Framework

Competency Framework

COLLABORATIVE PRACTICE AND PATIENT PARTNERSHIP IN HEALTH AND SOCIAL SERVICES

Université de Montréal

This document is available in its entirety in electronic format (PDF) on the website of the Centre of Excellence on Partnership with Patients and the Public: https://ceppp.ca/en/resources/

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For the sake of brevity, in the present document the notion of "patient" systematically includes caregivers. Caregivers can be family members or significant others that are not a member of the family, such as a close friend or a neighbour.

The notion of "team" includes the clinical manager, the patient, and the professional and non-professional health workers involved with a patient in the continuum of care and services.

A partnership is created when a practitioner enters into relationship with the patient and there is creation, between them, of a relationship of collaboration, equality, and recognition of each other's knowledge, with a view to progressively equipping the patient to take his/her own health situation in hand. In this sense, the patient and the service provider form a team.

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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 pancanadien pour l'interprofessionnalisme en santé
CIO-UdeM:	Comité interfacultaire opérationnel de formation à la collaboration interprofessionnelle en partenariat avec le patient 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 du partenariat en santé [Health Partnership School]
IIP:	Interdisciplinary intervention plan
IP:	Intervention plan
IISP:	Intersectoral individualized services plan
ISP:	Individualized services plan
MSSS:	Ministry of Health and Social Services
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 in partnership with patients offered to UdeM undergraduate students in health sciences and psychosocial sciences

WHAT COMPETENCIES?

> *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 patients and practitioners to achieve optimal health outcomes.*

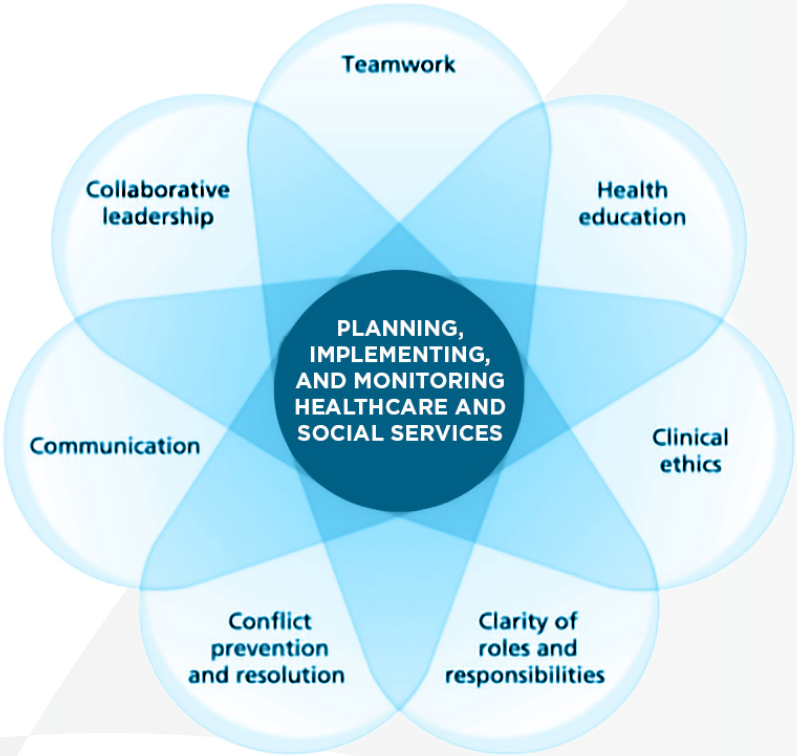
The proposed competency framework consists of a core competency with cross-cutting competencies that patients and health and social services professionals develop together over time, in carrying out their roles and responsibilities in various settings.

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 different 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.



In view of patients' inclusion as full partners in the team, they are expected, like practitioners, to develop and maintain the different competencies.

In what way is this framework a significant innovation?

- This framework is co-constructed

  Patients and family caregivers, educators, professionals, managers, and health and social services researchers worked together on its construction.

