COLLABORATIVE PRACTICE AND PATIENT PARTNERSHIP IN HEALTH AND SOCIAL SERVICES
A competency framework for Collaborative Practice and Patient Partnership in Health and Social Services

In what way is this framework a significant innovation?

Who are the intended users of this framework?

Under what circumstances could the framework be used?

Appendix 1: Clarifications regarding intervention plans and services plans

Appendix 2: Overview of the competencies related to collaborative practice and patient partnership in health and social services

Principal documentary sources

Competencies, capacities, and descriptors

Preambles

List of acronyms

Credits

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LIST OF ACRONYMS

CEPPP: Centre of Excellence on Partnership with Patients and the Public
CHU: Centre hospitalier universitaire [university hospital centre]
CIHC/CPIS: Canadian Interprofessional Health Collaborative/Consortium pancané-
dien pour l'interprofessionnalisme en santé
CIO-UdeM: Comité interfacultaire opérationnel de formation à la collaboration inter-
professionnelle et patient partnership de l'Université de Montréal [interfaculty operational committee for training in interprofessional collaboration and patient partnership of the Université de Montréal]
CISSS: Centre intégré de santé et de services sociaux [integrated health and social services centre]
CIUSSS: Centre intégré universitaire de santé et de services sociaux [integrated university health and social services centre]
CNESST: Commission des normes de l'équité, de la santé et de la sécurité du travail [commission on norms for equity, health, and workplace safety]
CSS: Cours Collaboration en sciences de la santé [course on collaboration in health sciences]
DCPP: Direction collaboration et partenariat patient (DCPP) [Collaboration and Patient Partnership Unit (CPPU)]
DIP: Disciplinary Intervention Plan
DPJ: Direction de la protection de la jeunesse [Department of Youth Protection Services]
EPS: École des partenaires en santé [Health Partnership School]
FPP: Direction de la protection de la jeunesse [Department of Youth Protection Services]
HSc: Health Sciences
IIP: Interdisciplinary Intervention Plan
IISP: Intersectoral Individualized Services Plan
IP: Intervention Plan
ISP: Individualized Services Plan
MSSS: Ministère de la santé et des services sociaux [Ministry of Health and Social Services]
MCU: Université de Montréal
SMART: Specific, Measurable, Attainable/Attractive, Realistic, Timely
UdeM: Université de Montréal
A competency framework for Collaborative Practice and Patient Partnership in Health and Social Services

WHY?

In a collaborative practice and patient partnership approach, optimal provision of healthcare and social services inevitably requires the development and maintenance of competencies and a change in behaviours, both in practitioners and in patients. The aim of the present document is to present these competencies. It is inspired by several works on this subject:

- the Canadian National Interprofessional Competency Framework (CIHC, 2010);
- the works of the Conseil central des compétences of the Université de Montréal’s Faculty of Medicine, with respect to adapting the CanMEDS 2005 Physician Competencies Framework (2013);
- the CanMEDs 2015 Physician Competency Framework;
- the Patient Competency Framework (DCPP, 2015); and
- the content of the CSS courses (1900-2900-3900) for training in interprofessional collaboration offered to UdeM undergraduate students in health sciences and psychosocial sciences.

WHAT COMPETENCIES?

The proposed competency framework consists of a core competency with cross-cutting competencies that patients and health and social services professionals develop together over time, in carrying out their roles and responsibilities in various settings. Each competency is expressed as a set of capabilities, that is, of moderately complex actions, behaviours, or tasks. Each capability, in turn, is broken down into a set of observable actions or tasks (descriptors), which are verbal or non-verbal behaviours specific to the context of care and services. Thus, the core competency of planning, implementing, and monitoring healthcare and social services encompasses seven cross-cutting competencies that will be mobilized to different degrees depending on the situation. These competencies will develop more or less rapidly depending on the level of education, practice, or experience of the persons involved and on the complexity of situations. The involvement of patient partners in education, in research, and in healthcare and services settings has led to the definition of patient partner profiles. For more information on this, consult the DCPP’s Terminology document.

These cross-cutting competencies are:

- teamwork;
- clarification of roles and responsibilities;
- communication;
- collaborative leadership;
- therapeutic education and health education;
- clinical ethics;
- conflict prevention and resolution.

