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Collaborative Learning Environments Project Final Progress Report

Produced By:

The Health Care Human Resource Sector Council on Behalf of the Atlantic Advisory Committee on Health Human Resources (AACHHR)

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FINAL PROGRESS REPORT

COLLABORATIVE LEARNING ENVIRONMENTS PROJECT

PRESENTED BY

THE HEALTH CARE HUMAN RESOURCE SECTOR COUNCIL

FOR

THE ATLANTIC ADVISORY COUNCIL FOR HEALTH HUMAN RESOURCES (AACHHR)

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EXECUTIVE SUMMARY

The Collaborative Learning for Health Professionals initiative (CLE) was a skills-building project with demonstration, research, and evaluation components. The CLE facilitated a partnership among health professions, other healthcare providers, employers, regulators and governments.

An integrated project framework was developed to capture the relationships among the project vision, education and skills enhancement, administrative supports (including communication infrastructure) and collaborative practice (page 2).

The CLE was delivered at four project sites:

1. Maternal/Child Clinic at St. Martha's Hospital, a facility of the Guysborough Antigonish Straight Health Authority (GASHA) in Antigonish, Nova Scotia;
2. Advisory Committee for the Healthy Baby and Me program in Miramichi, NB;
3. Obstetrical Clinic at James Paton Memorial Regional Health Centre, Gander NL; and
4. Facilitators of province-wide program of the Victorian Order of Nurses (VON) New Brunswick.

At each site, participants completed a questionnaire to self-assess their interprofessional skills. These skills envisage communication, conflict resolution, role clarification, team functioning, patient/family-centredness, and collaborative leadership. The CLE project team used the results of the questionnaire to identify and/or design learning modules aimed at addressing skills gaps and enhancing interprofessional competencies. At each site, healthcare providers participated in the learning modules as designed by the CLE project team. The delivery and timing of the modules varied from site to site in response to the identified needs of the providers. The interventions at each CLE site also were designed to both respect and accommodate the contextual factors.

Two established learning programs were implemented in response to the skills gaps and needs at the sites in Antigonish and Gander. The two were the MOREOB / AMPRO^{OB} Program developed by the Society of Obstetricians and Gynecologists of Canada; and the CREW (Civility, Respect and Engagement at Work) Program designed at the Veterans Health Administration in the United States, and adapted by Dr. Michael Leiter of Acadia University. Both of these programs involve classroom sessions and homework;

each is led by a peer facilitator identified by the organization executive, and trained through each of the Programs.

In addition, the CLE project team designed five modules for the two sites in New Brunswick; the modules dealt with: conflict resolution; environmental scanning; managing the stress of change; negotiation; and networking. The approach used for delivering these modules included workshops; self-directed assignments; and video.

A third approach was used at the site in Antigonish. A member of the CLE project team participated as an observer at meetings of the Clinic staff. This approach was used to offer insights to the staff on their interaction as well as on process.

The CLE project team interviewed administrative staff at each site to identify the administrative enablers and barriers to interprofessional collaborative delivery. In addition, to facilitate adoption of collaboration in delivery of health services, policy review processes were implemented at two CLE sites.
The results of the CLE provide practical information for decision-makers about the process, as well as the tools/resources and learning models needed to build interprofessional competencies and capacity to work in collaborative practice.

Through the CLE, the following products and processes were developed: tool for identifying gaps in interprofessional skills; learning modules; evaluation of various approaches to skills development; as well as methodologies for reviewing cases as well as for aligning administrative policies.

In partnership with the Western and Northern Health Human Resources Planning Forum, the CLE also developed an evaluation framework to track long-term progress and success of interprofessional collaborative delivery of health services.

INTRODUCTION

In 2008, the Atlantic Advisory Committee for Health Human Resources (AACHHR) recognized the need to address barriers to access to health services. Based on reports on the state of the health system, AACHHR identified the value of investigating methods to accelerate adoption of collaborative models of care. On behalf of its members, being the ministries of Health and of Education from the four provinces of New Brunswick, Newfoundland and Labrador, Nova Scotia and Prince Edward Island, AACHHR designed a project (proposal attached in Appendix 1) to assess the effectiveness of various approaches to strengthening interprofessional skills.

With funding support from Health Canada, AACHHR entered into an agreement with the Health Care Human Resource Sector Council to serve as agent with responsibility for the contribution agreement and management of the project funds. A team to deliver and evaluate the project was created. Price-MacDonald & Associates was contracted by the Health Care Human Resource Sector Council to provide Project Management service for the project.

