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# The Development and Implementation of Interprofessional Practice Councils in the Hospital Setting: Embarking on the Journey—Experience and Lessons Learned

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## Abstract

Collaborative Practice has been identified as playing an important role in improving patient outcomes, strengthening health care services and improving health workforce satisfaction. This pilot project explores one organization's experience developing and implementing Interprofessional Practice Councils (IPPCs) as a means of enhancing the culture of collaboration and implementation of best practices for three programs in the organization. Three key themes were identified as essential to the design of a successful comprehensive IPPC: 1) structure; 2) values; and, 3) education. Results suggest that the core content of focus for IPPCs be composed of collaborative practice, and evidence-based practice and knowledge translation, and that key components for sustainability include: i) senior team support; ii) accountability and decision-making; iii) medical staff engagement; iv) relationship to the strategic plan; v) clear leadership and training for council members; vi) clear principal statement and council terms of reference; vii) demonstration of positive outcome and value; and, viii) defining expectations. In addition, readiness assessment and strong leadership which includes allocation of resources for focused start-up to ensure sustainability appear to be necessary requirements for successful council integration.

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## Introduction

Rising healthcare costs place pressure on healthcare systems worldwide. In ensuring the greatest benefit for resource expenditures, healthcare must become increasingly more efficient. Collaborative practice has become a high priority for healthcare leaders, government funders, and decision-makers as a means of improving the efficiency of healthcare delivery because it “strengthens health systems and improves health outcomes” (World Health Organization, 2010). Interprofessional collaboration is relational and requires professionals to work together for patients.

In 2010, the Credit Valley Hospital (CVH) (now part of Trillium Health Partners) committed itself to integrating collaborative practice throughout the organization (Credit Valley Hospital 2010). To shift the institutional culture towards collaborative practice at CVH, Interprofessional Practice Councils (IPPCs) were initiated. The development of IPPCs was an evidence-based initiative focused on optimizing the culture of collaboration while implementing best practices.

IPPCs are based on a model of shared governance intentionally incorporating the underpinning principle of an “unconditional positive regard for one another” (Knickel and McNaughton, 2011). IPPCs give responsibility for practice-related decisions to those in direct patient care. This responsibility is intended to empower front-line healthcare workers from all disciplines and ensures accountability for quality and safety. Collaborative decision-making through the shared governance of councils promotes collaborative practice as care givers come together to decide the best way to deliver healthcare, and implement decisions for best practices locally.

In this paper we describe the design, implementation and initial outcomes of establishing IPPCs; as well as lessons learned and implications for future council integration in three programs at CVH, namely the Emergency Department, Mental Health Program and Obstetrics/Gynecology Program.

## Literature Review

A literature review was conducted to ensure the most successful strategies were incorporated into the councils during their design. The literature search was

conducted combining the search terms *governance* and *interprofessional*, *governance* and *interdisciplinary*, *practice committee* and *hospital*. The results were narrowed to articles which focused on nursing and/or interprofessional councils as a major theme of the article. A matrix of elements for successful implementation of councils was identified through content analysis of relevant literature. When no significantly unique new elements were identified, we considered we had reached saturation in the literature evaluation. Saturation was reached with nine articles (Braithwaite & Travaglia, 2008; Brody, Barnes, Ruble, & Sakowski, 2012; Dunbar, et al., 2007; Greenfield, Nugus, Fairbrother, Milne, & Debono, 2011; Howell et al., 2011; Hoying & Allen, 2011; Pinkerton, 2008; Scally & Donaldson, 1998; World Health Organization, 2010).

Individual elements of the matrix were grouped into themes, to form a framework for design of the IPPCs allowing us to focus on the major themes and minimize elements which may not be relevant to all contexts. From the literature review, three key themes were identified as essential to the design of a successful and comprehensive IPPC. These key themes are: 1) structure; 2) values; and, 3) education. These themes were almost universally identified, and in many cases included similar elements from one article to the next. For example, attention to education of council members was universally addressed in the literature on practice councils, yet individual elements in the education plans, while often similar, were not identical.

