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Strategic Community:

An Approach for Developing Interorganizational Collaboration

Final Research Report

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LIST OF ABBREVIATIONS

APPAMME	Association des proches de personnes atteintes de maladie mentale de l'Estrie *(association of families of persons suffering from mental illness in Estrie)*
ASSSE	Agence de la santé et des services sociaux de l'Estrie *(health and social services centre of the Estrie)*
CHUS	Centre hospitalier universitaire de Sherbrooke *(Sherbrooke University hospital centre)*
CMDP	Conseil des médecins, dentistes et pharmaciens *(council of physicians, dentists and pharmacists)*
CSSS	Centre de santé et de services sociaux (health and social services centre)
CSSS-IUGS	Centre de santé et de services sociaux – Institut universitaire de gériatrie de Sherbrooke *(health and social services centre – Sherbrooke University geriatrics institute)*
FMG	Family Medicine Group
MHAP	Mental Health Action Plan
MSSS	Ministère de la Santé et des Services sociaux du Québec
SC	Strategic Community
TOW PROJECT	Transformation of the organization of work project

KEY MESSAGES FOR DECISION-MAKERS

Improving the accessibility of healthcare services within the Estrie region of Quebec, a region characterized by scarce human and financial resources, was the catalyst for pursuing the "Strategic Community" (SC) approach. The SC approach set out to transform the organization of work among healthcare institutions in the region and has made it possible to:

- Breakdown the barriers between work silos in various institutions in order to jointly implement simultaneous changes and end the deadlock in situations initially perceived by the partners as unresolvable
- Significantly improve collaboration between institutions and trust between frontline, second line and third line players, thereby reducing tensions between the partner organizations
- Take action on concrete things to be changed, as defined by the managers and the caregivers who work with the same clients
- Transfer lessons learned to other parts of the care continuum

This approach works well in cases where:

- The target care continuum serves vulnerable people who require complex care (e.g. oncology, mental health) and frequent appointments in various institutions
- The existing situation is perceived as unsatisfactory by clients and caregivers in the partner organizations
- The shortage of human and financial resources encourages people to reconsider the way work is organized

This approach is based on:

- The conviction, held by all of the partners, that it is necessary to work together to improve the organization of work, and make it a strategic priority
- A management method that values research and the implementation of solutions from the ground up
- Active and ongoing participation by the general managers on the steering committee
- A financial investment to set up the Strategic Community and its supporting structure: a managing director in each institution, a support committee consisting of designated managers in the partner organizations, an advisor-facilitator assigned exclusively to the Strategic Community, an external intervener and an experienced moderator.

SUMMARY OF THE STUDY

Healthcare network managers are called upon to take on sizable challenges on a daily basis, such as the growing need, and the shortage (in some cases, the complete absence) of resources. To maintain a level of service suited to the needs of the population, institutional authorities must reconsider the way they provide services and organize their work. For many players, adopting solutions in silos is insufficient. The interdependence of activities requires setting up collaborative initiatives with other institutions and organizations within the healthcare continuum.

The concept of collaboration, which garners general consensus in principle, can prove difficult to put into practice. After several disappointing attempts, three healthcare institutions in Estrie, with the support of the Work Organization Studies Chair at the Université de Sherbrooke, decided to implement a Strategic Community approach as a way to transform the organization of work between their institutions, so that the quality of services intended for specific clients would not only be maintained, but if possible improved, without increasing the pressure on staff, given the existing shortages.

A Strategic Community is spearheaded by an intervention group consisting of individuals from the partner organizations, which is given a mandate to generate, try out and evaluate ideas for transforming the organization of work. This group reports directly to a steering committee on which the general managers of the partner institutions sit. One thing that is special about a Strategic Community is that it must consist of individuals who are close to the care and services (professionals, general practitioners, specialists and first-level managers), who are known to exercise leadership in their institutions and who are therefore likely to play the role of agent of change towards their colleagues.

Understanding how a Strategic Community can succeed in increasing collaboration between institutions that are willing to participate, was the question that initially prompted this study. Originally, the main goal of this approach, the first trial of which took place in the field of telecommunications in Japan, was to promote innovation and the discovery of new solutions by bringing together key players from various partner organizations After three pilot projects in Estrie, between 2007 and 2011, with two vulnerable client groups, it became evident that the main contribution of a Strategic Community was to promote the adoption of the desired interinstitutional changes.

Contrary to the initial assumptions, it is not so much the lack of innovation that is a problem for the healthcare community, as the difficulty in taking concrete action. A Strategic Community has made it possible to implement, relatively quickly, initiatives for improving the organization of work between institutions with a positive effect not only on the continuity and accessibility of services, but on the degree of trust between the partners involved. Despite their limited scope, these pilot projects have helped to increase collaboration between the partners.

This research is a continuation of the initial pilot project (2007-2009) that was conducted with institutions and organizations providing cancer care. The research team wanted to determine whether the approach could be transferred to a different type of care: that of mental health. The mental health Strategic Community project made it possible to define the prerequisite conditions for the success of such an undertaking: a significant commitment by the general managers (one meeting per month), the participation of assistant directors associated with the general managers of each institution, the spearheading of a Strategic Community by a credible and experienced person who values this approach, concrete support for the pilot projects from an advisor-facilitator recruited by the general managers, the forming of an influential and active interinstitutional support group, and the contribution of independent expertise to steer the thought processes.