OVERVIEW OF PROJECT

The Collaborative Learning Environments for Health Professionals Initiative (CLE) was a skills-building project. The aim of CLE was to develop, implement, and evaluate innovative approaches to enhancing collaboration among healthcare providers. CLE included the following components:

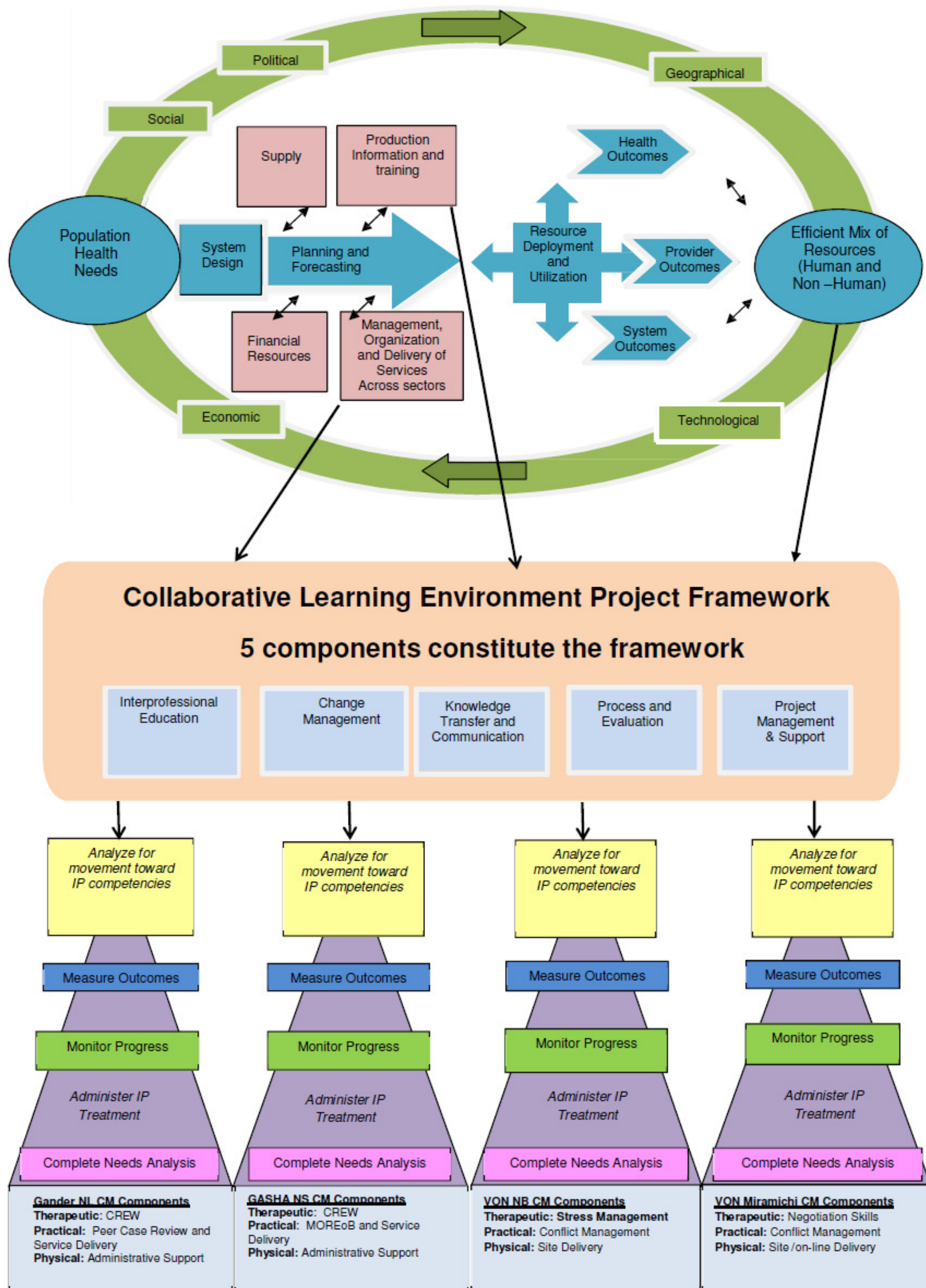
- Determine and address gaps in collaborative skills and change management capacity;
- Identify enablers and barriers to collaboration in workplace and administrative policies; and
- Communicate with stakeholders about findings and approaches.

A project team was created involving policy, pedagogical and evaluation expertise as well as clinical and administrative experience. A list of team members is attached in Appendix 2.

At each site, healthcare providers participated in learning modules developed to support the attainment of interprofessional competencies. Interprofessional competencies envisage communication, conflict resolution, role clarification, team functioning, patient/family-centredness and collaborative leadership. The delivery and timing of interventions varied from site to site in response to the identified needs of the providers at the CLE site. The interventions at each CLE site also were designed to both respect and accommodate the contextual factors.

A project framework was developed. The project framework was positioned within the HHR conceptual framework developed by O'Brien-Pallas, Tomblin Murphy, Birch and Baumann (2005).[1] The framework if found on the following page.

