April, 2011). The GPSC initiatives are created as “voluntary but irresistible”⁴. Although, some “family doctors view the ever-expanding number of incentives and support programs as simply more demands on their time” (Mazowita & Cavers, p. 13), there has been substantial uptake of the Divisions initiative by family physicians. As of March, 2013 thirty-two Divisions of Family Practice exist, representing 127 communities in BC (“Divisions,” n.d., para. 1). The number of Divisions is estimated to reach thirty-five by March 2014.

The first Divisions were formed in 2009. Family physicians in three communities – Abbotsford, Prince George, and White Rock South Surrey - agreed to prototype the Division of Family Practice strategy. The communities were selected by the GPSC because family physicians in these communities had already taken it upon themselves to work in partnership with other allied health professionals to create and establish local programs designed to improve primary health care services. Importantly, these family physicians were motivated to establish partnerships with the health authorities and the MOH as a strategy to gain access to both higher level policy makers and additional resources required to realize their goals. For example, the GPSC provides funding for physicians’ contributions and services provided through a division in the form of infrastructure funding for the forming, establishment and ongoing management of a division. There is also the potential to access additional MOH or health authority resources for programs and projects supporting the design and implementation of health related services. Although motivated, they were at the same time reluctant to join due to difficult past events that caused a diminishment of trust and deteriorated relationships with the MOH and the health authorities. The collaborative framework was instrumental in gaining the participation of physicians in the prototype communities because of its potential to promote partnership building through the process of joint decision-making and ongoing assessment and modification of health systems related policies and practices. The resulting model continues to be implemented through the Divisions of Family Practice initiative.

⁴ This term was coined by Dr. Dan MacCarthy and means that physicians have a choice to join in the initiative and the benefits are such that it is more advantageous to become involved than to not participate.

The Forming of a Division of Family Practice

The formation and ongoing development of the Divisions of Family Practice are supported by the Provincial Divisions Office. The PDO team consists of the Executive Lead, six Physician Engagement Leads (PELs), administrative, communications, and technology support teams, and the Strategic Initiatives Lead, see figure below.

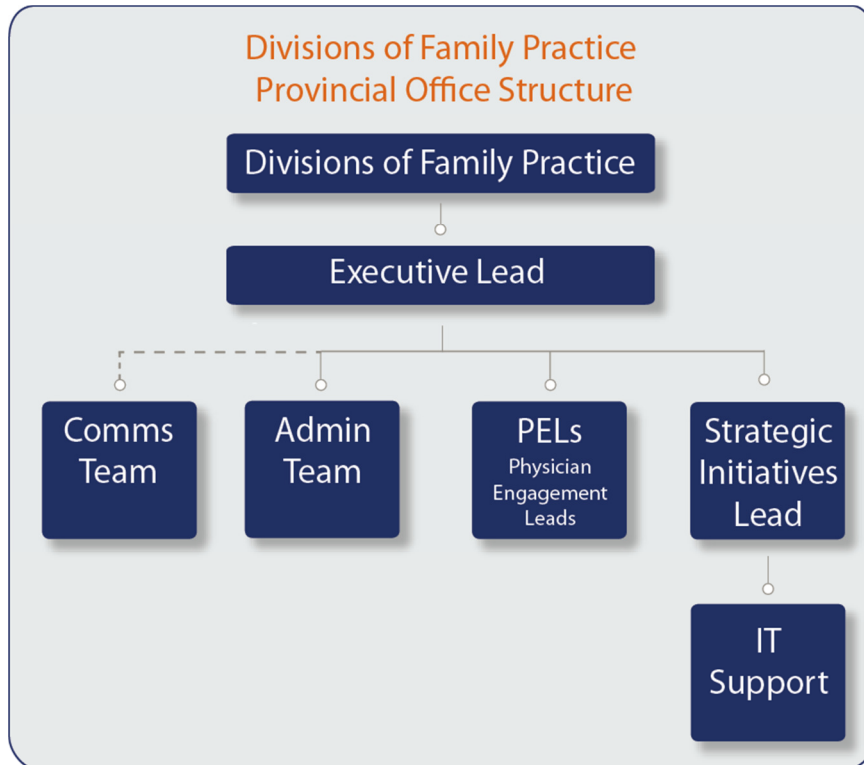


Figure 2: Structure of the Division of Family Practice Provincial Office

In the process of developing Divisions of Family Practice, the PDO works within a four phase framework encompassing the Initial, Incorporation, Establishment and Ongoing phases as shown in Figure 3. Following is a description of each phase.

Initial Phase

The initial phase of forming a Division consists of three parts: an expression of interest, an information meeting or series of information meetings, and a meeting or series of Document of Intent (DOI) meetings. The Divisions initiative, as a practice, does not solicit family physicians in the creation of a division of family practice. This policy is based on the philosophy that the process will engender more trust, and the physicians will engage more fully and take more ownership of the initiative, if they are not convinced to participate, but

rather, are inspired to become involved on their own. The PDO does not engage in any recruitment campaigns or outreach programs to engage physicians but rather responds when physicians reach out. Interest is generated by word of mouth. Physicians involved in divisions often share with their colleagues the benefits and accomplishments of their division through casual conversations. Thus, the initial phase is initiated when the PDO receives an ‘expression of interest’ from a family physician or group of family physicians from a specific community or broader geographical region. The expression usually takes the form of an email or phone call to the PDO from a physician inquiring about the initiative and how to become involved.

There are two streams of interest for forming divisions: urgent and emergent. Divisions form under urgent conditions when there is a crisis existing in a local health system which is threatening the effective delivery of primary care. For example, a high number of physicians leaving a hospital coverage program can add extensive stress to the lives of the remaining physicians. In this stream, physicians recognize that the formation of a Division can expedite the establishment of partnerships with the health authority and the MOH which can, in turn, facilitate an accelerated response and solutions to alleviate the critical situation. Emergent divisions form when there is not necessarily an eminent crisis, but, rather an interest and willingness on the part of physicians to become involved in the initiative in the hopes of gaining the professional benefits and health system improvements they have the potential to affect. In this case there is no urgency to establish partnerships. In both scenarios the physicians come to the table at least somewhat skeptical, if not openly cynical; a position often warranted due to physicians’ previous adversarial experiences within the health system.

Once an expression of interest is received the PDO provides detailed information about the Division initiative to the physician(s) and an offer is extended for a visit to the community to conduct an information meeting. If there is little or no interest they are informed that it is possible to re-engage at any time in the future. If there is interest they can choose to proceed to the next stage – holding an Information Meeting. It is the role of the local physicians to invite physician colleagues working in their community to attend the Information Meeting and the role of the PDO to arrange for the Executive Lead and Physician Engagement Lead along with representatives of the health authority and GPSC to attend the information meeting. During the meeting it will be the physicians in attendance

who determine whether they want to move forward with forming a Division. If there is no interest in forming a Division it is reiterated that they are welcome to re-engage again any time in the future. If they would like more time to consider the opportunity, or if they would like to invite additional physicians to become involved in the process, a second information meeting is offered. Alternately, if the group decides to form a Division a smaller group is selected from the physicians in attendance to participate in the next stage - the process of reviewing and signing the Document of Intent⁵.

The DOI stage is the convening of a collaborative relationship. The process is facilitated by a PEL and begins with a group of local physicians along with representatives of the local Health Authority, GPSC, MOH and BCMA (the partners) reviewing and signing into an aspirational agreement entitled the Document of Intent. The DOI is a compact between the partners supporting the establishment of a Division of Family Practice in the respective community. It articulates a new social contract between the partners, one that mirrors the process of the GPSC but at the local level. Notably, the DOI acknowledges the role of family physicians as the “cornerstone of Primary Care” and states that the partners to the DOI committed to working together and “are dedicated to improvement in access to primary care... and believe a sustainable primary care system is one where there is the least possible distance between the clinicians who deliver care and policy makers” (page 2, Appendix A, DOI Version 16).

The DOI establishes that the vehicle for bringing policy makers and clinicians closer together is the formation of a Collaborative Services Committee (CSC). The mandate of the CSC is for the partners to work as equals, through collaboration and consensus, each empowered with full decision-making authority and each contributing data, expertise, experience and knowledge from their respective organizations. The partners bring their issues, not solutions, to the CSC table and together, utilizing the Triple Aim framework, Process for Improvement and Framework for Spread, decide which issues to advance and which potential solutions to pursue⁶.

⁵ To date, only one community has not followed up from the initial stage.

⁶ It is important to note that although the CSC is defined at this stage the CSC it does not actually begin to meet until later in the process. It forms only after the division has had time to become established and has engaged their members in order to identify the issues of highest priority as defined by the members. Only once one or more of the priority issues identified by the members of the division is considered complex in

This stage is complete on the signing of the DOI by the group of local physicians, the Chief Executive Officer of the local health authority, the Co-chairs of the General Practice Services Committee, the Chief Executive Officer of the British Columbia Medical Association and the Assistant Deputy Minister of the Ministry of Health. Once complete the PDO team continues to work with each Division through the subsequent Incorporation, Establishment and Ongoing phases.

Incorporation, Establishment and Ongoing phases

The Incorporation Phase begins after the signing of the DOI is complete and with the identification of the founding members of the Division (usually the same as those who signed the DOI) agreeing to form a non-profit society. This phase involves a series of meetings facilitated by the Strategic Initiatives Lead and a PEL. The meetings are focused on developing and submitting the society's constitution and bylaws and other supporting documents required by the British Columbia Registry Services. Additionally, during this phase the founding board members begin to consider policy development and the hiring of Division support personnel. This phase converts to the establishment phase once the Registry Office returns the Certificate of Incorporation. The establishment phase consists of board orientation and development in the areas of governance, administration, financial and communication systems as well as membership recruitment and engagement strategies. Continuing the work begun in the incorporation phase, the ongoing phase emphasizes providing support to the division in the areas of organizational development, strategic planning, program development in addition to assisting the division in establishing and participating in collaborative partner and stakeholder relationships. Following is a diagram illustrating the stages of development for a Division of Family Practice.

nature or involves patient care, (i.e. issues that can't be solved by the physician community alone) does the CSC begin to meet.

For example, a division wouldn't need to establish the CSC to arrange for ordering stationery and medical supplies at a bulk discount for their members, but it would in order to consider changing how home care is allocated in the community. Any change to patient care requires involvement of the partners as the change may affect how physicians work in a health authority facility or how physicians are compensated by the Ministry of Health.

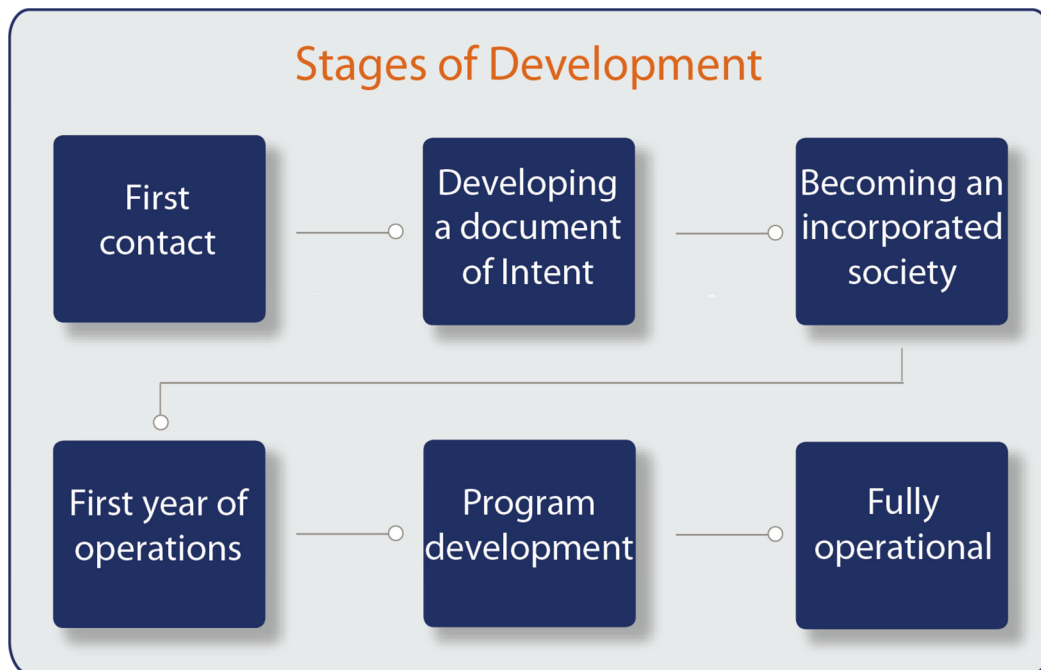


Figure 3: The Stages of Development of a Division of Family Practice

The Vision

The work of the GPSC, and by extension the Division of Family Practice initiative, is a dedicated undertaking by the MOH and the BCMA to create a sustainable health system; to commit to increasing physician involvement in designing health services; to increasing the effectiveness of health delivery systems; and ultimately to improving public health practices.

This initiative:

Envisions vibrant, effective Divisions of Family Practice firmly connected with and accountable to their communities. Ultimately, all family doctors will join the division and collaborate effectively with the health authorities on innovative solutions to regional health problems. With each success, trust will build and generate momentum and enthusiasm for addressing more complex issues, enabling the public to reap ever greater value and responsiveness from the local health care system. Divisions might even operate emergency departments or entire hospitals.

On a larger scale, the GPSC foresees a patient-centered system informed by population health. Among its attributes would be patient empowerment,

strong patient input, strong Dr.-patient relationships, self-management support for patients, and integration with public health. Allied health teams would develop and deliver services as close to the “clinical rockface” as possible. Every citizen in BC who wants a primary care provider could have one.
(Mszowita & Cavers, 2011, p. 15)

Recognizing the inter-organizational interdependence characteristic of public health, the vision articulated in the Primary Health Care Charter is to embed, through the collaborative relationship of the partners, effective and locally feasible solutions for better design and delivery of health care services contributing to improved population health and the sustainability of the health care system. In chapter four I will highlight some of the accomplishments of divisions and also identify some of the challenges that have been experienced as well as contribute observations and reflections on the process.

In this chapter I have told the story of the origin of primary health care reform in BC and described in detail how the GPSC and its initiatives play a predominate role. I have also described the collaborative strategy and tools that have been adopted to help move this work forward. This background frames a significant portion of the second part of this thesis. The next chapter is a review of the literature where I investigate the meaning of collaboration, frameworks that have been developed as collaborative models, the value of using collaborative processes and the complexities and challenges inherent in their use. My intent is to help advance collaborative endeavors by providing a common understanding of what collaboration is, and what collaboration is not, resulting in a shared understanding of collaboration.

Chapter Three: Literature Review

Introduction

My background in community development has taught me that you get further faster when you work with others. I have witnessed collaborative partnerships where all parties share knowledge and resources that are essential to achieving effective outcomes. This way of working together nurtures relationships to create networks connecting people and resources. Such environments foster a cooperative competition that benefits the whole. Here, all parties are motivated to actively contribute to solutions to complex problems. These collaborative processes hold the potential to break down professional isolation, creating peers/colleagues amongst seemingly disparate parties; where their interdependence becomes a strength rather than a weakness. This is a hallmark of collaboration. I have also witnessed collaborative partnerships that have been limited in their accomplishments. Where relationships have become adversarial and the processes mired in inertia. This review of the literature is an inquiry into the factors that create conditions for success and the factors which may make the process problematic.

