



Skills-Building for Interprofessional Collaborative Practice in Community-Based Health Settings

**Project proposal submitted by the
Atlantic Advisory Committee for Health Human Resources Planning
in response to Health Canada July 2009 letter of invitation**

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Skills-Building for Interprofessional Collaborative Practice in Community-based Health Settings

Project Title

Collaborative Learning for Health Professionals in Well-Woman, Maternal and Newborn Child Clinics (CLE)

The project supports the following definition of collaboration developed by Health Canada; "Collaborative patient-centred practice is designed to promote the active participation of each discipline in providing quality patient care. It enhances patient and family-centred goals and values, provides mechanisms for continuous communication among care givers, optimizes staff participation in clinical decision making (within and across disciplines), and fosters respect for the contributions of all disciplines."

Executive Summary

The Collaborative Learning for Health Professionals in Well-Woman, Maternal and Newborn Child Clinics (CLE) is a skills-building initiative with demonstration, research, and evaluation components. The CLE envisages a partnership among health professions, other health-care providers, employers, regulators and governments.

The project will involve sites in Atlantic Canada. At each of the sites, health professionals will participate in learning modules developed to support the attainment of inter-professional competencies. In addition change management processes will be implemented at each site to facilitate collaboration among providers at the site. The project sites will provide opportunities for clinical placements for students and future health care practitioners. Individually and collectively, these project sites will provide practical information for decision-makers about the process, as well as the tools/resources needed, to implement and sustain exemplary patient centred, collaborative practice and learning models that promote high quality care by optimizing the knowledge and skills of all members of the health care team, while enhancing work life satisfaction, recruitment and retention. Over time, the sites will serve as centres of excellence for other clinical sites for learning tools, resources, processes and modules to facilitate replication of the successful interprofessional competency development and change management processes.

The CLE supports both post-licensure educational activities as well as high quality clinical placements. While the CLE will focus on community-based women's health and child health services, the learnings will be adaptable to any community with a need for high quality, accessible, primary care.

This project is expected to be of considerable significance to the future sustainable delivery of health care in all participating jurisdictions. A longer time period to achieve the full benefit of the potential outcomes is hoped. These practice sites will be supported by provincial governments. A second phase is envisaged to allow the practice sites to market their expertise in change management and implementation of interprofessional collaborative models of care to other community-based settings in Atlantic Canada as well as to other Regions. This second phase is seen as key to accelerating and sustaining the adoption of team-based health services delivery.

Project Goal:

The aim of this project is to develop, implement and evaluate innovative approaches to enhancing the skills of health professionals to work together synergistically along with patients, their families, carers and communities to deliver the highest quality of care.

Ultimately, primary health care facilities will have access to regional expertise, interprofessional competencies training tools, and change management strategies.

Project Proponent

This project proposal is submitted by the Atlantic Advisory Committee for Health Human Resources Planning (AACHHR), 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 exists to improve the appropriateness and responsiveness of the health labour force by recommending to the deputy ministers how to effectively and efficiently match the human resource requirements of the evolving service delivery system to population health needs.

(See letter of support and AACHHR Strategy)

Project Rationale and Background

Recent reports on the state of the health system in Canada recognize the need for modification of existing models of health service delivery. Each in their turn, recommend actions in two areas: optimising the knowledge and skills of the health workforce; and revitalizing workplace policies to attract and retain the health workforce.

All four Atlantic provinces recognize that innovation is essential to sustain the health system; each is supporting initiatives that demonstrate the efficiencies of new models of care. In Newfoundland and Labrador, for example, an interprofessional approach to cancer screening has been implemented in some communities. Well Women Clinics in Prince Edward Island have enhanced access to some health services, by offering such services as cervical screening. Several hospitals in New Brunswick have introduced new models of pharmaceutical care which optimize the roles of pharmacists and pharmacy technicians. In Nova Scotia, the Models of Care Initiative is looking at the team and the associated competencies required to deliver services in a Medical-Surgical Acute environment. As well, the NS government is supporting “Team Collaboration Days” when teams come together to explore strategies to implement best practices related to chronic disease. Over 200 providers participated this year.