- The patient and practitioners develop their competencies together

  In view of patients' inclusion as full partners in the team, they are expected, like practitioners, to develop and maintain the different competencies, at their own pace. The processes for developing these competencies, as well as how these competencies are expressed, can be different for practitioners and for patients, depending on the context.

- Learning in action

  These competencies are developed in action, at times when patients and practitioners are engaged in healthcare 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.

Who are the intended users of this framework?

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 psychosocial sciences education
- researchers in health and psychosocial sciences education

Under what circumstances could the framework be used?

The framework will be particularly useful in the following circumstances:

- public education aimed at a general audience
- training students, trainees, and residents in health sciences or in psychosocial sciences
- continuing professional development of health and social services practitioners
- training trainers
- strengthening collaborative practice and patient partnership in teams
- evaluating the quality of collaborative practices and patient partnership in health and social services, teaching, and research organizations
- recruiting practitioners into health and social services organizations
- recruiting patient partners in health and social services, teaching, and research organizations

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 psychosocial situation. This collaboration taking into consideration 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 psychosocial problems*** ▸ Use their own specific tools* to collect the relevant information on the patient's health status, psychosocial situation, life project, expectations, and concerns. ▸ Share and validate the information coming from different sources. ▸ Identify the patient's life project, needs, expectations, and concerns. ▸ Prepare a list of the patient's health problems and any problems related to the patient's psychosocial situation. ▸ Assess the patient's desire and capacity to be involved in planning his/her care and services and take these into account in the following steps. * 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.
	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)*** ▸ Use their own specific tools to prepare the information that will be presented at the meeting to develop the IIP with the support of practitioners assigned to accompany the patient in this process. ▸ Determine together the patient's strengths and experiential knowledge so that these can be used to best advantage in preparing the IIP. ▸ 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 services.

CAPACITIES related to the competency	DESCRIPTORS (observable behaviours and attitudes)
	The patient partner and practitioners in a team:
1.2 Develop an intervention plan (DIP or IIP) or services 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 their knowledge in order to equip the patient to make free and informed choices. ▸ Prioritise with patient needs and problems to be addressed in the DIP/IIP objectives, 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 (ISP/IISP)*** ▸ 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).
1.3 Implement and monitor the intervention plan (DIP, IIP) or services plan (ISP/IISP)	▸ 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 ISP/IISP. ▸ Assess at a pre-determined 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.
1.4 Ensure continuity of care and services during the transition towards another stage 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 for this transition. ▸ Verify that the patient's transfer went well and that the continuity of care and services was maintained.

2. TEAMWORK

Description of the competency

The patient partner and the practitioners in the 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	▸ Recognize and value the contributions of other members of the team, including those of the patient. ▸ Establish a relationship of trust with the other members of the team. ▸ Facilitate the integration of a new member into the team. ▸ Show solidarity regarding the decisions taken by the team as a whole. ▸ Recognize when members of the team are experiencing difficulties, support them, and offer them help, according to one's own capacity. ▸ 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	▸ Take part in organizing the team and respect its rules and operational procedures. ▸ Help in identifying the most effective means for communicating within the team and managing time. ▸ Work together to achieve outcomes. ▸ Search for information needed for good team functioning. ▸ Help to identify difficulties when making decisions on the mandate and shared targets and participate in developing appropriate solutions. ▸ Participate in identifying factors that can impede the team's functioning and relationships among the members. ▸ Give feedback to the members of the team, constructively and respectfully, on any disagreement that negatively affects team functioning. ▸ Show flexibility with regard to changes aimed at improving service efficiency.
2.3 Encourage the implementation of principles of collaboration in decision-making	▸ Take into account, in their interactions, the roles and responsibilities, as well as the experience and expertise, of other members of the team. ▸ Ensure decisions are taken in an environment where every member of the team can express their opinion without undue pressure. ▸ Respect the opinions of the others and be open to their specific personal or professional attributes. ▸ Develop a critical vision of the different points of view expressed by their peers. ▸ Show their commitment to the decisions taken by the team.