As I embarked on research for this work I found that studies on collaboration are proliferating among a number of academic disciplines such as organization studies, public policy and administration, economics, nonprofit management, healthcare, education, and the natural environment (Selsky & Parker, 2005). Although much of this research has increased the knowledge of collaboration the breadth and scope has also created a challenge for those trying to integrate the findings, recommendations, theories and practices (Foster-Fishman, Berkowitz, Lounsbury, Jacobson, & Allen, 2001). Characteristic of this literature is a proliferation of research paradigms, theoretical perspectives, and sectoral foci from which the subject is advanced. This review aims to provide an overview of the theory and practice of collaboration developed in the last 20 years. I incorporate work related to collaborative theory and practice predominantly in the areas of inter-organizational collaboration between public and nonprofit organizations and give specific attention to the fields of healthcare, organizational studies and community development. I investigate the meaning of collaboration, frameworks developed as collaborative models, the value of using collaborative processes and the challenges inherent in its use. Hence, I do not systematically review more general work in this area or perspectives oriented toward collaboration within a

single focal organization, for example, the collaboration literature with a focus on inter-professional collaboration within an hospital, or with works related to convening collaboration. I begin with an exploration of the meaning of collaboration.

Defining Collaboration

Many definitions in the literature tend to express collaboration as form/noun, such as partnerships, alliances, parties and coalitions; or as process/verb, involving activities or strategies. These variations in descriptions seem to find their origins in two definitions. The first, and the most often cited, definition (London, 1995) is found in Barbara Gray's *Collaborating: Finding Common Ground for Multiparty Problems* (1989). Here, Gray defines collaboration as a "process through which parties who see different aspects of a problem can constructively explore their differences and search for solutions that go beyond their own limited vision of what is possible" (p. 5). A little further along Gray provides additional explanation:

Collaboration involves a process of joint decision making among key stakeholders⁷ of a problem domain about the future of that domain. Five features are critical to the process: 1) The stakeholders are interdependent; 2) Solutions emerge by dealing constructively with differences; 3) Joint ownership of decisions is involved; 4) Stakeholders assume collective responsibility for the future direction of the domain; and 5) Collaboration is an emergent process (p. 11).

The second foundational definition is Gray and Wood's revision of Gray's earlier meaning explaining that: "Collaboration occurs when a group of autonomous stakeholders of a problem domain engage in an interactive process, using shared rules, norms, and structures, to act or decide on issues related to that domain" (Gray & Wood, 1991, p. 146).

In the literature most conceptualizations of collaboration tend to restate and build upon Gray's original and Gray and Woods's revised meaning. For instance, definitions of collaboration typically stress how a unified approach enables outcomes not possible when

⁷ Gray defines stakeholders as parties with an interest in the problem and "include all individuals, groups, or organizations that are directly influenced by the actions others take to solve the problem. Each stakeholder has a unique appreciation of the problem." (1989, p. 5).

working in isolation (Huxham, 2003; Bryson, Crosby & Stone, 2006). Variations are often a matter of emphasis and a function of whether the author is highlighting process, outcome or both. From a process standpoint, for instance, authors emphasize the roles of negotiation (Thompson, et. al., 25) and voluntary agreements and adjustments (Axelsson & Axelsson, 2006). Himmelman's understanding of the collaborative process identifies how it is derived from "sharing risk, responsibility and reward" (1995, p. 26). On the whole, like Gray's original definition, most works emphasize that collaboration is "more than the "shipping of data back and forth," it entails all parties to share in the ownership of the issue and its resolution (Hansen, 2009, p. 15). In this sense collaboration can be viewed as a "mode of governance" (Ansell & Gash, 2008, p. 543). Definitions are crucial to theory and practice. Gray and Wood state that it is important for a definition to encompass "all observable forms and exclude irrelevant issues" (1991 p. 143). It is striking to me that an essential yet under-emphasized element of all these conceptualizations is relationship building.

I am often asked to define collaboration in my work and I find it helpful to draw on the definition articulated by Chrislip and Larson (1994):

It (collaboration) is a mutually beneficial relationship between two or more parties who work toward common goals by sharing responsibility, authority, and accountability for achieving results. Collaboration is more than simply sharing knowledge and information (communication) and more than a relationship that helps each party achieve its own goals (cooperation and coordination). The purpose of collaboration is to create a shared vision and joint strategies to address concerns that go beyond the purview of any particular party. (p. 5)

It is important to stress that collaboration is relational. It is a process for working together to find new ways of solving problems, improving situations, and realizing opportunities. This form of participation necessitates that the participants come in good faith and with the intent and commitment to contribute to the success of the endeavor. Hansen emphasizes: good collaboration amplifies strengths, poor collaboration is worse than no collaboration at all (2009, p. ix) - meaning that poor collaboration can destroy any thread of a relationship that may have been present and impede any potential for working together. When groups are positioned to gain through a collaborative partnership but are unable to build relationships due to poor ability or conditions it makes for a lost valuable opportunity for change.

Collaboration is a process; it is a means to an end not an end itself. In my work the most useful understanding of collaboration is one that stresses the relational aspects of engagement undertaken by people with complementary mandates to work together in partnership co-designing solutions to shared problems within local contexts. The entire process then must be geared toward establishing and maintaining relationships among the participants in a way that promotes the idea and skill sharing needed to collaborate effectively. To gain a greater sense of establishing what is required for success, I turn to an examination of current models of collaboration.

Frameworks and Conceptualizations of Collaboration

So, what is involved in collaborating? What does it look like? In my review of the literature on collaboration I found that, similar to the definition of collaboration, where the literature set out a framework for a collaborative process much of the work refers to or borrows from the foundational work of Barbara Gray. There is much more literature focusing on the conditions and aspects of process necessary for and the factors that determine the success and challenges of collaboration than works suggesting a general stage or phase-based framework for collaboration. The four models I exemplify here characterize common collaborative models and are illustrative of an overlap between stage and process orientations.

Gray outlines a “collaborative process model” comprised of three stages; problem setting, direction setting and implementation, each of the stages have several components (highlighted in the table shown later in this chapter). The first stage is problem setting. Gray (1989) describes this as often the most difficult stage as it is here that the parties lay the foundation for the work of the collaboration. In the second, direction setting phase, the parties identify their interests, articulate their values and begin to appreciate a sense of common purpose. This phase is characterized by components, both substantive and procedural. The third phase is the implementation phase during which the partners communicate their decisions to their constituents, establish structures to implement and administer the agreement, and process, effects and outcomes of the agreement (p. 86 - 92).

Bryson, et al. offer a six-part process framework focusing on: forging initial agreements, building leadership, building legitimacy, building trust, managing conflict and planning (2006, p. 47-48). Thompson, Perry and Miller, in their conceptual model of

collaboration offer five key ‘dimensions’ of collaboration: governance, administration, organizational autonomy, mutuality, norms. (2009, p. 25-28). In a framework capturing the conditions that facilitate successful collaboration, Foster-Fishman, Berkowitz, et al. (2001) focus on identifying four core competencies as a foundation for engaging in collaborative process. These are described as member, relational, leadership, and programmatic capacities. Following is a table showing the characteristics of these models.

Table 1: Summary of process and phase models of collaborative process

Comparison of 4 Collaborative Models	
Gray, (1989), Collaborative Process Model - 3 phases	
1. Problem setting <ul style="list-style-type: none"> • define a common definition of the problem as agreed to by all parties in addition to acknowledging that the parties are mutually dependent • gain the commitment of the parties to the collaboration • identify all stakeholders • ensure the legitimacy of the parties by all parties • identify the resources required for the collaboration (p.57 – 74) 2. Direction setting <ul style="list-style-type: none"> • establishing ground rules and group norms • setting the agenda in relation to the substantive aspects of the collaboration • organizing task forces or working groups if the number of issues to be addressed is substantial • joint information search and data sharing • identifying and exploring all of the options • reaching agreement and determining a way forward (p. 74 – 86) 3. Implementation <ul style="list-style-type: none"> • the parties convey to their constituents their rational and support for the agreement • build support especially from those who will be implementing the agreement; • establishing structures to administer the agreement; and lastly 4) monitoring the agreement and ensuring compliance (p. 86 - 92) • 	
Bryson, Crosby & Stone, (2006), Collaborative Process Components – 6 components	
1. Forming initial agreements <ul style="list-style-type: none"> • vision and purpose, • mandate • commitment of resources • designation of leadership • membership and decision making process 	

2. Building leadership

- roles and authority
- vision
- commitment to the collaboration
- integrity
- relational and political skills

3. Building legitimacy

- structures
- processes
- strategies

4. Building trust

- information and knowledge sharing
- demonstrating competency
- fair process
- commitment

5. Managing conflict

- use of resources and tactics to equalize influence
- assurance that all partners interests are being taken into account
- educating participants about the process

6. Planning

- combine deliberate and emergent models
- embed the analysis and responsiveness of stakeholders (2006 p. 47 - 48)

Thompson, Perry and Miller, (2009), Theoretical Model for Collaboration – 5 key dimensions**1. Governance**

- joint decision-making for governing behavior and relationships and about how to manage the collective mandate

2. Administration

- implementation and management – doing what it takes to achieve a goal; establishing role clarity, effective communication channels and managing the inherent tension between self and collective interests

3. Organizational autonomy

- managing tension between partners being able to maintain their organizational authority separate from a collaborative identity

4. Mutuality

<ul style="list-style-type: none"> • interdependence - addressing differing and shared interests to achieve mutually beneficial relationships and outcomes
5. Norms <ul style="list-style-type: none"> • developing modes of reciprocity, fair process and trust (2009 p. 25 - 28)
Foster-Fishman, Berkowitz et al (2001), Capacities of Collaboration – 4 capacities
1. Member capacity <ul style="list-style-type: none"> • encompasses the attitudes, knowledge and skills required of the partners, their ability to work together and the efforts required to build, support, and access this capacity
2. Relational capacity <ul style="list-style-type: none"> • developing social relationships needed to achieve desired goals
3. Organizational capacity <ul style="list-style-type: none"> • a strong leadership base and a vision to transform individual interests into a dynamic collective force that achieves targeted outcomes
4. Programmatic capacity <ul style="list-style-type: none"> • the ability to guide and design the implementation of programs that have meaningful impact within their communities (p. 249 - 256)

In my view, understanding a framework or model to manage collaboratively involves understanding the steps and procedures and knowing how to implement them successfully. I would also argue that more important is the understanding of the relational aspects of the frameworks and how they affect the dynamics of collaboration. Noticeable is the limited attention given to the infrastructure and resources needed to support collaboration – the models seem to focus on the individuals and process involved and less on the role of institutional resources.

The Value and Complexity of Collaborating

The literature appears to frame the benefits to collaboration in both broad and more specific terms. One broad framing is articulated by Axelsson & Axelsson (2006), who advise that a main motive for collaborating is to provide a more ‘holistic’ approach to delivering public health services and that through collaboration there is the potential to avoid the fragmentation of responsibilities of service providers. Lasker and Weiss (2003) state that:

At a practical level, many of the problems that affect the health and well-being of people and communities cannot be solved by any person, organization, or sector working alone. These problems are complex and interrelated defying easy answers. Only by combining the knowledge, skills, and resources of a broad array of people and organizations can communities understand the underlying nature of these problems and develop effective and locally feasible solutions to address them (p. 15).

Another broad framing is put forward by Gray (1989), who states that collaboration offers the opportunity to advance a shared vision among partner organizations and in the process build a common understanding of problems informed by the perspectives of all those involved leading to a richer, more comprehensive solution to the problems than any one organization could design working on their own). These broad articulations usefully capture overarching benefits but are limited in their communication of specific features which are most productive in the collaborative process.

The more explicitly⁸ expressed advantages of collaboration, as identified in the literature have to do with pooling knowledge, skills and resources. For instance, Lasker and Weiss (2003), point out that stakeholders working together have the opportunity to fashion an environment in which they can draw on a larger knowledge, resource and skill base. Such an environment can improve the quality of solutions and enhance the potential to discover innovative solutions though diverse and comprehensive analyses of all of the resources and options available. Sharing knowledge and information can reduce redundancy, re-creation of the wheel and duplication of efforts. Gaining increased access to greater resources creates the opportunity for partners to devise ways of using the existing resources in more efficient ways through exploiting different economies of scale and scope thus benefiting from cost savings (Lasker & Weiss, 2003; Axelsson & Axelsson, 2006). Working together also enables partners to share services or resources that would not have been possible if acting separately thereby generating an opportunity for each organization to experience an expansion of possibilities without any one having to spread too thin (Hord, 1986). Pooling skills and

⁸ Implicit is the avoidance of the possibility of another authority imposing a solution; that potential benefits may be better than taking no action and that there may be no other options outside of collaborating.

expertise from the different organizations involved can improve, streamline and align the quality of services delivered (Lasker & Weiss; Axelsson & Axelsson).

Importantly, a key strength of collaboration is that it enables the participation of each stakeholder and the opportunity for their interests to be considered in any agreement; it enhances the potential for ownership and acceptance of the solutions and the stakeholders' willingness to implement them. A successful shared experience may also lead to an improvement in relations between the stakeholders and the establishment of stronger bonds and mechanisms for future-ongoing stakeholder collaboration (Gray, 1989). Partners in collaboration may find it easier to share the responsibility than to carry it alone and the public may gain greater benefit from the joint efforts than by what each of the organizations could've offered alone (Hord, 1986).

The very environments that afford collaboration can also contain factors that inhibit its success. For instance, Richard Beckhard (1975) states that a condition required in order for people to change to a more collaborative approach is “a real dissatisfaction with the status quo, a high enough level of dissatisfaction to mobilize energy toward some change” (p. 424, as cited in Hord, p. 23). In addition, the interdependence of organizations that enables the opportunity for collaboration can also produce frustrations when it comes to initiating action. Functional and structural disparities, alongside ideological and cultural differences oftentimes exist among interdependent entities. Other complexities and challenges “have been attributed to factors such as environmental constraints; diversity in organizational aims; barriers in communication; and difficulties in developing joint modes of operating, managing perceived power imbalances, building trust, and managing the logistics of working with geographically dispersed partners (Babiak, 2009, p.117).

Public healthcare in British Columbia offers a prototype of such challenges. Family physicians in BC are, for the most part, self-employed in private practices working on a fee-for-service basis (Mazowita & Cavers, 2011, p. 2). They are required to attend to the primary care needs of their patients as well as the obligations inherent in managing the operations of their clinics. Health authorities, on the other hand, are large bureaucracies responsible for the provision of acute care and community care. Health Authorities operate hospitals and deliver most of the community services in the entire province in addition to providing contracts to nonprofit and for profit organizations to deliver services. The scope, needs and interests of

each have different points of emphasis and associated ways of engaging. Although BC family physicians as individuals and health authorities as organizations share the aim of creating a sustainable healthcare system, their structural, functional and ideological differences amid their common purpose pose complexities that must be attenuated in the collaborative process.

