2012

Collaborative Learning Environments (CLE) Project

Process Evaluation Report

Produced By

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

Prepared By

Pat Saunders, Andrea Patchett, and Jennifer Murdoch

5/31/2012

Table of Contents

Section 1: Summary and Introduction

EXECUTIVE SUMMARY:

This Report presents the findings and recommendations of a process evaluation that was conducted as part of the 2010-2012 AACHHR CLE Project. The evaluation was designed to provide ongoing formative evaluation of immediate and short-term project implementation outcomes for use by the Project Team. It also provides general *lessons learned* regarding implementation processes and success factors for use by future IPC project planners and evaluators. It was not intended to evaluate the long term outcomes of project implementation or health outcomes at any level.

The mixed–method evaluation design was based on Briggs' Presage, Process, and Product[1] and addresses a gap in previous evaluations of interprofessional collaboration in post-licensure contexts, which have paid little attention to formative processes. In particular, the focus of this evaluation was extended to include assessment of process/implementation factors with a particular interest in identifying and assessing the facilitators for organizational uptake of IP activities and organizational change for supporting ongoing collaborative learning.

- Level of uptake/support from Provincial Government Advisory Group was not in the sphere of direct CLE influence. *This factor was important for helping to recruit sites in NL and NS. (See further discussion of this factor in Conclusions section of this Report)*
- Introduction of new care providers/new professions into the health care systems and into existing teams- *Professional issues: Family physicians (FPs) not participating-there was some evidence that they see Midwives (MW) as competition; Midwives encountering resistance from their regulatory body and other professions over scope of practice and specific professional polices such as 'continuity of care' that are affected by an Interprofessional Practice (IP)*

1 Biggs, J.B. (1989) 'Approaches to the enhancement of tertiary teaching', *Higher Education Research and Development 8, 7-25.*

collaborative model. While these factors are not in the sphere of direct CLE influence- the evaluation may assist in clarifying MW scope of practice.

- Presence or absence of champions and direct institutional support- *the CLE project had some direct influence here. The GAHSA administration and site coordinator were supportive of the CLE presence, but not proactive in identifying probable barriers or with problem solving of existing barriers. More and different kinds of advance information and communication materials might have increased the level and types of support offered by site champions. Other potential champions in additional stakeholder groups might be a consideration for future reference. Champions need not be from the project site and in fact sustainability of projects may be enhanced by recruiting external stakeholder champions.*
- Pre-existing institutional policies and guidelines that may present barriers to full inter-professional collaboration: *clinical and service delivery policies have been identified that create barriers, such as policies that prevent MWs from ordering certain tests or procedures despite being within the MWs scope of practice; lack of clear guidelines for defining low-risk creating inequitable distribution of clients among the practitioners.*
- Pre-existing service delivery models*: the arrangements for on-call schedule and prior clinic model of distributing clients between Obstetricians (OBs), MWs and FPs were possible barriers. Other barriers noted was the impact of the changes to the service model including: use and allocation of clinic space, changing clinical and administrative policies, financial compensation, and referral patterns and practices by the physicians external to the clinic.*
- Previous billing patterns: *There are pre-existing financial disincentives for Interprofessional Collaboration: Alternate Payment Plans and other billing patterns for FPs and OBs are an issue that will require government and professional association attention.*
- Time constraints experienced by team members may hinder activities to facilitate full IP collaboration: *competing projects and initiatives and staff shortages all have an impact on engagement with CLE activities.*

- Competing initiatives at the organization: *MoreOB, CREW and other projects compete for time and may appear to duplicate some CLE activities. A careful review of pre-existing projects and initiatives to determine how they might be used to leverage as opposed to replicate one another, should become a part of future CLE /IP project planning and implementation.*
- Constraints of physical space to support IP care delivery model and/or team activities: *space for CLE learning activities was not an issue but space did become a significant issue for moving toward a more collaborative service delivery model. Lack of clinic space at the site meant that only one provider at a time could hold clinic hours*.
- Lack of IT capacity at sites: *this is an issue for working from a distance with CLE teams and for communicating with team members. The cost of IT and the uneven access and support across sites limits the types and frequency of CLE activities that can be offered. These impacts the sites abilities to take advantage of CLE/IP resources that exist on-line.*
- Capacity of organization to facilitate system-level change: *An important factor affecting the success of implementation of IP collaboration is the degree of capacity of project planners and an organization's ability to appreciate strategic system-level impacts. (* see below in Conclusions for further discussion)

General *Lessons Learned* and Conclusions concerning implementation of complex IPC projects in post-licensure contexts include:

- Multi-component and multi-site IP projects are challenging to plan and implement but much can be learned from projects of this type.
- Multi-component and multi-site IP projects encounter, perhaps ironically, the perils and productive gains of IP and interdisciplinary work within the project implementation team itself, and
- Just as it is crucial for IP teams in healthcare to take the time to arrive at common definitions, language and understandings before tackling more ambitious tasks, so too must Project Teams. This is likely the most important lesson learned at the project-implementation level.