[1] http://www.hc-sc.gc.ca/hcs-sss/pubs/hhrhs/2007-frame-cadre/index-eng.php#a8



ACHDHR Health System and Health Human Resource Conceptual Model
Political
Geographical
Social
Supply
Production Information and training
Health Outcomes
Population Health Needs
System Design
Planning and Forecasting
Resource Deployment and Utilization
Provider Outcomes
Efficient Mix of Resources (Human and Non –Human)
Financial Resources
Management, Organization and Delivery of Services Across sectors
System Outcomes
Economic
Technological
Collaborative Learning Environment Project Framework
5 components constitute the framework
Interprofessional Education
Change Management
Knowledge Transfer and Communication
Process and Evaluation
Project Management & Support
Analyze for movement toward IP competencies
Measure Outcomes
Monitor Progress
Administer IP Treatment
Complete Needs Analysis
Gander NL CM Components
Therapeutic: CREW
Practical: Peer Case Review and Service Delivery
Physical: Administrative Support
GASHA NS CM Components
Therapeutic: CREW
Practical: MOREoB and Service Delivery
Physical: Administrative Support
VON NB CM Components
Therapeutic: Stress Management
Practical: Conflict Management
Physical: Site Delivery
VON Miramichi CM Components
Therapeutic: Negotiation Skills
Practical: Conflict Management
Physical: Site /on-line Delivery

The members of the Atlantic Advisory Committee for Health Human Resources (AACHHR) recognized the need to support the implementation of the CLE project. They provided guidance in the search for project sites. They also helped to identify various advisory and communication mechanisms to follow the evolution of the CLE project in each of the four provinces.

Once an organization was identified as a possible CLE site, the CLE project staff worked with the administrative and clinical decision makers in the organization to determine the direction of the CLE intervention. This activity required at least two – and often more – meetings during which the various players negotiated the scope, participants and time requirements of the CLE intervention. CLE project staff then prepared the necessary documents for the organization's ethics approval process. As soon as ethics approval was received, CLE project staff assembled the identified participants to present the project and its parameters.

Partnerships were created with health-care providers, administrators, employers, educators, and governments. The CLE initiative included communication with these various partners on the progress and learning from the project.

At each of the four sites, nine operational elements were pursued:

- Determine the existing opportunities for, and status of collaborative delivery;
- Assess the gaps in collaborative skills of healthcare providers;
- Identify and/or design learning modules to address those gaps and support the attainment of inter-professional competencies;
- Deliver learning modules;
- Evaluate participation and impacts of learning on collaborative skills;
- Ascertain the infrastructure (records management practices, procedures and facilities for interaction among healthcare providers, and administrative policies related to collaborative delivery)
- Identify the needs, if any, for change in practices, procedures, guidelines, and processes;
- Share advice on best practices for infrastructure design to facilitate and support collaborative care; and
- Implement skills-building modules related to managing change.

In addition, at two CLE sites, CLE project staff worked with participants to review the concurrence between interprofessional collaboration and organizational policies, both administrative and clinical.

Process evaluations were undertaken at each site, assessing the participation and continuity of learning activities. There was also an assessment of the impacts of the various learning approaches.

PROCESS OF IDENTIFYING SITES

The CLE project involved working with each of the four Atlantic provincial governments to identify potential partner-sites. The following criteria were used:

- Sites must be community based and primary care driven
- Sites must have a focus on family primary care services
- Sites must involve people from a number of professional backgrounds

In NS and NL, government advisory committees were established; each proposed potential CLE project sites. In both NB and PEI, government officials determined that, due to workload issues, they were unable to participate in the site identification process. Once an organization was identified as a possible CLE site, the CLE project staff worked with the administrative and clinical decision makers in the organization to determine the direction of the CLE intervention. The CLE project staff then worked with the identified participants at each site to:

a. create and/or communicate a clear, inspiring and achievable vision of collaborative practice specific to the practice site;
b. identify enablers and barriers to achievement of the vision;
c. lead identification of solutions to break down institutional barriers; .
d. facilitate monitoring and evaluation of the impacts of new model of care.

GOVERNMENT ADVISORY COMMITTEES (GACs)

To ensure good communication between government stakeholders and the CLE project, the AACHHR tasked its members to guide the selection of sites as well as monitor and assist the implementation of the CLE project. In each of Nova Scotia and Newfoundland and Labrador, the members gathered together a group of government and non-governmental stakeholders in a Government Advisory Committee (GAC). The GACs met as needed. Meanwhile, in the other two provinces (NB and PE), government officials determined that workload issues prevented them from participating in the selection of CLE sites or the roll-out of the project. Both agreed to rely on discussions at the AACHHR to receive information on the CLE project.

Readiness for Interprofessional Learning

A study completed in Scotland looked at the attitudes of various professions towards interprofessional learning. From the results of that study, Parsell and Bligh (1999) developed a questionnaire to assess readiness of individuals for interprofessional learning. The resulting tool - RIPLS - provides educators with information regarding how to enhance interprofessional competencies.