AACHHR recognizes that in order to realize true innovation, effective leadership and change management techniques are imperative. The CLE project will have a strong focus on strengthening change management skills at each of the practice sites. The following approaches will be used throughout the project: effective communication; executive / senior management engagement; and employee involvement.

Research by the Health Council of Canada, the Canadian Health Services Research Foundation and others outline the potential of collaborative models of care delivery. At the same time, research identifies two barriers to implementation of collaborative delivery: lack of familiarity among individual health professionals related to the skills and knowledge of other professions; and knowledge gaps about how the shared and distinct knowledge and skill of individual providers of can be brought together.

The CLE project will focus on community-based women’s and child health services in rural and urban communities. It will build on the results of the 2006 *Multidisciplinary Collaborative Primary Maternity Care Project* (MCP²). Funded by Health Canada (through the Primary Health Care Transition Fund) to increase the availability and quality of maternity services for Canadian women, MCP² brought together the Association of Women’s Health, Obstetric and Neonatal Nurses (Canada), Canadian Association of Midwives, Canadian Nurses Association, College of Family Physicians of Canada, Society

of Obstetricians and Gynaecologists of Canada, and Society of Rural Physicians of Canada. Together, they developed a framework for multidisciplinary, collaborative, woman-centred models of care. The CLE project will build on the results of MCP². It will help meet the specific needs of individual communities and professional groups who deliver health services to women and children, including newborns.

Geography is one of the key barriers to access to health services. The population of Atlantic Canada is dispersed in villages and rural areas, whose size cannot sustain full-service health facilities. Individuals must often travel to major centres for primary and specialized care. Enhancing the number of team-based care options in smaller centres will augment the quantity and quality of services that can be accessed outside of major centres. This solution is particularly important for children, for whom dislocation from family reduces both the diagnosis of disease/conditions and the compliance with care plans. The 2006 census counts the number of children living in the four Atlantic provinces: New Brunswick has 210 000; Newfoundland and Labrador, 151 000; Nova Scotia, 262 000; and PEI, 43 000.

A particular challenge relates to maternal and newborn care. According to Statistics Canada, the birth rate in New Brunswick has grown continuously over the last several years. It is currently at 9.4 births per 1000 population. Newfoundland has 8.8 births per 1000; Nova Scotia 9 births per 1000; and PEI, 10.2 per 1000 population. Approximately 85% of childbearing women are classified as low risk and thus could receive obstetrical care outside a tertiary facility. Facilitating collaboration among various professionals working in community-based clinics could result in effective decentralization of quality maternal and newborn care.

The CLE project will bring together primary care practitioners, community agencies, educators, regulators and others. It will support the adoption of an inter-professional collaborative model of care in community clinics. This type of model may be used in areas to meet identified shortages of practitioners in addition to providing high quality care to women and their families.

The CLE project will also offer educational opportunities for both pre-licensure health sciences students. This will contribute to the sustainability of the inter-professional collaborative model of care and its attendant benefits in terms of access and quality.

The CLE project envisages a site in each of the four jurisdictions. These sites will be linked through an integrated project framework (e.g. shared vision, common project methodology, common definition of terms such as collaborative practice, common minimum set of evaluation indicators etc) and establishment of an infrastructure that will promote shared learning throughout the duration of this initiative.

Further, the sites will provide practical information for decision-makers about the process, as well as the tools/resources needed, to implement and sustain exemplary learning models that promote accessible, patient-centred care that optimizes the knowledge and skills of all members of the health care team, while enhancing work life satisfaction, recruitment and retention.

Over time, the sites will serve as centres of excellence for other clinical sites for learning tools, resources, processes and modules to facilitate replication of the successful interprofessional competency development and change management processes. There will be a focus on the processes for change management and learnings towards a collaborative approach required for the maternal/child context.

- organizational planning and analysis and
- widespread perceived need for the change and uptake of the model

Mandate, Capacity, and Experience of Applicant

The CLE project is designed by the Atlantic Advisory Committee for Health Human Resources. AACHHR uses contracting organizations to undertake multi-jurisdictional projects; the co-chairs of AACHHR oversee the work of the contracting organizations. AACHHR has assigned accountability for the management of the CLE project and for the achievement of deliverables to Health Care Human Resources Sector Council (Health Sector Council) The mandate capacity and experience of each of AACHHR and the Health Sector Council are described below.

