It Takes A Community: A Collaborative Approach to Brain Injury Rehabilitation

Presented by Kyle Medearis, MS OTRL, CBIS and April Bluck, CCC-SLP, CBIS

Objectives

- Participants will be able to:
  - Define interprofessional collaboration
  - Identify at least two models of interprofessional collaboration
  - Identify the advantages and challenges of interprofessional collaboration
  - Identify individuals involved
  - Understand and apply strategies for improving collaboration

Pre-Quiz

1. What does collaboration mean to you?
2. What are some ways you collaborate with others in your workplace or community?
3. Name as many individuals as possible that could be a part of the collaborative team following a traumatic brain injury?
4. How often do you collaborate and/or refer to these other prospective members?

Interprofessional Collaboration: What is it and Why is it Important?

- According to the World Health Organization, interprofessional collaboration (IPC) is defined as "multiple health workers from different professional backgrounds working together with patients, families, [caregivers], and communities to deliver the highest quality of care (World Health Organization [WHO], 2010, p.7)."
- In order to abide by revolving demands of health insurance entities and trends in practice, collaboration amongst all individuals is necessary to improve efficiency and quality of outcomes (Bronstein, 2003).
- Collaborative care achieves the following:
  - Optimizes health services
  - Strengthens health systems
  - Improves health outcomes
  - Increases both client and providers' satisfaction
  - Promotes provider retention and sustainable programs (Johnson, 2017)

Collaborative Models

- ***The Interprofessional Education Collaborative (IPEC)'s Four Core Competencies for Interprofessional Collaboration***
  - Developed in 2016 by the World Health Organization
  - *Goal:* Develop clear and defined competencies for collaboration amongst disciplines, providing a foundation for education of upcoming professionals in the education process, to improve overall health outcomes (Johnson, 2017).
- ***Interdisciplinary Collaboration Model***
  - A two-part model developed by Laura R. Bronstein, specifically within the field of social work.
  - *Part one consists of five core components:* interdependence, newly created professional activities, flexibility, collective ownership of goals, and reflection on the process.
  - *Part two consists of four influences on success:* professional roles, structural characteristics, personal characteristics, and history of collaboration (Bronstein, 2003).

Interprofessional Collaborative Practice

Competency One: Values/Ethics	Work with individuals of other professions to maintain a climate of mutual respect and shared values.
Competency Two: Roles/Responsibilities	Use the knowledge of one's own role and those of other professionals to appropriately assess and address the health care needs of clients and to promote and advance the health of populations.
Competency Three: Interprofessional Communication	Communicate with clients, families, communities, and professionals in health and other fields in a responsive and responsible manner that supports a team approach to the promotion and maintenance of health and the prevention and treatment of disease.
Competency Four: Teams and Teamwork	Apply relationship-building values and the principles of team dynamics to perform effectively in different team roles to plan, deliver, and evaluate client/population-centered care and population health programs and policies that are safe, timely, efficient, effective, and equitable.

(Johnson, 2017)

Interdisciplinary Collaboration Model

- Bronstein's Interdisciplinary Collaboration Model
  - Consists of 5 core components:

Interdependence	Ability to identify your specific goals for a client, as well as identify goals that may be similar or different as part of a different discipline.
Newly Created Professional Activities	"Collaborative acts, programs, and structures that can achieve more than can be achieved by the same professionals acting interdependently."
Flexibility	"Deliberate occurrence of role blurring." Ability to adapt, even under changing conditions.
Collective Ownership of Goals	All those involved in the process of care agree to work on collective, client-centered goals that put the focus on the client's goals and allow them to be an active participant.
Reflection on Process	Attention to the process of working together, including thinking and talking about the working relationship.

