

A Multi-disciplinary Professional Practice Model: Supporting Autonomy and Accountability in Program-Based Structure

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Abstract

This article addresses the challenge of maintaining high quality patient care in a large, diverse health care organization as it merged and moved from a functional to a program-based management structure. The article describes the Professional Practice Model (PPM) which was developed to address the professional issues inherent in a program-based management structure. The operationalization of the PPM, including the committee structures which were put in place to support it, are discussed. The final section of the article highlights the strengths and challenges which have arisen through the development and implementation of the Professional Practice Model.

Introduction

In 1995 the Health Care Corporation of St. John's, Newfoundland was formed with the merging of eight health care institutions. This merger created thirteen clinical programs (e.g., medicine, surgery, child health, mental health) bringing together approximately 6500 staff and physicians under a program-based management structure. In order to address the professional practice issues inherent in program based management the corporation hired Professional Practice Coordinators for the following disciplines: Clinical Nutrition, Nursing (3), Occupational Therapy, Physiotherapy, Psychology, Respiratory Therapy, Speech Pathology, Social Work and Therapeutic Recreation.

The Professional Practice Coordinators developed and implemented a Professional Practice Model (PPM) to support clinical practice with the ultimate goal of ensuring and enhancing quality client care. The purpose of this article is to describe the PPM, how it was operationalized and its strengths and challenges.

Development of the Professional Practice Model

The model was developed from a multidisciplinary

perspective and thus is flexible enough to encompass the needs of each profession. While the model evolved to address issues specific to a program-based management structure, it is equally applicable with few alterations to a functionally-based structure.

The PPM is an organizational framework designed to empower staff by supporting autonomous clinical practice with appropriate accountability. The model strengthens team functioning by ensuring competence in practice and enhancing the professional development of each team member. In having a strong and secure sense of professional identity, each team member can contribute uniquely, competently and powerfully to the care of the client.

Description of the Professional Practice Model

The Professional Practice Model (PPM) is schematized (see Figure 1) as a wheel comprised of concentric circles representing various aspects of clinical practice. The 3 inner rings represent the clinical setting in which the professional practices and illustrates the client-centred care provided by an interdisciplinary team within a variety of models of care delivery (e.g., case management). The sections in the middle part of the model identify the core components that support the autonomous practice of the professional. The outer ring represents the support from the corporate environment in which the model is embedded and includes the organization's mission, vision, values, guiding principles and quality initiatives. Each core component of the model identifies key ingredients of a system in which high quality professional practice is developed, supported and reinforced.

Core Components of the Model

The core components of the model include: Standards, Education, Utilization, Professional Strategic Planning, Evidence Based Practice and Performance Management. These core components are divided into sub-components. (See Table 1)

Standards

Development and maintenance of standards is central to professional practice and as such is an integral part of the model. The standards component includes Standards of Practice and Care, Codes of Ethics and Legislative Guidelines which are supported and mandated by each profession's regulatory body. The PPC and the Councils are responsible for ensuring that all applicable standards are maintained. In professions which are not regulated, the model provides a structure for the development of these fundamental components of professional practice. The model endorses the need for collaboration with the regulatory and professional associations in the implementation and ongoing evaluation of compliance in these areas. Where there are support personnel (e.g., LPN or OT Aides, etc.) the model