The Government of Nova Scotia established a GAC whose members included governmental staff (primarily Health Human Resources and Primary Care staff of the NS Department of Health and Wellness [DHW]) as well as non-governmental stakeholders, including Reproductive Care and the Association of Nova Scotia Midwives. The committee met several times to discuss possible sites and to review the learning modules that might be implemented by CLE.

In the spring 2010, the committee identified St. Martha's Hospital in Antigonish as a CLE site. The GAC membership expanded to include representation from the CLE site. It met quarterly – in person and via teleconference –during the first year of the CLE project. Secretariat support was provided by the DHW. However, in the second year, following staff changes within the DHW, the NS GAC was disbanded in favour of receiving project updates through AACHHR.

In NL, the GAC included governmental staff, academics, and clinicians. Initially Vernon Curran, a well-known interprofessional expert from Memorial University chaired the NL GAC. Later that role was passed on to Dr. Olga Heath, head of the Division of Community Health and Humanities at Memorial's Faculty of Medicine; secretariat support for the GAC was provided by Dr. Heath's staff. CLE project staff worked with the NL GAC and officials at several facilities in the province to secure a site in Newfoundland Labrador. During the summer 2010, CLE project staff met with clinicians and administrative staff at the Captain William Jackman Memorial Hospital in Labrador City West. Over the ensuing months, following conversations and e-mail interactions among the NL GAC, the COO of the Regional Health Authority, the chief of staff, and CLE project staff, the Labrador City facility withdrew from the CLE project.

CLE project staff contacted the NL Government Advisory Committee to request that an alternate site be identified. After discussions with several organizations, the NL Government Advisory Committee proposed the CLE staff work with the James Paton Memorial Regional Health Centre in Gander.

Collaborative Practice Assessment Tool

CPAT assesses the degree to which health care practitioners collaborate to provide comprehensive, timely and appropriate patient care. The tool is intended for use in a variety of settings involving providers from diverse professions. It is divided into 8 domains relevant to collaborative practice: Mission, Meaningful Purpose, Goals; General Relationships; Team Leadership; General Role Responsibilities, Autonomy; Communication and Information Exchange; Community Linkages and Coordination of Care; Decision-Making and Conflict Management; and Patient Involvement.

At an individual level, CPAT identifies skills gaps related to collaborative practice. The aggregation of individual results creates an understanding

At the end of 2011, the NL GAC proposed to host a 'summit' of the senior leadership of health authorities, to share information about interprofessional collaboration, including the CLE. Unfortunately, due to scheduling issues, the summit was not realized.

PROCESSES FOR NEEDS ASSESSMENT

At each site, the CLE project staff worked with administrators and clinical staff to:

- identify existing favourable conditions (e.g. communication structures or relationships between providers) that could be leveraged to support the changed model of care;
- assist staff in identifying "hot spots" in their current patient care delivery processes;
- engage staff and managers through formal and informal learning opportunities;
- work with staff to identify potential collaborators whose skills could enhance their own;
- support staff to implement practice changes.

CLE project staff identified several tools to assess interprofessional competencies. Two were deemed to be particularly important: the Collaborative Practice Assessment Tool (CPAT); and the Readiness for Interprofessional Learning (RIPLS). These tools are described in text boxes. Drawing on CPAT and RIPLS, CLE project staff designed a questionnaire for use by participants at the CLE sites; the questionnaire (Appendix 4) asks individuals to assess their skills in communications and negotiation as well as their relationship(s) with colleagues. The questionnaire was distributed at three CLE sites (NS, Miramichi, and VON). The results signaled skills gaps and were used to design learning interventions.

As well, at the NS site, a member of the CLE project staff participated as an observer at meetings of the clinical team. This process provided additional insights on the interpersonal behaviour and communication skills of the participants. Over the course of three months, four team meetings were observed and recorded. Based on these observations, the CLE project team proposed a tool that would support systematic reviews and discussion of cases (Appendix 6).

In addition, at the sites in both Nova Scotia and Newfoundland and Labrador, a program-based survey was implemented to measure attitudes, values, efficacy, decision-making, civility, psychological safety and involvement/ engagement of individual participants. The survey was developed by the CREW (Civility, Respect, and Engagement at Work) Program. The survey is

designed for use in clinical and administrative workplaces; survey results offer a profile of the team and provide the basis for learning interventions.

At the NS site, a benchmarking assessment was also undertaken to support the implementation of the MOREOB / AMPRO^{OB} Program. The benchmarking measures six elements that influence a patient safety culture: Empowering People; Learning; Open Communication; Patient Safety is a Priority; Teamwork; and Valuing Individuals.

IDENTIFICATION AND DESIGN OF LEARNING TOOLS

The CLE project staff worked with a Canadian Interprofessional Health Collaborative to identify existing programs, training modules and approaches to address the knowledge gaps identified through the needs assessments and benchmarking at the CLE practice sites. The contextual factors at each site were considered in choosing /designing and scheduling Interprofessional Education programs and activities.