(Bronstein, 2003)

Interdisciplinary Collaboration Model

- Bronstein's Interdisciplinary Collaboration Model
  - Four factors that influence success:
    - Professional Role
      - Too autonomous with own role vs. willingness and knowledge of other professional's roles
    - Structural Characteristics
      - Manageable caseload, culture of workplace, administrative support, professional autonomy, time/space for collaboration.
    - Personal Characteristics
      - The way collaborators view each other outside of professional role (trust, respect, understanding, informational communication, etc.).
    - History of Collaboration
      - Prior education and experiences shape collaborative "willingness (Bronstein, 2003)."

Traditional Care Vs. Collaborative Care

Traditional Care - Multidisciplinary Care	Collaborative Care
All team members are not present.	All team members ARE present.
Located in conference room or hallway ("meat" of discussion and plan here)	The "meat" of team conversation and plan formulation includes the client.
A select few do most of the talking.	A team member (often not the physician) facilitates the conversation.
When the client is in the room, the pace is brisk and does not include all voices. Medical jargon is used.	Everyone on the team has a role, voice, and space to contribute to the conversation. Everyone understands the language used.
Hierarchical undertones present. Physicians direct, disciplines report, clients and family informed.	Physicians participate, professionals confer, clients and families are engaged in the conversation.
Focus is on disease, treatment, and tasks.	Focus is on people, needs, and goals.
Whispered side conversations occur. The client is "talked about" in third person.	Few side conversations occur, allowing for transparency. Care progress is discussed.
Uniprofessional notes are taken. Parallel interventions occur.	Care plan is jointly developed with the client. Professionals collaborate on interventions.
Who will do what is assumed. Task delegation by team members is not reviewed or summarized.	Safety checklists are often used. The plan is summarized for the team, including the client.

(Johnson, 2017)

Evidence Supports Collaboration

- Current trends in healthcare research are beginning to include an in-depth focus on interprofessional collaboration.
- Several studies within the field of traumatic brain injury revealed positive impacts or achieved outcomes following an interdisciplinary, collaborative approach.
  - In a recent study titled, "Effectiveness of Occupation- and Activity-Based Interventions to Improve Everyday Activities and Social Participation for People With Traumatic Brain Injury: A Systematic Review," the researchers found:
    - Allows for increased level of intensity in provided care, yielding improved independence.
    - Improved delivery of functional-based interventions, furthermore increasing the amount of people living independently and working.
    - Decreased effort and increased efficiency with performance of activities of daily living in individuals with chronic acquired brain injury (Powell, Rich, & Wise, 2016).

Evidence Supports Collaboration

- *Interdisciplinary Residential Treatment of Posttraumatic Stress Disorder and Traumatic Brain Injury: Effects on Symptom Severity and Occupational Performance and Satisfaction* (Speicher, Walter, & Chard, 2014)
  - Studied the effects of interprofessional collaboration between Occupational Therapists, Social Workers, Psychologists, and Neuropsychologists on clients participating in an 8 week residential treatment program for 8.5 hours, 5 days a week.
  - Results revealed statistically significant improvements in self-rated performance and satisfaction scores, related to meaningful and individualized functional treatment.
  - Decreased overall score ratings in regard to PTSD and depression by 25-50%, reported post-treatment.
  - Supported use of client-centered, goal-specific interventions (Speicher, Walter, & Chard, 2014).

Evidence Supports Collaboration

- In a review of several systematic reviews across multiple disciplines listed in the World Health Organization's *Framework for Action on Interprofessional Education and Collaborative Practice* (World Health Organization, 2010, p.18-19), a collaborative approach to care:
  - Improved access to and coordination of health services
  - Appropriate use of clinical specialist resources
  - Improved health outcomes for those with chronic diseases
  - Increased client and provider satisfaction
  - Decreased mortality rates
  - Increased acceptance to treatment delivered.
  - Reduced overall cost of care and duration of visits required.

Incorporating Collaborative Care

- The **client** is at the forefront of the collaborative process.
  - What are his/her personal goals toward recovery and are these goals the foremost focus of treatment?
  - Include the client in all forms of communication regarding their care, when possible and appropriate.
  - Rapport building is key!
  - Place adequate responsibility on the client and their family.
- Be familiar with all of the potential members of the collaborative team.
- Don't be afraid to communicate.