Cultural idiosyncrasies among interdependent organizations are particularly evident in professional attitudes and behaviors. Such differences can pose a problem for developing the relationship necessary for collaborative endeavors. Often people coming together to address patient care, professional satisfaction, and health system issues through a collaborative process are working together in this manner for the first time. They may or may not know each other and they may or may not have experience in collaborative environments. It is quite possible that if they do know each other many, or even all, of the parties may come with histories mired in adversarial or contentious relations born of organizational cultural and ideological differences. When negative attitudes and beliefs are carried over into the collaborative environment people may come to the table with cynicism culminating in a lack of commitment to the process and an attitude resistant to change. If a collaborative relationship is beginning under these circumstances it can be very challenging for the collaboration to take hold. Therefore, under any conditions relationship building and attention to maintenance are essential alongside educating participants about the overall value of collaboration (Ansell & Gash, 2008), and especially so if the relationship amongst the participants is characteristic of the above. While not necessarily dissolving conflict, acknowledging the underlying issues and expressing a commitment to engage in good faith can help move the process forward (Gray, 1989). Awareness of the complexities of collaborating along with a willingness to have ownership of the process is fundamental to the success of the endeavor. Knowledge and commitment will assist those working together to resolve disputes, improve situations and design innovative solutions to system change; ideally fostering trust and building mutually beneficial and long lasting relationships along the way.

As is apparent, meeting preconditions and agreeing to collaborate do not predict stress free success. Even the most ideal circumstances, as in all relational venues, can hold very real potential for difficulties to arise. Further, there are circumstances when it would be

advisable not to enter into a collaborative relationship. Barbara Gray identifies these as situations where issues are rooted in basic ideological differences, one or more of the stakeholders cannot establish representation, issues are too threatening because of historical antagonisms or where maintenance of inter-organizational relationships represent substantial costs to the partners (1989, p. 255).

Keys to Success

In order for people to be motivated to collaborate they must have the belief that working with others will be productive in serving their interests (Gray, 1989), that benefits gained will offset the costs of the energy extended in effort (Foster-Fishman, Berkowitz, et al., 2001; Hord, 1986) and that their interests are better served by collaborating than by other means (Gray). Most significant are the attitudes and intentions held by the participants and their centrality to the success of collaborative endeavors (Gray). Also significant is the belief in the potential of, and commitment to, the process (Gray); along with acceptance of other stakeholders as legitimate and capable contributors (Foster-Fishman, Berkowitz, et al.) who bring valuable knowledge and skills to enrich the process (Gray).

When people come together in good-faith and are committed to taking ownership and responsibility of the process and outcomes there is a greater potential for the realization of their vision (Gray, 1989). For this to take place there must be present patience and persistence and a willingness to: cooperate and devote time and energy to building relationships and contribute to the activities of the collaboration; let go of personal control and take on more risk in order to help create a flexible environment where control is shared; consider the perceptions (Hord, 1986) and respect the different experiences of others (Foster-Fishman, Berkowitz, et al., 2001); and to share knowledge and resources (Hord), and to work together strategically representing the views of the member organization and not individual interests (Gray). Finally, an awareness of the challenges coupled with a realistic appreciation of the possible obstacles inherent to collaboration is essential to success (Gray).

In addition to the key participation factors described above there are many environmental and process factors that are also key to successful collaboration. An environment conducive to successful collaborative process is one where there is inclusion of all affected stakeholders, where there is a shared vision and shared goals and clarity about the aims of working together and clarity of the roles of each of the participants (Gray, 1989;

Foster-Fishman, Berkowitz, et al. 2001). It is an environment where stewardship is valued over individualism, responsibility and power are shared, and building trust, developing strategies of mutual empowerment and learning from experience are encouraged (Gray; Baum, van Eyk, & Hurley, 2006). The collaborative environment requires strong leadership, fair process and open and honest communication (Bryson, Crosby, & Stone, 2006; Foster-Fishman, Berkowitz, et al.; Gray). The collaborative process is emergent. Participants must agree on the procedural processes they will utilize (Gray). These include how they will: set group norms, set priorities, set up structures, plan and design programs, make decisions, manage differences and resolve conflict (Bryson, et al.; Foster-Fishman, Berkowitz, et al.; Gray). Combined, these factors all help build appreciation of the interdependencies of the stakeholders. When joint appreciation is present the potential for creating positive change for all parties is enhanced. The next section discusses a framework for measuring success.

Measuring Success

The GPSC has adopted the ‘Triple Aim’ and the ‘Model for Improvement’, both strategies supported by the Institute for Health Care Improvement. The Triple Aim measures against three goals: the improvement of patient and provider experience, the improvement of population health, and the contribution to the financial sustainability of the health care system. The Model for Improvement, initially developed by Associates in Process Improvement, embeds the concept of continuous quality improvement and is a tool for accelerating improvement by setting aims, establishing measures, selecting changes and then testing the changes on a small scale using the Plan Do Study Act cycles. The intention is for programs to have evaluations built in, be regularly reviewed and then ensure that the intended outcomes are being realized. This approach is seen as advantageous over applying evaluation at the end of a project as it provides the opportunity for applying learnings and making adjustments throughout the course of the project. Barbara Gray (1989) would advise that measuring the success of the process is just as important as measuring the projects as achieving success with the process is “often just as critical as achieving objective success because, if the parties are unhappy with the process of collaborating, they are unlikely to accept the outcome. If the parties do not believe that the real issues were addressed and their own interests were satisfied, then the collaboration has not been a success” (p. 256). Gray suggests the following questions as valuable for measuring success:

- Do the outcomes satisfy the real issues?
- Do the parties feel they affected the decision?
- Are the stakeholders able and willing to implement the decision?
- Does the agreement produce joint gains for the parties?
- Were communication between parties increased and the working relationship improved?
- Has the agreement held up over time?
- Was the process efficient in terms of time and resources?
- Does the solution conform to available objective standards?
- Do the parties perceive the procedures were fair?
- Do the procedures conform to accepted standards of procedural fairness? (p. 257)

In this chapter I provided a review of the literature of collaboration that specifically focused on exploring the meaning and frameworks of collaboration; the value and complexity of engaging in collaborative process; and the keys to and the measures of success. The next chapter contains my observations and reflections of the collaborative process within the Divisions of Family Practice initiative and describes some of the successful outcomes of the partners. Also highlighted are some of the challenges that have been experienced by the partners along with several strategies that have been helpful in overcoming or at least alleviating these challenges. The chapter concludes with the identification of future areas of study and a description of the participation guide and process handbook that is the second part of the thesis.

Chapter Four: Observations, Reflections and Conclusion

Observations and Reflections

The recent collaborative partnership approach between service providers and policy makers represents a deep change in policy direction for all the GPSC partners. Collaboration is a generative process that can enable organizations with similar goals regardless of their orientation to achieve more by working together than they can by working on their own (Hutchinson, 1999, p. 4). Within the Divisions of Family Practice Initiative this is witnessed by the many successful outcomes of the divisions and the Collaborative Services Committees. Some of the successes have come about through the new opportunity for physicians to work together to find efficient ways to approach time intensive administrative tasks thus allowing more of their time to be spent providing patient care. Examples of these successes include: designing strategies for finding locums to provide temporary practice coverage and also to recruit physicians to relocate to communities with a shortage of family physicians; offering professional and educational development opportunities to members in their own communities; and negotiating group bulk purchasing rates for clinical and office supplies. Other successes have come about through the new opportunity for the partners to work together to address efficacy and capacity issues directly effecting patient care. Some examples of successes in this area include: resolving hospital care issues in order to make it more feasible for physicians to manage their own clinics in addition to providing care for patients admitted to hospital who do not have a family physician; coordinating discharge planning and the transition of patients from acute care settings to community settings; designing solutions to maternity care challenges by opening clinics and providing obstetrics experience to medical students; and for matching patients who do not have one to a family physician. However successful many of the division and CSC projects have been they have not come about without significant challenges experienced in the collaborative process. Below I describe several common experiences, highlighting the challenges and the strategies that have helped overcome, or at least alleviate, their effects when engaging in the collaborative process. I have arranged these challenges in the following categories; developing relationships, setting agendas, and managing expectations.

Developing trust has been an essential factor in attaining the successes of the collaborative partnerships - facets of collaboration such as the sharing of perspectives and

willingness to consider diverse viewpoints necessitate the presence of trusting relationships. When collaborative partners come from differing organizational and professional cultures (especially if they have been marked by adversarial past relationships) the potential for participants to protect individual organizations' interests can hamper trust building (Vangen & Huxham, 2003) and create a hindrance to the collaborative process (Huxham, 2003). Early Divisions are exemplary in demonstrating the process of building trust and developing relationships in the collaborative process. In essence, embarking on the DOI review and signing process was the first project that the partners engaged in together. It took up to 8 months for the first DOIs to be signed. The process entailed the participating partners to work through numerous draft versions of the DOI in several face to face meetings to clarify its language and intent before signing. Although the process was lengthy, it strengthened partners' ability to form agreements and was instrumental in fostering an environment where they began to build common meaning, shared vision and trusting relationships preparing them to work effectively together at the CSC. Working within the PDSA Cycle, once a DOI signing process was complete, the modifications resulting from the group discussion were assessed and if seen as beneficial to the project, incorporated to create an updated DOI template. In this way improvements made to the DOI through each review process were shared with new partnerships as they emerged. The streamlining of the DOI process, however, has had consequences both beneficial and detrimental for new partnerships. A benefit has been that the process of review and signing of the DOI is completed more quickly; often in a single meeting, allowing the partners to begin working together on their mandate much sooner. A detriment to the shortened process is that there is less opportunity to spend time establishing relationships between the partners prior to embarking on the work of the collaboration. This has often limited the development of an environment conducive to successful collaboration during the early formation of the new partnerships. Consequently, partners now often come to the CSC table without the benefit of having developed common understandings and trusting relationships and as a result, newer partnerships have experienced many of the challenges inherent to collaboration.

Collaboration is a relational process. Creating gains and achieving success requires that people come prepared to act in good faith and with the intent to participate and contribute in a positive manner. If people behave in ways that restrict the process little gets

done, the process moves slowly or comes to a halt, and frustration among the participants builds. I have found that educating participants about the significant role of the individual in the collaborative process and about the impact of participants' attitudes and beliefs to the success of the partnership while also acknowledging that there may be underlying issues such as difficult past histories, cultural professional differences and diversity in organizational aims useful in helping to avoid the likelihood of this happening and to help get unstuck if frustration and inertia do occur. Key to this is the understanding that it takes time and energy to develop relationships and create an environment of joint appreciation, how participants see each other, whether as partners or adversaries affects this greatly. Also helpful is focusing on the benefits that may be gained through collaboration and making connections where the benefits will offset the costs and energy expended and that ultimately the process has the potential to serve everyone's interests.

The ability to develop common agendas and to set priority areas to work on has also been an essential factor in attaining the successes of the collaborative partnerships. For example, the recognition of the potential to resolve a common problem area is often viewed as the overarching reason to collaborate. If a group has formed due to a crisis situation the priority issues are easily defined. On the other hand, when there is no crisis involved in the formation of the group (as is true with more recent partnerships) and numerous problem areas are present it can be a significant challenge for these groups to identify and prioritize areas of common interest to work on together and then formulate processes in which to address those areas. What has been successful in overcoming this challenge has been when partners have been able to come to the table with problems rather than solutions. It is important to note that when the division partners of a CSC reach beyond their own issues and can articulate the problem areas of the larger membership through the engagement of their members, the issues they identify seem to gain more traction with the rest of the partners of the CSC. It is also helpful when the partners are able to consider the diverse perspective of others when there are differing perspectives on the criticality or emphasis places on the problems put forward. Identifying problems rather than solutions is effective as it allows the group to explore the current state of the problem areas from the perspective of each of the stakeholders providing the opportunity for the groups to exploit the knowledge and resources of all of the partners ultimately leading to the design of solutions that are more innovative and robust than would

be possible to design by any one partner alone. It requires considerable time and commitment on the part all the partners in order to reach a unified way of working together to realize shared goals.

Due to the variety of organizational cultures and mandates, as well as the professional dynamics present between participants, many groups have come to the table with different perspectives on the types of problems they want to work on and on how much might be achieved in certain timeframes. This has necessitated the creation of strategies to manage differing expectations, some of these strategies include: having awareness of the challenges and potential obstacles of collaboration; understanding that it takes time and energy to achieve goals and being patient and persistent with the process; and identifying and implementing a framework or model of collaboration to help guide the work of the partnership. The following additional strategies have also been found to be helpful: concentrating on problems that if resolved create win-wins or quick wins at the beginning of the collaborative relationship in order to create an early sense of accomplishment; providing clear communication and explaining the rationale of organizational activities when acting unilaterally on autonomous but overlapping interests; being open about having multiple roles when there are potentially competing objectives or agendas; and, framing conversations on what works from the patient perspective in order to circumvent vested interests within the partnership.

Conclusion

In the first chapter I posed my main research question as “how can divisions create and sustain collaborative practice?”. In the second chapter I wrote about the background of the GPSC and I placed the Divisions of Family practice within that context. In the literature review of the third chapter I set out a definition of collaboration and explored several frameworks. In addition, I wrote about the value and complexities of collaboration, what helps to make collaboration successful and how the activities of collaboration can be measured. In this chapter I reflected on my experience working with the divisions and articulated several challenges and strategies for overcoming them. Through this project I would conclude that creating and sustaining collaborative practice absolutely requires an understanding of the processes and structures of a collaborative model and knowing how to

engineer them successfully. In addition, and I would argue as importantly, it also requires the understanding of the relational aspects of collaboration and how they affect the dynamics of a collaborative process. It is interesting to surmise that the most significant and common challenges witnessed through the Divisions of Family Practice are largely relational in nature. It is also interesting to note that much of the experience of the collaborative process of the Divisions initiative is mirrored in the theory of collaborative practice. For example, the findings of the inquiry support the notion, both in theory and in practice, that educating about the processes of collaboration, the inherent obstacles and challenges, and the role of the behaviours of the participants, are instrumental in supporting effective collaborative partnerships.

The Divisions of Family Practice initiative is a relatively new program. The initiative has created an opportunity to develop a new social contract between family physicians, health administrators, and community organizations and it has opened a space for meaningful engagement to take place among these partners. To date the achievement has been to involve more family physicians in the design of primary care solutions than there have been a very long time. It has been about improving the immediate lived experience of family physicians and also about creating longer term solutions beneficial to primary health care reform. Nevertheless, it takes time to build and mature networks and relationships and it will require several more years of divisions in operation before the impact, or even the success of this initiative can be determined. In the meantime I will continue to bring inquiry into my work and I will continue to provide accessible language and tools to help translate general theories into practical knowledge and skills. Below I have identified several scenarios that appear to be problematic and would benefit from future study.

- The first wave of physician leaders has come forward to govern the divisions as nonprofit organizations. This takes considerable effort and time further increasing workload and stress levels. Many of these physicians are coming to the end of their terms as board members and are struggling to engage others to take over their positions. Will division leaders be able to make their governing structures sustainable?

- The current environment contains the political will to support the initiatives of the GPSC. If this environment changes, and with it healthcare policy and funding direction, would divisions have the capacity to carry on without this support?
- Noticeable is the limited ethno cultural diversity within the leadership of the healthcare system. Would the collaborative frame work within a more diverse cultural environment? What would it look like?
- It has been a challenge for Divisions and the Collaborative Services Committees to identify the potential of patient involvement and to integrate patient involvement in their activities. Would patient involvement in more of the partner projects alter the solution designs?

The second part of this thesis is a participation guide and process handbook for supporting people to participate in the collaborative process. The creation of this tool is informed by the literature and also my experiences, reflections, and observations gained through facilitating collaborative processes. The environment I comment on is one where multiple stakeholders come together with a vision of improving an entire system⁹ and their relationship is ongoing and encompassing multiple problem areas. The goal is to provide groups working together across organizations a practical guide for understanding and engaging the collaborative process while navigating its complexity and conveying it in a way that seems real to them. This guide will provide an assemblage of guidelines and tools to help address the practical issues, both synergistic and frustrating, that are experienced in collaborative process. Major components of the guide include: a definition of collaboration; the value of collaborating; overarching themes and concepts; harnessing collaborative potential; what it takes to collaborate; and overcoming obstacles and challenges inherent in the process. It also includes a framework for effective meeting processes and scenarios to be used as tools for gaining collaborative insight.