In addition, it has proven preferable to begin with projects where results are achievable in the short term. Particularly those which have the potential to overcome obstacles encountered by individuals who interact with clients. In light of the positive outcomes produced by the earliest initiatives, we have noted that the issues tackled have gradually become more complex.

We also wanted to verify how lasting the changes that were introduced between 2007 and 2009 by the two cancer Strategic Communities, were proving to be. On this point, the general managers agreed that it was necessary to use an existing, permanent regional structure to continue the interinstitutional change process once it was started. Moreover, all the conclusive results of the pilot projects conducted by the Strategic Community have been maintained and are continuing to evolve.

The study on the Strategic Community approach was carried out using a methodology of research and participative action. The assessment of the experience was based on a series of semi-directed interviews and discussion groups (n = 87), on the minutes of 28 meetings of various authorities concerned, and on field notes on the Strategic Community activities that were compiled over a period of 12 months. At the conclusion of the research project, the partner organizations decided to continue the project, and the general managers of the institutions in the region unanimously adopted this transformation methodology as an appropriate approach for resolving unsatisfactory situations where the clientele is vulnerable and presents complex health problems that require frequent and urgent attention from the first, second and third lines of care.

BACKGROUND

The problems of growing needs on the part of an aging population, in a situation of limited financial resources and staff shortages resulting from demographic conditions that are limiting the arrival of replacement workers, are creating difficulties in terms of the accessibility, continuity and quality of care and services provided to the public. Although many conventional methods are being deployed to address the current and anticipated lack of professional resources (proactive hiring measures, staff retention strategies, increasing the numbers of people trained in the regions, partnership with the education sector, etc.), it would seem that these are insufficient to deal with the situation. In these conditions, it has become evident that we must innovate and rethink the organization of work, not only within the institutions, but across the entire network.

Quebec's health and social services system consists of a series of independent institutions, with complementary missions, which are grouped together in networks to serve the local populations. In practice, however, we note that, typically, each of the institutions that are called upon to intervene mainly focuses on, and worries about, the episode of care and services that falls under its own jurisdiction. In many cases, anything that happens upstream, downstream or in parallel receives little or no consideration, despite the strong interdependence of the care and services that are provided within the various silos. Frequently, a patient or his family members are obliged to interact with various healthcare professionals who belong to different organizations, and who do not know each other.

In such a situation, work and activities that affect the interface between institutions is of particular importance if we are to avoid duplication of effort (e.g. avoidable repetition of diagnoses, files, interventions, multiple reiterations of the patient's history, etc.), the loss of information in transit from one institution to another, medical errors, loss of continuity, unwarranted service slowdowns (e.g. waiting lists at each service point) and the deterioration of patients' state of health. Accordingly, revamping the organization of work between institutions seems to be a promising path towards achieving gains in terms of improving the delivery of care and services. The challenge is all the greater, in that each healthcare institution taken on its own is already complex, and in that we must confront the inherent inertia in the system when the time comes to take action.

This report describes the trial of a new, innovative approach to interinstitutional collaboration, "Strategic Community", which has been applied during the past two years in the continuum of mental health care and services, based on lessons learned in a previous study conducted in oncology in the Estrie region of Quebec between 2007 and 2009[1]. Strategic Communities have been tried out thanks to collaboration between the various healthcare institutions and community organizations that have taken part in the transformation of the organization of work project (TOW project).

Three healthcare institutions were involved in the latest mental health trial: the Centre hospitalier universitaire de Sherbrooke (CHUS), the Centre de services sociaux – Institut universitaire de gériatrie de Sherbrooke (CSSS-IUGS) which serves the population of the city of Sherbrooke, and the CSSS de la MRC-de-Coaticook which provides care and services to a rural population of approximately 18,000 people[9]. Two community organizations also took part in the activities of the mental health Strategic Community: the Association des proches de personnes atteintes de maladie mentale de l'Estrie (APPAMME) and Jevi, the suicide prevention centre in Estrie. The CHUS and the CSSS-IUGS were also partners in the original oncology project with the CSSS du Granit.

The concept of Strategic Community (SC) was initially developed in the work of Kodama[2-4] and Shibata[5]. SC is an approach that brings together resources from various organizations with the goal of accelerating innovation in a given field of activity. It was used in the telecommunications sector in Japan to enable various internal and external players in the sector to extricate themselves from their usual operating framework and develop a better understanding of each other's situations, in order to discover innovative solutions to meet challenges that affected all of them.

When adapted to the healthcare sector, SC becomes a temporary structure for interorganizational collaboration, consisting of professionals, first-level managers, general practitioners, specialist physicians, representatives of community organizations, etc., whose mandate is to generate, apply and evaluate new ideas for the organization of work among institutions.