CAPACITIES related to the competency	DESCRIPTORS (observable behaviours and attitudes)
	The patient partner and practitioners in a team:
2.4 Participate in developing and evaluating the team	▸ Participate in a collective learning process to continuously improve their competencies and to improve team practices. ▸ Participate in team self-evaluation and in the implementation of improvements. ▸ Participate in identifying any difficulties when decisions are taken by the team. ▸ Use tools to support collaborative work (e.g. IIP). ▸ Participate in a process of improving the quality of care and services provided by the team. ▸ Contribute to periodically obtaining feedback on the team's functioning.

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)
	The patient partner and practitioners in a team:
3.1 Encourage each person's full exercise of their roles and responsibilities in the team: the clinical manager, the practitioners, and in particular, the patient	▸ Recognize the importance of the roles and responsibilities of each person in the team, and give the patient the time and space required to assume his/her own roles and responsibilities. ▸ 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. ▸ Identify together the patient's needs so that the patient can carry out his/her role in the team optimally. ▸ Identify together the resources available to support the patient in carrying out his/her responsibilities in the team.
3.2 Carry out their roles and responsibilities in the team	▸ Clarify their roles and responsibilities towards other members of the team, and particularly towards the patient. ▸ Carry out the tasks inherent to their roles, in a spirit of complementarity. ▸ Assume their responsibilities by doing all of the tasks assigned to them within a reasonable time frame. ▸ Use their knowledge of the other team members' roles and responsibilities to optimally assess the patient's needs and to address those needs while taking into account the patient's life project and priorities. ▸ Adapt their roles to the contexts and constraints of different health and social services settings.
3.3 Identify areas of overlap (grey areas) in team members' roles and responsibilities and share tasks optimally.	▸ Explain the limitations of their roles to other members of the team. ▸ When acting, take into account the scope of action of other team members. ▸ Accept the support provided by members of the team who have complementary expertise and strengths. ▸ Support the members of the team in carrying out their roles and responsibilities. ▸ Share tasks, taking into account the complexity, nature, and urgency of the situation, as well as the availability, constraints, and responsibilities of the various team members. ▸ Use the formal tools available for sharing the responsibilities and interventions, particularly the IIP.

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 professional or technical terminology that could impede the understanding of the information being exchanged. They adapt the level of their language to that of the different people with whom they interact. They are sensitive to the expression of emotions and respond with tact. The patient partner participates actively in conversations about him/herself, including in teaching situations with trainees and residents.

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 discussion among the team members. ▸ Communicate with each other as equals. ▸ Exchange ideas with team members that are free of any value judgments and that are adapted to each person's demographic and sociocultural characteristics, particularly those of the patient. ▸ Optimize the physical environment to ensure everyone's comfort and safety and to support discussion in a spirit of partnership, with respect for the patient's dignity and private life. ▸ Encourage team members' expression of emotions and concerns and respond to them appropriately. ▸ Measure the impacts of their statements on others and adjust themselves accordingly.
4.2 Establish and maintain communication	▸ Identify the best method of communication to use with each member of the team. ▸ Take into account the various team members' receptivity, availability, and constraints whenever they are communicating information to them. ▸ Respond to team member's non-verbal behaviours to optimize communication.
4.3 Share relevant information clearly, concisely, and securely	▸ Use language that is common to everyone and that is understandable and adapted to the patient. ▸ Provide information and explanations that are clear, precise, and timely, and ensure they are understood by everyone, and in particular, the patient. ▸ Obtain, summarize, and communicate all relevant information, with the patient's consent. ▸ Synthesize for team members, at the appropriate times, relevant information on the patient's situation, according to their own specific perspectives. ▸ Use various information and communication technologies appropriately to facilitate discussions.

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 take part in developing the team and in improving the quality of care and services. Acting with determination, enthusiasm, and humility, they support and inspire their care and services partners. They question practices constructively and guide the team towards potential solutions, in a strategic manner, while taking into account the context.