PREAMBLE

A competency is a set of knowledge, skills and attitudes that, when coupled with good judgment and used in a specific healthcare and social services context, enables practitioners to achieve optimal health outcomes. In view of patients’ inclusion as full partners in the team, they are expected, like practitioners, to develop and maintain the different competencies.

The proposed competency framework consists of:

- conflict prevention and resolution;
- clinical ethics;
- therapeutic education and health education;
- collaborative leadership;
- communication;
- clarification of roles and responsibilities;
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Under what circumstances could the framework be used?

- Public education aimed at a general audience
- Training students, trainees, and residents in health sciences or psychosocial sciences
- Continuing professional development of health and social services practitioners
- Training trainers
- Strengthening collaborative practice and patient-partnership in teams
- Evaluation of collaborative practice and patient-partnership in health and social services organizations
- Recruitment of practitioners into health and social services organizations
- Recruitment of patient partners in health and social services organizations

In what way is this framework a significant innovation?

- This framework is co-constructed by patients, family caregivers, educators, professionals, managers, and health and social services researchers.

Toward the development of collaborative practice and patient-partnership in health and social services organizations

The competencies developed in the framework may be expressed in different ways as follows:

- Knowledge: the practitioners share their knowledge and knowledge with their own patients and caregivers.
- Skills: the practitioners share their knowledge and knowledge with their own patients and caregivers.

This competency framework is intended for the following users:

- The public at large (summary version)
- Patients and caregivers (family members or significant others)
- Health and social services practitioners and students
- Health and social services decision-makers
- Health and social services researchers
- Teachers in the fields of health sciences and psychosocial sciences
- Managers and decision-makers in health and social services organizations
- Students in fields of health sciences and psychosocial sciences

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The framework will be particularly useful in the following circumstances:

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- Training students, trainees, and residents in health sciences or psychosocial sciences
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Learning in action

These competencies are developed in action, at times when patients and practitioners are engaged in health and social services. The development of competencies is strengthened by mutual feedback at opportune times (reflection on action). Practitioners provide support to facilitate the development of patients' competencies, while patients broaden the practitioners' vision and knowledge with their own experiential knowledge.

What are the intended users of this framework?

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- Researchers in health and psychosocial sciences education
COMPETENCIES, CAPACITIES, AND DESCRIPTORS

1. PLANNING, IMPLEMENTATION, AND MONITORING OF HEALTHCARE AND SOCIAL SERVICES

Description of the competency

As partners in healthcare and social services, patients and practitioners collaborate to plan and coordinate their actions in response to the patient’s needs, health problems, and psycho-social situation. This collaboration takes into account the patient’s life project. They function in ways that are concerted, personalized, integrated, and continuous.

Based on mutual recognition of the complementarity of scientific, professional, and experiential knowledge, the relationship that is thereby developed among the partners is part of a dynamic process of interaction, learning, and exchange of information with a view to supporting patients in making free and informed choices. Patients and practitioners share responsibilities synergistically to achieve optimal health outcomes in accordance with the patient’s specific situation.

Planning of healthcare and social services is accomplished by developing and implementing an intervention plan or service plan. Four instruments are used for this purpose: the disciplinary intervention plan (DIP); the interdisciplinary intervention plan (IIP); the individualized service plan (ISP); and the individualized and intersectoral services plan (IISP). (See the description of these instruments in Appendix 1.)

CAPACITIES

related to the competency

DESCRIPTORS

(observable behaviours and attitudes)

The patient partner and practitioners in a team:

1.1 Prepare to develop the intervention plan (DIP or IIP, as appropriate)

A) Identify the patient’s life project, needs, health problems, and psycho-social problems

1. Identify the patient’s life project, needs, expectations, and concerns.

2. Prepare a list of the patient’s health problems and any problems related to the patient’s psycho-social situation.

3. Assess the patient’s current and expected health status and any problems related to the patient’s psycho-social situation.

4. Share and exchange information coming from different sources.

5. Use their own specific tools* to collect the relevant information on the patient’s health status, psycho-social situation, and psycho-social problems.

B) Prepare for the various steps involved in planning healthcare and services, in particular, for the team meeting to develop the interdisciplinary intervention plan (IIP)

1. Determine together the patient’s strengths and experiential knowledge so that these can be used to best advantage in preparing the plan.