Multiple approaches ranging from face-to-face workshops, on-line seminars, case vignette videos, simulations, role-playing, presentations, observation, group and one-on-one meetings were used. As noted existing successful programs and materials were identified and used where appropriate.

Given the obstetrical mandate of the CLE site in Antigonish, NS, the CLE project staff engaged the managers of the MORE^{OB} / AMPRO^{OB} Program created by the Society of Obstetricians and Gynecologists of Canada to deliver the MORE^{OB} / AMPRO^{OB} professional development program to the participants at the site. The aim of the program is to improve patient safety in obstetrical services; it is based on up-to-date clinical practice. The components of MORE^{OB} / AMPRO^{OB} are:

- Apply a shared, current, evidence-based body of knowledge in practice.
- Perform fundamental skills confidently and automatically.
- Manage emergencies in an automatic and well-coordinated fashion.

- Use interprofessional collaborative teamwork and communication practices in partnership with patients and families to enhance safe care.
- Evaluate processes and outcomes of clinical practice and organizational systems through interprofessional reflective learning methods.
- Maintain vigilance in order to anticipate and mitigate potential safety risks.
- Modify care practices and organizational systems to reduce safety risks and prevent harm.

A second established program, Civility, Respect, and Engagement at Work (CREW), was implemented at the CLE sites in NS and NL. The CREW program is a culture change initiative. (Appendix 5) The goal of CREW is to improve the work climate through more civil and respectful interaction trained facilitators meet regularly with identified groups for six months with the intent to give the group the necessary time to focus on creating a respectful and civil work environment. Facilitators come to the meetings prepared to facilitate discussions encourage problem-solving efforts, and conduct exercises and activities from the CREW Toolkit that can help improve how the group participants relate to one another. The regular meetings provide a forum for discussions on how to improve the work environment as well as provide a place to practice new behaviors and ways of interacting so these can become the cultural norm. The leadership team, the workgroup's manager, as well as the group members themselves, must be committed to and willing to engage in the process.

GASHA Perinatal Team Make-Up

Manager

2 Midwives

LC

Clinic nurse

PH nurse

Social worker

Family physician (chose not to participate)

Chief of staff

3 OB

Civility, Respect and Engagement at Work (CREW) was implemented at St. Martha's Regional Hospital (Guysborough Antigonish Strait Health Authority) in September 2010. Initially, the Midwifery Steering Committee had two months of CREW meetings before it became apparent that the group was not suited for a CREW intervention. Subsequently, the Perinatal Clinic group, comprised of 12 members, was chosen to do CREW. The majority of the Midwifery Steering Committee members were also part of the Perinatal Clinic group. This group met for a CREW meeting once a month, for one hour, from November 2010 to April 2011.

Monthly summary of GASHA CREW sessions

Month 1: Attendance 9

- Introduction to CREW
- Ice breaker
- Civility exercise (Section 4.20 in Toolkit)
- Johnny the Bagger exercise
- Homework: giving out CREW pins to deserving colleagues

Month 2: Attendance 9

- Ice breaker
- Respect PowerPoint (in Toolkit)
- Discussion on respect
- Homework: "Juicy Problem" exercise (Section 5.04 in Toolkit)

Month 3: Attendance 7

- Evaluation on process so far
- Continuation with "Juicy Problem" exercise
- Discussion on Forni's rules of behaviour
- "Survivor" exercise from Toolkit
- "How we treat people" exercise (Section 4.06 in Toolkit)

Month 4: Attendance 7

- Review of civility and respect
- Discussion on accountability and engagement (Section 4.01 in Toolkit)
- "How we treat people" exercise (Section 4.06 in Toolkit)
- "Survivor" exercise from Toolkit

Month 5: (no record of attendance)

- Facilitator was away, group met however discussion was not necessarily focused on civility and respect.

Month 6: Attendance 3

- Final meeting with celebratory cake
- Exercise "I consider it a great day at work when…" in Toolkit
- Evaluation of process
- Discussion on follow-up to "official" 6 months of CREW

James Paton Memorial Regional Health Centre (Gander) Perinatal Team Make-Up

Social worker

Respiratory therapist

Public Health Nurse

Dietician

3 Maternal/Child Care Nurses (acute care)

Pediatrician

Ob/Gyn

The Maternal/Child Unit at James Paton Memorial Regional Health Centre (JPMRHC) in Gander, NL is currently participating in Civility, Respect and Engagement at Work (CREW). CREW meetings began in January and are expected to continue for six months, until June, 2012. CREW is designed to contribute to a healthy workplace at the facility.

Monthly summary of JPMRHC CREW sessions

Month 1: Two meetings, attendance 11 and 10

- Introduction to CREW
- "Two truths and a lie" ice breaker (Section 5.01 in Toolkit)
- Discussion on civil and respectful behaviours (Section 4.03 in Toolkit)
- Discussion on disrespectful behaviour on OBS

Month 2: One meeting, attendance 7

- Continuation of discussion of respectful behaviours, including inappropriate sexual touching/comments, relationship between staff, especially between junior and senior staff, etc.