Strategies to Improve Collaboration

Table 2 Actions to advance collaborative practice for improved health outcomes

ACTION	PARTICIPANTS	LEVEL OF ENGAGEMENT EXAMPLES	POTENTIAL OUTCOMES
1. Structure processes that promote shared decision-making, regular communication and community involvement	• Health facility managers and directors • Health workers	CONTEXTUALIZE • Discuss and share ideas for improved communication processes • Develop a sense of community through interaction and staff support	• A model of collaborative practice that recognizes the principles of shared decision-making and best practice in communication across professional boundaries
2. Design a built environment that promotes, fosters and extends interprofessional collaborative practice both within and across service agencies	• Policy-makers • Health facility managers and directors • Health workers • Capital planners • Architects/space planners	CONTEXTUALIZE • Relocate and rearrange equipment to better facilitate communication flow	• Improved communication channels • Improved satisfaction among health workers
3. Develop personnel policies that recognize and support collaborative practice and offer fair and equitable remuneration models	• Government • Health facility managers and directors • Policy-makers • Regulatory/labour bodies	COMMIT • Review personnel policies and consider innovative remuneration and incentive plans	• Improved workplace health and well-being for workers • Improved working environment
4. Develop a delivery model that allows adequate time and space for staff to focus on interprofessional collaboration and delivery of care	• Health facility managers and directors • Policy-makers • Health workers	COMMIT • Set aside time for staff to meet together to discuss cases, challenges and successes • Provide opportunity for staff to be involved in development of new processes and strategic planning	• Improved interaction between management and staff • Greater cohesion and communications between health workers
5. Develop governance models that establish teamwork and shared responsibility for health care service delivery between team members as the normative practice	• Health facility managers and directors • Policy-makers • Government leaders	CHAMPION • Review and update the existing governance model • Develop a strategic plan for an interprofessional education and collaborative practice model of care	• A sustained commitment to embedding interprofessional collaboration in the workplace • Updated governance model, job descriptions, vision, mission and purpose

World Health Organization, 2010, p.30

Strategies To Improve Collaboration

- Facility/Team Considerations
  - Discuss and communicate what you already know about each other's role.
  - Professional role in-services
  - Create "Psychological Safety"
  - Ensure "Equal Voice"
  - Set aside time for reflection of a group's performance
  - Consistency with scheduling and location of services
  - Plan-Do-Study-Act Model

(Johnson, 2017)

Strategies To Improve Collaboration

- Individual Considerations
  - Interactions and meetings that include the client
  - Self-initiated education of resources available
  - Take time to build rapport
  - Request and review medical records together
  - Challenge negative assumptions or misinterpretations
  - Self-reflect on own performance consistently
  - Re-assess client's perceptions and goals regularly
  - Communicate
    - Utilize Technology (following HIPAA)
    - Communication Logs
    - Postings in Shared/Common Areas
    - Team Meetings
    - Informal Communication

(Johnson, 2017)

Meet Jake...

The Client

- Jake is a 27 year old male who sustained a mild traumatic brain injury one year ago due to an automobile accident.
- He was the driver and only passenger of the vehicle which struck a deer late at night on his way home from his girlfriend's house.
- Left hemispheric involvement of the fronto-temporal lobe, as well as fracture of the left femur.
- Prior medical history includes anxiety and obesity. To address the anxiety, Jake was taking 5mg of Xanax twice a day and seeing a social worker once a month for counseling.
- He was right-hand dominant prior to TBI. Lived independently in a single-level house. Worked as a journalist for the local news, primarily writing columns for the website.
- Because of his accident, his mother has assisted with decision-making during his recovery but he remains his own guardian.