2. Identify together, if needed, the member of the patient’s family or network who will accompany the patient in the process of planning healthcare and social services.

3. Prepare to develop the interdisciplinary intervention plan (IIP) in cooperation with practitioners assigned to accompany the patient in this process.

4. Prepare the information that will be presented at the IIP meeting, taking into account the needs, health problems, and psycho-social problems.

* Patient: diary or logbook, observation grids, online tools (telehealth), etc.

* Practitioners: DIP template specific to their profession, validated questionnaires, electronic patient record, practice guidelines, etc.
### Planning, Implementation, and Monitoring of Healthcare and Social Services

#### 1.1 Develop an Intervention Plan (DIP or IIP) or Service Plan (ISP/IISP)

**A)** Identify the patient’s priority needs and the objectives to be targeted to consider while developing the DIP (patient and practitioner) or the IIP (patient and practitioners on the team)

- Exchange information and share knowledge to equip the patient to make free and informed choices.
- Prioritize with patient needs and problems to be addressed in the DIP/IIP, taking into account the patient’s life project, desires, and expectations.
- Formulate SMART (Specific, Measurable, Attainable/Attractive, Realistic, and Timely) goals for each of the priority problems.

**B)** Plan the interventions for each objective

- Determine the appropriate interventions for each of the SMART goals by analyzing the different possible options (advantages, risks, and potential difficulties) and ensuring that everyone understands them.
- Specify the frequency, duration, sequence, and schedule of every intervention.
- Clarify the roles and responsibilities of the patient and practitioners for each intervention.
- Determine the methods that will be used to monitor the interventions and the date at which the intervention plan (DIP/IIP) will be reviewed.

**C)** Plan the services that will be provided by different resources

- Coordinate the services in accordance with the patient’s life situation.
- Determine the type, frequency, sequence, anticipated duration, and schedule of services allocated, taking into account the patient’s health status and psychosocial situation.
- Specify the needs not met by the resources allocated and propose alternative solutions.
- Specify the roles and responsibilities of each person, including those of the patient and caregivers (family members or significant others).

#### 1.2 Implement and monitor the intervention plan

- Carry out, in a concerted manner, the different interventions specified in the intervention plan (DIP/IIP) or provide the services allocated in accordance with the patient’s health status.
- Assess, at predetermined time and, if necessary, again at later dates, whether the objectives targeted by the intervention plan (DIP or IIP) were attained or are in the process of being attained; and whether the services allocated were provided in accordance with the services plan (ISP/IISP).
- Analyze, as needed, the reasons why the objectives (DIP or IIP) were not attained or the allocated services (ISP/IISP) were not provided, and then adjust the objectives, interventions, or services accordingly.

#### 1.3 Ensure continuity of care and services during the transition to another stage

- Plan (DIP/IIP) or services plan (ISP/IISP)
- Ensure the continuity of care and services.
- Plan, verbally and in writing, a safe transition, whether within the same institution, between points of service, or in the community (including the patient’s home), or even to another sector (education, work, etc.).
- Prepare the patient’s transfer well and ensure that the continuity of care and services is maintained.
- Ensure that the patient’s transfer goes well and that the continuity of care and services is maintained.
2. TEAMWORK

Description of the competency

The patient partner and the practitioners in a team implement processes for teamwork and group dynamics to achieve optimal functioning. The team includes the patient partner, and, depending on the setting, practitioners from community services, primary care services, or specialist services. It can also include practitioners from the entire health and social services continuum.

CAPACITIES related to the competency

DESCRIPTORS (observable behaviours and attitudes)

The patient partner and practitioners in a team:

2.1 Interact in ways that will create and maintain healthy team dynamics

- Show respect for the members of the team, their roles, and responsibilities, and for their decision-making.
- Encourage a climate of respect among team members.
- Help to identify difficulties in decision-making to the members and seek ways to manage them and address them.
- Search for information needed for good team functioning.
- Work together to achieve outcomes.
- Help to identify the most effective means of communication within the team and maintain them.
- Take part in organizing the team and respect its rules and operational procedures.
- Express disagreement constructively if they witness any member’s lack of respect towards another member.

2.2 Participate in the team’s organization and functioning

- Show that they understand the climate they witness among members, the level of respect towards another member.
- Respect the members of the team and their decision-making, support them, and offer them help according to one’s own capacity.
- Show solidarity in decision-making by the team as a whole.
- Respect the participation of the members in the team.
- Respect the participation of other members of the team.
- Respect and show the contribution of other members of the team, including those of the patient.