CAPACITIES related to the competency	DESCRIPTORS (observable behaviours and attitudes)
	The patient partner and practitioners in a team:
5.1 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 their team members and value their contributions. ▸ Use available human and material resources judiciously.
5.2 Apply their knowledge (scientific, professional, and experiential) when exercising their leadership in the team	▸ Express their intentions clearly and with conviction. ▸ Inspire 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.
5.3 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.

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 him/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.

N.B.

While therapeutic education may be practised in all health and social services contexts, it is particularly used in the management of chronic illnesses. ***Therapeutic education*** *will be optimal to the extent that continuity of care and services is ensured by the same practitioner or team of practitioners so that a relationship of trust is created between the patient partner and the practitioners.*

As for the ***health education*** *competency proposed in this framework, it refers mainly to illness prevention and health promotion interventions (e.g. breastfeeding, physical activity, prevention of sexually transmitted and blood-borne infections, vaccination). It is exercised in the context of an individual consulting a practitioner or a team and differs from the population-based approach, which is the responsibility of public health teams.*

CAPACITIES related to the competency	DESCRIPTORS (observable behaviours and attitudes)
	The patient partner and practitioners in a team:
6.1 Share an overall understanding of the patient's situation, illnesses, and risk factors for illnesses and identify the patient's priority needs	▸ Explore the patient's personal, family, psychosocial, and environmental characteristics, as well as any biological and genetic factors that could influence his/her health status (health determinants). » needs » values, beliefs » culture, religion, spiritual life » income, work » general literacy and health literacy » interests and recreational activities » living and working environments » family, social, and community support networks ▸ Identify the patient's strengths and experiential knowledge related to living with illness. ▸ Clarify the patient's emotional reactions in response to his/her health situation. ▸ Exchange relevant information on the patient's health situation, illnesses, and risk factors for illnesses, making sure there is a common understanding. ▸ Identify the patient's life project and what impact his/her health situation has on the ability to carry out this life project. ▸ Identify what is impeding the patient's well-being and ability to carry out his/her life project. ▸ Agree on priority needs in a climate of respect for the patient's free and informed choice.

CAPACITIES related to the competency	DESCRIPTORS (observable behaviours and attitudes)
	The patient partner and practitioners in a team:
6.2 Explore possible therapeutic options and identify the educational objectives	▸ Identify the behaviours and attitudes that support the patient's physical and emotional well-being. ▸ Examine the different options available in light of the patient's living environment and support network, as well as the patient's material and financial resources. ▸ Select the acceptable options and set educational objectives in line with those.
6.3 Plan and implement a personalized educational program	▸ Formulate a personalized program that involves sharing responsibilities. ▸ Develop therapeutic strategies that the patient can apply in daily life and that take into account the patient's strengths, limitations, and emotions around his/her health situation and its impacts. ▸ Identify the support resources to be mobilized in order to implement the program. ▸ Use personalized information and monitoring tools. ▸ Incorporate the patient's experience into the educational process. ▸ Adjust the educational interventions gradually and periodically depending on the patient's progress (improvements and difficulties encountered).
6.4 Gradually build a relationship of trust through continuous mutual exchange of information	▸ Recognize the complementarity of their respective knowledge. ▸ Express their expectations and needs, and ask for the help required. ▸ Practise active listening and adapt to the other's resistances. ▸ Assert their knowledge in communicating information (collaborative leadership) ▸ Create and maintain relational dynamics that support the development of self-confidence and confidence in others. ▸ Monitor the situation closely at critical times in the illness. ▸ Develop the patient's capacity to communicate relevant information about the illness and its effects to others in his/her family, social, and professional networks.
6.5 Create a reflexive approach to their shared process.	▸ Create a conducive environment for exchange to help the patient adapt his/her life project to the health situation. ▸ Periodically re-assess their educational methods and adjust their interactions accordingly. ▸ Identify facilitators and obstacles to implementing the targeted strategies and build on the facilitators to find alternative solutions.

7. 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.