The members of the SC are usually leaders in their respective organizations and are mainly drawn from the staff and line groups of the participating organizations. Contrary to communities of practice, which are informal structures for sharing knowledge, problems and experiences between individuals holding similar positions[6], SC is a formal, interdisciplinary structure which is entrusted with a major organizational mandate. SC also stands apart from project teams which are expected to carry out specific mandates, defined by the management of their organizations, within a prescribed period of time. In contrast, SC enjoys great freedom of thought and of action. It is a bottom-up, counter-cultural approach in the very hierarchical world of health and social services. SC has the luxury of considering alternatives outside the conventional management frameworks of the organizations involved. It can dream up innovations or ways of doing things that will enable the participating organizations to pursue a common goal based on the values that the members share. Putting together and running such a community inevitably involves phases of exploration and incubation, and periods of trial and error that will eventually lead to a new strategy and new actions arising from the collaboration. It is as if the design of the innovation took shape gradually, as it was put into action. The fact that the participants come from various organizations enables them to remove themselves from their respective silos, understand the realities of other environments and give free reign to the process of generating ideas in a less formal framework that is prepared to receive them.

The trial that was carried out between 2007 and 2009 with the players involved in the oncology continuum of care and services as part of the TOW project[1] modified the approach to adapt it to the question of transforming the organization of work in the healthcare sector. New ideas are needed not so much for "what to do", as for "how to do it". The difficulty of implementing changes in the healthcare sector is commonly noted by observers, whether they come from the public arena or from the scientific community[7-8]. In 2009, when the research team approached the general managers with the idea of repeating the SC experience with a different clientele, a mental health intervention clearly emerged as a vital necessity. One of the factors that argued in favour of this choice of continuum, was that the medical and clinical administration managers of the CHUS and of the CSSS-IUGS welcomed the bottom-up approach of SC and thought it was a good idea for an independent party to help resolve a situation in which interinstitutional relations seemed to be getting bogged down and were in danger of reaching an impasse.

The key players of the mental health network agreed that an intervention was imperative. The state of care and services in the Sherbrooke region was regularly making the headlines in the local press, while it seemed to be impossible to shorten the waiting times for people requiring walk-in follow-up. The players involved readily acknowledged these problems: "There is a crisis of trust between the CHUS and the CSSS;" "So far, we note that collaboration is a one-way street…;" "We're not seeing any action. It's taking a long time, and there is no progress."

IMPLICATIONS FOR DECISION-MAKERS

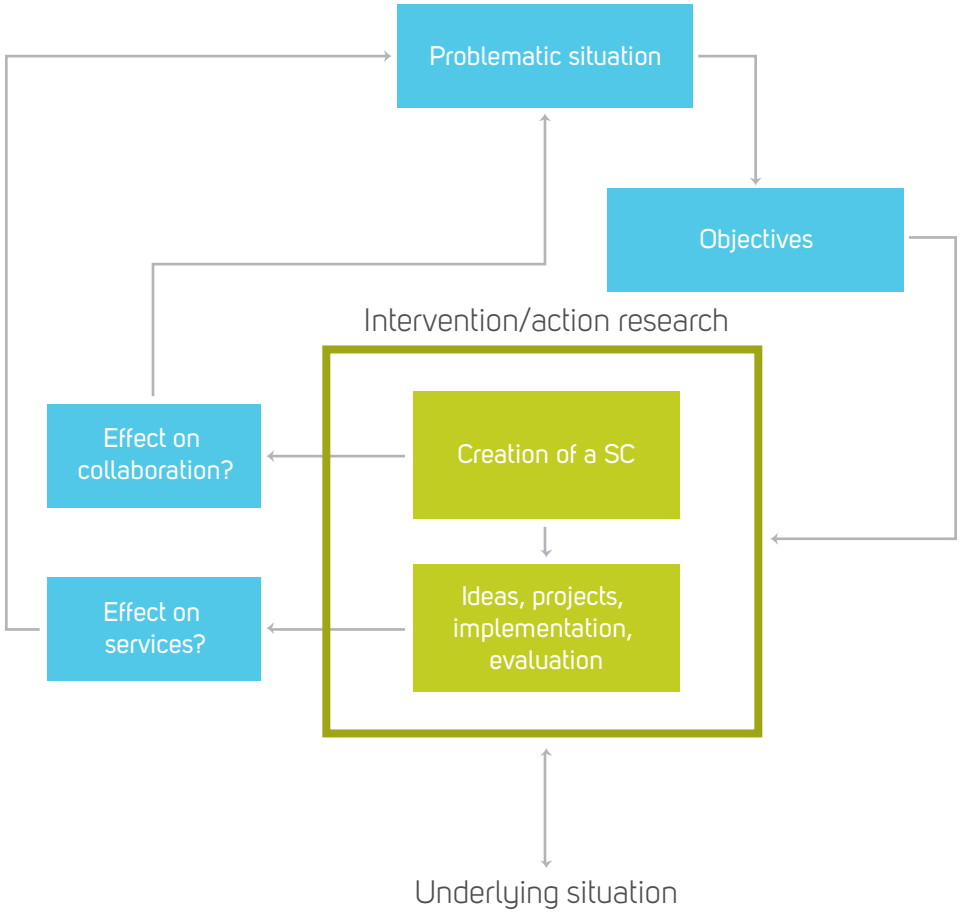
The study shows that decision-makers who are interested in adopting SC as a strategy for interinstitutional change in the organization of work must take the following factors into consideration:

- The degree of trust between the general managers, and their interest in jointly carrying out interinstitutional changes in care continua, must be high.
- The simultaneous adoption of changes within the partner organizations requires that these take precedence over the everyday intrainstitutional priorities.
- The SC approach is highly structured, which requires guidance and ongoing effort on the part of decision-makers, contrary to other change strategies that require a significant amount of effort mainly at the outset of the project.
- The managers must agree to "let go" to some extent, because the changes are initiated from the ground up, by those who labour "in the trenches".
- Using SC makes it possible to involve categories of professionals who, traditionally, have been difficult to mobilize, such as physicians.
- The SC approach must be viewed as a long-term project, rather than an experiment.
- The values and participatory principles used by SC are likely to influence the way that other, more directive organizational changes, are perceived.