2.3 Encourage the implementation of principles

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- Show solidarity in decision-making by the team as a whole.
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<table>
<thead>
<tr>
<th>The patient partner and practitioners in a team:</th>
<th>Related to the competency CAPACITIES</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.4 Participate in developing and evaluating</td>
<td>- Participate in collective learning processes to continuously improve their competencies and improve team practices.</td>
</tr>
<tr>
<td>observed behaviors and attitudes</td>
<td>- Use tools to support collaborative work (e.g. IIP).</td>
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<tr>
<td>DESCRIPTORS</td>
<td>- Participate in a process of improving the quality of care and services provided by the team.</td>
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<td>- Participate in a collective learning process to continuously improve their competencies and improve team practices.</td>
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<td>- Participate in identifying and discussing any difficulties when decisions are taken by the team.</td>
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<td>- Participate in team self-evaluation and in the implementation of improvements.</td>
</tr>
</tbody>
</table>

The patient partner and practitioners in a team:
- Participate in developing and evaluating observed behaviors and attitudes (descriptors) related to the competency CAPACITIES.
### 3. CLARIFICATION OF ROLES AND RESPONSIBILITIES

#### Description of the competency

The patient partner and the practitioners in the team understand each other's roles and responsibilities. Because of this, they are able together to attain the health and well-being objectives targeted for the patient partner. They are able to explain or clarify their roles and responsibilities in different health and social services contexts.

#### CAPACITIES related to the competency

**DESCRIPTORS** *(observable behaviours and attitudes)*

<table>
<thead>
<tr>
<th>The patient partner and practitioners in the team</th>
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</thead>
<tbody>
<tr>
<td><strong>3.1</strong> Encourage each person's full exercise of their roles and responsibilities in the team: the clinical manager, the practitioners, and in particular, the patient partner.</td>
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<tr>
<td>Recognize the importance of the roles and responsibilities of each person in the team, and give each person the time and space required to assume his/her own roles and responsibilities.</td>
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<tr>
<td>Make it possible for each person to mobilize their strengths and take into account their limitations in carrying out their roles and responsibilities in the team.</td>
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<tr>
<td>Identify together the patient's needs so that the patient can carry out his/her role in the team optimally.</td>
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<tr>
<td>Identify together the resources available to support the patient in carrying out his/her role in the team.</td>
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<td>Assume their responsibilities by doing all of the tasks assigned to them within a reasonable time frame.</td>
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<tr>
<td>Clarify their roles and responsibilities towards other members of the team, and particularly towards the patient.</td>
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<tr>
<td>3.2 Carry out their roles and responsibilities in the team.</td>
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<td><strong>3.2.1</strong> Identify the areas of overlap (grey areas) in team members' roles and responsibilities, and share tasks optimally.</td>
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<tr>
<td>Explain the limitations of their roles to other members of the team.</td>
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<td>When acting, take into account the scope of action of other team members.</td>
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<tr>
<td>Accept the support provided by members of the team with complementary expertise and strengths.</td>
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<tr>
<td>Support the members of the team in carrying out their roles and responsibilities.</td>
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The patient partner and practitioners in the team understand each other's roles and responsibilities in different health and social services contexts. They are able to explain or clarify their roles and responsibilities. Because of this, they are able together to attain the health and well-being objectives targeted for the patient partner.
4. COMMUNICATION

Description of the competency

The patient partner and the practitioners in the team communicate with each other in a timely manner, effectively, and in a spirit of respect, openness, and collaboration. They specify the most appropriate methods of communication according to the nature of the information to be shared, the time available, and the persons involved. They are careful to select and arrange a physical space that will be conducive to discussions and support confidentiality. They clarify all technical or professional terminology that could impede understanding and adapt their language to the different people with whom they interact. They are sensitive to the expression of emotions and concerns and respond to them appropriately. They measure the impact of their statements on others and adjust themselves accordingly.