## Structure

A structure that incorporates shared governance, accountability, support from the senior level, and the reporting of outcomes was identified as integral to the success of councils. The IPPCs were designed to incorporate these structural elements.

The IPPCs are based on a model of shared governance, which “gives those in direct patient care the responsibility for decisions related to their practice,” (Howell et al., 2001 as cited in Hoying & Allen, 2011, p. 252). Common to successful governance structures is the capacity of councils to provide evidence-based recommendations to change practice. Clinical Governance, a term coined by the United Kingdom’s National Health Service, has at its heart collaboration, partnership, and locally implemented evidence-based practice

(Sally & Donaldson, 1998). Clinical governance is “intended to bring about accountability for the quality and safety of health care by creating an environment in which excellence in clinical care will flourish” (Sally & Donaldson, 1998 as cited in Greenfield et al., 2011).

Organizations with successful councils have strong governance and reporting mechanisms for their councils. Ensuring adequate reporting mechanisms and reviewing performance via the governance structure and associated accountability using accurate data were described as preconditions to effective leadership (Braithwaite & Travaglia, 2008). The ability to demonstrate that the activity of the councils results in beneficial outcomes through accurate reporting of data is important for council sustainability (Campbell, Stowe, & Ozanne, 2011). Reporting mechanisms mentioned in the literature differed based on the structure and function of the council, with some councils reporting through already established structures (i.e. to Senior Management/Board or a Nursing or Professional Practice Committee) and some reporting to newly established corporate councils. Although the exact reporting structure differed the common elements of accountability, reporting, and management support were identified as key components necessary for practice councils.

At the Cincinnati Children’s Hospital Medical Centre shared governance was incorporated into the strategic plan (Hoying & Allen, 2011), and the entire management team was taught problem solving and innovation as part of the kick-off for the program councils. Another example of shared governance comes from Northern California, where the Chief Nursing Executive (CNE)

of each hospital was the authority to empower nursing staff to lead the nursing councils (Brody et al., 2012).

Structure and governance are essential elements for the development of a successful IPPC, as demonstrated repeatedly as a theme in the literature on practice-based councils. It is important to carefully consider and plan the structure early in the design phase of the development of IPPCs.

### Values

An aspect of effective teamwork that has been identified in the literature is person-environment fit (Kristof-Brown, Barrick, & Kay Stevens, 2005 as cited in Mitchell, Parker, Giles, Joyce, & Chiang, 2012). In terms of fit, value congruence has been identified as an important element “because values are relatively enduring and guide attitudes and behavior” (Chatman, 1991; Schein, 1992 as cited in Mitchell, et al., 2012, p. 627). Value congruence increases trust and cooperation (Tsui & O’Reilly, 1989 as cited in Mitchell, Parker, Giles, Joyce, & Chiang, 2012) as team members are more likely to be attracted to and trust those they perceive to hold similar values (Festinger, 1954; Williams & O’Reilly, 1998 as cited in Mitchell, et al., 2012).

A successful council is built upon a set of agreed upon values. These values are articulated in the literature in a various number of ways such as ground rules, statements of purpose, team declarations, etc. The values most commonly identified for council success were active participation, care-givers’ autonomy to make decisions, accountability, evidence-based practice and patient-focused care (Table 1).