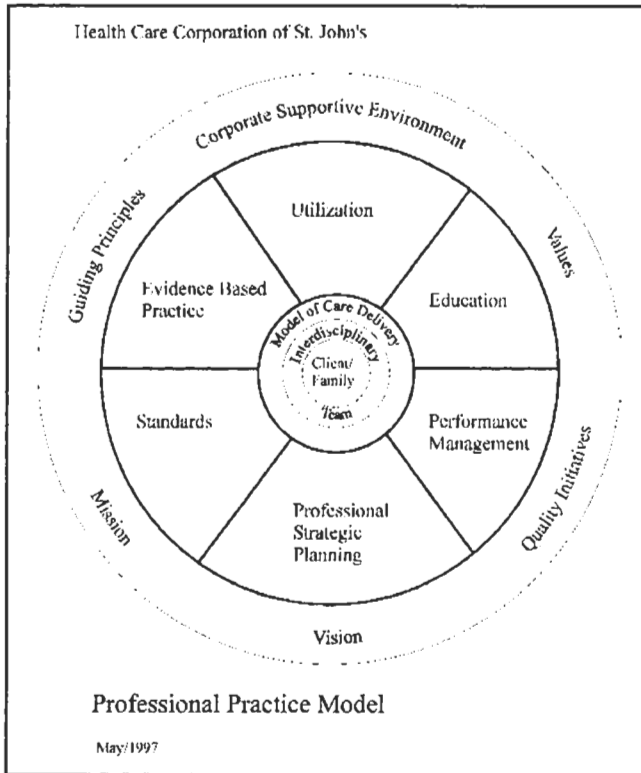


Figure 1 (left)
Professional Practice Model

Table 1 (below)
Professional Practice Model
Components and Sub-Components

TABLE 1: PROFESSIONAL PRACTICE MODEL COMPONENTS AND SUB-COMPONENTS

STANDARDS	EDUCATION	UTILIZATION
<ul style="list-style-type: none"> • Standards of Practice • Standards of Care • Legislation • Accreditation CCHSA Discipline • Code of Ethics • Documentation 	<ul style="list-style-type: none"> • Orientation • Specialization • Curriculum Advisory • Continuing Education • Student Clinical Education • Preceptorship • Mentoring 	<ul style="list-style-type: none"> • Workload Measurement • Clinical Assignment • Resources
PROFESSIONAL STRATEGIC PLANNING	EVIDENCE BASED PRACTICE	PERFORMANCE MANAGEMENT
<ul style="list-style-type: none"> • Philosophy • Mandate • Goals • Objectives • Strategies • Advocacy • Human Resource Planning • Career Ladder 	<ul style="list-style-type: none"> • Utilization of Research • Clinical Practice Guidelines • Outcome Measurement • Conducting Research 	<ul style="list-style-type: none"> • Position Description • Competence • Core Competencies • Credentialling • Peer Review • Clinical Leadership

ensures that the scope of practice of professional and support personnel are clearly defined. The model also recognizes the role of accreditation at both the institutional (Canadian Council of Health Services Accreditation) and professional level in developing and ensuring compliance with standards.

Education

The PPM defines education as crucial in the development and maintenance of competent clinical practice. The education component has two aspects. One refers to the initial and ongoing education of practitioners when they become employed within the Health Care Corporation. This includes orientation, development of specialization, ongoing professional continuing education and preceptorship/mentoring where applicable. The second aspect refers to the importance of liaising with the professional schools in developing and modifying curricula and in providing quality student placements.

Utilization

Recognizing utilization as a key factor in professional practice, the model highlights the impact of workload levels and associated resourcing on clinical practice. The allocation of clinical staff may need to be revisited by the PPC in consultation with the Council as client needs and program key directions change or the professional group alters its strategic direction.

Professional Strategic Planning

Professional Strategic Planning identifies the need for professional groups to develop a philosophy, mandate, goals and objectives common to all members of the discipline within the program based structure. It also acknowledges the importance of developing strategies as a professional group which allow for achievement of key directions. The model supports the PPC and Council's involvement in advocacy and human resource planning on behalf of the professional group which is important given that within a program-based structure, managers will be of a different professional group from some of their staff.

Evidence-Based Practice

This component of the model emphasizes the importance of the integration of research into clinical practice. To this end, the model identifies and supports structures to facilitate development of clinical practice guidelines, use of evidence to inform practice, use of outcome measures and involvement of staff in planning and conducting research.

Performance Management

The Performance Management component focuses on developing and reviewing scope of practice issues in position descriptions to clarify and evaluate the role of the

practitioner in providing care to the client. Credentialling, development and measurement of competencies, self-review and peer review are identified by PPCs and Councils as processes which ensure that the professional has the knowledge and skills to fill the role described in the position description. The development of clinical leadership positions is highlighted in the model as another way to enhance competence in clinical practice through the provision of supervision, expert consultation and mentoring.

Structure to Operationalize Professional Practice Model Central Council

The Professional Practice Model (PPM) is operationalized through a Council Structure (Figure 2). A Central Council has been established by each of the disciplines involved and is designed to provide leadership and ensure professional autonomy and accountability for clinical staff. It is the most senior body for each discipline within the Corporation to which all committees/councils for that discipline ultimately report. The membership is comprised of the Professional Practice Coordinator for the discipline and frontline staff. With the exception of the PPC, managers do not sit on this council.

The Councils (Research, Education & Practice) are some examples of the types of standing councils/committees that may be required to address the needs of the discipline. The Program Councils are designed to provide leadership and ensure professional integrity for clinical staff at the program level. The membership for each program council is comprised of clinical staff from the program as well as any other individuals who have the knowledge, interest and expertise to fulfill the mandate of the council. For some disciplines, managers may be included on the Program Councils.