APPROACH AND METHODOLOGY

The goal of the project was to demonstrate "how SC can be used as a mechanism for introducing and implementing organizational changes across a network." The evaluation framework that was adopted split this goal into two objectives: first, evaluate how the **SC approach** works as a strategy for generating, putting in place and evaluating ideas for transforming the organization of work, and, secondly, evaluate **the effect of the trials and the approach** on collaboration between institutions. In addition to this exercise, the research team also wanted to verify in what ways the work that was initiated by the oncology SC in 2007-2009 had been continued after 2009.

Figure 1 – General framework for project evaluation



Evaluation of how the Strategic Community approach works

A participatory research/action strategy was chosen as the methodology to support the setting up of the mental health SC and the execution of its activities. What the researchers were interested in was to understand how and to what extent the SC approach facilitates the introduction and implementation of changes in the organization of work between the partners who wish to increase their collaboration.

From a methodological point of view, participatory research/action represents both a research method and a method for implementing changes that generates new knowledge, through the resolution of the organizational problems under study, jointly by the researchers and the practitioners. It comprises several cycles or iterations in which the members of the organizations and the researchers collaborate at every step of the problem-solving process, as well as in the study and cogeneration of knowledge that arise from it. In each cycle, data are systematically collected and information is regularly disseminated to the various partners to enable them to share their experience and receive feedback on the impact of the project on each system taken individually, as well as on the continuum as a whole. The methods of continuous, systematic data collection (field notes, observations, reports, log book, interviews, discussion groups) are adapted as the change project progresses (see Appendix I – Detailed tables of data collection). The relevance of the

results and the credibility of the methods used to achieve them provide a rich description of the situations being studied; this makes it easier to transfer the lessons learned to other institutions and networks of care and services that might wish to adopt SC as a mechanism for transforming the way they organize care and services (see Appendix II – Dissemination activities carried out as part of the TOW Project). A description of how the SC project unfolded will be presented in more detail in the Results section.

Evaluation of trial results

Evaluating the trials chosen and conducted by the members of the SC was an integral part of their terms of reference. Quantitative data drawn from the tracking files that were compiled by authorities in the institutions and by the SC advisor-facilitator were gathered together, and the research team conducted a qualitative evaluation in three steps (set-up, execution and post-trial period).

Table 1 – Persons interviewed to evaluate the mental health SC trials

TIME PERIODS	NUMBER OF PERSONS INTERVIEWED*
Set-up (Oct. – Nov. 2010)	35 persons
Execution (Nov. 2010 – Jan. 2011)	49 persons
Post trial period (March-April 2011)	56 persons

* A total of 68 persons (including general practitioners) from the three institutions and the community organizations affected by the trials were interviewed at various times, individually or in group meetings.

We also followed up on the trials that were carried out by the oncology SC, to see whether the institutions had created conditions conducive to sustaining the desired changes. To that end, 14 semi-directed individual interviews and one group meeting (10 people) were conducted with key players of the oncology trials that took place between 2007 and 2009.

Evaluation of the impact that the Strategic Community trial had on interorganizational collaboration

In view of the impossibility of isolating the subject of the study from its context, we opted for an evaluation strategy based on qualitative data collected during semi-directed interviews of key informers recognized as being credible and representative of the wealth of points of view that are expressed in the organizations. The sample was compiled using a dual strategy (intentional and snowball)[10]. The picture of the initial problem situation that existed in the mental health sector in Estrie, and more specifically in Sherbrooke, was drawn based on interviews of 20 people carried out between October 2009 and March 2010. The picture of interinstitutional collaboration after the project was drawn based on 28 interviews using the same sampling strategy. All of the interviews were transcribed, coded and analyzed by three judges against the interorganizational collaboration model put forward by D'Amour et al.[11-12]. The agreement between the judges as to the coding of the initial situation was 93%. It was 83% for the coding of the situation in 2011. Interjudge agreement higher than 80% is considered satisfactory for this type of content analysis[13]. The variations noted are attributable to the subjective assessment of the degree of variation in the progress achieved with respect to collaboration. The final scores given to each of the variables of the D'Amour et al. model reflect the consensus arrived at following discussions between the judges.

RESULTS

How the Strategic Community works

The results of the research project suggest that SC significantly increases the collaborative capability of the partner organizations in terms of implementing the agreed-upon changes relatively quickly. After four years of trials in two different continua (oncology and mental health), we are able to propose recommendations regarding the main ingredients that are required to enable a SC to intervene in the operations of institutions with a good chance of success.