Functional Limitations/Problem List

- As a result of the mild traumatic brain injury Jake experienced, he suffers from the following:
  - Impaired cognitive skills.
    - Poor initiation, difficulty with multitasking, impaired memory.
  - Increased muscle tone throughout his right side.
    - Impaired leg and arm function.
    - Can walk with use of a cane, but right sided weakness exists.
  - Difficulty with social pragmatics and management of PTSD and depression.
    - Overstimulated in demanding social contexts, easily frustrated, poor coping skills.
- Personal Goals:
  - Jake expresses he would like to live independently in his own home, resume work, and improve use of his right side.
- Jake has just been referred to an outpatient brain injury rehabilitation and wellness program by his physician to continue his recovery.

Establishing Jake's Team...

The Client and Family's Role

- ***A critical member(s) of the team!***
- Can positively influence the collaborative process by:
  - Communicating openly and honestly about deficits and goals
  - Sharing applicable information with all members of the team
  - Actively collaborating in course of treatment
  - Following through with recommendations provided
  - Providing feedback throughout the process about what is working and what is not working

The Physician a.k.a. The Hub

- Primary Care Physician (MD, DO) and/or Specialist(s) (Neurologist, Physiatrist)
- The primary professional and integral piece of the client's established medical team, sometimes established prior to injury.
- May be involved in acute stages of care and follow client throughout their recovery.
- The gatekeeper of recommendations, especially following the initial onset of injury.

What about Jake?

- Prior to Jake's accident, Dr. Andrea Jordan, MD oversaw his health as a primary care physician.
- Following the accident, Dr. Timothy Smith, DO, a physiatrist, followed him throughout his acute and inpatient phases of recovery. Dr. Smith is not accepting new patients at this time on an outpatient basis, however.
- Dr. Jordan, MD will remain Jake's primary care physician, however he will require a recommendation for a specialist to coordinate care following the traumatic brain injury diagnosis.
- Jake has been referred to Dr. Julie Bennett, DO, and physiatrist, who specializes in care following catastrophic neurological injuries.

Case Manager a.k.a. The Organizer

- A primary and foundational aspect of the team.
- According to Intagllata (1982), case managers have three fundamental, core responsibilities:
  - To maintain a comprehensive understanding and awareness of the client's needs.
  - To link the client to appropriate resources and services, through collaboration with physician and necessary community/professional members.
  - To maintain close collaboration with service providers, ensuring collaboration of goals are at the center of care (Intagllata, 1982).

What about Jake?

- A local case manager, was assigned to Jake's case, per request of his mother to the insurance company.
- The case manager has taken immense stress off Jake and his mother, working closely with Dr. Bennett, D.O., to provide recommendations for rehabilitation, setting up future medical appointments, communicating with the insurance adjuster for services, and ensuring Jake's goals of returning to work are being heard.

Physical Therapist a.k.a. The Strengthener

- As a client is able to tolerate and participate in more recovery-based activity, a physical therapist (PT) can utilize exercise, task-specific training, client/family/caregiver education, and various equipment to:
  - Increase strength, endurance, and flexibility.
  - Improve quality of movement patterns and overall posture.
  - Improve safety and balance with sitting, standing, and walking.
  - Improve independence with transfers and movement within a bed or on various surfaces.
  - Re-introducing client-specific activities that incorporate all planes of movement for re-integration into individual communities.
  - Increase success and safety with assistive device or equipment within the daily routine ("Traumatic Brain Injury", 2017).

What about Jake?

- Jake received a Physical Therapy evaluation, completed by a local physical therapist (PT).
- Through evaluation and collaboration, the PT and Jake have decided that the focus of sessions should be on improving Jake's right leg and arm strength, balance during standing activities, and safety with walking.
- Keeping in mind Jake's goals living independently and returning to work, the PT has requested to perform an evaluation of his home in order to understand his situation, related to needs and desires.