**Table 1** *Values Identified for Successful Implementation of Practice Councils from Literature Review*

Value	Percentage of references citing this value
Evidence-Based Practice for Decision-Making	80%
Active Participation of Members	50%
Autonomy (Care-givers Make the decisions)	50%
Accountability (including reporting of data)	50%
Patient focus	50%
Teamwork or Morale	30%
Diversity in terms of each discipline represented	20%
Sense of Community or Morale	20%
Professional practice as an Intellectual Discipline	10%

Values are an essential element required to formulate group identity. Mitchell et al. (2012) provide evidence that common identity is an essential component of the interprofessional team, with a correlation between common group identity and team innovation:

When members perceive that the team shares values that are central to their task, their perceptions of cooperation is enhanced, and the importance of each member's contributions to the team's goal is reinforced. This builds commitment and develops a shared team identity, which stimulates collaborative interpersonal interaction and constructive analysis of member's diverse perspectives. (p. 639)

### *Education*

The third theme essential to the development of practice councils is education, particularly to address baseline perceptions and ensure minimum understanding on specific topics. This is essential to the effective functioning of the council, as members may come with varying skill sets. The most comprehensive description of the educational program we found was described by Brody et al (2012) and would be useful for anyone establishing curricula for councils to review.

Educational topics described in the literature varied according to the needs of the councils being described. Frequently identified educational topics included:

- **Knowledge:** Critical Appraisal and Evidence-Based Medicine Theory, Human Factors Theory; Scopes of Practice
- **Skills:** Conflict Resolution; Decision-Making; Data analysis
- **Attitude:** Change Process Management

The education topics most relevant to our local context included understanding of the professional roles of all team members (Campbell, Stowe, & Ozanne, 2011), the role of evidence-based practice and decision-making (Newhouse, Dearholt, Poe, Pugh, & White, 2007), and developing ways to encourage decision-making at all levels through the use of data analysis (Braithwaite & Travaglia, 2008). Education needs to be an ongoing consideration and managing/reshaping culture is critical to maintaining momentum for shared

governance, and the creation of decision-making councils (Dunbar et. al., 2007). All the successful councils described in the literature incorporate some sort of a baseline education program for council members to facilitate decision-making.

In summary, the successful councils described in the literature were designed around common themes, with flexibility to account for local context. The themes included:

- **Structure:** which almost universally included shared clinical governance, accountability to report outcomes and adequate support;
- **Values:** including evidence-based practice, respect, participation and quality improvement; and,
- **Education** tailored to the needs of the councils.

As supported by the literature, the transformation of clinical practice through councils is a journey, rather than a project with a defined end. The destination for the journey is a practice culture of respect through shared governance, evidence-based practice through quality improvement and measurable accountability for outcomes. Every step the councils take towards this practice results in improved patient care and allows those engaged in direct patient care to make practice-related decisions.

### **Methods**

The three key themes identified from the literature review: 1) structure; 2) values; and, 3) education were intentionally integrated into the design of the IPPCs and associated curriculum. Given that the antecedents of the IPPC (Nursing-based Council (NBC) and Evidence-Based Practice Council (EBPC)) share the two common foci of evidence-based practice and collaboration, our curriculum focused on two core components: 1) evidence-based practice and knowledge translation; and 2) interprofessional collaboration-utilizing the National Interprofessional Competency Framework (CIHC, 2010).

Data were gathered for this project via a two-phased pre/post design that included qualitative and quantitative methods. Pre-rollout knowledge acquisition was captured via meetings with stakeholders including the

program directors their steering committees, physician's business meetings, local clinical practice stakeholders and our newly merged partner Trillium Health Centre (THC) for their experience with Partnership Councils. The strategy department was engaged to help design the governance and reporting structures. The pre-knowledge was assessed through the examination of meeting notes and feedback for the stakeholders described above. Post-knowledge was assessed via two modes: i) an online survey which explored the CIHC 6 Core Competencies for Collaborative Practice and, Evidence Based Practice and Knowledge Translation; and, ii) debrief meetings with stakeholders.

An iterative, evidence-based strategy was used to plan and execute the rollout of the IPPCs. The content for the rollout focused on two core components: 1) Evidence-Based Practices and Knowledge Translation; and, 2) Collaborative Practice. The evidence-based practice and knowledge translation component was presented via a prepared presentation and guided hands on demonstration and training (Beechinor, 2012). Learning around the collaborative practice component was supported with sessions addressing The National Interprofessional Competency Framework, focusing on its 6 Core Competencies (CIHC, 2010) as follows:

1. Interprofessional Communication;
2. Patient/Client/Family/Community Centered Care;
3. Role Clarification;
4. Team Functioning;
5. Collaborative Leadership; and,
6. Dealing with Interprofessional Conflict.