Professional Practice Coordinators' Interdisciplinary Committee

Each of the Central Councils link through the Professional Practice Coordinator for their discipline into the Professional Practice Coordinators' Interdisciplinary Committee which is composed of the Professional Practice Coordinators and chaired by a Vice-President. This committee guides and supports professional practice through a collaborative problem solving and decision-making process. Its purpose also includes the maintenance of the PPM and resolution of those issues that impact several disciplines.

There are linkages with the PPC Interdisciplinary Committee and the 3 other corporate-wide committees/councils; Senior Advisory Council, Professional Practice Coordinators/Program Liaison Council, and the Medical Advisory Committee. This structure is designed to facilitate communication and enhance collaboration with a variety of stakeholders. The Senior Advisory Council, composed of a cross section of representatives from unions, management

Figure 2 Professional Practice Model Council Structure

and administration, advises the Chief Executive Officer on key directions. The Professional Practice Co-ordinators/Program Liaison Council facilitates collaboration between the program leadership and the Professional Practice Co-ordinators to address the impact of clinical issues on program delivery. Crucial issues, such as allocation of human and fiscal resources and role clarification are the foundation of this group's discussions. The Medical Advisory Committee functions as a forum for discussion and decision-making for medical staff.

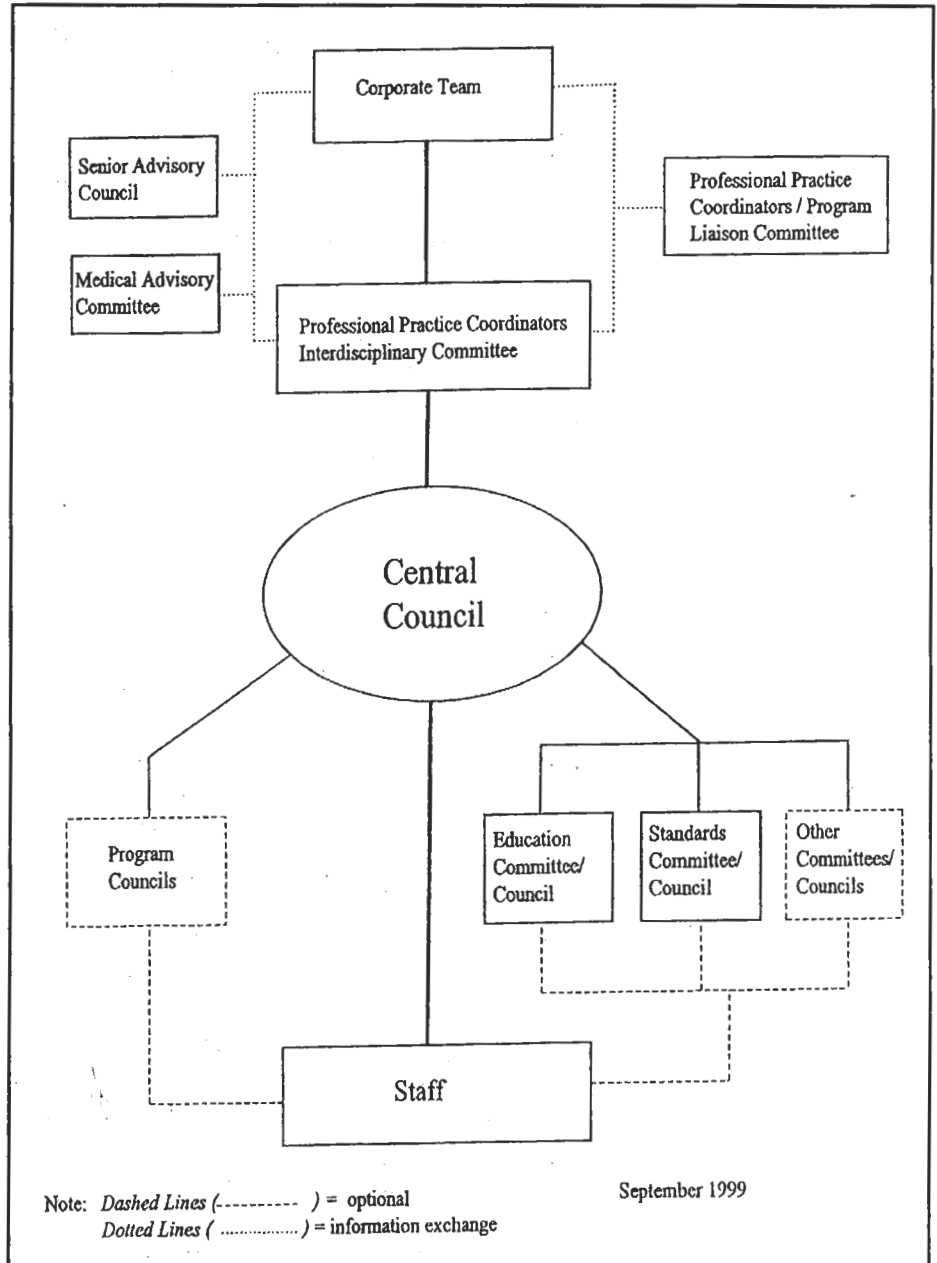
Strengths and Challenges

Although the model has been in place for the past 6 years, it has not yet been fully operationalized primarily due to fiscal restraint and thus has not been formally evaluated for all disciplines. There is, however, ongoing feedback from a variety of sources on the model's strengths and the challenges associated with operationalizing it.

Strengths

The model recognizes the need for both consistency and flexibility to accommodate the uniqueness of each discipline including non-regulated disciplines. In terms of decision making the structure which evolved out of the PPM is less hierarchical than traditional departmental structures which commonly featured a top down decision making process. The model supports clinical decision making as close to the client as possible which empowers both the practitioner and the client. This helps make the service delivery system more timely and responsive to client needs.

The model provides a structure which supports cross-disciplinary collaboration and this has streamlined several processes across the corporation which were developed by the PPCs and Councils such as the process for the orientation of new staff and the development of discipline



specific policy and procedure manuals. Through the council structure there has been increased opportunity for front-line staff involvement in several key areas, such as the allocation of continuing education funding and resolution of professional practice issues.

Another strength of the model is that it drives the development of continuing education opportunities based on needs identified by practitioners. The PPCs and Councils regularly discuss continuing education needs and identify innovative ways to meet as many needs as possible. For example, several of the PPCs have partnered with professional organizations to provide quality continuing education for staff. There have also been educational opportuni-

ties initially developed by one PPC for a specific discipline that when discussed with the other PPC's, have been recognized as valuable to other disciplines as well. The opportunity was then extended to all interested staff. This process occurred as a function of PPC Interdisciplinary Committee and the communication between disciplines which it fosters.