The Atlantic Advisory Committee for Health Human Resources (AACHHR) was created by Deputy Ministers of the departments of health and education from the four Atlantic provinces. The role of AACHHR is to provide policy advice and enhance intra-regional cooperation on issues relating to health human resources. Specifically, AACHHR has identified the following strategic priorities:

Promote a coordinated approach to policy and planning issues and initiatives related to supply, demand, utilization, distribution, education, and regulation of the health professions.

Act upon any recommendations accepted by the Atlantic Deputy Ministers of Health and of Education on regional human resource and education planning initiatives.

Liaise with national, regional, and provincial health resource planning groups, and form new partnerships, as may be appropriate in the carrying out of its mandate.

Review all proposed new programs, and programs in which significant change is planned, as initiated by the institutions, and programs resulting from discussions with the institutions which would support a plan to meet the health human resource needs of Atlantic Canada.

Based on input from committee members, develop recommendations to the deputy ministers on the education and training programs at community colleges and universities in the Maritime provinces to be supported by provincial departments.

AACHHR maintains a number of networks, partnerships, and relationships with regional, provincial and national stakeholders in both health and education sectors. These collaborative relationships create efficiencies, and lever opportunities, allowing the four Atlantic provinces to achieve outcomes that none could accomplish individually.

The Health Care Human Resource Sector Council was created to address human resources issues in Nova Scotia. The mandate of the Council includes research, occupational and labour market analyses, and knowledge dissemination. The Council works with employers, employees, industry organizations and related government departments and agencies. The Sector Council has a board of directors that is drawn from key industry stakeholders and is comprised of 12 voting members who are nominated to the Board for their expertise and knowledge in the area of health human resource planning and development. The Sector Council has vast experience in managing large Federal Contribution Agreements (see website <http://www.hcsc.ca/index.php>)

The scope of the Council is reflected in the following descriptions of projects:

- implementation of Prior Learning Assessment and Recognition;
- the development of a current profile of Registered Social Workers (RSW's) to be integrated into the Nova Scotia health human resource strategy;
- development and maintenance of a directory of French Speaking Primary Health Care Providers in Nova Scotia;
- in partnership with the College of Registered Nurses of Nova Scotia, the College of Licensed Practical Nurses of Nova Scotia, and the Continuing Care Assistant Program Advisory Committee review of relevance of entry-

- level competencies to current and anticipated practice environments; delivery and evaluation of training in the Acute and Continuing Care health sectors in Nova Scotia;
- design of a conceptual framework and implementation guide for the integration of individuals into the health workforce

Many of these projects span several years and involve government and non-government partners. Most involve large budgets. The Council has experience in managing projects funded through contribution agreements with the federal government.

Collaboration with others

The Atlantic Advisory Committee for Health Human Resources (AACHHR) CLE project will involve partnering with the following: community-based health facilities; organizations that regulate health professions; health educators; and provincial departments of education and health and researchers.

Information from these partners will contribute to the identification of community needs at each of the project sites. Focus on needs-based planning in the health system, will ensure that each site is able to identify accurately the appropriate skills mix to address the individual community needs.

One of the elements of the workplan for the CLE project involves a joint activity with the Western and Northern Health Human Resources Planning Forum (the Forum) to develop an evaluation framework which will track progress and success of inter-professional collaborative delivery of health services.

Building capacity in Atlantic Canada, will rely on methodologies and tools available through the Canadian Interprofessional Health Collaborative, The CLE project manager and other staff will liaise with CIHC staff to identify training modules and approaches to address the knowledge gaps at the CLE practice sites..

The Collaboration for Maternal & Newborn Health (CMNH) is an initiative designed to increase communication and interdisciplinary practice between all maternity care providers. With funding from the UBC Department of Family Practice, School of Medicine, the initiative was started in 2001. Professional participation included family physicians, obstetricians, nurses, midwives, researchers and doula educators. The resulting integrated approach to maternity care education, research, advocacy, and policy provides critical information for AACHHR's CLE project.