CAPACITIES related to the competency

DESCRIPTORS (observable behaviours and attitudes)

The patient partner and practitioners in a team:

4.1 Promote a climate of openness and respect

- Contribute to creating a climate of trust that is conducive to open, respectful, and honest discussions among team members.
- Encourage team members to express their emotions and concerns in an open and respectful manner.
- Ensure the physical environment is conducive to open, respectful, and honest discussions.
- Support team members in expressing their emotions and concerns appropriately.
- Communicate effectively with each other and with the patient.
- Contribute to creating a climate of trust that is conducive to open, respectful, and honest discussions among team members.

4.2 Establish and maintain communication

- Identify the best method of communication to use with each member of the team.
- Respond to team members’ non-verbal behaviours to optimize communication.
- Make the impact of their statements on others and adjust themselves accordingly.
- Ensure that all team members express their emotions and concerns in an open and respectful manner.
- Observe the physical environment to ensure everyone’s comfort and safety and to support discussions in a spirit of partnership.
- Exchange ideas with team members that are open and transparent and that are adapted to each person’s demographic and cultural characteristics.
- Communicate effectively with each other and with the patient.

4.3 Share relevant information clearly and securely

- Use various information and communication technologies to facilitate discussions.
- Provide information and explanations that are clear and precise and that are understood by everyone, and in particular, the patient.
- Use language that is common to everyone and that is understandable and adapted to the patient.
- Train members to communicate in a timely manner, effectively, and in a spirit of respect, openness, and collaboration.
- Contribute to creating a climate of trust that is conducive to open, respectful, and honest discussions among team members.
5. COLLABORATIVE LEADERSHIP

### Description of the competency

The patient partner and the practitioners in the team each contribute, from their particular knowledge base, to the construction of a shared vision for the optimal provision of care and services. They question practices and policies that are inconsistent with the vision, and they work together to develop and implement strategies that are consistent with the vision. They also work to improve the quality of care and services by identifying areas for improvement, developing action plans, and evaluating the impact of their actions.

### CAPACITIES related to the competency

#### DESCRIPTORS (observable behaviours and attitudes)

- The patient partner and practitioners in a team:
  - Exercise their leadership while respecting that of other team members
  - On their own initiative, take their proper place on the team.
  - Assert their own convictions, while respecting those of others.
  - Solicit opinions or suggestions from other members of the team.
  - Express their concerns about a decision that is in the process of being adopted.
  - Are willing to tolerate ambiguity as long as the situation does not have a negative impact on the patient's well-being, health, or needs.
  - Recognize situations in which leadership from other members of the team should be encouraged.
  - Actively support other team members and value their contributions.
  - Account for situations in which leadership from other members of the team should be encouraged.
  - Actively work to develop an environment of respect and trust, where members of the team feel safe to express their thoughts and feelings.
  - Establish a collaborative approach to decision-making that includes input from all members of the team.
  - Assess their own contributions and evaluate their impact on the team.
  - Consider their role in facilitating the team's progress towards achieving its goals.
  - Express their leadership style and values with confidence.

### LEADERSHIP IN THE TEAM

- 5.1 Apply their knowledge (scientific, professional, and experiential) when exercising their leadership in the team
  - Express their intentions clearly and with conviction.
  - Drive respect and attention when they speak.
  - Create opportunities for team members to discuss and share knowledge and experiences from their field of expertise, including the patient's experiential knowledge related to living with illness.
  - Use effective arguments that stimulate team members' interest.
  - Tailor their strategies for persuasion and influence according to their audience.

- 5.2 Support the team in attaining its mission and objectives
  - Question the team on its mission and objectives when it is veering away from them.
  - Help the team to structure its actions.
  - Initiate actions that will enable the team to attain its objectives.
  - Encourage reflection within the team to deepen the understanding of a complex situation.
  - Initiate a review by the team of its functioning when a situation calls for an adjustment.

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### Related to the competency

5. COLLABORATIVE LEADERSHIP

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6. THERAPEUTIC EDUCATION AND HEALTH EDUCATION

Description of the competency
The patient partner and the practitioners in the team commit to a continuous learning process, through which the patient develops an understanding of his/her health status and illnesses. They periodically assess the patient's needs and decide together on the best ways to help the patient look after himself/herself. They co-construct solutions that are appropriate and acceptable to each person. As such, the patient progressively becomes more autonomous in managing his/her health status and becomes an integral part of the team. The ultimate aim of this process is to enable the patient partner to have a better quality of life and carry out his/her life project optimally.