Month 3: Two meetings, attendance 10 and 8

- Deeper discussion on issue of two sides of the rotation/schedule on the floor
- "Disruptive Behaviour in the Workplace" video

As well, when existing programs and materials did not address the skills gaps identified through the needs assessments and benchmarking, CLE project staff developed new learning materials. Appendix 6 includes copies of the following five learning modules developed for the CLE project:

- Managing Stress of Change
- Negotiating Skills
- Networking
- Environmental Scanning
- Working Effectively Together

The "Working Effectively Together" module uses on an on-line, interactive approach. Each of the other modules involves classroom activities. Some include self-directed learning in the form of advance preparation for the workshops/classroom sessions and/or homework following those sessions. The program can be accessed from the CLE webpage.

In addition, two tools were developed to enhance the abilities of the participants to work collaboratively:

- a policy review tool; and
- a case review tool.

Each of the tools was offered to the sponsoring organization and the team participants for their use. They are attached in (Appendix 6).

PROCESS FOR ETHIC APPROVALS

Ethics approvals were sought for the sites. In NL and NS, the processes involved completion of a form for review by a committee designated by the sponsoring organization. CLE project staff submitted ethics approval forms for the Antigonish, NS site, the Labrador City site, and the Gander site. In each case, the process took at least 3 months before approval was received. In NB, following discussions with CLE project staff, the NB Victorian Order of Nurses, the sponsoring organization for both sites, determined that, because no interaction with clients/patients was involved, ethics approval was not required for the CLE interventions. Copies of the approvals are attached in Appendix 7.

DESCRIPTION OF PROJECT SITES

The CLE was delivered at four project sites:

1. Maternal/Child Clinic at St. Martha's Hospital, a facility of the Guysborough Antigonish Straight Health Authority (GASHA) in Antigonish, Nova Scotia;
2. Advisory Committee for the Healthy Baby and Me program in Miramichi, NB;
3. Obstetrical Clinic at James Paton Memorial Regional Health Centre, Gander NL; and
4. Facilitators of province-wide program of the Victorian Order of Nurses (VON) New Brunswick.

Separate reports have been prepared describing the activities and results at each of the four sites. (Appendix 8). An overview appears below:

The Obstetrical Clinic at St. Martha's Hospital, a facility of the Guysborough Antigonish Straight Health Authority (GASHA) in Antigonish, Nova Scotia.

- The clinic staff includes: Manager; two Midwives; Lactation Consultant; Registered Nurse; Public Health Nurse; Social worker; Family Physician; Chief of staff; and three Obstetricians.
- The needs assessment questionnaire showed gaps in interpersonal communication skills as well as some lack of understanding of knowledge about the abilities and roles of other clinicians. Further, in discussing the project, there was clear disinclination among some clinic staff to participate in joint learning activities; some expressed the belief that they knew about interprofessional collaboration.
- Three types of learning interventions were identified: a six-month session with the CREW (Civility, Respect and Engagement at Work) program; a three-year session with the MOREOB / AMPRO^{OB} program; and observation at team meetings. In addition, a policy review process was implemented.
- The CREW program trained a hospital staff member, an educator, as a facilitator. Using the CREW Toolkit, a learning program was designed to improve the work climate through more civil and respectful interactions. One hour learning sessions were held monthly from November 2010 to April 2011. The facilitator participated in various CREW community events: monthly calls and attendance at the Orientation meeting and the Mid-Point meeting.
- A benchmarking survey of individual participants revealed both communication gaps related to patient care and inconsistent experiences with teamwork. The MORE^{OB} / AMPRO^{OB} facilitator focused the clinical learning and activities elements of the curriculum to include and address the benchmark results.
- As of March 2012 there is steady growth related to provider satisfaction of teamwork within the unit. 96% of participants stated "information is communicated accurately between people and between shifts"; this is a 16% improvement over the previous survey responses. However, only 55% of participants felt that patients were involved in decision-making. Further, 41% of participants felt regular discussion of unit issues/patient care concerns and potential solution building together was not a routine

process. The provider questionnaire shows only a slight improvement among participants feeling included in activities/discussions to improve patient care and safety.

- The priorities for the team in the next phase of the MORE^{OB} program lie in two distinct areas: improving patient participation in care decisions; and promoting discussion and opinion sharing between all participants. The latter will involve the introduction of new activities such as event review and debriefings.
- In the winter 2011-12, CLE project staff designed an activity to support the collaborative review of clinical and administrative policies to address barriers to team-based delivery of care.