Because of their role in assuring appropriate educational preparation for competency development, the regulatory bodies for health professionals will be engaged in the CLE project. Their involvement will build from the results of a 2009 Health Canada funded project to identify common principles for inter-professional competencies. The role of the regulatory bodies will be to encourage their members – individual clinicians – working at the project sites to participate in the CLE project; as well the regulatory bodies can play a role in the dissemination of the results of the CLE project.

Project Objectives

In the long-term the objective of the CLE project is to improve patient health outcomes as well as the efficiency of the health system.

The medium-term objective of the CLE project is the enhancement of the capacity of health-care providers, managers, and regulatory bodies to collaborate in the delivery of well-woman and maternal/child services.

There are seven specific project objectives:

1. Development of a framework applicable in any jurisdiction and/or community charged with the task of providing seamless care to women and children.

2. Development of learning modules to support acquisition of competencies required to work in inter-professional teams to deliver services to women and children, including newborns.
3. Establishment of a minimum set of indicators to assess the impacts of capacity building approaches
4. Implementation and evaluation of innovative models of capacity building. The evaluation would include the following:
 - a. Describe the target population to be reached by the collaborative practice and learning model.
 - b. 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.
 - c. Describe current roles and relationships and examine degree to which roles are to be optimized.
 - d. Determine patient/family, provider and system outcomes to be targeted.
 - e. Describe the learning and change management strategies to be used to achieve the new service model, the optimized roles and the multi-target outcomes.
5. Describe change management processes needed to support, and resource implications of, inter-professional collaboration at each site.
6. Design of knowledge transfer strategies that promotes application of evidence to improve long-term practice/behaviour, which is “generalizable” across project sites, as well as across other potential new sites with differing contexts. .
7. Document the process of implementation, lessons learned, successes and challenges, barriers and facilitators, and recommendations for creation of new sites of interprofessional collaborative practice and learning environments.

Workplan

Throughout the project period the following principles will guide the work:

1. All knowledge gained and tools and educational resources developed during the project will be openly shared with all participants, stakeholders and partners.
2. Governance and management of the project will accommodate variations in experience, capacity and performance in project sites and variations in jurisdictional policies and practices.
3. Collaboration will be pursued with all relevant stakeholders, as appropriate and used as basis for designing processes and methodology appropriate to the community and the site.
4. Key partners, jurisdictions and health employers will be asked to support this project, financially and/or in-kind, and to facilitate the dissemination of project outputs.

An overview of the elements of the workplan are described herein. A table showing workplan elements, outputs and duration is attached. (workplan is in Excel format)

Each of the four provincial governments will identify a project-site within its jurisdiction. Initially, the sites for this project will be in Nova Scotia and New Brunswick. During the course of the project, governments in both NL and PE will assess options for CLE project sites. In New Brunswick the potential sites are:

- Collaborative practice recently set up at the Centre Samuel de Champlain in Saint John, New Brunswick, involving a minority French community. Given the unique partnership this health centre has with St Joseph’s hospital, it lends itself quite well to such a project;
- Collaborative practice being set up at the Centre Doreen Richard in Fredericton, New Brunswick, again, involving a minority French community.

At both sites, services are delivered by a health care team, including a family physician, nurse practitioner, and other health care professions.

In Nova Scotia:

- There is a strong movement to develop collaborative health care teams through a number of different DoH initiatives. Nova Scotia has recently introduced midwifery services into the health care system in an employer/employee model. One site that is recognizing the benefits of collaboration is the GASHA site. This site may benefit through support and participation in the development of a competency based CLE.

Each government will use the following criteria in the selection process: :

- Sites must be community based and primary care driven
- Sites must have a focus on family primary care services
- Sites must have professionals who share a similar scope of practice including family physicians, nurse practitioners, nurses, other health professions, and where appropriate, midwives

Other criteria may also be used. For example, the New Brunswick government is considering sites which provide health services to a minority French community; have staff that includes a number of health professionals; and is partnered with a hospital.

The work envisaged at each project site can be grouped under two types of interventions:

- a. Creating a climate of change and engaging the organization; and
- b. Sustaining change.