⁹ In contrast to a vision limited to solving a specific problem or improving a limited situation. The guide is still relevant in this case.

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Appendices

Appendix A: Document of Intent Template

DOCUMENT OF INTENT

BETWEEN

The Family Physicians of

AND

General Practice Services Committee

AND

Health Authority AND BC Ministry of Health

AND

British Columbia Medical Association

PREAMBLE

“Evidence of the health-promoting influence of primary care has been accumulating ever since researchers have been able to distinguish primary care from other aspects of the health services delivery system. This evidence shows that primary care helps prevent illness and death, regardless of whether the care is characterized by supply of primary care physicians, a relationship with a source of primary care, or the receipt of important features of primary care.”(Starfield et al, 2005).¹⁰

General Practitioners are the cornerstone of Primary Care. General Practitioners, in concert with allied health professionals recognize the importance of long-term person-focused care, or continuity of care as expressed through an ongoing relationship between the patient and his/her primary care provider, has been reinforced through the recent evaluation of the BC-based Full Service Family Practice Incentive Program. This research on the impact of the program, which offers various incentives designed to promote full service family practice, identified an inverse relationship between cost of care and attachment to practice (i.e. an ongoing relationship with a family physician). The more that higher care needs patients were

¹⁰ Starfield, Barbara; Shi, Leiyu; MacInko, James. Contribution of Primary Care to Health Systems and Health, *The Milbank Quarterly*, 83(3), September 2005.

attached to a primary care practice, the lower the costs were for the overall care system (Hollander et al, 2009).¹¹

The Primary Health Care Charter and its key initiatives, including Patients as Partners, together with the various initiatives supported by the General Practice Services Committee (GPSC), provide the opportunity to support a shift to a more comprehensive primary care practice, organized around patient needs and with full patient participation, and supported by partnerships between physicians, the Ministry of Health (MoH), health authorities (HAs) and other non-government organizations.

The partners to this document are dedicated to improvement and access in primary care. Primary care is where most people, most of the time, encounter the health care system. As such, it is the greatest point of leverage for improving population health, the patient experience and reducing pressure on the overall system (Hollander et al, 2009).¹² The partners to this document believe a sustainable primary care system is one where there is the least possible distance between the clinicians who deliver care and policy makers.

PURPOSE

This Document of Intent demonstrates that the above-named partners support the development of the Division of Family Practice (the Division). The purpose of the Division is to provide a collaborative and innovative approach to patient care through this partnership. It is expected that this collaboration will result in:

- Family physicians in receiving professional support and the ability to influence patient care in the region
- Patients in receiving increased access and enhanced quality of care
- A contribution to sustainability of the health care system.

Divisions of Family Practice (Divisions) will not duplicate the roles and responsibilities of the Health Authority, but will provide family practice clinical influence and leadership at the community, regional and provincial level. It will act as a hub for the integration of care for patients at a community level. The Division of Family Practice will be open to all family physicians offering primary care in their community, including those who provide full service, specialized (obstetrical, ER), hospitalists and walk-in clinic services. A Division also provides the formal platform for the building of partnerships with the MoH, the HA and other partners for better primary care.

¹¹ Hollander, Marcus et al. Increasing Value for Money in the Canadian Health Care System: New Findings on the Contributions of Primary Care, *Healthcare Quarterly* , 12 (4), 2009

¹² Hollander, Marcus et al. Increasing Value for Money in the Canadian Health Care System: New Findings on the Contributions of Primary Care, *Healthcare Quarterly* , 12 (4), 2009

This Document of Intent demonstrates the parties' commitment to work collaboratively and does not create any legal obligation between the parties. Collaborative working involves a commitment to the co-design of potential clinical programs in a way that acknowledges the unique perspective of each partner and supports the common goal of improved access and health outcomes for patients.

ROLES AND RESPONSIBILITIES OF THE PARTNERS

PART 1 - Role and Function of the Division of Family Practice

1.1 General Duties

(a) The Division will:

1. Work with partners and allied health professionals to facilitate comprehensive primary health care for the people of .
2. Work with the partners to reach the aim that everyone who wants a family doctor can become attached to one.
3. Work through the Collaborative Services Committee (CSC) to co-develop, co-design, co-evaluate and properly administer clinical Service Agreements and other arrangements, using continuous quality improvement methodology.
4. Work within its sphere of influence to remove family practice barriers to improving care and increasing system sustainability.
5. Work with current HA services, community agencies and/or other health professionals to increase integration and collaboration to improve patient and community outcomes.
6. Facilitate integrated care with Specialists or with other FPs with specialized or focused practices.
7. Work to provide opportunities for increased community family practice organisation such as coordination of call schedules and after hours services, advanced access, and the attachment of patients.
8. Develop leadership, actual and potential, in the physician community and will pursue joint learning with other partners.

(b) The Division will undertake the following administrative functions:

1. Develop infrastructure to receive and disburse Division infrastructure dollars according to local needs and by agreement of the membership and the Partners.
2. Co-chair the Collaborative Services Committee.
3. Provide family physician(s) as member(s) of the CSC as determined by local need.
4. Support the ongoing evaluation of its initiatives, programs and operation.
5. Provide anonymous practice level data to facilitate evidence-informed decision making - such data must be expressly requested by the physician or CSC and disclosed in accordance with all privacy legislation; and the policies/standards set by the College of Physicians and Surgeons of BC. No such data shall be collected from individual physician practices as a result of his/her Division membership, except with the express consent of the physician.

(c) The Division will work with partners to provide its members with infrastructure and clinical supports.

Infrastructure Supports:

1. Professional, clinical and practice supports focused on continuous improvement for patient care and professional satisfaction, such as facilitating or informing members of Practice Support Program (PSP) or Continuing Medical Education (CME) opportunities.
2. Formal and informal networking opportunities.
3. Regular opportunities to be informed and involved.

Clinical Supports:

1. Physician or locum retention and recruitment planning and supports.
2. Support for physician wellness.
3. Roles in medical education through accepting family practice residents, nurse practitioners and medical students, and taking a leadership role in organizing and sustaining activities such as regular medical staff rounds, journal clubs, and subspecialty interests within family medicine.
4. Increased potential opportunities for developing and participating in multidisciplinary models of care.
5. Family practice voice and influence in the community and health authority in the delivery of integrated care.

(d) The Division will work with its partners to provide its community with:

1. Branded awareness of its services, collective hours of operation, membership and affiliations in order to enhance patient access and attachment.
2. Comprehensive primary health care, provided in collaboration with other health care providers as appropriate.
3. Continuity of care for patients throughout the ambulatory, ER, hospital, residential care experiences to improve patient experiences and outcomes.
4. A voice in the planning and improvement of the primary health care system for their community.

1.2 Partnering in Health Authority Facilities

The Division will follow all laws, guidelines and rules around operating in HA facilities and work with Department(s) of Family Practice.

PART 2 - Responsibilities of the Partners to the Division

2.1 Health Authority will:

1. Provide a co-chair and membership to the CSC as is determined by local need, ensuring that membership is at the executive level and capable of making decisions on behalf of the HA.

2. Provide membership to working groups, ensuring that local operational directors are supported by the executive.
3. Ensure that the value of its relationship with the Division is widely understood inside the HA.
4. Work through the CSC and its working groups to co-develop, co-design, co-evaluate and properly administer clinical Service Agreements or new ways of working together, using continuous quality improvement methodology.
5. Work within its sphere of influence to remove systemic barriers to improve care and system sustainability.
6. Explore how the Division can benefit from existing HA systems, such as economies of scale for supplies or purchasing discounts.
7. Partner with the Division to re-orient current health services and/or support multidisciplinary practice and the development of innovative wrap-around services for complex patients.
8. Partner with the Division to ensure functional electronic delivery of lab, imaging, pathology and other regional patient reports to all physicians using Electronic Medical Records (EMRs).
9. Provide regional and community specific data expressly requested by the physicians or CSC and disclosed in accordance with all privacy legislation; and the policies/standards set by the College of Physicians and Surgeons of BC. No such data shall be collected from individual physician practices as a result of his/her Division membership, except with the express consent of the physician. Data may also include demographics and community health status, including disease burden.

2.2 The GPSC will provide:

1. Annual infrastructure funding at \$3000 per participating physician.
2. A provincial Team to support Divisions of Family Practice and assist all partners in the full use of the initiative, including the facilitation of inter-Divisional communication and collaboration.
3. Oversight.
4. Support through family practice initiatives including the PSP and the Physician Information Technology Office (PITO).
5. Aggregate planning data captured from GPSC-funded initiatives.
6. Mechanisms for the voice of the Divisions to be heard at GPSC.

2.3 The MoH will provide:

1. Appropriate membership, data and support for each CSC to assist in determining the scalability of co-designed initiatives.
2. Opportunities for funding to prototype new models of care or local initiatives as co-designed by the CSC.
3. Details of service funding parameters to ensure equity amongst Divisions.
4. Ongoing oversight and contract adjudication as appropriate.
5. Data including individual practice profiles and overall Division of Family Practice profile - such data must be expressly requested by the physician or CSC and disclosed in accordance with all privacy legislation; and the policies/standards set by the

College of Physicians and Surgeons of BC. No such data shall be collected from individual physician practices as a result of his/her Division membership, except with the express consent of the physician.

2.4 The British Columbia Medical Association (BCMA) will:

1. Provide temporary organizational support to the newly developed Division until such time that the Division can discuss and sign contracts.
2. Provide administrative and professional support services where appropriate.
3. Ensure its membership is aware of the Divisions initiative and its important role in improving the primary health care system.

2.5 Building Public Confidence

All partners, including the Division, will seek to make this innovative model extremely visible at the local, regional and provincial levels. To ensure this occurs, all partners will facilitate the publishing or distribution of information and education on primary health care services to the public, highlighting innovative and continuous quality improvement activities.

PART 3 - The Collaborative Services Committee

The CSC provides the formal interface between the Division, the HA and the MoH. The intent of this committee is to ensure strategic alignment, information sharing, and cooperation between the partners in the development and implementation of innovative models of primary care patient services. Membership will be defined in a Terms of Reference to be collaboratively agreed upon by the Partners. The expectation is that HA involvement is at the executive or vice-president level, allowing appropriate influence to effect fundamental changes in service delivery required to facilitate innovative, co-designed clinical services.

As needed, permanent and ad hoc members representing specialists, allied health professionals, the community, patients and other appropriate voices will be added to ensure comprehensive understanding of the community issues and possible solutions. The CSC will ensure that patient, family and community perspectives are engaged throughout the planning processes.

The CSC and its working groups will provide a collaborative venue and new ways of working together. The CSC will co-design clinical programs when all partners agree an issue raised is a priority for all. This assessment is informed by data and when the proposed program area fulfills the objectives of the Triple Aim system of review (improves patient and provider experience, is financially sustainable and improves population health). The CSC will operate by consensus, which is achieved when everyone accepts and supports a decision and understands how it was reached.

The Division and its partners agree to use continuous quality improvement methodology to develop and evaluate all proposed programs and activities. Programs developed using continuous quality improvement are designed to be continuously evaluated. As these

programs are implemented, what works is expanded and what does not work is modified and evaluated again.

The CSC, its members, its working groups and ad hoc participants will be supported by the provincial Divisions Team in understanding and using the methods and tools of Triple Aim¹³, collaboration and Continuous Quality Improvement¹⁴.

PART 4 - Division of Family Practice Programs and Services

The Division may use infrastructure funding and associated supports to work independently when designing and creating solutions to issues of practice efficiency or organization, professional satisfaction, professional development and any other area that does not require the funding, facilities or involvement of its partners.

The infrastructure and funding of the Division are also intended to facilitate the development, implementation and administration of new and innovative patient care programs. In areas of clinical patient care the Division will work with its partners to establish shared areas of priority and work to co-design clinical solutions. These programs are expected to be consistent with the goals of access to care, attachment of unattached patients to community practitioners, sustainability of health care, support for complex patients and continuity of care.

When the Partners agree on programs to pursue, investments in these programs may be made by the Division, the HA, GPSC and the MoH. The GPSC, the MoH and the HA will be involved in the co-design and co-development of any program or initiative of the Division that will require funding outside the Division's resources. The value and outcomes of the programs will be collaboratively evaluated by the partners using the Triple Aim lens and be subject to change and modification. MoH funding support will be based on the principle that any program must be affordable if offered to any appropriate community that desires it and consistency with the Patients as Partners principles and approach.

Priority Areas of the Funding Partners

Below is a list of program areas that have been previously developed by Divisions or which represent the priority areas of the funding partners. They fall under two broad categories of Comprehensive Care & Attachment and Coordinated Care. Divisions are encouraged to use this list to understand the priorities of their partners and to add to it the priorities of their communities.

¹³ Triple Aim initiatives have positive impact in three areas – patient/provider experience, population health and the financial sustainability of the health system.

¹⁴ See the Institute for Healthcare Improvement website (ihi.org) for the article “Road map for quality improvement” and other resources on continuous quality improvement (CQI). Essentially, programs designed with CQI will have evaluations built in, will be regularly reviewed and, if needed, will be adapted to ensure that the intended results are happening. This contrasts with using evaluation only at the end of a project, when adaption is no longer possible.

Comprehensive Care & Attachment

4.1 Access to Primary Care Physicians

Divisions are encouraged to develop activities to make it possible for people in the community to have access to a family physician. The Division will make a targeted effort to address requirements of high needs patients (See section 4.6 High Needs Patients).

4.2 Enhanced Access Primary Health Care

Divisions are encouraged to consider prototyping enhanced access models, ranging from practice efficiency to new or expanded clinics. These programs reduce the use of emergency departments for primary care and increase patient attachment in the community.

4.3 Palliative Care

Divisions are encouraged to develop programs that provide coordinated palliative care supports and services. Family physicians have always played important roles in providing comfort to their dying patients. These programs provide comprehensive end-of-life care and recruit and support physicians to deliver that care.

4.4 Maternity Networks

Divisions are encouraged to develop programs that support physicians in delivering maternity care and encourage new physicians to join them. One possible program direction could be Maternity Networks that support family physicians in group maternity practice to help prevent burnout. These programs provide access to comprehensive maternity care for patients and recruit and support physicians to deliver that care.

4.5 Enhanced Community Care Capacity

Divisions are encouraged to develop programs and supports that assist the local physician community in recruitment of physicians, the placement of locums and the development of multiple physician practices. These programs could have the additional focus of attaching patients, improving practice efficiency or developing multi-disciplinary practices. These programs reduce the numbers of unattached patients and increase primary care capacity in the community.

4.6 High Needs patients/Integrated Health Networks

Divisions are encouraged to develop programs that link family physicians with existing health authority and community resources. These programs can improve coordinated community care through an integrated team of providers wrapped around high-need priority patient populations. These programs may include services like patient self-management, group clinical visits or increased links to home or community care, all of which can improve patient outcomes for the chronically ill and more effectively use resources. Divisions are encouraged to provide leadership to collaborate and participate in Integrated Health Networks in their communities.

4.7 Integration of Home and Community Care and Mental Health and Substance Use Services with Divisions for High Need Patients.