Occupational Therapist A.K.A. The Optimizer

- According to AOTA, occupational therapists (OTs) "help people across the lifespan participate in the things they want and need to do through the therapeutic use of everyday activities (occupations)." They do so by:
  - Improving strength, endurance, and flexibility.
  - Improving quality of movement patterns and overall posture.
  - Improving memory and attention with specific activities important to the client.
  - Increasing safety and efficiency with activities of daily living (i.e. dressing, bathing, toileting, eating/cooking, shopping, cleaning, driving, return to school or work, play, preferred leisure activities, etc.)
  - Adapting and/or modifying activities or equipment for improved usage ("What is occupational therapy", 2017).

What about Jake?

- Jake's case manager recommended a local Occupational Therapist(OT) for OT services.
- Following an evaluation, the OT and Jake have set goals to improve his right arm function, memory and attention deficits, as well as return to both work and independent living at his home.
- The OT plans to attend the home evaluation with his PT, as well as complete an additional evaluation of Jake's job.

Speech Therapist A.K.A. The Yapper

- It is ASHA's position that speech-language pathologists play a primary role in the assessment, diagnosis and treatment of cognitive-communication disorders. This may include:
  - improving speech and/or voice to allow an individual to be intelligible to others
  - addressing receptive and expressive language needs (listening and reading comprehension, verbal and graphic expression)
  - improving swallowing to allow safe oral intake
  - improving cognitive skills (memory, attention, executive functioning) through education, therapeutic exercises and compensatory strategies
  - providing counseling for individuals and their significant others about cognitive-communication disorders and their impact (Speech-language pathologists, 2017).

What about Jake?

- Evaluate and determine SLP goals consistent with Jake's desire to return to independent living and work.
- Discuss cognitive needs for Jake's work environment with Jake and occupational therapist.
- Develop and implement compensatory strategies for cognitive deficits to increase Jake's level of independence.
- Problem solve with Jake potential social encounters which may arise with return to work and plan appropriate responses.

Collaboration Begins...

- Following the first week of PT, the PT believes Jake would benefit from personal training to improve his cardiovascular health and overall endurance, in addition to PT sessions.
  - The PT discusses this with Jake's case manager and a referral is sent to Dr. Bennett, D.O.
- During Jake's first team meeting at the facility, OT and SLP discuss his memory and attention deficits in relation to his right arm function during a work-simulated typing activity. The OT recommends vocational counseling to jump-start the process for returning to work.
  - Contact is made with the case manager and to a vocational counselor.

Vocational Counseling A.K.A. The Employer

- Vocational Counselors assist clients in regaining employment, whether it be return to previous employer or seeking a new career path.
- Wealth of knowledge and resources within the community to improve job placement and success.
- Can provide one-on-one evaluation and training on the job, through counselor or job coach.
- Can serve as a "safety net" for those requiring additional accommodations, impacting ability to return to work on their own (Johnstone, Vessell, Bounds, Hoskins, & Sherman, 2003).
- Through state funding, vocational counselors can often provide additional funding opportunities for equipment (purchased or rented), therapy sessions, job site modification/training, testing, etc.

What about Jake?

- A vocational counselor has been contacted by Jake's case manager and OT to assist in returning to his job as a journalist.
- The counselor has evaluated Jake and requested job site evaluation findings from the recent OT visit to his Jake's employer. As a team, the vocational counselor works with OT, Jake, and his employer to develop an understanding that deadline extensions and shorter work days are beneficial and necessary for successful return to work in the next month.

Personal Trainer A.K.A. The Drill Sargeant

- Personal Trainers help drive and motivate the client to meet their personal fitness goals. They may work on a individual basis or in a group within a variety of settings to achieve the following:
  - Improve cardiovascular and muscular endurance, as well as overall strength and flexibility
  - Increase intrinsic motivation and willingness to exercise
  - Improve successful understanding of proper form during exercise
  - Basic nutritional guidelines to assist with weight loss goals
  - May include training in gym, personal studio, client home, office building, sports arena, park, beach, or via phone/internet (The Role of a Personal Trainer (n.d.)).
  - A script signed by a physician is recommended to begin personal training for medical clearance following brain injury.