While further study of the interactions between presage/contextual factors is needed to determine which factors are most important for impacting the implementation and sustainability of collaborative IP change it is clear that they play a large role in the success of such efforts in post-licensure contexts.

There is a need to study further the ways in which IPC projects and facilitators might increase capacity for organizational and systems thinking for teams and healthcare organizations. Teams cannot effectively form and perform in new ways without recognition of how professional perspectives and practices are embedded in the structures of an organization and the healthcare system more broadly.

New and extended forms of change management support must also be developed and applied to IPC change initiatives. Supporting change for individual team members or even for whole teams in isolation from change management support for the organizational change process will not provide full benefits of IPC; nor is the change created in the short term likely to be sustained.

Four recommendations for supporting future IPC projects and research have been made:

1. Develop planning and implementation guides for IPC projects based on past evaluations and Lessons Learned for use by future project teams during project design, start up and implementation planning an activities.
2. Develop assessments of organizational readiness for IPC learning and change to be used by funders, potential sites, and project planners.
3. Develop IPC organizational level change-management support materials to increase capacity for system-level change.
4. Support further study and evaluation with CLE sites that are now moving into the phase of IPC organizational and system-level change in order to identify how presage factors and other influences impact the full integration and sustainability of increased IPC within post-licensure contexts.

INTRODUCTION:

This report presents the results of the AACHHR CLE Project Process Evaluation. The evaluation was led by Pat Saunders. Andrea Patchett and Jennifer Murdoch contributed to both the data collection and the review of findings. Contributions to Project-Level Implementation and lessons learned were made by the CLE team: Janet Davies, Janet Everest, June MacDonald and Kelly McKnight. The report is divided into six sections: Introduction, Background and Evaluation Design, Description of Evaluation Method, Discussion of Results, Conclusions and Recommendations and Appendices.

The process evaluation was conducted as part of the AACHHR CLE Project and provides ongoing formative evaluation of immediate and short-term project implementation outcomes for use by the Project Team. It also provides general lessons learned regarding implementation processes for use by future IPC project planners and evaluators. It was not intended to evaluate the long term outcomes of project implementation or health outcomes at any level.

Section 2: Background

BACKGROUND:

During 2010-2012 a regional Atlantic CLE Project was conducted**.** The Primary Project Objectives were to:

1. enhance collaborative skills of *post-licensure* clinicians;
2. develop innovative learning strategies and resources for post-licensure clinicians and organizations;
3. make direct connections between CLE and Health Human Resource (HHR) policy priorities, for example HHR initiatives such as Nova Scotia 'Models of Care';
4. generate project findings and resources that are adaptable to any community with need for high quality, accessible *primary* care.

The project design included extended needs assessment of the collaborative IP teams and organizations; offered all participating sites teams organizational level change management and learning support; identified site specific learning needs, and included the design and piloting of resources/tools for targeted learning interventions.

The Project design further included a Presage, Process and Product evaluation to identify strategies for increasing success of CLE Project implementation and site team/ organizational outcomes. This report presents the findings of that process/formative evaluation of the 2 year multi-site, regional Health-Canada funded CLE Project.

FOCUS OF THE AACHRR CLE PROCESS EVALUATION:

In 2006 Reeves and Freeth[2] extended Brigg's systems-based Presage, Process, Product evaluation model (3P model) to identify presage, process and product factors relevant to an IP post-licensure educational intervention. They noted that presage factors were understudied, but very likely to be relevant to the success and sustainability of collaborative learning initiatives in post-licensure context. These included factors such as the political context, regulatory frameworks, funding restrictions, demographic issues, learner numbers, space and time limitations, competing demands, facilitator conceptual orientation, level of facilitator experience and approach to teaching; and pre-existing learner perceptions, conceptions of collaboration, and motivation. Although Reeves and Freeth did point to other factors, the specific presage and process factors they focused on were primarily those affecting traditional education activities, such as the type and nature of learning activities offered, underlying educational theory and length of intervention, and methods of facilitation style and learner assessment.

There appear to have been very few subsequent evaluations of collaborative learning interventions that have directly addressed implementation challenges and presage factors that relate to organizational and professional contextual factors. A preliminary literature review suggests that most evaluations to date have continued to focus on *describing* barriers to enhanced interprofessional collaboration and some impacts with little analysis of the wider causes and dynamics of initial and ongoing organizational change needed to sustain the effective delivery of interprofessional care.

This evaluation attempts to address that gap by drawing on the basic 3 P approach. The focus has been extended to include evaluation of process/implementation factors with a particular interest in identifying and assessing the facilitators for organizational uptake of IP activities and organizational change, to support ongoing collaborative learning.