Creating a climate of change and engaging the organization: The change process is meant to be dynamic, continuous and iterative, with ongoing implementation and adaptation. While AACHHR envisions that all participating sites across the four jurisdictions will follow the general approach for creating change outlined below, it recognizes that flexibility in the type and timing of different interventions is needed to accommodate contextual differences.

During the initial phase, it will be essential that the CLE Project Team (CLEPT):

- Builds a sense of urgency within the participating organization
- Explains why the change is needed, and
- Addresses fears expressed by participating staff.

At each site, an individual will be identified from among senior management to “Champion” the adoption of the new – collaborative – model of care. The Champion will be the main contact for the site. The selection of the ‘Champion’ will be critical to the successful implementation of the inter-professional collaborative model of care at the site.

The Champion will in turn identify a clinical member of the team who will be supported by research staff, trainers and facilitators hired for the CLE project. As well, the CLE project will design a training program to enhance the capacity of each clinical member to deliver the following tasks:

- a. creating and communicating a clear, inspiring and achievable vision of collaborative practice specific to the practice site;
- b. identifying enablers and barriers to achievement of the vision;
- c. leading implementation of solutions to break down institutional barriers; .
- d. where appropriate and possible, and based on evidence relating to workforce optimization, will facilitate changes to staff mix and operational protocols at the practice site to facilitate collaborative practice and shared patient assignments. This might include the introduction of providers that previously have not been part of the care team; and
- e. develop practice policies to facilitate monitoring and evaluation of the impacts of new model of care.

For the practice sites, the CLE project will employ a clinical member to support the site. This role will include change management facilitation. A research and data collection analyst will support the assessment of the current state of collaborative practice at the site and develop a workforce profile which will include a description of competencies of staff to work with individuals in other professions. In addition, the clinical member and trainer will prioritise the interventions (education, practice, organization) that are needed. In this regard, access to the expertise of the trainer in the identification of strengths at the site as well as areas of deficit will be identified.

The level of training effort (and numbers of staff) may vary from site to site as it will depend on the results of the above-described assessment and workforce profile at the site.

The CLE project will build on the successful change management actions at each site. Through the knowledge transfer strategy, outlined below, the project will make tools, methods and learnings available for use in other health facilities.

Sustaining change:

AACHHR recognizes the importance and significance of skills building to facilitate the implementation of inter-professional collaborative delivery of health services. Further, AACHHR is committed to facilitate sharing of best practices and learnings as well as achievement of their respective deliverables

At each practice site, the CLE-funded training and facilitator staff will work with health providers, unit managers, practicum students, their preceptors/field supervisors, and faculty liaisons to implement and facilitate collaborative practice and IP learning. Specifically, the work of the training and facilitator staff will be 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..

The CLE-funded training and facilitator staff at the sites will develop and deliver implementation strategies for education and practice interventions. Education interventions consist of formalized education opportunities for front line staff, managers and students. The focus will be on developing and strengthening inter-professional competencies (communication, conflict resolution, role clarification, team functioning, patient/family-centredness, collaborative leadership. Multiple teaching approaches ranging from face-to-face workshops, on-line seminars, case vignette videos, simulations, role-playing will be used. Existing teaching modules and learning materials will be identified by the CLE project manager and used as appropriate at each site as a basis for the education interventions. The CLE project manager working with research and training staff, will identify gaps in education/learning materials and manage the development of additional materials to fill those gaps.

Practice Interventions will creating IP learning experiences for students through mentoring and/or team placements. IP ‘mentoring’ takes place when students in clinical placements are mentored by staff and students from a range of health disciplines. These mentoring experiences supplement formal preceptorship/clinical supervision. IP ‘team placements’ have been successfully employed in a number of projects in Ontario, Manitoba, Saskatchewan and BC. Students from different disciplines conduct their clinical placements together and typically develop shared care plans or jointly conduct a community project or other learning activities. Both IP mentoring and IP team placements promote collaborative learning among staff and students and act as a catalyst for enhancing collaborative practice.