Prerequisite conditions

Since the SC approach is quite demanding, it is preferable to resort to it in cases where the initial situation of the clientele is clearly unsatisfactory in the partners' eyes. The managers involved at all levels must embrace the principles underlying the approach, be prepared to engage in the process, and release the necessary staff and resources to allow the project to be carried out. SC is suitable for application to clienteles for whom interinstitutional collaboration is necessary due to the frequent to-ing and fro-ing of patients between the institutions. This approach is also appropriate in cases where the state of health of the patients changes quickly and requires complex care, as in the case of individuals living with cancer or mental health problems. It also proves helpful when a lack of resources makes it difficult, if not impossible, to maintain the existing organization of work.

Initial diagnosis by an external intervener

It is necessary to draw a picture of the initial situation of the continuum of care and services provided in the organizations concerned, before embarking on the project. This diagnosis must be carried out by a credible, independent intervener who is not associated with any of the partners. It must be based on individual interviews with managers and key staff members of the organizations concerned, and must identify the strategic, functional and operational issues. The picture of the situation is then presented publicly, for validation, to the respondents, to the prospective members of the support group and to the members of the SC, at a general meeting in which the general managers will be invited to participate.

The membership of the Strategic Community

The interviews conducted during the initial diagnosis also provide an opportunity to identify the individuals who should be part of the SC, in order for it to enjoy the credibility and legitimacy necessary to carry out transformation-of-the-organization-of-work trials throughout the continuum. In the mental health SC, the group consisted of ten individuals: a general practitioner, a psychiatrist, directors of community organizations (2), unit or department heads (3), a psychologist and nurses (2).

The moderator of the Strategic Community

The moderator plays a key role in the unfolding of the SC. She must take care to constantly steer the members towards interinstitutional initiatives, whereas they frequently have an intrainstitutional, or sometimes even intradepartmental, vision of the continuum of care and services. For the sake of her credibility in the members' eyes, she must have experience in leading discussion groups. She must have a good reading of the political and strategic interinstitutional issues, and be familiar with the care and services in question, although without being directly associated with them. The players concerned by the SC emphasized the importance of all these characteristics of a moderator, as was noted across the mental health SC. The moderator ensures that a good work atmosphere develops, by giving everyone a chance to speak in an egalitarian

fashion. In collaboration with the advisor-facilitator, she is the guardian of the SC process. Using the tools available to her, she oversees the execution of the following steps: identification of ideas, prioritization of ideas, development of ideas in the form of trials, and follow-up after the trials. This last step, carried out within the SC, often provides an opportunity to shed light on the real issues and opens the door to new ideas.

The advisor-facilitator

The intervention by an advisor-facilitator hired by the steering committee is essential to provide the support that is needed for the entire SC process to proceed smoothly. She plays the role of liaison between the institutions, maintaining links with the groups and departments concerned by the SC's work. Given her pivotal role, the organizations emphasized how important it is that this resource demonstrate neutrality, and that she be dedicated to the SC project. Her duties include planning, organizing, preparing and even facilitating as needed, with respect to the SC activities and the various authorities of the project. The SC meetings also generate work to be done for the members, in particular for the managers in each of the organizations. The coaching and support for the agents of change that are provided by this resource, who is dedicated to them, drives the project forward from one SC meeting to the next, encouraging action. This support can take the form of helping to disseminate the work of the SC, and coaching managers in carrying out changes.

The support structure

The best ideas chosen by the SC are submitted, for consultation, to an interinstitutional support group consisting of the senior managers who run the programs in question[i]. The idea here is to enlist the support of those who will be responsible for promoting the changes to the other members of their respective organizations. The ideas are then submitted, for approval, to a steering committee consisting of the general managers of the partner institutions and the managers assigned to the project (ideally one per institution). The latter managers become champions of the project in their institutions and serve as political and strategic liaisons in between the steering committee meetings, in collaboration with the advisor-facilitator.

Once approval has been obtained for carrying out the trials, the SC immediately proceeds with the implementation, and plans the evaluation of the chosen initiatives. Experience shows that it is preferable for the SC to start by tackling minor changes, to give the participants a chance to learn to work together, to trust each other and to take concrete action in the field.

Getting down to business

The activities of the Strategic Community start with a public presentation of the initial diagnosis, which is immediately followed by a training session for the members of the SC to familiarize them with the SC approach and its methods of operation. Next, the SC focuses its energy on developing a common view of the continuum of care and services. In mental health, this task proved to be quite complex, given the multiplicity of care paths that exist. The testimonial of a beneficiary of care provided a concrete picture of the tribulations he went through to access the services provided by the various resources. As was done in oncology, the SC also compiled an inventory of the problems that were likely to attract its attention, and decided to tackle three trials in which it thought it would be able to take action quickly: 1) the use of a follow-up sheet for the referring physician, 2) sharing of information between the caregivers at the CSSSs and the team working at a unit of the CHUS during

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[i] The membership of the support group can vary, depending on the clientele and programs affected; it can include human resources managers.

a hospital stay, and 3) gaining more knowledge about the community organizations. Between April 2010 and March 2011, the members of the mental health SC held 15 meetings with an average duration of 3 hours. The average participation rate was 86%. Between meetings, the members occasionally had to do some preparatory work to promote the advancement and buy-in of projects in their respective organizations. When this research project reached its conclusion, new trials had been identified, and the organizations had made a commitment to continue the work.