CAPACITIES related to the competency

DESCRIPTORS (observable behaviours and attitudes)

<table>
<thead>
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<th>The patient partner and practitioners in a team:</th>
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<tbody>
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<tr>
<td>Explore the patient’s personal, family, psychosocial, and environmental characteristics, as well as any biological and genetic factors that influence his/her health status (health determinants).</td>
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<tr>
<td>Identify the patient’s strengths and experiential knowledge related to living with illness.</td>
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<tr>
<td>Clarify the patient’s emotional reactions in response to his/her health situation.</td>
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<tr>
<td>Exchange relevant information on the patient’s health situation, illnesses, and risk factors for illnesses, making sure there is a common understanding.</td>
</tr>
<tr>
<td>Identify the patient’s life project and what impact his/her health situation has on the ability to carry out this life project.</td>
</tr>
<tr>
<td>Identify what is impeding the patient’s well-being and ability to carry out this life project.</td>
</tr>
<tr>
<td>Agree on priority needs in a climate of respect for the patient’s free and informed choice.</td>
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</tbody>
</table>

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Collaborative practice and Patient partnership in health and social services

6.2 Explore possible therapeutic options and outcomes.

6.3 Plan and implement a personalized educational program.

6.4 Gradually build a relationship of trust.

6.5 Create a reflexive approach to their shared professional networks.

6.6 Create and maintain an environment of trust through continuous mutual exchange of information.

6.7 Collaborate and adapt to challenges in the educational process.

6.8 Use the educational sessions to strengthen and mobilize the patient's social networks.

6.9 Develop strategies for the patient's daily life and the patient's experience and the patient's experience and the patient's experience and the patient's experience and the patient's experience and the patient's experience and the patient's experience.
### Clinical Ethics

**Description of the competency**

When faced with an ethical problem, the patient partner and the practitioners in the team enter in good faith into a dialogue to ensure the patient is fully supported throughout a process of free and informed choice. Once the problem has been clearly explained, their process consists of identifying the elements of the problem, analyzing it, and resolving it, taking into account collective needs and available resources. Afterwards, all the partners involved conduct a reflexive assessment of the process.

### Capacities related to the competency

**Descriptors (observable behaviors and attitudes)**

<table>
<thead>
<tr>
<th>Capacities</th>
<th>Descriptors</th>
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</thead>
<tbody>
<tr>
<td>Participate in identifying the elements of the situation</td>
<td>Agree on the complexity of the situation and initiate a problem resolution process. Identify the actors involved in the problem. Describe the facts and the emotions related to the situation and validate each person's perceptions. Recognize the multiplicity of values involved and their influence on each person's perceptions and behaviors.</td>
</tr>
<tr>
<td>Participate in analyzing the situation</td>
<td>Identify the problems arising from the description of the situation. Clarify each person's motives and intentions. In choosing what actions to take to resolve the situation, consider the overall context, and the various requirements—scientific, professional, ethical, organizational, and governmental (e.g. laws and norms on free and informed choice, confidentiality)—as well as the availability of resources. Engage the controversies and developments in the values, perceptions, and options of all the partners (patient, practitioners, clinical managers, and managers of health and social services organizations). Identify the problems arising from the description of the situation.</td>
</tr>
<tr>
<td>Participate in resolving the situation</td>
<td>Based on evaluation of the different possible options, ensure the patient chooses, in a free and informed manner, the one that seems most appropriate to him/her in the given situation. Adapt their actions to the patient's preferences, as well as to the patient's life project, needs, and health status. Determine whether the situation has been resolved in the patient's best interests, with the participation of all partners involved, and with full respect for the patient's decision. If necessary, adjust their actions to achieve an optimal resolution of the situation.</td>
</tr>
<tr>
<td>Participate in reflexively assessing their process</td>
<td>Identify the strengths and pitfalls of their process. Participate, with all the partners, in a self-assessment of their actions and of the team's functioning. If a recurrent issue is identified on the basis of this particular situation, identify possibilities for improving the health and social services system. Clarify what has been learned on all sides.</td>
</tr>
</tbody>
</table>

Ethical problems can arise in complex human situations and can involve

- Technological, physical, moral, medical, or ethical problems.
- Decision-making processes of patients, practitioners, and auxiliary professionals.
- Conflicts or disagreements among patient, practitioners, and auxiliary professionals.
- Limited or non-existent accessibility to resources (specialized, technological, physical, material, medication, or others).
### 8. CONFLICT PREVENTION AND RESOLUTION

#### Description of the competency

The patient partner and the practitioners in the team engage actively in preventing and resolving any conflicts that emerge within the team, in a spirit of collaboration where all opinions are taken into account. The practitioners in the team avoid inflicting unnecessary tension on the patient caused by strained relationships among themselves and strive to resolve any such tensions quickly.