CLE partnered with the Advisory Committee for the Healthy Baby and Me program in Miramichi, NB

- The Advisory Committee includes twelve people who volunteer their time to work with the program facilitator of the Healthy Baby and Me Program. The role of the Advisory Committee is to direct and guide the delivery of a program to people living in the geographic area. The Advisory Committee members are drawn from the community and represent various professions and areas of expertise; the members include a dietician, family physician, social worker, nurse educator, public health nurse, and other community-based service providers. The Committee is chaired by a program Facilitator; it meets irregularly. In-between meetings, when necessary, the Facilitator communicates with members of the Committee via e-mail for advice or reaction to issues. Many members of the Advisory Committee also interact with each other regularly in various other working groups (with other people) as well as service delivery and client support (beyond VON program).
- In October 2010, members of the Advisory Committee completed the CLE needs assessment tool during one of their meetings. The tool – in English and French - had been distributed electronically in advance of the meeting. The results showed skills gaps in conflict resolution / management. As well Committee members lacked confidence in their skills in managing the stress caused by change in their work environments.
- Due to the infrequency and tight agendas of the Advisory Committee meetings, CLE project staff and the HBM program facilitator agreed that a workshop format was the best

approach for delivering learning interventions. CLE project staff decided to develop two workshop-based modules to address the results of the needs assessment.

- Discussion with VON about their ethics approval policies determined that, as no direct contact with patients was envisaged, ethics approval was not required for the CLE interventions. A letter to this effect is attached in appendix 7.
- A two-day module (Appendix 6) was developed to build skills to manage the stress of change. The module included theoretical components as well as role-playing and case studies.
- A second module on managing conflict was designed for delivery in December 2011. That training session was cancelled at the request of the Advisory Committee. The CLE project staff decided to revise the learning module and for delivery electronically. The CLE team negotiated dissemination of the on-line course by the Nova Scotia Community College On-Line Learning group. (Appendix 6). Advisory Committee members were advised of the electronic training program.

The James Paton Memorial Regional Health Centre, Gander NL.

- This site is an inpatient Maternal/Child team. The site is similar in makeup and focus to the site at Antigonish, NS. The team includes the following staff: social worker; respiratory therapist; two public health nurses; lactation consultant; dietician; twenty acute care nurses; two pediatricians; and two obstetricians.
- The mandate for the Maternal Child team is to provide holistic care for the maternal child population.
- The executive of the Gander facility had recently introduced collaborative model of care in the Maternal/Child team. CLE project staff agreed to use the results of skills inventory research done at the Regional Health Centre Area as the basis for defining gaps in skills.
- The experience and learning from the Antigonish site was used to inform the design and delivery of learning and policy review interventions in Gander. In particular, it was agreed that the CREW program would frame the capacity building / learning interventions. CREW surveyed the Maternal/Child team in January, 2012. The results show that individual team members had a low sense of personal efficacy. As well their sense of reliability among the team, personal interest, and anti-discrimination values were

near the poor range of scores. Trust of management stood out as a strength for the group. The CREW program trained a member of the hospital as a facilitator. CREW meetings to improve the work climate through more civil and respectful interactions began in January 2012 and will continue until June 2012.

- In February and March 2012, CLE project staff initiated an activity to address barriers to team-based delivery of care in clinical and administrative policies.

CLE is working with the facilitators of province-wide program of the Victorian Order of Nurses (VON) New Brunswick.

- The site is a group of individuals who are employed by the New Brunswick chapter of the Victorian Order of Nurses. The individuals work in eleven separate communities throughout the province, facilitating delivery of a VON program with, and for, people who live in their respective communities. The facilitators have backgrounds in social work, early childhood education, nursing, and other health services. The majority of the facilitators are bilingual. Their job involves work with municipal governments, the financial sector, corporations in their communities, as well as the education and voluntary sectors. The facilitator’s meet two or three times a year for the purpose of program planning and training. They also communicate electronically with each other to seek advice or share best practices.
- The results of the CLE needs assessment tool during the meeting showed gaps in negotiation skills as well as in area of environmental scanning related to policy and emerging technologies. Responses on conflict management showed that half the group felt they were effective, and the other half assessed their skills as weak.
- VON determined that, as no direct contact with patients was envisaged, ethics approval was not required for the CLE interventions.
- CLE project staff considered various approaches to support the skills gaps identified by the facilitators; it was recognized that the choice of approach had to take account of contextual factors such as their infrequent meetings, their geographically distinct networks, and the fact that they do not share an office. Thus, to address the results of the needs assessment, CLE project staff decided to develop workshop-based modules supported by self-directed learning.

- Educational programming involved distribution of two syntheses of literature to each of the facilitators: one related to environmental scanning; and the other to conflict resolution. In addition each participant received tasks which involved their considering and applying the elements of the syntheses. Workbooks for each of the subjects were prepared and discussed in a classroom session (Appendix 6). A half-day workshop on negotiation skills was also designed. All three modules were delivered over two days in November 2011. (Appendix 6). The sessions involved 14 participants each.
- In January 2012 interviews with three of the participants were used to evaluate the effect of the training.