Ethical problems can arise in complex human situations and can involve the various care and services partners (patients, practitioners, clinical and organizational managers). Examples of situations that can cause tensions among the partners are: differences in how they perceive a situation; divergences in their values or regarding the choice of level of medical intervention; and limited or non-existent accessibility to resources (specialized, technological, physical, material, medication, or others).

CAPACITIES related to the competency	DESCRIPTORS (observable behaviours and attitudes)
	The patient partner and the practitioners in a team, when faced with a complex human situation that creates an ethical problem:
7.1 Participate in identifying the elements of the situation	▸ 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 behaviours.
7.2 Participate in analyzing the situation	▸ 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. ▸ Make explicit the convergences and divergences in the values, perceptions, and options of all the partners (patient, practitioners, clinical managers, and managers of health and social services organizations). ▸ Express their respective constraints in the context.
7.3 Participate in resolving the situation	▸ 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.
7.4 Participate in reflexively assessing their process	▸ 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.

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 (observable behaviours and attitudes)
	The patient partner and practitioners in a team:
8.1 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.
8.2 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. ▸ Seek, as needed, the assistance of a third party to resolve a problem before it degenerates.
8.3 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 towards reaching a common understanding. ▸ Strive to actively seek and suggest appropriate solutions for the situation. ▸ Participate in developing and implementing an action plan to resolve the conflict. ▸ Refer to the person in authority or to any other appropriate resource person, in cases where an action plan to deal with a complex conflictual situation is not successful.

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APPENDIX 1: CLARIFICATIONS REGARDING INTERVENTION PLANS AND SERVICES PLANS

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.

An IIP has 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 priorities.
- 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.

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. monitoring

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), municipalities (e.g. recreation). This involves coordinating the provision of services among the service providers of these different establishments or organizations and with the patient: frequency and schedule of service provision, distribution of roles and responsibilities, etc.

Sometimes the patient will need to transition towards another stage of care and services. In this case, the transitional care and services need to be planned to ensure the quality and safety of interventions carried out with the patient during this period. For example, the hospital discharge should be planned with the patient, caregivers, and service providers in the hospital and community, including the family physician.

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:

Teamwork

- **Interact** in ways that will create and maintain healthy team dynamics
- **Participate** in the team's organization and functioning
- **Encourage** the implementation of principles of collaboration in decision-making
- **Participate** in developing and evaluating the team

Communication

- **Promote** a climate of openness and respect
- **Establish** and maintain communication
- **Share** relevant information clearly, concisely, and securely

Clarification of roles and responsibilities

- **Encourage** each person's full exercise of their roles and responsibilities in the team: the clinical manager, the practitioners, and in particular, the patient
- **Carry** out their roles and responsibilities in the team
- **Identify** areas of overlap (grey areas) in team members' roles and responsibilities and share tasks optimally.

Planning, implementation, and monitoring of healthcare and social services

- **Prepare** to develop the intervention plan (DIP or IIP, as appropriate)
- **Develop** an intervention plan (DIP or IIP) or services plan (ISP/IISP)
- **Implement** and **monitor** the intervention plan (DIP, IIP) or services plan (ISP/IISP)
- **Ensure** continuity of care and services during the transition towards another stage of care and services

Therapeutic education and health education

- **Share** an overall understanding of the patient's situation, illnesses, and risk factors for illnesses and identify the patient's priority needs
- **Explore** possible therapeutic options and identify the educational objectives
- **Plan** and implement a personalized educational program
- **Gradually** build a relationship of trust through continual mutual exchange of information
- **Create** a reflexive approach to their shared process

Collaborative leadership

- **Exercise** their leadership while respecting that of other team members
- **Apply** their knowledge (scientific, professional, and experiential) when exercising their leadership in the team
- **Support** the team in attaining its mission and objectives

Clinical ethics

Faced with an ethical problem,

- **Participate** in identifying the elements of the situation
- **Participate** in analyzing the situation
- **Participate** in resolving the situation
- **Participate** in reflexively assessing their process

Conflict prevention and resolution

- **Establish** and maintain harmonious relations
- **Detect** and defuse situations that could create tensions
- **Participate** in resolving conflicts within the team