Planning meetings with stakeholders identified the specific needs of each area. These meetings were instrumental in honing the rollout schedule and preparing the environment for Interprofessional Practice Councils. Rollout of the IPPCs was carried out over the course of a six week period with three education sessions separated by two weeks. The sessions were as follows:

1. Introduction to IPPCs (1.5 hours)
  - a. Tool Kit
  - b. Terms of Reference
  - c. Reporting Documents
  - d. Governance
  - e. CIHC Core Competencies

2. Team Dynamics (1.5 hours)
  - a. CIHC Core Competencies
3. Evidence-based practice and knowledge translation (2 hours)
  - a. Guided hands-on training

## Results

### *Pre-Knowledge Acquisition Assessment*

Eight key components were identified for sustainability of IPPCs. These components are:

- **Structure:** i) senior team support; ii) relationship to the strategic plan; iii) clear terms of reference; iv) accountability and decision-making structure;
- **Values:** v) demonstration of positive outcome and value vi) physician engagement; vii) defined expectations and clear principle statement;
- **Education:** viii) Clear leadership and training for council members

These components align with the three key themes identified in the literature as essential to the development of a comprehensive interprofessional practice council: Structure, Values and Education.

### *Structure*

#### **i. Senior Team Support**

Councils need to be supported openly by the senior leadership. Additional support including re-moving barriers to participation such as backfill for staff to attend council meetings, and additional administrative support is important to ensure ongoing participation (Dunbar et al., 2007; Hoying & Allen, 2011). Over and over, the planning group heard the need for resources to support council members' time on the council and associated project work. This required budgetary allocation to permit meeting attendance and continued in kind support from other departments.

#### **ii. Relationship to the strategic plan**

The CVH strategic plan incorporates interprofessional collaboration and care as an important component of patient-centred care. Alignment with the strategic plan is essential for sustainability and continued

support from senior leadership as well as increasing staff buy-in.

**iii. Clear Council Terms of Reference**

The Terms of Reference forms the understanding of the purpose and accountability of the council. It is important to ensure that all council members understand their function, and that the council’s role is to address practice issues, not operational issues. Initial and annual review of the Terms of Reference is necessary to ensure awareness and understanding with ongoing training for new members.

**iv. Accountability and Decision-Making Structure**

All members of the council need to understand and appreciate accountability. While the councils should not have direct accountability to approve and implement practice changes without senior level review and approval, their authority to recommend those changes should be clear.