Building on the many successful innovative projects undertaken in B.C., the Ministry's Integration Strategy is supporting health authorities to realign Home and Community Care, Mental Health and Addictions around Divisions of Family Practice to more effectively link primary care physicians with community-based services, and supporting shared care models of family physician and specialist medical services. As a starting point, current collaborative initiatives will be leveraged to better identify persons at risk, and ensure that they are linked with the necessary services and supports.

Coordinated Care

4.8 Family Practice Hospital Care Program

In programs such as these Divisions are encouraged to support existing full service family practitioners engaged in hospital care and to encourage others to join them. This will be accomplished by approaches that promote the benefit to patients and professional satisfaction of increased involvement in the hospital and acknowledge the financial realities of being called away from an active practice. These programs reduce length of stay, re-hospitalization and improve patient care.

4.9 Family Practice Residential Care Program

Divisions are encouraged to consider developing programs that deliver proactive as well as urgent primary health care needs of patients in residential care that might otherwise be referred to an emergency department. These programs reduce transfers to the hospital, increase primary care for a vulnerable population and allow more people to die in their residential care homes rather than spend their last hours in the hospital.

PART 5 - Goals

Within one year of signing the Document of Intent, all of the Partners will be able to report progress in the following areas:

1. Improved Patient Care

Some examples may include:

- a. decreased unattached patient population
- b. improved access and patient care
- c. an active CSC exploring multiple possible clinical program areas
- d. the community will express greater confidence in the health system
- e. clinical and practice improvement activities.

2. Increased Physician Satisfaction

Some examples may include:

- a. family physicians will feel more connected to each other and experience increased professional satisfaction
- b. recruitment and retention of family physicians will be explored
- c. Division members will feel confidence in their organization and its ability to effectively relate to the partners, providing them with a collective voice used for positive results

- d. Division membership will engage with and include the majority of the community's family physicians.
- 3. Improved Health Care Integration and Coordination
 - Some examples may include:
 - a. family physicians will be able to identify improved relations with specialists and improved access for their patients to specialty services
 - b. the Division will have helped to accelerate integration of Health Authority services with primary health care
 - c. increased awareness among family physicians of HA and community-based services and resources.
- 4. Increased Communication and Collaboration Across the Partners
 - Some examples may include:
 - a. The partners will have positive reports about the benefits of using continuous quality improvement methods when co-designing programs
 - b. CSC actively exploring multiple possible clinical program areas.
- 5. Increased Role in Education
 - Some examples may include:
 - a. the Division will be known by the universities and be aware of potential opportunities for teaching, training, preceptor and research
 - b. increased involvement in medical education of students and residents with an enhanced relationship between professional schools and the GP community.
- 6. Improved Public Confidence
 - Some examples may include:
 - a. the community will express greater confidence in the health system
 - b. visibility of the Division through media, brochures, advertised services and public statements will aid patient awareness of and access to services.

PART 6 - Dissolution

The Partners acknowledge that the collaboration contemplated by the Document of Intent may be dissolved at any time or that any Partner may withdraw from the collaboration at their discretion.

Before dissolution becomes permanent all partners are encouraged to request a hearing of concerns at a meeting of the GPSC.

Appendix B: Divisions Development Flow Chart



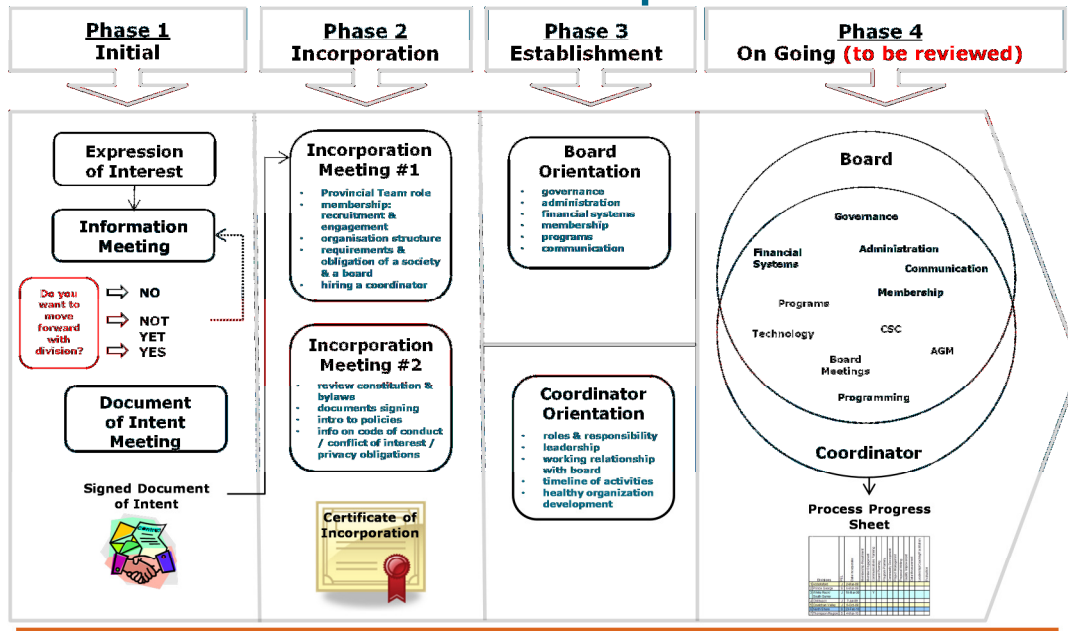
Divisions Development Flowchart



Divisions of Family Practice
A GPSC initiative









Overview of Divisions development



How to read the flowchart

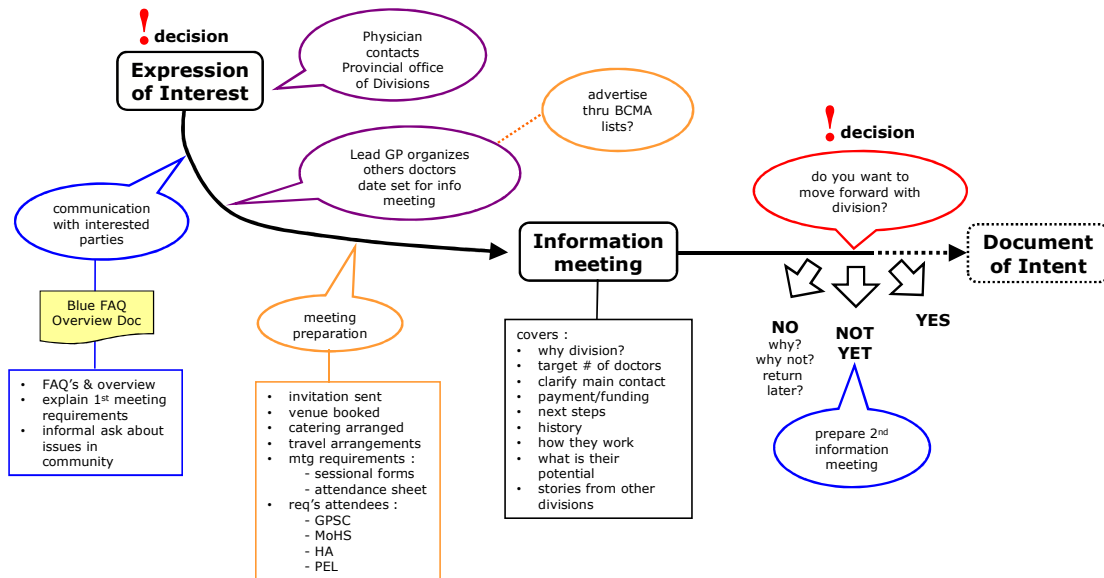
Colour Legend

-  Physician Engagement Leader (PEL)
-  Business Systems Leader (BSL)
-  Division Leadership
-  Provincial Administration
-  Provincial Communication
-  Resources

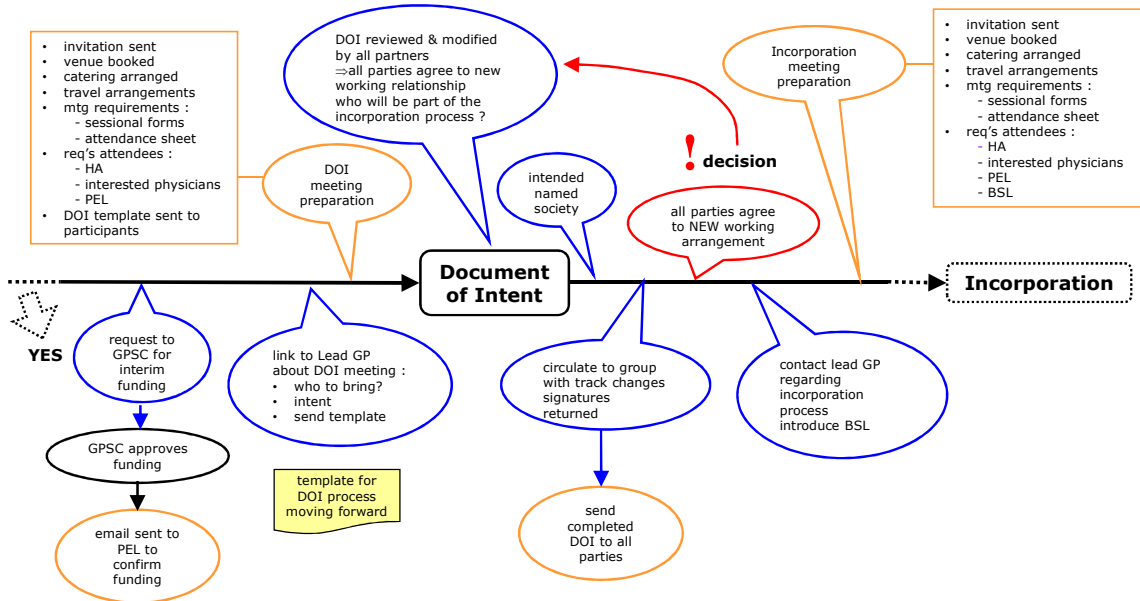
Acronyms Dictionary

- BCMA: British Columbia Medical Association
- BSL: Business Systems Leader
- DOI: Document Of Intent
- GPSC: General Practice Services Committee (BCMA)
- HA: Health Authority
- Lead GP: General Practitioner who is interested in creating a division
- MoHS: Ministry of Health Services
- PEL: Physician Engagement Leader

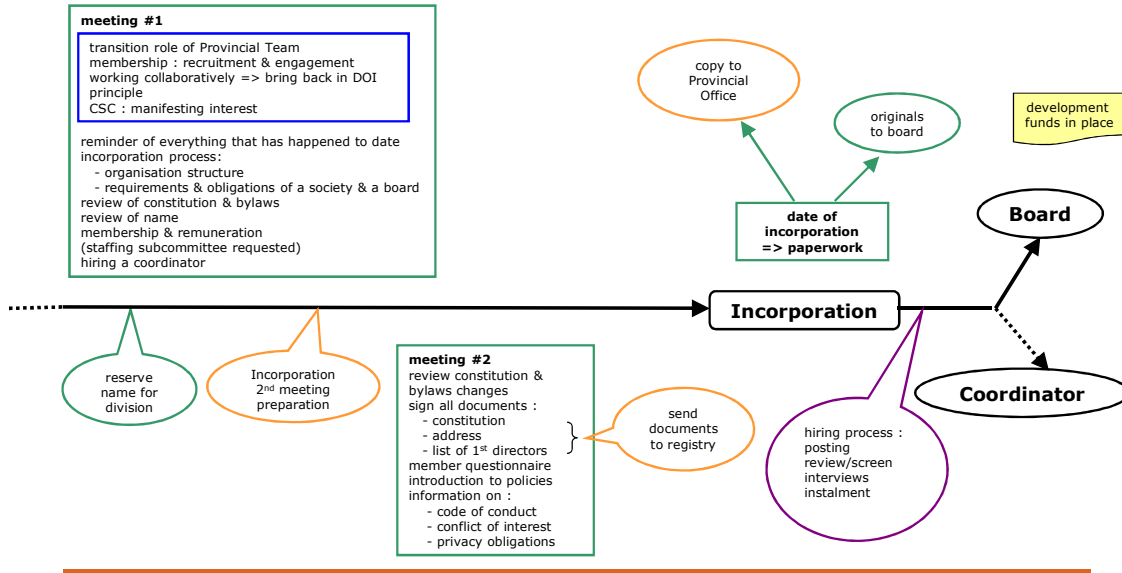
Phase 1: initial



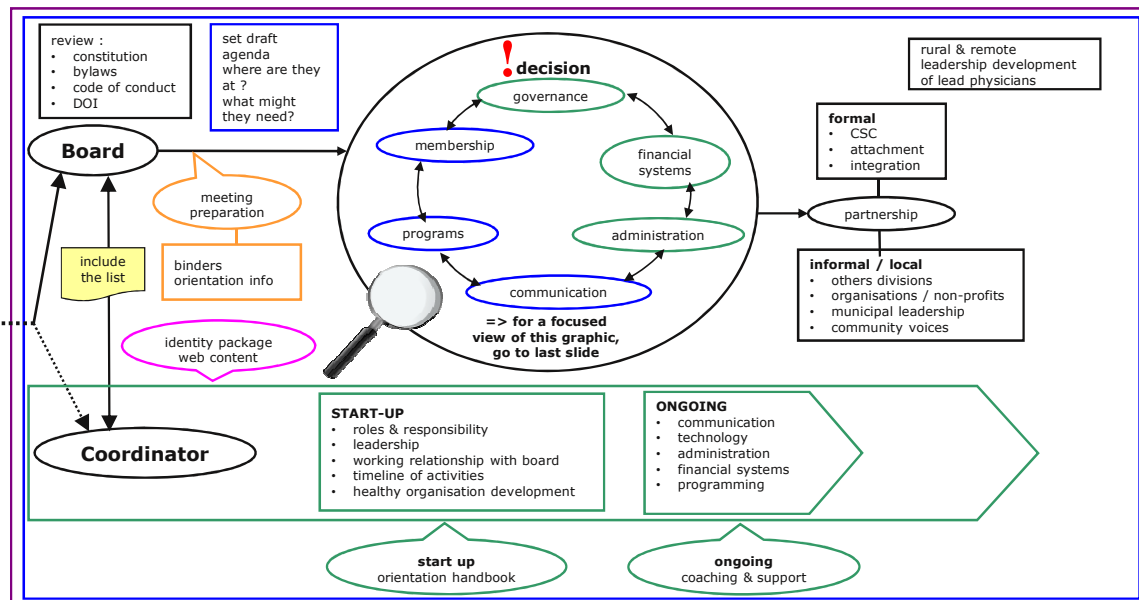
Phase 1: initial (continued)