#### CAPACITIES related to the competency

**DESCRIPTORS**

The patient partner and practitioners in a team:

1. **Establish and maintain harmonious relations**
   - Practise active listening and show empathy towards the members of the team, while respecting each person's point of view.
   - Interact constructively and with tact.
   - Are receptive to feedback given to them on their behaviours or attitudes.
   - Express to other team members, when appropriate, their discomfort with any behaviours towards themselves, stating the facts without making value judgments.
   - Recognize and manage their emotions appropriately in situations of tension or disagreement.

2. **Detect and defuse situations that could create tensions**
   - Identify, individually or as a team, any disruptive tensions or behaviours in the team.
   - Participate in analyzing the nature and source of these tensions.
   - Intervene rapidly and with tact when a team member behaves disruptively.
   - Acknowledge, when appropriate, their own responsibility with regard to any tense situation.
   - Suggest ways of alleviating tensions when there are disagreements in the team or with another health and social services partner.

3. **Participate in resolving conflicts within the team**
   - Identify their instinctive approach to conflict resolution.
   - Adapt their conflict resolution strategy to different contexts.
   - Participate in describing the conflict to be resolved.
   - Separate out the similarities and differences among the team members’ views, with a view toward reaching a common understanding.
   - Strive to actively seek and secure support among the team for the conflict.
   - Support the patient partner in developing and implementing an action plan to resolve the conflict.
   - Implement the action plan and monitor the outcome of the conflict.
Competency Frameworks


CLARIFICATION OF ROLES AND RESPONSIBILITIES


COMMUNICATION


CLINICAL ETHICS


THEORETICALLY FUNDAMENTED MEDICAL EDUCATION

Therapeutic education and health education

Collaborative practice and patient partnership in health and social services
Competency Framework


COLLABORATIVE LEADERSHIP


CONFLICT PREVENTION AND RESOLUTION


Conseilrh.ca. (n.d.). Workplaces that work. Conflict at work. Available at: http://hrcouncil.ca/hr-toolkit/workplaces-conflict.cfm

Planning healthcare and social services is accomplished by the patient partner and the practitioners working together to develop and implement an intervention plan or service plan.

A. The disciplinary intervention plan (DIP) is developed by the patient and a practitioner from a single discipline. Each practitioner develops, with the patient, an intervention plan (IP) that is specific to their profession, using their own particular tools. Thus, for example, a physician, a nurse, a pharmacist, or a social worker working with the same patient will each develop an IP with the patient, individually and in parallel.

B. The interdisciplinary intervention plan (IIP) is developed when the complexity of the patient's health and psychosocial situation requires mobilizing and coordinating the efforts of several professions with those of the patient, based on priorities assigned to certain problems as well as on shared objectives. To develop an IIP, a formal team meeting is held (in person, by telephone, or through other communication methods), with the patient included as a full member of the team along with all practitioners concerned. Before this meeting, the practitioners will have shared information either through the patient's medical record, by telephone, or in informal meetings. Besides preventing duplications and inconsistencies in the actions of various partners, the IIP meeting is an opportunity to encourage development of the patient's self-determination, while taking into account his/her capacities and presenting different options for intervention. In some cases, a pivot practitioner or case manager will coordinate the interventions.

The process around the IIP consists of four major steps, which call for specific and different contributions from the patient, the practitioners, and the clinical managers:

1. Preparation
2. Development
3. Implementation
4. Evaluation

C. An individualized services plan (ISP) or an intersectoral individualized services plan (IISP) may also be developed when several health and social services organizations are involved with the patient (e.g. CISSS and CHU), or when partners from other sectors work together with the health and social services sector, such as: education (e.g. schools), justice (e.g. department of youth protection), employment (e.g. businesses and CNESST), housing (e.g. affordable housing), and municipalities. These plans focus on coordinating the provision of services among the service providers of these different establishments or organizations, with the patient: frequency and schedule of service provision, distribution of roles and responsibilities, and so on. The development of these different plans must be in accordance with the patient’s preferences and needs, and the results of the IIP must be integrated into these plans.