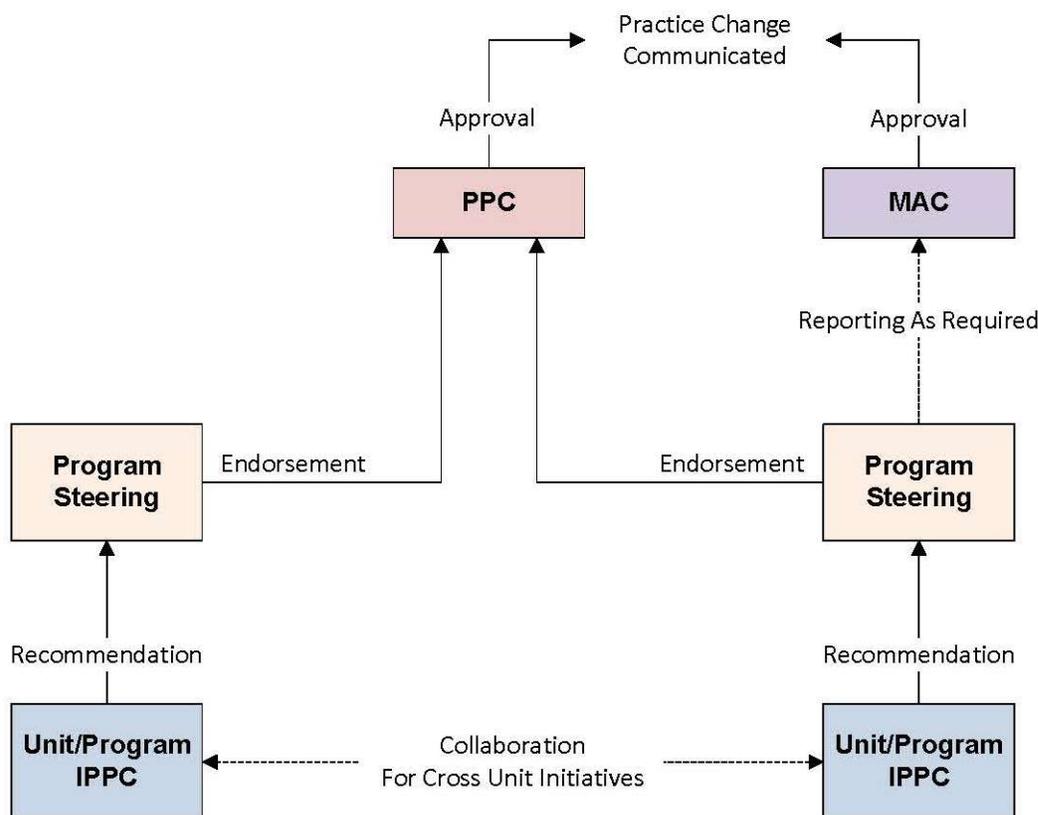
Practice changes that affect multiple programs require the endorsement from all affected program councils and steering committees before being presented for approval. This necessitates a communication process between councils to share ideas and proposed practice changes (See Figure 1).

*Values*

**v. Demonstration of Positive Outcome and Value**

To demonstrate the value of the council, outcomes from proposed practice changes should be monitored. The IPPCs should be directly linked with the program’s Quality Committee to review data and outcomes before and after a practice change has been implemented. The outcomes should then be communicated broadly to members of the council and the unit/program as a whole. The IPPC and Quality Committees should have the ability to review data and identify any areas that

**Figure 1.** Proposed Process of Recommending and Approving Practice Changes



Note: PPC - Professional Practice Committee MAC - Medical Advisory Committee

require further action which may require additional administrative support.

#### vi. Physician engagement

As part of the care delivery team, the physician is an integral component. Practice change recommendations will undoubtedly affect how the physician provides care to their patient. Hence, a parallel process should be in place for practice changes recommended for approval to the Professional Practice Committee (PPC) and the Medical Advisory Committee (MAC) as required (see Figure 1).

#### vii. Defined Expectations and Clear Principle Statement

Newhouse et al. (2007) indicated that as part of changing the culture of the organization to one that is more evidence-based, job descriptions were modified after input from staff, managers, and councils to promote this behavior. Dunbar et al. (2007) incorporated the performance evaluation criterion of shared governance for managers and senior leaders. Staff need to appreciate the commitment to evidence-based medicine and collaborative practice is the new norm in the healthcare setting that extends far beyond the role of the IPPCs and that IPPCs serve as a means of modeling this behaviour within the care environment. Pinkerton (2008) forwards that the Principle Statement is the “Philosophic statement which supports the belief that the staff closest to patient care are the best people to involve in improving healthcare outcomes and the practice environment” (p. 401), and this is integral to the values of the councils.

#### Education

#### viii. Clear leadership and training for council members

Successful councils utilize training modules to ensure members have a baseline understanding of the overall governance flow for councils and encourage understanding of the roles and accountabilities of the council members. A facilitator or coordinator with the responsibility of educating new council members, continuing to move forward the council work and ensuring the practice changes are in alignment with the goals and objectives of the program and the organization is beneficial (Campbell, Stowe, & Ozanne, 2011; Pinkerton, 2008).