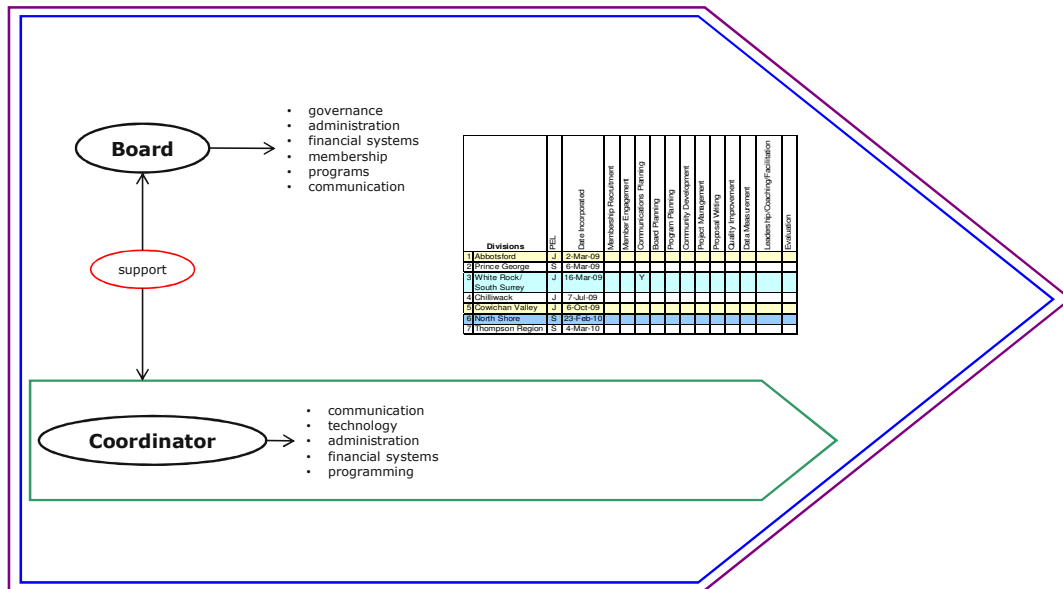
Phase 2: incorporation



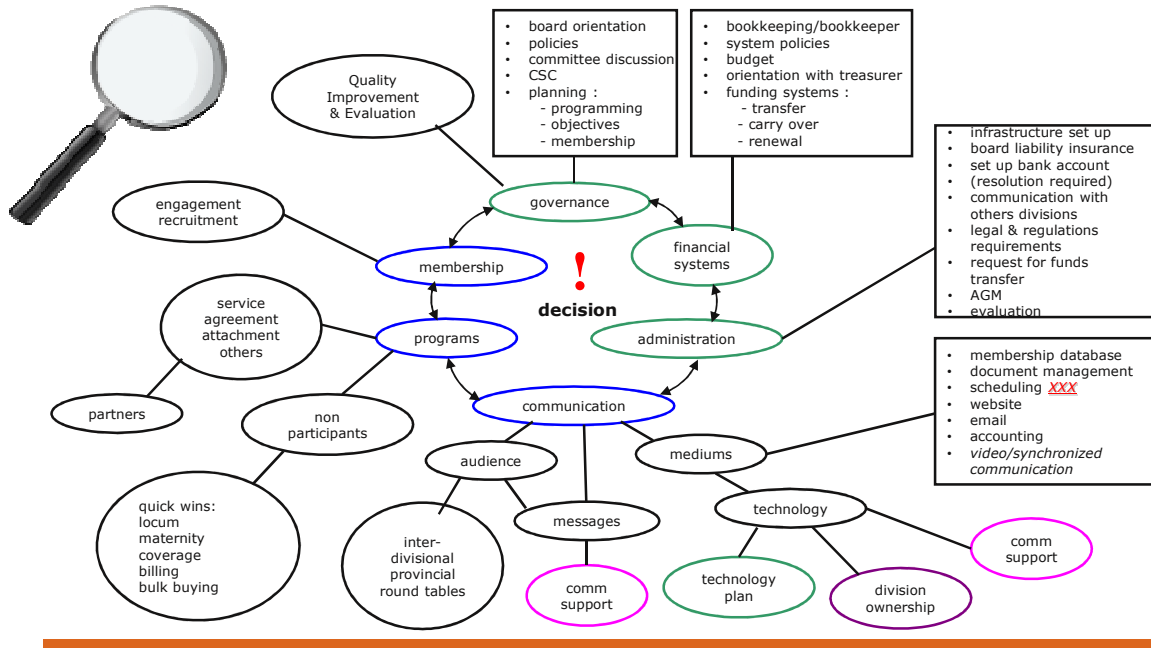
Phase 3: establishment



Phase 4: ongoing (to be reviewed)



Focused view of the graph on Phase 3



Part B: A Participation Guide and Process Handbook

**A participation guide
and process handbook**

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Purpose of this Guide

As the world becomes more and more complex, groups need to work together more and more to solve complex, wicked, messy problems.

Often the meaning of collaboration and the differing expectations about the purpose and nature of involvement in collaborative process vary substantially among participants. These factors are fundamental challenges to the success of collaborative relationships and projects.

The purpose of this guide is to translate the rhetoric and abstract principles of collaborative theory into a framework for collaborative practice. It is provided in the hopes of assisting people working together across organizations in forming a solid foundation for enriching their collaborative experience in order to cultivate collaboration in a way so that great things can be achieved when working together that are not possible when working separately.

This guide offers an assemblage of resources and tools to help address the complex issues, both synergistic and frustrating, that are experienced in navigating collaborative practice. Among others, this guide will address questions such as:

What is collaboration?

What is the value of collaborating?

How can collaboration be successful?

What can be done to make the reality more like the ideal?

What is expected of individual participation?

This guide has been created to support the Divisions of Family Practice initiative, but it is hoped that it will also be of value to the work of others.

What is Collaboration?

Collaboration is a way of working together, in partnership, to realize a shared vision through forming collective responses to shared goals.

Collaboration often begins with the recognition that a problem situation is too complex to be solved by any one organization alone and that solutions are best sought through opportunities created by exploiting the interdependence and the interrelationships of the goals and mandates, and skills and resources of the affected organizations. Beyond problem solving collaboration is a valuable process of discovering new ways to harness opportunities.

The collaborative process involves more than communicating, sharing knowledge and information, and more than cooperating, each working to achieve their own goals.

Collaboration is:

- the development of mutually beneficial relationships and partnerships among people and organizations working together to create and steward a shared vision that goes beyond the possibilities of any one party working alone
- a process of co-designing solutions that address common interests - taking and sharing responsibility, authority, and accountability for achieving results.

Collaboration is a shift away from hierarchical & autocratic way of working. Collaboration requires letting go of old ways and being open to new ideas and new ways of thinking and working together with a willingness to learn from others and to understand others' perspectives & perceptions.

What is the Value of Collaborating?

Collaborating provides a more 'holistic' approach to delivering public health services - through collaboration there is the potential to avoid the fragmentation of responsibilities of service providers.

Runo Axelsson and Susanna Bihari Axelsson¹⁵

Many problems affecting the health and well-being of people and communities are complex and interrelated. A greater understanding of the underlying nature of these problems can be informed through the diverse perspectives of a broad spectrum of people and organizations working together.

The value of collaboration arises when partners working together generate an environment where they are able to draw on a combined pool of knowledge, skills, and resources.

Such environments allow for more diverse and comprehensive analyses of the options available enhancing the potential for the discovery of innovative and higher quality solutions. Solutions borne from collaborative practice have the potential to be richer and more comprehensive than those that could be envisioned by organizations working alone. Ultimately, optimizing the partners' opportunities to achieve shared goals and advance shared visions.

¹⁵ Axelsson, R., & Axelsson, S. B. (2006). Integration and collaboration in public health: a conceptual framework. *The international journal of health planning and management*, 21(1), 75-88.)

The Benefits of Working Together

Working together creates the potential for:

- ensuring every partner's interests are considered in endeavours of joint concern
- making common goals easier to attain through the sharing responsibility and relieving the burden of any one organization
- developing trusting relationships through shared successes laying the foundation for further work together
- delivering greater public benefit through joint efforts than by what organizations could accomplish in isolation

The Benefits of Sharing Knowledge, Skills & Resources

Sharing knowledge, skills and resources creates the potential for ensuring existing resources are utilized in more efficient ways through:

- streamlining and aligning the quality and delivery of services
- maximizing the advantages of economies of scale and scope
- decreasing redundancy in services and duplication of efforts
- enabling organizations to focus on core proficiencies

Themes & Overarching Concepts – Collaboration in Context

Several themes recur in the literature of collaboration: fairness, trust, emergence, power and control, stewardship, and leadership. Positive characteristics of each must be interwoven into all aspects of the collaborative process in order for it to be viable.

Trust

Although common wisdom often assumes that trust is present in successful collaborative partnerships it is also common that there is often caution and hesitation among the partners at the start of the collaborative relationship. It is the establishment of formal agreements that articulate the expectations of each of the partners and the scope of the collaborative work that can assist the participants in trusting each other enough to agree to begin to work together.

Once people do begin to work together trust must continue to be fostered. Often this is accomplished by starting with some small but realistic goals (quick wins or win wins) that are likely to achieve success. This initial strategy of achieving easy wins together is meant to strengthen trusting attitudes and stimulate enthusiasm for further work together.

Fair Process

The basic tenant of fair process is that people “are most likely to trust and cooperate freely with systems - whether they themselves win or lose by those systems – when fair process is observed”¹⁶. Fair process builds trust, cooperation and commitment and is accomplished through engaging people in an impartial mode of decision making that results in decisions being made in the best interests of the overall goals of the group and further, involves clearly communicating why and how the decisions have been made.

Fair process fortifies a valuing of individuals’ ideas and contribution to the process and enhances the opportunities for finding better solutions and deeper commitment to implementing the solutions.

¹⁶ W. Chan Kim, Renee Mauborgne, Fair Process, Managing in the Knowledge Economy, HBR 2003.

Emergence

Emergence is a process and a strategy for accomplishing system-wide change. Networks are the vehicles for emergence¹⁷. Networks are formed when people from interdependent organizations join to work together on common goals and vision.

As relationships are developed within the networks and people begin to utilize their interdependence by sharing resources new knowledge is created allowing for the design of innovative practices. From here, new systems emerge that are better suited in terms of inclusivity, efficiency and capacity for reaching their goals than could have been previously imagined.

With the commitment to share new knowledge and practices among others doing similar work and as promising ideas flow and are adopted among networks, what comes about are powerful new systems that soon become the norm. Working intentionally with emergence can significantly support efforts in making meaningful system-wide change.

Power and Control

It is often perceived that organizations holding the most resources have the most control over an environment and that those without resources are often not in a position to participate equally. However, when partners begin to acknowledge their complimentary sources of power (knowledge, skills, and resources) and their interwoven goals collaboration is made possible.

Shared power and control is central to the notion of collaboration. Once the dynamic associated with control shifts away from unequal distributions of power and dominant decision making processes towards more participative and collaborative decision making processes collaboration becomes possible. Collaboration is only possible when no partner is able to exert unilateral control.

¹⁷ Wheatley, M., & Frieze, D. (2006). Using emergence to take social innovation to scale. *The Berkana Institute*, 1-7.

Stewardship

Collaboration highlights stewardship over individualism. Stewardship is seen as working with a dynamic wholeness, where parts of the whole are not seen as distinct elements but rather integrated in a holistic manner. Barbara Gray believes that a new metaphor of dynamic wholeness is beginning to replace the old individualistic one. Stewardship therefore is a move from old command and control dynamics to one of sharing power and resources.

Leadership

Leadership in collaboration is concerned with the ways and means of reaching the collaborative vision. This includes both behavior of people and the processes embraced. Collaborative leaders should have a strong vision for the collaborative goals, the ability to build relationships with diverse partners, a sense of optimism in the process and a commanding understanding and knowledge of process tools.

Chris Huxam puts forward an interesting perspective: that, although much of what leaders do to forward collaboration is highly facilitative, those same people leading may also be “engaged in manipulating agendas and playing politics”¹⁸. Huxam further contends that those who are successful in leading may operate from both perspectives and that the latter may be a strategy that may help get past stuck places and to resolve collaborative inertia.

¹⁸ Huxham, C. (2003). Theorizing collaboration practice. *Public management review*, 5(3), 401-423.

Harnessing Collaborative Potential: the People and the Processes

Building trusting working relationships in a collaborative partnership depends on the successful merger of personalities and processes.

Understanding the fundamental value of collaboration and having knowledge of the role of individuals and the processes required for collaborative partnerships to be successful is central to harnessing collaborative potential.

The knowledge and understanding of the role of people and processes help build appreciation of the interdependencies and contributions of the parties. When joint appreciation is present the potential for creating positive change and overcoming inherent obstacles is enhanced.

People Factors

The issues of member participation are complex and dynamic. Participants may be coming from new, agile and relational organizations others from more established, bureaucratic and command and control ones. Some may come with skepticism and others with optimism, some with nothing to lose and others with much to lose; some experience change as favorable and others experience it as uncertain or threatening. Recognition of these differences and commonalities will help members to understand their partners' interests and the role of each in the partnership.

Whatever their history, each individual participating in a collaborative partnership shares a pivotal role in creating the successes and obstacles of the collaborative relationship and process.

Successful collaborators have insight into how the attitudes, intentions and behaviours of those working together are central to their successful collaborative endeavours; and that it is essential for people to come together with a willingness to act in good-faith and with a commitment to take ownership and responsibility for the collaborative relationship, process and outcomes.

It is more likely that people will participate collaboratively if they believe that:

- working with others will be productive in serving their interests
- the benefits of participating will offset the efforts
- their interests are better served by working together than by other strategies
- other participants can be legitimate and capable contributors with valuable knowledge and skills to contribute to the process

It is more likely that the collaboration will be successful if the participants enter the relationship willing to:

- devote time and energy for building trusting relationships and for contributing to the activities of the collaboration
- take ownership of their involvement through shared accountability and responsibility
- consider and respect the diverse perceptions and experiences of others
- let go of personal control in order to help create a flexible environment where control is shared
- work together strategically and have a commitment to share and contribute knowledge and resources
- represent the priorities of their organization and not their individual interests
- be aware of inherent challenges and have a realistic approach to addressing the possible obstacles
- be patient and persistent with the process

Process Factors

Establishing processes enables successful collaboration through clarifying expectations and providing guides for people to work together. However, taking the time to identify and implement agreed upon processes can be challenging to new groups as they often focus on substantive issues as priorities.

Groups who understand the value and importance of establishing processes to support their collaborative work and who invest the time it takes to develop them (and their relationships) will assuredly find few obstacles in their path to achieving their expected outcomes.

Defining processes assists with creating environments that value:

- the inclusion of all affected stakeholders
- shared responsibility and control
- mutual empowerment
- learning from experience
- a tolerance for change
- strong leadership
- stewardship over individualism
- opportunities for capacity building

Processes provide strategies for:

- creating shared vision
- articulating group norms and values
- developing trust
- embedding fair practices and open and honest communication
- identifying practical projects to work on
- clarifying role definition of participants
- institutionalizing the collaborative processes and removing disincentives for collaborating
- managing differences and resolving conflict

Explore new ways of working. Be open to new ideas and new ways of thinking and working together.

Keys for Success

There is recognition within the Division initiative that success is supported when the partners are able to:

- hold a patient centered perspective and an emphasis on improving patient experience
- consider the diverse perspectives of others
- to identify problem areas and set priorities
- put forward organizational issues rather than personal interests
- identify their differing interests and priorities and how they relate to the organizations and the partnership
- be open about having multiple roles, objectives and potentially conflicting interests
- provide clear communication explaining activities of their organization when acting on autonomous but over-lapping interests
- clarify any assumptions made based on how they have interpreted information they have received
- take ownership of their participation and responsibility for their role in the success of the collaborative process/relationship
- be patient and persistent with the process
- create opportunities for capacity building and for removing disincentives

What it Takes to Collaborate: Foundations of Collaboration

The foundation of collaboration is fundamental to fostering collaborative success. A supportive foundation is created when shared vision and goals are articulated among the partners and there is clarity about both the aims of working together and the roles of each of the participants.

Establishing and developing thorough frameworks for: making agreements among the participants; communicating within the group and with others, how decisions are made and problems are resolved, as well as for evaluating the outcomes of the group lay the base of the foundation.