The CLE-funded staff will provide in-services (presentations, group and one-on-one meetings) on IP education and collaborative practice principles according to each site’s

needs. They will be able to draw on the expertise of trainers and facilitators identified as well as learning tools developed through previous projects related to inter-professional education, including Building Better Tomorrow and the Canadian Interprofessional Health Collaborative

The workplan envisages strong and on-going liaison with the project managed by the Western and Northern Health Human Resources Planning Forum. CLE project management will be responsible for delivering and accelerating workplan elements such as decisions in each of the four Atlantic provinces on practice sites, facilitating identification of site ‘champions’, and the development of appropriate training for each as well as supporting the hiring of research, training and facilitator staff. The CLE project manager will identify sources of expertise and manage collaboration with partners. The manager will also develop an inventory of tools, learning modules and other IP support materials.

The workplan envisages on-going evaluation and tracking as described in this proposal.

Project Governance Structure and Accountability

Experience with multi-jurisdictional projects has demonstrated the value to the sustainability of project outcomes of a formal project governance structure (see **organizational chart attached**). It is also important in enabling individual jurisdictional flexibility and variation and facilitates good project communication. By ensuring each level of the project has appropriate oversight and clear roles, rights and responsibilities, the project governance structure supports clear accountability for all partners and stakeholders. The following components of the governance structure will be established:

- a. Health Canada will provide a Contribution Agreement to the Project Management Group (Health Sector Council) who will administer the funding on behalf of the AACHHR. Health Canada utilizes a “reimbursement of expenditure” system for contribution agreements which will be administered by the Health Sector Council.
- b. The Health Sector Council will be responsible for the management of the Contribution Agreement, and for overall project oversight on behalf of AACHHR. The Health Sector Council will provide financial and program
- c. Health Sector Council will be responsible for the operational management of the project and for the contracting of all resources and expenditure of all costs associated with the project. The Health Sector Council will be directly responsible for the engagement of essential resources required and will be legally responsible for providing the project deliverables. Advice will be sought from AACHHR, through the co-chairs, as required.
- d. A CLE Project Team (CLEPT) will be established to guide major policy decisions related to the CLE project. The CLEPT will hold face-to-face meetings, at least twice per year, as well as teleconferencing as needed. The membership of CLEPT will include:
 - a. Representative of the Health Sector Council
 - b. AACHHR representative
 - c. Competency and IP expert
 - d. Health Canada representative as observer
 - e. Clinical site Champions,
 - f. Clinical and non-clinical staff

This team will ensure that the focus of the work is in achieving sustainable results that are capable of being replicated and institutionalized within the health authorities over time, based on the successful collaborative practice and learning models of care developed in the project sites.

Working Groups will be established as deemed necessary by the CLEPT to deal with the following: Process Evaluation, Outcomes Evaluation Framework; Sustainability Plan; KT & Dissemination Plan

Target Audiences

The multi-jurisdictional nature of this project and the knowledge transfer strategy promise to inform a wide audience locally, regionally, and nationally. The project will increase the IP collaborative awareness, knowledge, skills and behaviours of a growing number of health professionals. It will provide IP clinical placements for students. Other target audiences include:

1. Patients, their families and communities that will benefit by the improved quality of health care delivery
2. Health providers in the project sites that will benefit by improved understanding of team members roles and improved collaboration with other team members and an increase in provider satisfaction.
3. Health science students who fulfil their clinical placement requirements in the project sites that will see and participate in positive collaborative care models.
4. Middle managers, senior managers and executives of the health facilities and health authorities that will see significant improvements in the efficiencies and outcomes, including patient outcomes, from the project sites due to improvements in the models of health care delivery and provider and patient satisfaction.
5. Health profession regulatory bodies which will have access to project learnings and use of CLE tools.
6. Government policymakers and decision-makers who will see the potential benefits to the overall health system functioning if successful CLE could be replicated across their jurisdiction(s) in a future phase.
7. Managers in other health facilities which will have access to the project learnings and CLE tools.
8. Health educators and university faculty, clinical instructors and community-based preceptors will have access to the project learnings and CLE tools.

Based on regular update reports on the CLE project, AACHHR members will engage and inform P/T governments, health employers, health professional associations, federal health research and information agencies as well as other health policy and decision makers.