COMMUNICATION & KNOWLEDGE TRANSFER

CLE project staff had identified five target audiences:

1. Health care providers interested in improved understanding of team-based care and interprofessional collaboration;
2. Middle managers, senior managers and executives of the health facilities and health authorities interested in implementation of inter-professional collaboration and/or post-licensure skills and capacity building;
3. Health profession regulatory bodies interested in continuous learning and in interpersonal skills development;
4. Government policymakers and decision-makers interested in accelerating uptake of interprofessional collaborative delivery of health services;
5. Health educators and university faculty, clinical instructors and community-based preceptors interested in modules and tools for post-licensure learning.

Presentations and letters were used to introduce the CLE project to these various audiences. In some instances, CLE project staff engaged representatives of interested organizations in discussion over several meetings. These are appended in Appendix 9.

In addition, CLE project staff provided regular status reports to the Health Care Human Resource Sector Council for submission to Health Canada and to AACHHR. The former took the form of

quarterly reports and inclusion of HC officials in meetings and teleconferences as well as in site visits. These are appended in Appendix 10.

With agreement from the four project sites, CLE developed a bilingual video presentation of the perspectives and experiences of staff in the learning activities and policy review processes. The video is bilingual. It includes perspectives of participants in each of the four CLE sites about their experiences with the CLE project and the impacts of the CLE learning modules on their practices. The video is under twelve minutes in length.

EVALUATION

There is a separate report on the evaluation components of the project. Evaluation assessments for the project occurred at two levels: *individual* site, examining the impact of learning modules and other CLE interventions on the providers; and *across project sites,* to identify lessons learned across the project.

Meetings with the Western and Northern HHR Forum (WNF) and the Atlantic Advisory Committee on HHR (AACHHR) to develop a framework of indicators and processes for measuring the medium- and long-term outcomes of interventions to enhance the interprofessional skills of post-licensure healthcare providers. The framework was completed in March 2011. (Appendix 11) It addresses the following:

1. Describe the target population to be reached by the collaborative practice and learning model.
2. Describe the service delivery model (e.g. staff mix, education, experience) and context (e.g. organizational supports, leadership, policies) within which the collaborative model is to be implemented.
3. Describe current roles and relationships and examine degree to which roles are to be optimized.
4. Determine patient/family, provider and system outcomes to be targeted.

5. Describe the learning and change management strategies to be used to achieve the new service model, the optimized roles and the multi-target outcomes.

PROJECT MANAGEMENT

The Health Care Human Resource Sector Council, as agent AACHHR contracted with Price-MacDonald & Associates (PMA) to provide project management services for the project and worked with the CLE project team to deliver and evaluate the project.

PMA provided financial management and reporting functions to the Health Care Human Resource Sector Council as well as administrative infrastructure, including website and on-line course development and evaluation supports for the project.

The project identified an individual at each site to "champion" the CLE activities. The Champion was also the main contact between the CLE project and the administrators, and providers.

CONCLUSION

The CLE project identified and delivered professional development training to staff in two acute care units as well as two groups responsible for delivering community-based services.

As well, the CLE project included skills development to address resistance to change. CLE project also offered modules to enhance inter-personal communication skills, as these are integral to effective collaboration. A variety of learning modules were used; the approaches to delivery of the learning included workshops, on-line seminars, case vignette videos, self-directed learning, simulations, role-playing, presentations, observation, as well as group and one-on-one meetings. Participants identified value in each of the modules and each of the various delivery mechanisms; in some cases the value took the form of a particular skill; in other cases, the value was in increased knowledge of the competencies of other team members. That said there was not full participation in all modules; time constraints were named as the barrier.

The CLE project demonstrated the assertion by John Gilbert that the viability of interprofessional collaboration requires that each member of the team be able to "identify sufficient benefit individually as to outweigh the disadvantages of interprofessional collaboration" (Gilbert, 2005, p. 35).

The CLE project also showed that the successful implementation of interprofessional teams depends on the 'readiness' of both the staff and the organization. However, while interventions involving staff training to nurture 'readiness' are important, they are not sufficient. Making the change to collaborative practice models is not easy. The experience of the CLE project illustrated that factors such as unclear support from policy-makers, as well as administrative and clinical leaders, and pre-existing systemic organizational and healthcare system factors are also significant to the successful implementation of interprofessional collaboration.

An evaluation framework that integrates current findings and that responds directly to the necessity of assessing 'readiness' of both organizations and professionals to embrace and support interprofessional teams, with targeted intervention strategies; needs to be considered as a next step.

Appendices to Accompany the CLE Final Report (included under separate cover):

Appendix 1_AACHHR project proposal 2009

Appendix 2_ CLE team members

Appendix 3_Framework for CLE Project

Appendix 4 _CLE Needs Assessment tool

Appendix 5_CREW Program Information

Appendix 6_Learning Modules & Tools

Appendix 7_Ethics approvals

Appendix 8_Site reports for each of 4 sites

Appendix 9_Communications materials

Appendix 10_Quarterly progress reports to HC

Appendix 11_Long-term evaluation framework