What about Jake?

- Jake's case manager successfully sets up personal training, with assistance from his PT and Dr. Bennett to guide the formulation of the plan of care.
- Jake begins participating in cardiovascular and endurance training twice a week. He notices improved ability to form thoughts and participate in work-related activities for longer durations. PT has even commented about his improved right leg strength during walking as a result of this addition.
- PT monitors and works closely with the personal trainer to ensure cohesiveness with treatments while abiding by restrictions and progress. They meet weekly to discuss ideas to progress treatment.

Collaboration Continues...

- During a recent personal training session, Jake mentions feeling miserable, tired, and hopeless.
  - Aware of the benefits of social work/counseling, the personal trainer recommends Jake and his mother consider meeting with MSW.
    - They inquire at the facility and discuss this with the case manager. A script is signed by the physician and Jake begins social work services at the same facility he receives Physical Therapy, Occupational Therapy, Speech Therapy, and Personal Training.

Social Worker A.K.A. The Counselor

- Social work focuses on the assessment, diagnosis, treatment, and prevention of mental illness, emotional, and other behavioral disturbances. Individual, group and family therapy are common treatment modalities.
- Some examples of social work interventions include:
  - Promotion of acceptance
  - Resolving grief
  - Community re-integration, including identification of available resources
  - Improving communication
  - Healthy coping strategies and emotional regulation
  - Providing overall support

What about Jake?

- The social worker, begins a collaborative assessment with Jake to identify strengths and challenges following his accident. She also assists in identifying support systems in his life (i.e. his mother, his girlfriend, friends).
- Within a few weeks of intervention, Jake is able to identify pleasurable activities and begin working them into his schedule with support. He has also reported slight improvement in feelings of self-worth, which helped him feel comfortable reaching out to a friend he hasn't seen since the accident.
- The social worker has also helped Jake explore the use of healthy coping strategies that he can utilize when he is feeling hopeless. As a result, she and Jake have shared this information with the collaborative team to incorporate both in and outside of the clinical setting.

Examples of Collaboration Within Jake's Team

- The vocational counselor is unfamiliar with the role of personal training and social work overall, and within Jake's recovery. She asks for an in-service at her office from these individuals to educate herself and job coaches.
- The occupational therapist finds herself with a busy caseload and is unable to make a recent team meeting. She requests notes from the meeting and makes an adjustment to the next treatment session according to a report from the vocational counselor.
- The speech therapist believes that an external memory aid would be beneficial for Jake's return to work. She contacts the physician via phone to share the recommendation. A script is obtained and case manager assists Jake in obtaining the device. Once the device is received, the speech therapist and Jake educate all members of the team to ensure consistent use at home and in treatment.
- The social worker recently discussed Jake's desire to resume kayaking during a team meeting. As a result, the case manager and physician agree that recreational therapy may be a beneficial addition to the team. The occupational therapist and physical therapist will provide adaptation suggestions for safety due to his right sided weakness.

Who Else Could Be Involved?

Potential Collaborators

- CLIENT
- Client's Family/Caregivers
- Primary Care Physician, Physician Assistant, Nurse Practitioner
- Specialty Care Physicians
  - Neurologist, Physiatrist, Endocrinologist, Urologist, Ear Nose Throat Specialist, Optometrist, Opthamologist
- Case Manager and/or Nursing Manager
- Nurse
- Neuropsychologist and/or Psychologist
- Social Worker/Licensed Personal Counselor
- Rehabilitation
  - Physical Therapist, Occupational Therapist, Speech Language Pathologist, Recreational Therapist

Potential Collaborators

- Attorney
- Substance Abuse Counselor
- Insurance Adjustor
- Employers
- Teachers
- Assistive Technology Professional
- Personal Trainer
- Dietitian
- Vocational Counselor and/or Job Coach
- Vision Therapist
- Art/Music Therapist
- Massage Therapist
- Attendant Care
- Office Support Staff

Real-World Collaborative Examples Shared

Any Questions?