Official Languages

In terms of sustainability and relevance of the CLE project to both francophone and anglophone settings, the Health Sector Council has bilingual staff.

New Brunswick is a bilingual province. As such deliverables, will be translated from English to French, or vice-versa. At the New Brunswick site, attention will be paid to ensuring that CLE staff has bilingual capacity; in particular, facilitators and training staff must be able to support of clinicians in both official languages.

Sustainability

A number of steps will be taken to further facilitate sustainability. Throughout the project, the engagement of partners and stakeholders from all levels of the health system will reflect the full range of commitment and participation required to ensure sustainable success. By engaging all the relevant players, the knowledge transfer should be more effective and more likely to achieve sustainability. In-kind contributions will be sought from key partners during the CLE project. Wherever possible, the CLE manager, champions, facilitators and other project staff will engage others within the health sector so that the knowledge and skills developed in the project can be distributed. This will facilitate the prospect of sustainable behaviour/practice change. Analysing and interpreting the findings from the project sites will be used to identify key success factors and barriers to the implementation of collaborative practice across the sites and of necessary adjustments to the structure, process and methodology.

Furthermore, sustainability of the relationships, networks, structures and processes created as a result of the CLE project is expected. Employers/manager engagement should be viewed as a clear indicator of sustainability.

Performance Measurement and Evaluation Plan

An evaluation working group, consisting of members of the project teams from both AACHHR and Western and Northern Health Human Resources Planning Forum, will be established to identify precise evaluation foci/domains and determine common measures (indicators & tools), data collection and analysis processes, and timelines. The working group will develop a framework with a minimal set of common indicators that can be applied by both the CLE project and project proposed by the Forum. The expertise and experience of the WHO Collaborating Centre as well as the governments of BC and SK which have both coordinated cluster evaluation frameworks for a number of provincial projects associated with Health Canada funding. Due to the short duration of the CLE project, Outcomes Mapping (OM) will be used to track impacts of the various factors on the system, patients and the providers.

A comprehensive evaluation plan will be developed to capture the impact of the CLE project on the health system, on patient health outcomes, and on providers. The Evaluation Plan may involve concurrent measurement of process and outcomes indicators at baseline and follow-up stages, allowing for summative analysis of the association between process and outcome indicators. Focus groups may also be implemented at various points throughout the project, and provide meaningful qualitative information. Such information early in the implementation period informs and guides the strategies and activities of a project and, at the end of the project provides insights about project outcomes. Mixed methods, (i.e., both qualitative & quantitative approaches) will be used for formative (process) and summative (outcome) assessments. The evaluation use participatory approaches that engage expertise within and across sites, build evaluation capacity, and ensure usefulness of the evaluation for a broad range of stakeholders.

Projects will be evaluated at several levels:

- 1) *individual* site, which examines the impact of individual project sites against goals established for the site; and
- 2) *across* project sites, where a cluster evaluation method examines indicators and identifies lessons learned across sites.
- 3) *Capacity increase* for the implementation of collaborative practice across participating jurisdictions.

Evaluation at the individual site:

A core data set will be developed consisting of a number of validated measurement tools, outcomes and indicators for collaborative practice and patient-centred care. This core data set will allow comparison of outcomes across the project sites. The measurement tools will be chosen to answer the following questions:

- a) What changes in outcomes for health providers occurred at each site (e.g. collaborative skills, team cohesion and efficiency, work life satisfaction, readiness for team practice)?
- b) What changes in outcomes occurred in the health care system (e.g. increased efficiency, recruitment and retention, HHR planning and supply)?
- c) What are the changes in outcomes for patient, families and communities (e.g. quality of care experience including patient safety, access to providers and information, self-care capacity, reduced health services utilization, improved health outcomes, etc.)?

While sites will be asked to utilize common tools that reflect the core data set, they will also be encouraged to establish indicators that uniquely reflect each site's individual focus. Existing tools will be used where appropriate. Resources developed through this project will be available to all other sites across the country to assist with development of new tools. The quantitative measurement tools will be complemented by individual and group interviews to provide insight into how the different sites approached the challenge of enhancing collaborative practice. The process evaluation will be critical to understanding the issues that emerged and how they could be dealt with in the future. Evaluation assessments will occur at baseline, and appropriate intervals. The core data will be analysed for each site individually as well as collated across all jurisdictions.