These eight key components formed the backbone of the core content and resources (Toolkit, Governance Model, and Reporting Documents) that were created to support council development. Facilitated council development using these resources was planned and implemented. Protected and defined time-lines, using project management principles, were essential to establish and maintain momentum.

#### Post-Knowledge Acquisition Assessment

##### i. Online Survey

An online survey via Survey Monkey™ was utilized to capture post-knowledge acquisition and experiential data from 40 individuals who participated in the Practice Council rollout for either Mental Health or the Peri-natal programs at CVH. (Emergency did not participate in this part of the project-see Discussion Section). Nineteen responses (47.5%) were captured. Respondents predominantly answered “Strongly Agree” or “Agree” to all of the questions associated with knowledge acquisition with the exception of two questions: question 2 regarding individual members’ roles on the council; and, question 6 regarding gaining knowledge about health professions working at CVH (see \* in Table 2). Participants self-assessed as having increased knowledge about the 6 CICH Core Competencies for collaborative practice and evidence-based practice and knowledge translation. Results are shown in Table 2 (following page).

##### ii. Debrief meetings with stakeholders

Debrief meetings with stakeholders from each of the pilot areas were carried out. Of the three pilot programs only two completed the project, as the Emergency department could not participate due to high volumes in their area at the roll out time. There was variability in the experience of the remaining two groups. One group was extremely satisfied with their rollout experience and were clearly engaged in their commitment to moving forward with the councils and commented, “*Great work has been done on this development and it shows. The team was fun, dynamic and easy to work with. Exciting times for CVH staff. Thank you!*” The other group was less enthusiastic and concerned about their next steps “*I still find it unclear as to how this group is going to move forward and who will be leading these efforts.*” This other group also expressed concerns that the roll-out took too long with too much information

**Table 2.** *Post Knowledge Acquisition Data*

<b>Role of the Interprofessional Practice Council (IPPC)</b>	<b>Agree/Strongly Agree</b>
1. “I have gained knowledge about the role of the IPPC from this session”	77.80%
2. “I have gained knowledge about my personal role on the IPPC from this session”	50%*
3. “I know where to find the necessary resources/tools I need to carry out my role on the IPPC”	77.80%
4. “I have been properly equipped to move forward and carry out the activities associated with IPPC membership”	57.90%
<b>Establishing the Council Framework (CIHC Core Competencies)</b>	<b>Agree/Strongly Agree</b>
5. “I have gained knowledge about Credit Valley’s Interprofessional Framework” (CIHC #2-Patient/Family Centred Care)	77.80%
6. “I have gained knowledge about the variety of healthcare professionals working at Credit Valley” (CIHC #3-Role Clarification)	50%*
7. “I have gained knowledge about Team/Group Theory” (CIHC #4- Team Functioning)	72.20%
8. “I have gained knowledge about Personal Perspectives and Attention” (CIHC #3-Role Clarification)	83.30%
9. “I have gained knowledge about Conflict Management” (CIHC #6 Conflict Management)	77.80%
10. “I have gained knowledge about Interprofessional Communication” (CIHC #1-Communication)	Omitted (see discussion section)
11. “I have gained knowledge about Collaborative Leadership” (CIHC #5 Collaborative Leadership)	83.30%
<b>Evidence-based Literature and Knowledge Translation</b>	<b>Agree/Strongly Agree</b>
12. “I have gained knowledge about how to do an appropriate evidence-based literature search”	85.70%
13. “I have gained knowledge about knowledge translation”	92.90%

and time allotted for each session “*I think there was too much information presented during this session that created confusion for people*” and that staff still did not have a clear understanding of what their role is on the council and how to proceed. This feedback is further supported by narrative from the survey that stated “*The session could have been shorter*” and “*I am still somewhat unclear as to my role on the team*” and “*I still feel vague about what exactly this council is supposed to do.*”