Political and organizational issues

Collaboration between institutions brings its share of political and organizational issues that inevitably arise between the partners along the way. During this trial, the researchers played the role of external advisors to help the parties take a step back, openly discuss the difficulties experienced and the lessons learned within each of the institutions, and develop joint strategies in order to simultaneously carry out the necessary changes. The presence of an external advisor who is trusted by the general managers promotes balanced relations between the general managers and helps to maintain the momentum in carrying out the interinstitutional initiatives.

The active and ongoing engagement of the general managers proved necessary to ensure that everyone concerned clearly perceived that the interinstitutional initiatives of SC were a top priority, taking precedence over everyday, internal priorities. The fact that the general managers clearly affirmed their position in favour of SC, in particular when reassigning certain resources to different positions in order to facilitate the progress of the project, sent a clear signal to the various partners that the issues raised were being taken seriously.

The SC approach targets interinstitutional relations by promoting change initiatives that are thought up by managers and professionals who work closely with the clientele. In this respect, it is a bottom-up approach to change, which runs against the general culture of the very hierarchical and bureaucratic sector of health and social services. It can only be deployed in organizations that support such a delegation of power to the base of the pyramid.

To give a concrete example of the nature of the activities carried out in the SCs, we briefly present, below, the three trials conducted in mental health, as well as the oncology trials whose results were made permanent.

Strategic Community trials in the mental health continuum

During the first year of the mental health SC, three trials were carried out (see Appendix III – Evaluation of the effects of the SC trials in mental health).

Use of a follow-up sheet for the referring physician. The purpose of this sheet is to ensure continuity in intervention follow-ups, while reassuring the attending physician that his client is being taken care of and making progress. The CSSS and Jevi players say that the introduction of this new tool systematizes a practice, develops a collaboration reflex among physicians, and even moves up the client's next appointment if need be. The physicians appreciate finding out quickly which approach is favoured by the specialists who were consulted, and this enables them to reinforce the approach that was undertaken.

Sharing of information between the caregivers at the CSSSs and the team of a unit at the CHUS during a hospital stay. The purpose of this trial was to harmonize interventions between the team of caregivers and psychiatrists at the CHUS and the caregivers at the CSSSs. It consisted in increasing the frequency of contacts between caregivers, by making quick calls between the CHUS and the CSSSs during a hospital stay, and in having a caregiver from the CSSS attend multidisciplinary meetings held at the CHUS. Given the collaboration resulting from this practice and its noteworthy positive effects, everyone hopes that it will be expanded to the other mental health units of the CHUS.

Greater knowledge about the community organizations. This trial consisted in inviting the various community organizations, in turn, to present their service offers to the caregivers at the CSSSs, while adopting a mode of operation that promoted real dialogue with the participants. The goal was to increase the degree of mutual trust, promote links and increase the number of referrals. Here again, the outcome was positive, and this practice should continue.

Overall, the outcome of the trial is so positive that the general managers have agreed that the mental health SC should continue its work beyond the period originally planned by the research project. The level of comfort attained by the SC is so high that complex problems concerning, among others, the operation of the mental health access point in Sherbrooke, as well as disputes regarding the distribution of clienteles between the first and second lines of care, will be included in its future efforts. Clearly, the impasse that participants felt they were in at the beginning is starting to dissolve; as one participant commented, "We are gradually taking the wall down". SC encourages people to move beyond working in silos: "We get out of our little sandboxes"; "Before, we were running a relay race; now, we are all running together".

Making the trials of the oncology continuum Strategic Community, permanent

The work that was carried out by the oncology SCs between 2007 and 2009 has become permanent. Be it internally or between the institutions, the changes that were adopted have been maintained and adapted over time to the needs of the various organizations[ii].

Stable or dedicated care teams. In 2007, the participants in the first SC came to the conclusion that the work should be reorganized around relatively stable care teams in each of the target organizations, in order to make coordination between the institutions, possible. At the CSSS-IUGS, the inherent benefits of creating a dedicated oncology team (i.e. breaking down professional silos internally, reducing duplication of activity, a marked improvement in the quality of service provided to this clientele, etc.) were so great that the institution formed a new, dedicated team in the area of physical impairment. At the CSSS du Granit, working as a team made it possible to include nursing assistants, a practice that had never been accepted before then. Working in teams was also continued at the CHUS. The team approach is now considered whenever restructuring is needed in a clientele program. In fact, training on working in teams[14] was developed based on this oncology trial.

Self-administration of Neupogen. The practice of teaching clients to self-administer Neupogen has now been broadly adopted by the majority of target clients who receive care at home. The presence of the team that is dedicated to home care seems to have had a positive effect in this regard. Meanwhile, the staff of the regular sector has yet to adopt this practice.

[ii] For a detailed description of the trials developed by the oncology SCs, see Roy et al. (2009).

Use of group prescriptions. The use of group prescriptions to relieve constipation and to remove staples is now an established practice in all the organizations. Despite the speed with which these prescriptions were designed and put in place, no other prescription has been developed, even though the interest in doing so is recognized.

Early intervention by community organizations. In light of the conclusions arising from the trial of early intervention by community organizations, such intervention has been reconfigured to take the real needs of clients into account.