References

- Bronstein, L. R. (2003). A Model for Interdisciplinary Collaboration. Social Work. 48(3), 297-306. doi:10.1093/sw/48.3.297
- Clinical Social Work. (n.d.). Retrieved July 13, 2017, from http://www.naswdc.org/practice/clinical/default.asp
- Cox Thomas. L., Burker, E. J., & Kazukauskas, K. A. (2015). Thinking Outside the Box: Maximizing Vocational Outcomes Post-Traumatic Brain Injury through Rehabilitation Counseling and Recreation/Leisure Activities. Journal of Applied Rehabilitation Counseling, 46(4), 37-44.
- Godwin, E. E., Lukow, H. R., & Lichiello, S. (2015). Promoting Resilience Following Traumatic Brain Injury: Application of an Interdisciplinary, Evidence-Based Model for Intervention. Family Relations, 64(3), 347-362. doi:10.1111/fare.12122
- Intagliata, J. (1982). Improving the Quality of Community Care for the Chronically Mentally Disabled: The Role of Case Management. Schizophrenia Bulletin. 8(4). 655-674. doi:10.1093/schbul/8.4.655
- Johnson, C. E., OTD, OTR/L. (2017). Understanding Interprofessional Collaboration: An Essential Skill for all Practitioners. OT Practice.22(11). CE-1-CE-7.
- Johnstone, B., Vessell, R., Bounds, T., Hoskins, S., & Sherman, A. (2003). Predictors of success for state vocational rehabilitation clients with traumatic brain injury. Archives of Physical Medicine and Rehabilitation, 84(2), 161-167. doi:10.1053/apmr.2003.50098
- Mahar, C., & Fraser, K. (2011). Barriers to Successful Community Reintegration Following Acquired Brain Injury (ABI). International Journal of Disability Management. 6(01). 49-67. doi:10.1375/jdmr.6.1.49
- Mahar, C., & Fraser, K. (2011). Strategies to Facilitate Successful Community Reintegration Following Acquired Brain Injury (ABI). International Journal of Disability Management. 6(01), 68-78. doi:10.1375/jdmr.6.1.68
- Petri, L. (2010). Concept Analysis of Interdisciplinary Collaboration. Nursing Forum, 45(2), 73-82. doi:10.1111/j.1744-6198.2010.00167.x

References

- Powell, J. M., Rich, T. J., & Wise, E. K. (2016). Effectiveness of Occupation- and Activity-Based Interventions to Improve Everyday Activities and Social Participation for People With Traumatic Brain Injury: A Systematic Review. American Journal of Occupational Therapy. 70(3). doi:10.5014/ajot.2016.020909
- Skidmore, E. R. (2015). Training to Optimize Learning After Traumatic Brain Injury. Current Physical Medicine and Rehabilitation Reports, 3(2). 99-105. doi:10.1007/s40141-015-0081-6
- Speech-Language Pathologists - Job Description and Career Information. (n.d.). Retrieved July 13, 2017, from http://www.asha.org/students/speech-language-pathologists/
- Speicher, S. M., Walter, K. H., & Chard, K. M. (2014). Interdisciplinary Residential Treatment of Posttraumatic Stress Disorder and Traumatic Brain Injury: Effects on Symptom Severity and Occupational Performance and Satisfaction. American Journal of Occupational Therapy, 68(4), 412. doi:10.5014/ajot.2014.011304
- The Role of a Personal Trainer. (n.d.). Retrieved July 11, 2017, from https://www.nfpt.com/the-role-of-a-personal-trainer
- Traumatic Brain Injury. (2017, July 03). Retrieved July 11, 2017, from [illegible]
- Trudel, T. M., Nidiffer, F. D., & Barth, J. T. (2007). Community-integrated brain injury rehabilitation: Treatment models and challenges for civilian, military, and veteran populations. Journal of Rehabilitation Research & Development, 44(7), 1007-1016. doi:10.1682/JRRD.2006.12.0167
- What is occupational therapy? (2017). Retrieved July 13, 2017, from https://www.aota.org/About-Occupational-Therapy.aspx
- World Health Organization. (2010). *Framework for action on interprofessional education and collaborative practice*. Retrieved from http://www.who.int./hrh/resources/framework_action/en/
- Wright, C. J., Zeeman, H., & Biezaitis, V. (2016). Holistic Practice in Traumatic Brain Injury Rehabilitation: Perspectives of Health Practitioners. Plos One. 11(6). doi:10.1371/journal.pone.0156826