These frameworks support the participants to take ownership and responsibility of the collaborative process as well as the outcomes.

Making Agreements

Agreements cover all aspects of collaboration. They serve to clarify the scope including defining the vision and the intent of the collaboration and, further, help to define the problem areas and set out their desired outcomes.

Taking into consideration the principles of interdependence, mutuality and autonomy, agreements guide how the partners will work together - they set the expectations for the collaborative process and clarify the roles and responsibilities for all the participants.

Implicit or explicit in every agreement are the underlying values and principles for working together in a collaborative partnership:

Values

- inclusion of all relevant stakeholders
- agility/flexibility and acceptance of change
- move from command and control to stewardship
- commitment to building trusting relationships
- fair process
- continual learning

Principles

- openness and honesty
- transparent and respectful communications
- ownership and responsibility for process and outcomes
- engaged participation
- dealing constructively with differences

Most importantly, agreements serve as guides for getting things done and moving through impasse.

Open and Clear Communications

Transparent and respectful communication by all participants is of paramount importance for building trust, setting clear expectations and goals, and gaining commitment to engage in fair process from each of the partners. Open and clear communications will assist the partners in working together agreeably.

Even though partners agree to collaborate it doesn't mean that there is no conflict present or that conflict won't arise. Conflict can arise in several areas, for example, from past histories, or through working together to define problems, set priorities or implement solutions.

Developing communicative processes that acknowledge the potential for conflict can expand rather than reduce the capacity for effective collaborative process.

Raising concerns early, discussing issues openly, transparent sharing of relevant information, acknowledging underlying, and addressing difficult issues all help minimize or avoid obstacles that may arise.

These characteristics also set in place support for resolving critical dilemmas in partnerships early and can establish new levels of trust that allow for stronger relationships and more commitment to the partnership.

Decision Making

Decision making is a key responsibility in collaborative processes. Partners need to make decisions by a process of careful deliberation and inclusive of the knowledge and experience of as many stakeholder voices as appropriate.

All decisions need to be aligned with the agreements of the collaborative partners. Examples include the Document of Intent, Terms of References, existing contracts, policies and strategic plans. It is expected that each person will make decisions based on the best interests of the partnership as a whole, exclusive of any personal interests.

There are a number of different approaches to collaborative decision-making, the most common being consensus based. The consensus process allows all participants to be heard and to participate in decision-making. The goal of consensus decision-making is to bring groups to mutual agreement by addressing all concerns, thus helping groups of people work together to make better decisions and get greater results.

Consensus does not require unanimity. Rather, everyone must agree they can live with the decision. Though this process can take longer than other decision-making methods, it fosters creativity, inclusion and commitment to final decisions.

Collective Problem Solving

Collective problem solving provides the opportunity for exploiting collaborative advantages.

Recognizing that the diversity of experiences, knowledges and skills brought to the collaboration are resources the partnership can utilize can highly increase the possibilities for designing better problem solutions. Collective problem solving can lead to opportunities to pool and share resources in ways that enable the provision of services in a manner greater than could be provided working alone.

Collective problem solving can advance efforts to:

- form common definitions of problem areas and more comprehensive understandings of the problems
- generate solution options that address as many interests as possible
- design solutions that represent the complexities of the problem and that are “robust enough to withstand the buffeting from the environment”¹⁹

¹⁹ Gray, B. (1989). Collaborating: Finding common ground for multiparty problems. *San Francisco*.

Measuring Collaborative Outcomes

The GPSC has adopted the 'Triple Aim' and the 'Model for Improvement', both strategies supported by the Institute for Health Care Improvement. The Triple Aim measures against three goals: the improvement of patient and/or provider experience, the improvement of population health, and the contribution to the financial sustainability of the health care system. The Model for Improvement, initially developed by Associates in Process Improvement²⁰, embeds the concept of continuous quality improvement and is a tool for accelerating improvement by setting aims, establishing measures, selecting changes and then testing the changes on a small scale using the Plan Do Study Act cycles.

The intention is for programs to have evaluations built in, be regularly reviewed and then ensure that the intended outcomes are being realized. This approach is seen as advantageous over applying evaluation at the end of a project as it provides the opportunity for applying learnings and making adjustments throughout the course of the project.

When measuring success of a project it also is important to measure the process outcomes as well as the objective outcomes as the more satisfied the participants are with the process the more satisfied and the more ownership they will take of the outcomes²¹.

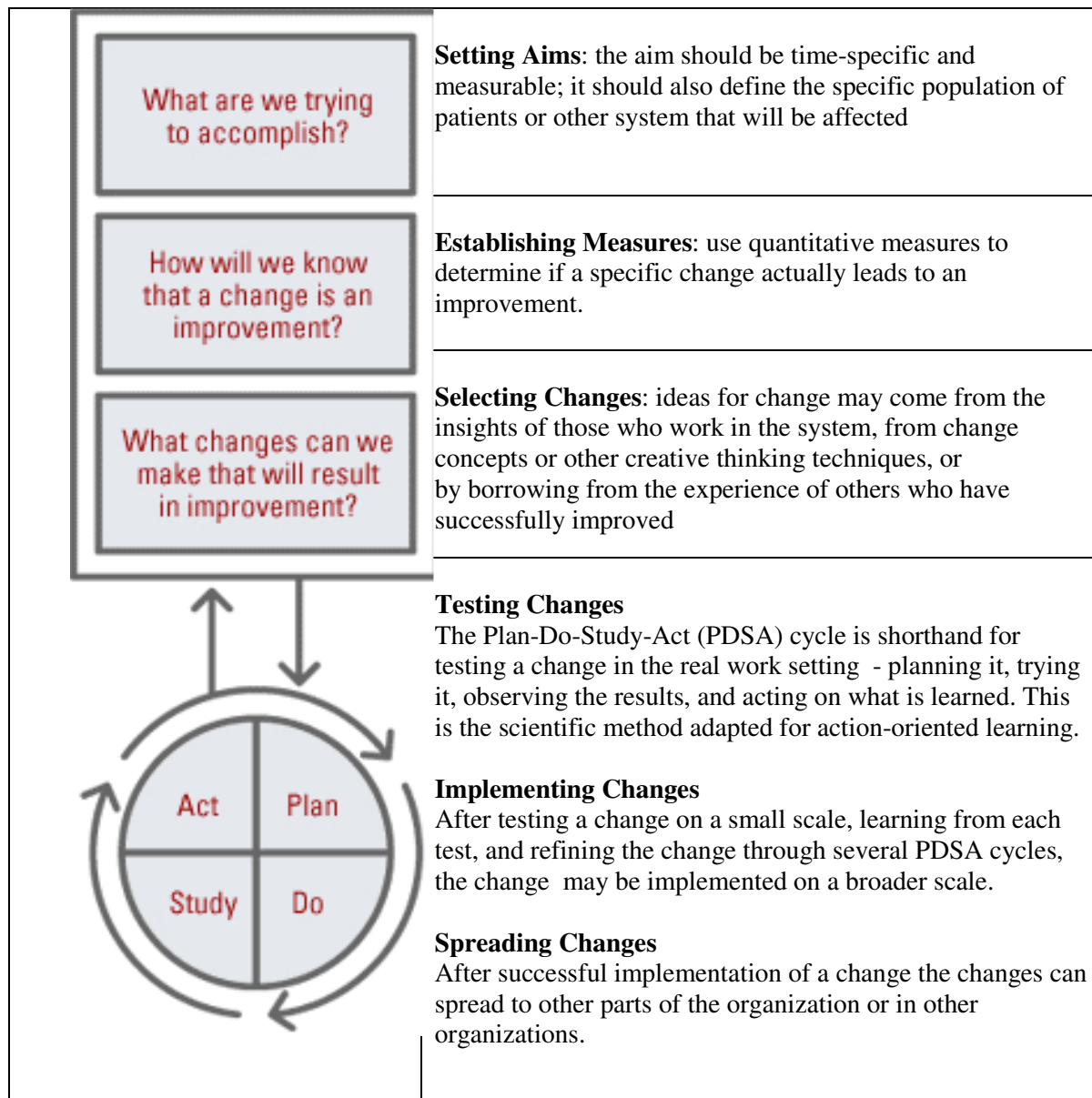
In other words, if the participants do not believe that the issues were addressed and their own interests were satisfied, then the collaboration will not have successful.

²⁰ Langley, G. J., Moen, R., Nolan, K. M., Nolan, T. W., Norman, C. L., & Provost, L. P. (2009). *The improvement guide: a practical approach to enhancing organizational performance*. Jossey-Bass.

²¹ Gray, Ibid

The Model for Improvement

The Model for Improvement²² has two parts: three fundamental questions that can be addressed in any order and the Plan-Do-Study-Act (PDSA) cycle.



²² ²²Adapted from: the Institute for Healthcare Improvement Science of Improvement Series
<http://www.ihl.org/knowledge/Pages/HowtoImprove/ScienceofImprovementHowtoImprove.aspx>

Guiding Questions for Measuring Success:

Were the participants able to:

affect the solution design?
improve their working relationship?
follow fair process?

Was a solution:

- designed?
- implemented?

Does the solution:

- improve/resolve the problem situation?
- create efficiencies?
- produce joint gains?

Is the solution:

- able to be implemented?
- sustainable?

Obstacles and Challenges to Collaborating

A paradox of collaboration is that the same circumstances that can motivate people to collaborate frequently harbour influences that challenge its success.

For instance, often, collaboration is initiated because of a discontent with a current situation. When this is the case the level of discontent that it takes to mobilize collaborative action often stems from past strained relationships often caused by political alliances and/or maneuvering. This history can embed cynicism and skepticism leading to suspicion and distrust among the partners.

In addition to weak or strained relationships among the partners, complexities and challenges derive from several additional potential conditions.

Challenges arise when participants:

- lack insight on how their attitudes and beliefs impact the success of the collaborative process/relationship
- have differing expectations of the vision and goals
- have an agenda pertaining to personal interests beyond their organizational interests'
- do not clarify the assumptions that are made based the presented information
- have a resistance to change
- take unilateral action

Challenges arise when partners:

- have differing perspectives on the criticality or emphasis placed on the problems put forward by the other
- agree on a problem but focus on differing aspects of the problem
- have differing expectations on how much any single or series of meetings might achieve - frustration that process is not moving fast enough, or conversely, is moving too fast
- have different objectives or agendas that occasionally conflict with each other
- there is absence of communication by partner organizations when acting autonomously on over-lapping interests

Challenges are exasperated when there:

- are limited strategies and tools to address the differing positions and issues of the partners
- are clashes of organizational cultures and partners struggle to overcome biases and learn how to work within the characteristic differences within the organizational styles
- is a loss of direction or focus
- is excessive bureaucracy or conversely too little structure

Good news:

Many people find that simply understanding that the problems that they are experiencing are often common in collaborative process is empowering. This knowledge is often enough to enable a shift in collaborative inertia.

Overcoming Obstacles and Challenges

Participants have found the following strategies helpful in overcoming some of the common challenges and obstacles they have faced when engaging in the collaborative process.

When there is:

Indecision about what issues the group should address - Bring problems rather than formulated solutions to the table and engage all parties in framing the issues and designing solutions so that they can be informed by the knowledge and resources of all of the partners

Differing perspectives on the criticality or emphasis placed on the problems put forward by others - Consider the diverse perspective of others

Loss of direction or collaborative inertia - Refocus on the shared vision and goals of the partnership

Lack of insight into the significance of the role of the individual - Educate about the collaborative process and the impact of participants attitudes and beliefs to the success of the partnership

Unilateral activity on autonomous but overlapping interests - Provide clear communication explaining the rationale of the activities

Potentially competing objectives or agendas - Put forward organizational issues rather than personal interests and be open about the presence of partners having multiple interests

Differing expectations of how much might be achieved - Remain patient and persistent with the process and developing meeting processes and group norms to help set the expectations of the group.

Meeting Processes

Designing and implementing meeting processes helps to create an environment where participants can make good use of meeting time by focusing on high level governance issues rather than operational or administrative issues. When time is spent working with the essential or strategic issues of the group participants will be more engaged and be able to provide a higher value contribution.

Michael Wilson, in *The Secrets to Masterful Meetings: Ignite a Meetings Revolution*²³ sets out the following guidelines for preparing for and facilitating meetings in addition setting meeting norms.

Preparing for Meetings – Setting the Agenda

The Agenda is a tool to name, order and prioritize the meeting's topics; prime member participation; and promote and manage a flow of conversation conducive to the desired outcomes.

Used well, an agenda helps keep the discussion on topic and to limit repetitious and out of scope conversations increasing allotted time and opportunity for deeper discussion on issues of focus.

Guidelines for developing effective agenda:

- Structure the agenda to include discussion, information and action topics.
- Draft, and distribute the agenda prior to the meeting.
- Incorporate relevant feedback to the agenda prior to the meeting.
- Make final adjustments to the agenda at the start of the meeting.

²³ Wilkinson, Michael. *The Secrets to Masterful Meetings: Ignite a Meetings Revolution*. Leadership Strategies Pub., 2005.

Facilitating Effective Meetings

The role of the facilitator is either rotated or held by the meeting chair. The role is put in place to assist the participants to have a constructive dialogue by:

- Managing the agenda to ensure it is flexible in order to align with the goals of the meeting
- Checking in with participants at various stages to see if things are going the way they want and incorporating any adjustments needed
- Helping to determine the interests and promote understanding among the participants
- Finding mutually agreeable resolutions to any disputes and facilitating consensus
- Summarizing the decisions made, the actions assigned and to who and timeline for completion, and any outstanding issues to be brought to a future meeting
- Evaluating meeting process to reflect in a constructive manner whether objectives were achieved, highlighting things that were done well and things that could be done better
- Facilitating the conversation to abide by the meeting norms and creating a standard of fairness and equitable representation

Meeting Norms

Meeting norms make explicit the expectations of individual behaviour and articulates the culture that guides collaborative activities. Providing clarity to these processes helps participants to work more effectively with each other. Norms for participating meetings include considerations such as:

- Coming to the meeting prepared and ready to contribute perspective and information
- Respecting meetings start and end times
- Staying on agenda - if during the conversation other topics arise agree to adjust the time allotments or else put them aside to be discussed later in the meeting, or at a future meeting
- Including the participation of everyone - engaging in respectful, open and honest communication
- Discussing difficult issues as they arise
- Honouring opinions and focusing on issues not personalities
- Having no side conversations
- Keeping an action item list and a decisions made list

Meeting Tips:

- Trust the process and know that there will be obstacles and challenges
- Don't attempt to do in half a day what you know to take a day. Understand the tension between getting something done quickly and getting it done well – not always compatible
- Don't undervalue prep time
- Recognize that the presenting issue may not necessarily be the real issue: it may be an initial perspective that focuses more on the symptoms than on the real problem

When Not to Collaborate²⁴

When:

- there are basic ideological differences between the partners that cannot be resolved
- one or more of the partners is not able to be fairly represented
- there are historical antagonisms that cannot be overcome
- an hierarchical structure or a culture of command and control cannot be altered
- the vision of the collaboration is misaligned with the mission of the partner

“IF any of the stakeholders are capable of exerting unilateral control, collaboration does not make sense. It is precisely because the partners hold interdependent sources of power and their fates are interwoven that collaboration is made possible.”

²⁴ Gray, Ibid

The Partnership Committee and Working Groups

Role of the Partnership Committee

The work of a partnership is managed through a partnership committee, for example, a Collaborative Services Committee is a partnership committee.