## Discussion

### Core Content

The importance of training and education for the successful implementation of interprofessional, shared governance and evidence-based decision-focused work is supported by the literature (Campbell, Stowe, & Ozanne, 2011; Dunbar et al., 2007; Newhouse et al., 2007), “to ensure participants had the skills needed to participate fully and productively on a council,” (Dunbar et al., 2007, p. 197). As a result, curriculum and training was purposefully developed focusing on the core content of: collaborative practice; and, evidence-based practice and knowledge translation. Although participants attending the rollout sessions gained knowledge about the core content, concerns about the length of time to deliver the content and amount of information being delivered indicate there is a need to refine the content in such a way as to be meaningful without being overwhelming. Finding just the right amount of time to deliver just the right amount of content is a common educational concern, further complicated by time constraints associated with health care delivery and the capacity to liberate staff to attend sessions. Additionally, considerations should be given to the current team function and their experience of learning in an interprofessional environment which may require exploration prior to rollout and customization to meet the specific needs of the audience.

Clarity of purpose was a sub-theme identified with the content rollout for some participants who expressed ambiguity about their individual roles on the council and the role of the IPPC itself. It is uncertain if this lack of clarity was associated with core content delivery or the newness of councils within the organization and the usual growing pains associated with any new strategy, for with culture change comes a natural

confusion and ambiguity (Dunbar et al., 2007). Further evaluation of these councils down the road when they become deeply involved in addressing practice issues, may provide the best opportunity to determine if the delivered core content was helpful in supporting their processes. This is supported by narrative from the survey stating, “*I think until we get started and develop our first item to tackle, the application of what was learned will be even more clear and understandable.*” That being said, further refinement of the content with the intent of clarifying roles may address these indicated shortcoming immediately for other councils slated for the rollout process.

Review of the rollout program by the development team identified a failure to address Interprofessional Communication despite it being one of the 6 CIHC Core Competencies. As a result, the core content requires amendment to ensure a comprehensive delivery of the core competencies for future councils.

### Understanding Each Others' Professional Roles

A surprising theme identified in this pilot project was the lack of understanding of each others' professional roles. With a great deal of IPE/IPC work being done locally and globally over the past few years, it would seem a reasonable assumption that individuals would have an understanding about each others' roles. During the rollout, however, it became very clear that despite working together on a daily basis, professionals often have limited knowledge of the scopes of practice or education of their colleagues. There were incidents of clear surprise during rollout discussions about what one can and can't do in one's respective role that was further exacerbated with the recent changes in scopes of practice for some professions under the Regulated Health Professions Act (RHPA, 1991).

Why do we, despite considerable efforts and resources being put towards IPE/IPC, fail to appreciate each other's professional scopes of practice? In his 2008 book *Why Hospitals Should Fly: The Ultimate Flight Plan for Patient Safety and Quality Care*, John Nance lists the three main producers of human error: perception, assumption and communication. Surely our error in understanding each other's professions could be similarly attributed if we fail to appropriately communicate with our colleagues and appreciate their perspectives as care providers; make assumptions about

their roles, scopes of practice, knowledge, skills and judgement capacities; and/or our perceptions of their profession are not comprehensive. Often what seems self evident and obvious is not and requires considerable routine practice to be habituated. Caregivers need to be given the opportunity to work and learn about, from and with each other on a continuous basis with a culture of inquiry in a safe environment that encourages them to ask one another, “how would you approach this issue from your professional perspective?” and “who else ought we engage in this discussion?”