Continuation of the oncology SC's work. Based on the outcomes achieved, the general managers of the institutions concerned agreed that it was necessary to use a permanent regional structure, i.e. the regional oncology round table, to continue the interinstitutional efforts towards continuous improvement. Of the many possible projects identified by the oncology SC, the members of this round table chose three: 1) clarification of the role of nurse navigators in oncology, 2) the adoption of the network oncology data sheet, and 3) the development of the oncology and palliative care program as well as the care trajectory for the Estrie region. More fluid communications between the players, a clear improvement in interinstitutional links despite the need for more progress, and better collaboration due to the fact that the players knew each other better, were observed. Moreover, the fact of having dedicated oncology staff increases dialogue, sharing of information and mutual familiarity.

The diagnosis of the initial state of affairs in the oncology continuum showed that operating in silos was so entrenched in people's customs that not only did the first-level managers and professionals in the network's institutions not maintain regular relations, most of them did not know each other. In 2007, interinstitutional communications were basically limited to faxing a patient's continuity data sheet, briefly completed. Today, a myriad of interaction mechanisms is noted (i.e. regular phone calls between caregivers, liaison committee between managers, regional round table on oncology, round table of nurse navigators in oncology, network data sheet, etc.)[15]]. Communications now take place in a more personal way, because the people know each other and have a better understanding of other people's work environment, and of the operation of the continuum as a whole.

Trends in interorganizational collaboration

We decided to use the interorganizational collaboration model put forward by D'Amour et al.[11-12] to evaluate changes in the perceptions held by the main players in mental health in Estrie, and more specifically in the Sherbrooke area. This model consists of four dimensions and ten variables (see Appendix IV – Variables used to analyze interorganizational collaboration). The table below provides a description of each of these variables.

Table 2 – Variables of the D'Amour et al. interorganizational collaboration model

VARIABLES	BRIEF DESCRIPTION
Centrality	Existence of a clear, central authority that guides the action towards strategic and political collaboration, in order to promote the adoption of, or changes to, structures and collaborative processes.
Leadership	Existence of a local leadership (formal or informal) that promotes interprofessional and interorganizational development. The partners feel that their point of view is taken into consideration, and that they participate in the decision.

VARIABLES	BRIEF DESCRIPTION
Support for innovation	The collaboration generates new activities and new sharing of responsibilities. This involves providing support for learning and access to internal or external expertise to guide this change.
Connectivity and concerted action	Interconnection is facilitated by the existence of forums for holding discussions and forming ties between the partners. This facilitates coordination by allowing adjustments to be made in response to problems that arise.
Formal agreements	Existence of formal agreements that clarify the responsibilities of the various partners. These can take the form of contracts, protocols, letters of engagement, etc.
Exchange of information	Existence of an infrastructure enabling the systematic exchange of information between the partners and the professionals. This reduces uncertainty about patient follow-up, and provides an opportunity to appreciate the professionals through the written messages and the feedback provided.
Goals	Presence of common, shared goals that make it possible to develop a consensual approach, e.g. improving the care provided to patients, meeting their needs, etc.
Allegiances	Presence of converging interests that influence the direction of decisions and actions.
Knowing each other	The players know each other personally and professionally (values and competencies, frame of reference, services provided, approach to care, scope of practice).
Trust	Trust reduces uncertainty about other people's competence and their ability to take responsibility for the care provided.

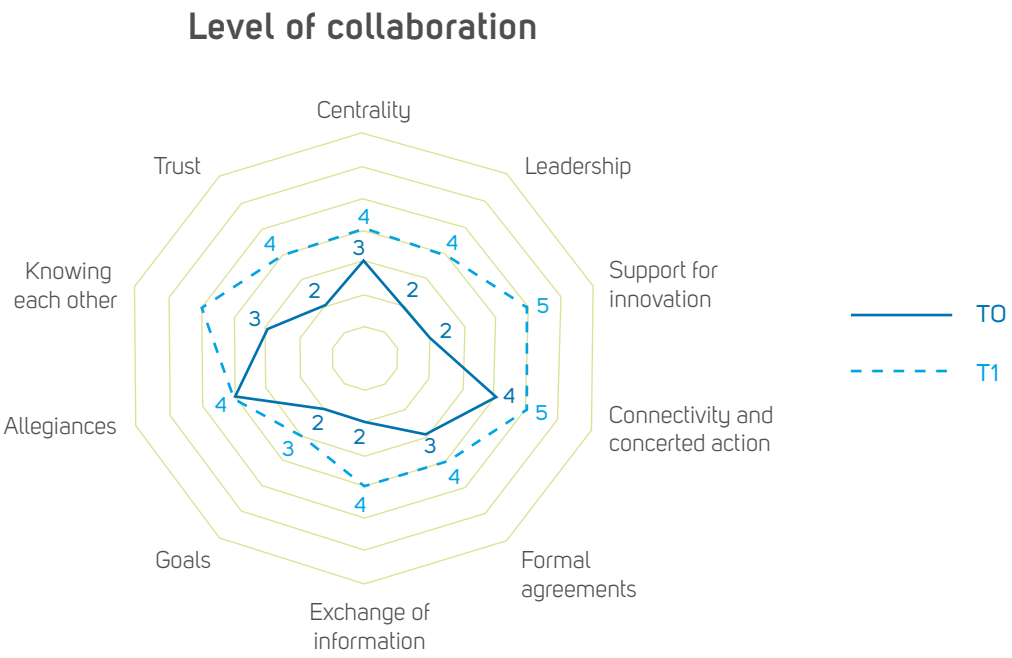
The model rates the intensity of collaboration according to a typology with three levels[iii]: 1) The weakest intensity is referred to as *latent collaboration*. At this level, the collaboration variables are described as being absent, or quasi absent. 2) The intermediate level of intensity is referred to as *collaboration under construction*. At this level, the collaboration variables are described as being diffuse, ad hoc, incomplete or fragmentary. 3) The strongest intensity is referred to as *collaboration in action*. At this level, the collaboration variables are described as being firmly anchored, consensual, shared or coordinated.