The first task of a partnership committee (committee) is to develop their Terms of Reference (TOR). A TOR is an agreement among the committee members setting out: the purpose, scope and desired outcomes; the parameters of the work to be undertaken along with their authority and accountability. In addition, the TOR can set their group norms such as how they will meet, make decisions, solve problems and communicate with each other as well as guidelines for meeting schedules, project time frames, resource allocation and reporting procedures²⁵.

The TOR is a great tool for guiding the committee's work, for keeping them on track and for assisting in evaluating their process and progress.

Early in the partnership it is likely that the committee will form as a working committee. As the relationship develops and the responsibility grows the committee will transform to a managing or governance committee.

Whether a working committee or a governance committee it is usual that a committee establish working groups. Working groups are an effective way to better utilize the time, skills and interests of committee members.

Working groups may be formed to fulfill several functions of the committee; these may include, but are not limited to:

- overseeing specific responsibilities of the committee
- managing one of its projects
- enabling the committee to enlist additional more bodies to help accomplish their goals
- performing detailed work on well-defined tasks and make

²⁵ Refer to the Collaborative Services Committee Draft Terms of Reference Template in the Appendix

Working groups take direction from, and act as advisory bodies to the board.

A working group is valid only if it is created at the request of the committee.

Upon appointing members to a working group, the committee will draft a Terms of Reference for the group to complete before they begin their work.

Guidelines for Working Groups

Working groups must follow the direction of the committee and operate in a manner that aids in the fulfillment of the committee's mandate.

The first task of a working group is to develop their Terms of Reference (TOR). A TOR is an agreement among the committee and working group members setting out: the vision and desired outcomes; the parameters of the work to be undertaken along with their authority and accountability.

In addition, the TOR can set their group norms such as how they will meet, make decisions, solve problems and communicate with each other as well as guidelines for meeting schedules, project time frames, resource allocation and reporting procedures.

The TOR is a great tool for guiding the working group's work, for keeping them on track and for assisting in evaluating their process and progress.

Working groups are required to keep the committee informed of their activities.

Unless otherwise specifically provided for through terms of reference the role of all committees shall be advisory only.

All working group members are required to abide by the policies of the committee.

Working Group Terms of Reference - Sample Template

This template provides an outline for establishing the terms of reference for a working group.

Terms of Reference

1. Purpose, Scope & Objectives

The group's mandate: encompassing what problem area or issue is affected and the desired outcomes.

2. Membership Composition

- Composition – who makes up the membership?
- Chair or co-chairs
- Quorum - a majority of the members of the committee.

Working group members are appointed by the committee. Each working group will have a chair or co-chairs. The chair of the committee may be selected by the committee or decided by the working group. Quorum will be a majority of the members of the committee.

3. Member Roles & Responsibilities

Responsibilities of chair(s):

- prepare the agenda and ensure its circulation to attendees (timeframe) prior to each meeting
- facilitate meetings
- ensure that minutes are recorded and distributed to members within (timeframe) of the meeting
- ensure that a record of all meeting documents are maintained
- maintain communication and reporting relationship with the committee

Responsibilities of all members:

- prepare for and attend all meetings
- contribute to the activities of the group
- Respond to committee directives in a timely fashion
- engage in respectful, open and honest communication
- raise underlying or difficult issues, explaining reasoning and intent
- act in good faith and abide by fair process

4. Frequency of meetings

Meets at the call of the chair(s), or insert schedule i.e. 2rd Wednesday of each month from 7 to 9 AM.

5. Minutes

Minutes of meetings will be recorded and circulated to committee members and board.

6. Reporting relationship/procedure

Will report to the committee on matters relating to its responsibility and authority on a regular (insert here i.e. quarterly basis). Items of business are brought to the attention of the committee by the chair(s).

7. Remuneration of Committee Members

Will committee members be compensated – what are the terms?

8. Committee Budget

Define the budget for the committee and the committee projects?

9. Decision-making

Decision will be made by consensus. Consensus decision-making is a group decision making process in which all committee members have their chance to express their views with a focus of discussion amongst the group. Consensus seeks the agreement of participants with minority objections. Consensus does NOT mean everyone gets exactly what they want. It does mean that everyone can live with and support the decision.

10. Meeting Ground Rules

Ground rules set the norms that guide meeting management and help members to work more effectively with each other. Ground rules for committee meetings may include considerations such as:

- meetings start and stop on time
- everyone participates and contributes to the conversation
- there will be no side conversations
- an action and decision item list will be kept

11. Review of Terms of Reference

Schedule for the review of the Terms of Reference, i.e. annually

12. Evaluation – Outcome Measurement

Outline the evaluation process here.

Insight – Developing Collaborative Perspective

These interactive scenarios assist practitioners in exploring the research and conceptual framework underpinning collaborative process. Considering these situations will allow practitioners to explore the stages of collaboration and help highlight why collaborative partnerships work best to address the multifaceted opportunities and challenges involving diverse partnerships.

These scenarios were first introduced at a collaboration workshop designed by the Strategic Initiative Lead and two Physician Engagement Leads²⁶. Participants had the opportunity to share their experiences and engage in group problem solving based on real or case study situations.

Scenario One

The community of Complete, BC and surrounding area is made up of several small suburban and rural communities. Some doctors in the area have formed a clinic that provides specialized care to the Aboriginal communities, with a focus on diabetes. The members of this clinic approached the local division - the Complete Division - stating that there is:

- A shortage of doctors interested in working with this community and several physicians are planning to retire in the next year.
- Exponential growth in the population of Aboriginal people with diabetes.

These colleagues are urging the Division to support their work and to help put something in place to assure that the provision of this care can continue to be provided to this community.

The Bingo Division has been incorporated for 8 months and has held two member engagement meetings. They have begun work on their strategic plan but it is not complete. Through the member engagements, the Division did not identify Aboriginal care as one of their top priorities but did name recruitment as an issue. The board agrees with the clinic physicians that this is important issue and would like to be involved in finding a solution.

²⁶ Thank you to Jim Mactair and Lisa Adams

The Division has just begun to build their relationship with their local health authority and are unsure of how the health authority is structured and do not know what issues the health authority has prioritized. Historically, their relationship with the health authority has been “spotty.” The Division is also aware of other community organizations but are unsure of their mandates or involvement in health generally or with the Aboriginal community.

What steps would you take to develop a division, health authority and community supported response to supporting an Aboriginal health program in collaboration with the partners?

Guiding Questions:

1. What could the Division do to ensure they have the support of their members?
2. In moving forward, who should be at the table and how would you get them there?
3. What do you see as the role of each of these partners, including the Division, the health authority, any community players, Aboriginal people and the PEL?
4. What options do you see for funding models and what process would you use to ensure this support?
5. Can you identify the potential barriers to progress and suggest ways to mitigate these?
6. What factors would be essential in the design of any program to support this issue?
7. Focus on evaluating the “process” for this, using a ‘collaboration lens’. What would tell you you’ve had a successful collaborative partnership?

Scenario Two

Identify the challenges at building a collaborative relationship and suggest changes/solutions to both parties.

Situation: Poor Attitudes/Lack of a Trusting Relationship

The HA partner is on the verge of retirement. He has been asked to sit on this new committee to work “collaboratively” with doctors. After years of working with doctors he feels annoyed and angry that he has to sit at a meeting with them. He finds them annoying, entitled and spoiled. He is NOT looking forward to this experience.

The physician partner has had nothing but bad experiences whenever she has come into contact with any health authority staff. Her colleagues have warned her about this particular HA representative and she is coming to the table fully forewarned and nervous based on her past experience. She is NOT going to let any bureaucrat “push her around.”

Guiding Questions:

1. What do you see as the role of each of these partners, including the Division, the health authority, and the PEL?
2. What options do you see for building trust and improving attitudes and what process would you use to ensure this support?
3. Can you identify the potential barriers to progress and suggest ways to mitigate these?

Scenario Three

Identify the challenges at building a collaborative relationship and suggest changes/solutions to both parties.

Situation: Structural Challenges/Lack of Understanding of Each Other's Worlds

The HA representative is a willing and sympathetic listener and understands the challenges family doctors have in working with the system. Her boss has put her at this table because he was instructed to. However there is no budget, it is added work to her already very busy schedule and there is little support from her boss, or her boss's boss to do anything meaningful in terms of system change.

The division representative is full of grand ideas and wildly enthusiastic to change many many things within the system. He has NO idea how a HA works and is not really interested in finding out. He wants change YESTERDAY and can't understand what the problem is and why the HA rep is NOT listening to him.

Guiding Questions:

1. What options do you see for identifying issues to work on and what process would you use to ensure this support?
2. Can you identify the potential barriers to progress and suggest ways to mitigate these?
3. What factors would be essential in the design of any program to support this issue?

Scenario Four

Identify the challenges at building a collaborative relationship and suggest changes/solutions to both parties.

Situation: Hidden Agendas/No Commitment to Shared Priorities

The HA rep. comes to the table with a specific project that he wants to convince the division they must do. If he can convince the doctors that this HA priority is a good one, he'll receive a bonus from his boss.

The physician representative has a pet project. She has not passed this project by her board and the board has not polled the general membership about the idea. She feels this would be great for her practice and can't understand why the HA is being obstructionist in not agreeing to help her implement this project.

Guiding Questions:

1. In moving forward, who should be at the table and how would you get them there?
2. What could the Division do to ensure they have the support of their members?
3. What could the HA do to encourage the support of the partners?
4. Can you identify the potential barriers to progress and suggest ways to mitigate these?

Resource Guide Appendix

Collaborative Services Committee Terms of Reference – Sample Template

DRAFT - COLLABORATIVE SERVICES COMMITTEE, TERMS OF REFERENCE - T E M P L A T E – Version 8

BACKGROUND:

The _____ Division of Family Practice (the Division), the _____ Health Authority, the British Columbia Medical Association (BCMA), the Ministry of Health (MoH) and the General Practice Services Committee (GPSC) (hereafter “the Partners”) recognize a shared responsibility for the health of the community. These Partners agreed upon signing the Document of Intent forming the _____ Division that they would work together through a Collaborative Services Committee (CSC) to address issues in the health care system.

PURPOSE:

The _____ CSC embodies the collaborative working relationship among the Partners. Here the Partners will present clinical issues of concern for patient care outcomes, co-determine priorities and co-design solutions, calling on additional voices from patients and the community. This collaborative process is not intended to mirror traditional negotiations.

SCOPE:

The _____ CSC is an innovative way of co-generating solutions to the complex, serious and interconnected issues facing the health care system, the delivery of care and the experience of care. Supported by the _____ CSC, it is expected all Partners will work to continually improve patient care and systems efficiencies within their sphere of influence.

MEMBERSHIP:

From the Division: 2 or 3 members, at least one from the Board executive or designate
From the _____ Health Authority: 2 members, one a primary care executive or designate
From the GPSC: 1 member or designate
From the Community: 2 members,

The Division and the _____ Health Authority will co-chair the _____ CSC.

Additional Division members, _____ Health Authority, MoH, GPSC, or BCMA leaders will be invited to attend discussion and decision making processes where the topic under discussion affects their area of responsibility.

As needed, representation will be requested from the medical community, patients and the community at large to ensure the _____ CSC is addressing issues that reflect community concerns for primary care, support existing programs and answer the needs of those they are intended to serve.

Working groups of the CSC will have membership as established by the Partners and a Terms of Reference based on this document.

DECISION MAKING:

Decisions will be made by consensus. Consensus is achieved when everyone accepts and supports a decision and understands how it was reached. In meetings where significant decisions are to occur, all partners will be notified and encouraged to attend.

OBJECTIVES:

The CSC will:

- provide a forum for the Partners to develop a mutual understanding of the problems, priorities, strengths and issues of the community, supporting a population health approach
- provide a forum to bring together those who deliver clinical services and those charged with designing and supporting the health care system, to ensure all Partners understand each others cultures, strategic priorities, ways of working, points of view, priorities, points of leverage and limitations
- enhance working relationships of the Partners, ensuring broad clinical influence in system design, improving opportunities for alignment and supporting the overall sustainability of the system, recognizing that this creates a partnership greater than the sum of its parts.
- co-determine the development of clinical priorities and innovative clinical activities of the work in common, developing and monitoring these initiatives using the principles of continuous quality improvement
- ensure the Partners are supported (through data, administrative assistance, governance systems, etc) to understand and address gaps in patient care or quality of care in community and facility settings
- ensure all Partners understand their role in supporting continuous quality improvement²⁷ through mechanisms such as imbedding on-going evaluation and measurement to ensure emerging programs are meeting intended outcomes.

EXPECTATIONS OF PARTNERS:

- All Partners agree to use Triple Aim²⁸ to discuss which issues to move forward and which possible solutions to pursue. The Triple Aim approach ensures three things:
 - an improved patient or provider experience of care
 - an improvement in population health. The population will be defined by the project being considered
 - the financial sustainability of the system. Financial sustainability is defined here as the need to ensure all proposed programs are financially scaleable and

²⁷ See the Institute for Healthcare Improvement website (ihi.org) for the article “Road map for quality improvement” and other resources on continuous quality improvement (CQI). Essentially, programs designed with CQI will have evaluations built in, will be regularly reviewed and, if needed, will be adapted to ensure that the intended results are happening. This contrasts with using evaluation only at the end of a project, when adaption is no longer possible.

²⁸ See ihi.org for more information on the Triple Aim and examples of projects.

able to be offered Province-wide to any appropriate community, physician or patient who wants them

- All Partners will agree to provide or collect data to support or clarify the concerns they bring to the CSC for consideration, understand the potential impact of solutions and support the on-going evaluation of co-designed programs
- The Partners agree to bring issues or root causes to the table and not pre-determined solutions, trusting that the co-design of solutions using the perspectives of all Partners will generate innovation
- All Partners will facilitate the sharing of knowledge, success stories and learnings among the Partnership organizations, Divisions, patients and the community.
- All Partners will be transparent with each other about
 - their areas of influence and barriers to influence
 - their strategic and operational priorities for primary care
 - proposed changes in their organizations that will affect local health care.

ACCOUNTABILITY:

- The Partnership is accountable for the results achieved or not achieved, with an emphasis on continuous quality improvement and a commitment to the ongoing improvement of co-developed programs to ensure the best possible results for patients, providers and the community
- All Partners are accountable to any funding Partner or outside funding agency to ensure funds provided for programs are used effectively. External funders will determine their systems for accountability. When the funding is internal to the CSC, accountability for effective use of funds will be contained in the measures and evaluation sections of any agreement.
- After the first year the CSC will create an annual report to be distributed to the organizations that support the CSC and the constituencies it serves, such as its patients and communities.
- The Division of Family Practice coordinator will collect items for the agenda, compile and circulate the agenda, record minutes at meetings and circulate them promptly with action items clearly listed.
- Members will communicate matters of importance between their own organizations and the CSC. The minutes and records of the CSC will be available to members to circulate inside their organizations to cultivate support.

MEETINGS:

Meetings will be held as deemed necessary or requested by the Partners, with a minimum of quarterly meetings. Any Partner can request a meeting of the CSC.

AMENDMENTS:

In the spirit of continuous quality improvement, the Partners will continually evaluate if the CSC structure and terms of reference are supporting innovation and better patient care. Amendments to the terms of reference based on community and regional differences can be made and approved through the consensus of all Partners, represented by their CSC members. If the CSC needs additional support or assistance it may approach the GPSC.