Traditional Care Vs. Collaborative Care

Traditional Care - Multidisciplinary Care	Collaborative Care
All team members are not present.	All team members ARE present.
Located in conference room or hallway ("meat" of discussion and plan here)	The "meat" of team conversation and plan formulation includes the client.
A select few do most of the talking.	A team member (often not the physician) facilitates the conversation.
When the client is in the room, the pace is brisk and does not include all voices. Medical jargon is used.	Everyone on the team has a role, voice, and space to contribute to the conversation. Everyone understands the language used.
Hierarchical undertones present. Physicians direct, disciplines report, clients and family informed.	Physicians participate, professionals confer, clients and families are engaged in the conversation.
Focus is on disease, treatment, and tasks.	Focus is on people, needs, and goals.
Whispered side conversations occur. The client is "talked about" in third person.	Few side conversations occur, allowing for transparency. Care progress is discussed.
Uniprofessional notes are taken. Parallel interventions occur.	Care plan is jointly developed with the client. Professionals collaborate on interventions.
Who will do what is assumed. Task delegation by team members is not reviewed or summarized.	Safety checklists are often used. The plan is summarized for the team, including the client.

(Johnson, 2017)

TABLE 2 Actions to advance collaborative practice for improved health outcomes

ACTION	PARTICIPANTS	EXAMPLES OF LEVELS OF ENGAGEMENT	POTENTIAL OUTCOMES
1. Structure processes that promote shared decision making, regular communication and community involvement.	• Health facility managers and directors • Health workers	CONTEXTUALIZE • Discuss and share ideas for improved communication processes • Develop a sense of community through interaction and staff support	A model of collaborative practice that recognizes the principles of shared decision making and best practice in communication across professional boundaries
2. Design a built environment that promotes, fosters and extends interprofessional collaborative practice both within and across service agencies	• Policy-makers • Health facility managers and directors • Health workers • Capital planners • Architects/space planners	CONTEXTUALIZE • Relocate and rearrange equipment to better facilitate communication flow	• Improved communication channels • Improved satisfaction among health workers
3. Develop personnel policies that recognize and support collaborative practice and offer fair and equitable remuneration models	• Government • Health facility managers and directors • Policy-makers • Regulatory/labour bodies	COMMIT • Review personnel policies and consider innovative remuneration and incentive plans	• Improved workplace health and well-being for workers • Improved working environment
4. Develop a delivery model that allows adequate time and space for staff to focus on interprofessional collaboration and delivery of care	• Health facility managers and directors • Policy-makers • Health workers	COMMIT • Set aside time for staff to meet together to discuss cases, challenges and successes • Provide opportunity for staff to be involved in development of new processes and strategic planning	• Improved interaction between management and staff • Greater cohesion and communication between health workers
5. Develop governance models that establish teamwork and shared responsibility for health-care service delivery between team members as the normative practice	• Health facility managers and directors • Policy-makers • Government leaders	CHAMPION Review and update the existing governance model Develop a strategic plan for an interprofessional education and collaborative practice model of care	• A sustained commitment to embedding interprofessional collaboration in the workplace • Updated governance model, job descriptions, vision, mission and purpose

World Health Organization, Framework for Action on Interprofessional Education & Collaborative Practice pg. 30