Evaluation across project sites:

A second level of evaluation will focus on synthesizing the learning and outcomes across all participating sites. This will be achieved by using a cluster evaluation approach to

highlight themes cutting across all sites, contextual issues, lessons learned and future directions. To examine the developmental and qualitative aspects of implementing collaborative practice models, as a cluster, the following types of questions will be asked of key stakeholders (project team, managers/staff/students, etc.) at appropriate intervals:

- a) What factors have facilitated or contributed to change across sites?
- b) What factors challenged or served as barriers to change across sites?
In what type of settings/contexts have what types of change occurred?
- c) What types of models were successfully used by the sites within the project?
What lessons have been learned that could be helpful to similar initiatives in the future?
- d) What are the key requirements at the site level to sustain the changes that have been achieved?
- e) Have the sites demonstrated any unanticipated impacts, events or outcomes?
- f) What are recommended actions for development of collaborative practice and learning models in the short and longer term?
- g) What is the impact on recruitment and retention of staff and other HHR factors?
- h) How has the CLE affected staff and patient satisfaction?
- i) What impact has the CPE had on patient and system outcomes?

Evaluation of increased capacity across the jurisdictions:

Another component of the evaluation will demonstrate the increase in capacity for the implementation of collaborative practice across the participating jurisdictions through the coordinating, facilitating and knowledge dissemination role created by formal networks or communities of practice. The evaluation will answer the following three key questions: 1) what were the key roles played by effective KT and networking throughout the project? 2) To what extent does the networking increase the capacity for implementation of collaborative practice and knowledge translation? 3) What is the sustainability of the network as a knowledge hub for the western provinces and northern territories and beyond?

The evaluation approach will draw on methods and tools to describe the relationships, networks and activities emerging over the course of this initiative. The evaluation will be used to provide ongoing feedback to the project team to inform their decisions and actions in the course of the project.

The main evaluation outputs of this project (at 18 months) will be to finalize the Evaluation Plan, to undertake the baseline studies in all sites and to implement the evaluation processes necessary for a full evaluation by the end of the Second Phase. These will provide valuable insight and functionality to the ongoing monitoring and evaluation process for the full project.

The main evaluation outputs of the First Phase of this project (at 17 months) will be to finalize the Evaluation Plan, to undertake the baseline studies in all sites and to implement the evaluation processes necessary for a full evaluation by the end of the Second Phase. Only intermediate results will be available at the end of the First Phase, but these will provide valuable insight and functionality to the ongoing monitoring and evaluation process for the full project.

Knowledge Translation (KT) and Dissemination Plan

The KT and Dissemination Plan for this project will be a multi-level strategy (developed in collaboration with the Forum) to build capacity for embedding project findings into HHR planning, policy and decision-making at various levels of the system. The Plan will aim for broad impact via development of context-relevant approaches, coordinated planning and leveraging of relationships, partnerships and technology to support dissemination. The target audiences for the KT and Dissemination Plan would be similar to the Project Target Audiences described above.

The 2009 Strategic plan of the AACHHR identifies knowledge transfer as a priority. AACHHR is currently considering initiatives to deliver that priority. The outputs of the CLE project will be included in these region-wide initiatives.

Harnessing the KT and dissemination processes of the various partner organizations will facilitate access to the established networks and members as well as the communications capacities, of those organizations. Detailed tactics will be developed within the first few months of the project. The tactics will include: participation at national and international audiences via organizations like the CIHC and Health Canada and by pursuing opportunities that link with existing conferences such as the Canadian College of Health Service Executives (CCHSE) annual conference, and conferences organized by national health research organizations and national health profession associations.

The key items of knowledge to be disseminated through this plan will include:

- Project Report (both mid-term and final reports)
- The Evaluation Plan and indicators
- Tools for IP education and mentoring interventions
- Lessons learned from undertaking successful change management approaches in a system wide regional approach in health care in western and northern Canada.

The Evaluation Plan includes a component that will monitor and evaluate the effectiveness of the KT and Dissemination Plan over the course of the project.