The model has also guided the development of a formal process across disciplines through which staff may identify and resolve specific practice issues such as a breach of ethics or standards. The PPM has impacted on every facet of professional work in our organization principally through its clear and unequivocal identification of and support for the components of professional practice. The danger in not having the essential components of what drives high quality, low risk professional practice defined in a program managed system is that significant factors will be overlooked (e.g. continuing education, professional strategic planning) or taken for granted (e.g. standards, utilization). The PPM has, in our organization, prevented this from happening. Staff have generally been supportive of the model and we continue to look for ways to improve its ability to support professional autonomy and accountability.

Challenges

Although staff find the system which has evolved out of the PPM has allowed them to be more independent, some have commented that they feel increasingly isolated without peer and "same discipline" management support. Some practitioners have raised the concern that the PPM limits the expression of unique professional identity, as a result of the focus on consistency of process across the Corporation. The challenge, therefore, is to continually strive to respect the differences between disciplines while keeping in mind the need for consistent process where appropriate.

There is an ongoing need to educate managers and staff in order to reinforce decentralized decision making and to achieve an evolving trust in the clinical autonomy of staff.

Although the model clearly supports the autonomy and accountability of practitioners within a clinical setting, council autonomy and accountability is less clear. Currently, the Professional Practice Coordinators have been assigned accountability (responsibility which cannot be delegated) for most aspects of the PPM. This accountability is embedded in a collaborative, decentralized approach to decision making. Most of the councils are advisory (i.e., make recommendations) to the Professional Practice Coordinator who is ultimately accountable for the decision.

Another major challenge has been to develop an effective and efficient way to evaluate clinical performance in a system in which staff report to a Program Manager who may not be of their discipline.

Summary

This integration of eight separate hospitals into a program-based management structure under one administrative team has resulted in staff moving through various stages of emotional reaction including anger, excitement, trepidation and acceptance. The collective response of the professional groups to this major transition was the development of a Professional Practice Model to ensure quality client care in clinical practice.

The interdisciplinary process involved in the creation of the Professional Practice Model was both challenging and rewarding. The challenges were related primarily to the magnitude of the number of sites and professionals to be integrated, as well as the expected pace of implementation. For the staff and physicians involved, these seemingly insurmountable challenges have been overcome although there are a number yet to be addressed.

The rewards were primarily centered around the benefits acquired from the combined knowledge of many professional groups coupled with an atmosphere of collaboration which strengthens our ability to fully operationalize the model, formally evaluate it and address the goal of enhancing client care.

Authors

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