### *Readiness to Rollout*

Of the three pilot groups, the Emergency Department was not able to participate in the rollout during the scheduled time frame due to acuity, over admissions and staffing shortages. The rollout occurred during the winter months at CVH, which are months known for high admissions, bed shortages, and staffing issues. Prior to rollout in the Emergency Department, it was identified that staff could not be liberated from the clinical care areas to attend the required sessions. Upon reflection, the development team felt that given previous years data, this barrier may have been identified early on prompting recommendation that a readiness to rollout assessment be developed and carried out for future areas specifically reviewing: acuity, competing demands and staffing. As rollout of the IPPCs requires a great deal of coordination and commitment from educators, readiness to rollout assessments have the potential to maximize the resources associated with rollout and help the development team focus on areas more likely to support the process and subsequently succeed as a collective.

### *Leadership*

Reflection of the two remaining pilot groups’ leadership was an important factor in determining success. The group that was engaged and had greater clarity also had strong prior involvement from its program leadership and a strong chair/co-chair dyad defined early on in the process before rollout of the councils. For the group that was feeling challenged about moving forward with its councils, its leadership involvement had been inconsistent, and the group had not yet identified a chair/co-chair dyad even after the rollout had commenced. These results suggest a correlation between rollout

success and confidence of the team moving forward with strong dedicated and supportive leadership.

### *Physician Engagement*

As identified in the pre-knowledge acquisition phase of this project, physician engagement is a key component necessary for sustainability. The model of care of this community hospital does not include protected time and physicians identified this as a barrier to their engagement. To-date, there is inconsistent physician engagement on the IPPCs of these three pilot areas. Furthermore, the rollout team was met with an unexpected outcome from the physician group—obstruction. In determining the root of this issue it became apparent that each of the three pilot areas’ physicians groups saw evidence-based practice as their exclusive domain and expressed concern with the interprofessional team taking on this role.

Despite the best efforts of IPE and IPC, healthcare has its historical foundations in the hierarchical and somewhat patriarchal medical model. Having “carve[d] a distinct and prestigious niche” (Whitehead 2007, p. 1011), physicians are socialized into roles of responsibility and authority that creates barriers to collaboration (power, status, professional socialization, decision-making responsibility) that may limit their engagement and make it difficult for interactions that involve sharing responsibility (Whitehead, 2007). The move to a flattened hierarchical model, where health-care professionals interact as a system of “cooperating independent equals who contribute to a common vision of health” (Herbert 2005, p.1), is one that is appealing and sought after for, arguably, the majority of professionals within healthcare. If, however, this model implies a reduction of physicians’ traditional status, power and decision-making responsibility, “it is critical to contemplate how doctors will be encouraged to engage in this process” (Whitehead 2007, p.1011).

Whitehead (2007) suggests that physician engagement might be improved by demonstrating improved patient outcomes. Arguably, that is indeed the intention of the IPPCs—to address practice with the most relevant evidence and best practice approach to provide the best possible care and hence, improve patient outcomes, particularly in environments that have failed to utilize best evidence previously. Without a doubt, physicians

are an integral part of the healthcare team and as such it would follow that a team approach to evidence-based practice via the IPPCs would include their skills. Engaging the physician group to see the value of its involvement in terms of improving patient outcomes rests in testing an interprofessional approach to practice versus a uniprofessional one which is, ironically, dependent upon physician involvement.

### Limitations

The findings associated with this project come from the limited data of one organization's experience with councils in three pilot areas of the organization. Further exploration with additional areas of this organization and other organizations with varied structures would be valuable in supporting our observations.

### Conclusions

In summary, designing IPPCs has provided valuable information for future organizations considering similar structures. From the literature, we identified three key themes essential to the design of a successful comprehensive IPPC: 1) structure; 2) values; and 3) education.

Our experience in implementing and evaluating IPPCs suggests that the core content of focus for IPPCs be composed of collaborative practice, and evidence-based practice and knowledge translation. The key components for sustainability include: i) senior team support; ii) accountability and decision-making; iii) medical staff engagement; iv) relationship to the strategic plan; v) clear leadership and training for council member; vi) clear principal statement and council terms of reference; vii) demonstration of positive outcome and value; and viii) defining expectations. In addition, readiness assessment, physician engagement and strong leadership appear to be necessary requirements for successful council integration.

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