In all cases, multiple objectives:

- Synthesize the essential information collected by the patient and the practitioners.
- Create a tool (digital or paper) to be consulted by the patient and practitioners to keep track of the intervention.
- Structure the discussions to produce an overall assessment of the patient’s needs, while taking into account his/her life project.
- Set shared objectives based on the list of needs and problems considered to be of primary importance.
- Take into account the patient’s capacities and vulnerabilities.
- Encourage development of the patient’s self-determination, as well as the development of different options for intervention.
- Agree together on the interventions that are most realistic, appropriate, and suited to the patient’s needs, based on the patient’s strengths and experiential knowledge, and taking into consideration his or her vulnerabilities and limitations.
- Distribute the various tasks and responsibilities among the patient and the practitioners.

Sometimes the patient will need to transition towards another stage of care and service providers in the hospital and community will be involved in the transitions.

An IIP has multiple objectives:

- To manage concurrent intervention in some cases, a pivot practitioner or case manager will coordinate the interventions.
- To develop different options for intervention in some cases, a pivot practitioner or case manager will coordinate the interventions.
- To develop different options for intervention in some cases, a pivot practitioner or case manager will coordinate the interventions.
APPENDIX 2: OVERVIEW OF THE COMPETENCIES RELATED TO COLLABORATIVE PRACTICE AND PATIENT PARTNERSHIP IN HEALTH AND SOCIAL SERVICES

The patient partner and the practitioners in a team develop the following competencies and capacities:

- **Collaborative leadership**: 
  - The team in resolving conflicts within current tensions and design situations that could enhance and maintain harmonious relations.

- **Teamwork**: 
  - Participate in resolving the situation and making the team decisional elements face with an ethical approach.

- **Conflict prevention and resolution**: 
  - Establish and maintain harmonious relations.
  - Detect and defuse situations that could create and maintain healthy team dynamics.

- **Further education and health education**: 
  - Share an overall understanding of the patient's situation, illnesses, and risk factors.
  - Explore possible therapeutic options and educational objectives.
  - Plan and implement a personalized educational program.
  - Gradually build a relationship of trust through continual mutual exchange of information.

- **Planning, implementation, and monitoring of healthcare and social services**: 
  - Participate in developing and evaluating the intervention plan.
  - Participate in the development of the intervention plan (DIP or IIP).
  - Develop an intervention plan (DIP or IIP) or services plan (DSO or ISP).
  - Prepare to develop the intervention plan (DIP or IIP).

- **Communication**: 
  - Participate in identifying the elements of the patient's situation.
  - Participate in analyzing the situation.
  - Participate in resolving the situation.

- **Clinical ethics**: 
  - Participate in reflecting on the ethical problem.
  - Participate in analyzing the situation.
  - Participate in resolving the situation.

- **Clarification of roles and responsibilities**: 
  - Encourage each person's full exercise of their roles and responsibilities in the team.
  - Carry out their roles and responsibilities in the team.
  - Identify areas of overlap (grey areas) in team members' roles and responsibilities and share them.

- **Therapeutic education and health education**: 
  - Share an overall understanding of the patient's situation, illnesses, and risk factors.
  - Explore possible therapeutic options and educational objectives.
  - Plan and implement a personalized educational program.
  - Gradually build a relationship of trust through continual mutual exchange of information.

- **Teamwork**
  - Participate in resolving the situation and making the team decisional elements face with an ethical approach.

- **Planning, implementation, and monitoring of healthcare and social services**: 
  - Participate in developing and evaluating the intervention plan.
  - Participate in the development of the intervention plan (DIP or IIP).
  - Develop an intervention plan (DIP or IIP) or services plan (DSO or ISP).
  - Prepare to develop the intervention plan (DIP or IIP).

- **Communication**: 
  - Participate in identifying the elements of the patient's situation.
  - Participate in analyzing the situation.
  - Participate in resolving the situation.

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  - Participate in reflecting on the ethical problem.
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  - Plan and implement a personalized educational program.
  - Gradually build a relationship of trust through continual mutual exchange of information.