Based on the analysis of the interviews conducted before and after the project, it appears that the level of collaboration between the partners has improved considerably (Figure 2). It should be noted, though, that the progress in the level of collaboration between the organizations cannot be attributed exclusively to SC, even though several people mentioned that it played a key role in this regard. Many of the players involved in the SC also participate in other bodies (round tables, regional committees, etc.) and many concomitant changes were underway during the same period. The variation that is observed is attributable to a series of factors that cannot be isolated. In cases where a trend emerges more clearly in attributing an effect to one cause rather than another, this is mentioned in the text.

[iii] The gradation of the scale has been adjusted, by subdividing the three levels into seven degrees to refine the degree of precision for describing the development of the situation between the beginning (T0) and the end (T1) of the project.

In general, the collaboration between the partners moved from *latent* to collaboration *under construction* (see Appendix V – Measurement of collaboration using the D'Amour et al. model).

Figure 2 – Changes in mental health interorganizational collaboration in Estrie (Sherbrooke) between the autumn of 2009 (T0) and spring 2011 (T1)



The initiatives that had the greatest impact on progress in collaboration were those associated with support for innovation. In 2009, the individuals who were questioned lamented the small amount of expertise available to support the changes needed to implement the Mental Health Action Plan[iv]. In 2011, the respondents remarked that expertise is increasingly available. Many noted positive effects linked to the presence of medical expertise (physician and psychiatrist respondents) and appreciated the fact that training focused on the needs of the CSSS teams was offered. The support for the SC trials provided by the advisor-facilitator also contributes to this positive perception.

The other aspects that show significant progress are exchange of information, knowing each other and trust. These three aspects are linked and influence each other.

The trials that the SC decided on were mainly focused on increasing exchanges of information (e.g. follow-up sheets, systematic contact between the interveners in a case, informational visits) between the partners. These trials helped people to get to know each other better and to understand the role they each played. This in turn helped to do away with old perceptions about the willingness or the ability of the various partners to participate in generally improving the care and services provided. Many of the individuals who were questioned noticed an increase in the number of referrals made to them, and an improvement in their quality.

[iv] The Mental Health Action Plan (2005-2010), a reference framework developed by the Ministère de la Santé et des Services sociaux (MSSS), aims, among other things, to develop new ties between healthcare institutions.

As a direct consequence of the increase in opportunities for dialogue and of getting to know each other better, trust between the partners has also increased. Whereas there was a notable absence of trust between the partners in 2009, all of the respondents note an improvement, at all levels of the hierarchy. The members of the SC in particular have developed great trust in each other and a good deal of respect. Since many of these individuals intervene in mental health in the region in several ways, trust has had a perceptible positive impact on the progress of many projects.

Progress has also been achieved in the connectivity and concerted action and formal agreements variables. The cooperative forums that existed prior to the project have remained, and new ones have sprung up, linked to the SC. For example, the SC support group, on which the managers and directors sit, is perceived as a discussion forum where problems can be dealt with concretely. In addition, many respondents mention having adopted the habit of telephoning each other to verify the information that comes to them, in order to avoid generalizing impressions based on epiphenomena. New agreements have appeared. While the extent of their formalization varies, the respondents point out progress relating to the development of a clinical path, and agreements associated with the new way of organizing residential services.

While the situation has improved between 2009 and 2011, the respondents' perceptions show more variation in the dimensions relating to governance and vision. When it comes to identifying which authority plays a central role in guiding collaboration in the region (centrality), the opinions are still mixed. Many respondents mention the MSSS's Mental Health Action Plan, while the ASSSE seems to exert greater influence than formerly. The role played by the CHUS remains ambiguous, however. While, in general, the respondents' perception has improved regarding the leadership exercised by the CHUS at the local level, many people still reproach some of its representatives for too often adopting a directive, rather than a consultative, attitude.

Finally, everyone agrees that work remains to be done to achieve greater harmony between the goals and the actions. The visions have come closer together, but the divide between the hospital approach (taking care of the patient) and the community vision (developing independence) is still present. Professional affiliations continue to influence the courses of action (allegiances).

CONCLUSION

Based on the results achieved in the mental health and oncology care-and-service continua, SC has proven itself to be an interinstitutional approach to change that makes it possible to take action in systems with a reputation of being difficult to change. Not only do the changes succeed in lasting over time, but the best achievements are transferred to other continua. Interprofessional and interorganizational collaboration and trust have increased significantly in environments where relations were, at the outset, non-existent in one case, and problematic in the other. The investment required to implement a SC, in terms of time and energy, is substantial at all levels of the hierarchy. However, the gains have been so significant that all of the general managers in the Estrie region express strong interest in this approach. Many are considering potential clienteles for future SCs, and steps are already underway to evaluate the feasibility of a SC for a specific clientele.

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