[2] S. Reeves & D. Freeth. Re-examining the evaluation of IP education for community mental health teams with a different lens: understanding presage, process and product factors. (2006) *Journal of Psychiatric and Mental Health Nursing* 13, 765-770.

SECTION 3: DESCRIPTION OF EVALUATION METHODS (METHODOLOGY)

PURPOSE OF THE EVALUATION:

The purpose of this process evaluation was to provide formative evaluation of the implementation of the CLE project: to identify presage factors relevant to successful implementation and organizational uptake of collaborative learning activities, to inform ongoing project improvement, and to inform implementation of future projects addressing interprofessional collaborative learning in post-licensure contexts.

LIMITATIONS:

This process evaluation was limited in scope by level of resources for data collection across 4 sites, 2 of which (NB) involved activities that were very different from the NS and NL sites. As it was not possible to develop full-scale site evaluations at each of the sites, the focus was on the presage factors that were relevant for the two clinical sites, lessons learned regarding project implementation, and the immediate and short-term results of targeted project activities introduced in year two of the CLE project.

A second limitation is that data collection from sites was a challenge. We were unable to directly collect all data from the sites, and the sites did not always comply with requests for submission of data. At one site there was a very low response rate on the practitioner project–end survey.

EVALUATION DESIGN:

The mixed-method, realist CLE formative/process evaluation framework addressed the following primary evaluation questions:

1. What presage factors create barriers or facilitators for successful implementation of CLE interventions? Which of these factors are most significant for individual participants and which are most important at the level of professions and/or healthcare organizations? Which of these identified factors are generic-likely to be encountered at any post-licensure site-and which are the result of specific/unique site contexts? Which of these identified factors are within the sphere of our project's direct influence and which are largely, or completely, beyond our influence?

2. How might knowledge of presage factors be used in project planning to increase uptake and impact of CLE activities-for our project and for future projects?

3. What 'lessons learned' can be gleaned from this complex and challenging multi-component and multi-site CLE project that will be helpful for future project planning and implementation?

The evaluation was conducted in two stages:

- Stage 1 was focused on identifying the relevant presage factors for implementing CLE interventions and lead to an interim review of formative results from the project's year one extended needs assessment activities. The interim analysis and reporting of preliminary findings resulted in specific recommendations for new CLE site selection strategies, educational interventions and project activities.

- Stage 2 (20111-2012) focused on assessing the immediate and short-term results of implementing the new project activities at two of the CLE sites as recommended by the interim CLE report.

DATA-COLLECTION INSTRUMENTS USED:

Needs assessment surveys
Patient and Practitioner surveys
Meeting observations
Participant observations
Key informant interviews
Participant Self-Reports
Service delivery Clinic data
CLE Project Document Review

DATA COLLECTION PROCEDURES:

Year 1:

- CREW and CPAT Needs assessment survey conducted at GASHA and Gander sites.
- 4 meeting observations conducted at GASHA
- 19 Key Informant Interviews conducted with GASHA site administrators, clinical CLE Team members and extended care team care providers
- Service delivery Clinic data collected from administrator at GASHA site
- 4 Key Informant Interviews held with stakeholder groups
- Feedback gathered from GAHSA CLE clinical team members on Case Review Tool
- Feedback gathered from Presentation to GASHA CLE participants of the CLE Interim Evaluation Results

Year 2:

- 4 Phone consultations to recruit Gander Site: conducted by Project Lead and site facilitator
- CREW and CPAT final survey conducted at both Gander and GASHA sites. Administered by CREW team.
- Participant observation by CLE site facilitators: 4 Action Plan Review meetings at Gander-one conducted on location and 3 held by teleconference
- Self-report on Action Plan Review Process: Gander Action Plan Review team
- Participant observation by CLE site facilitators: 6 on location IP Policy Development working meetings: GAHSA
- Mail out of 103 Patient Satisfaction Surveys: GAHSA. Mail out by GAHSA and returned to Project evaluator
- Updated clinic service delivery data collected from GAHSA
- Final practitioner survey distributed to all CLE participants: GAHSA
- Final Self-report; Gander, NL

Section 4: Discussion of Results

Project Year 1 Interim Results:

This section reviews results from findings on the extended needs assessment; data on presage factors; and the process of project-level implementation**:** *(see Appendices 2, 3 & 4 for detailed review of findings)*

The objectives of the first year of formative evaluation of the AACHHR CLE Project were to:

1. monitor the overall project implementation and to make recommendations regarding the development and introduction of learning and support activities to

facilitate implementation, growth and retention of the CLE shared-care across our project sites;

2. assess how successful the implementation of the CLE shared-care model had been at the GAHSA site;
3. identify the specific presage/contextual challenges and specific implementation needs of shared-care primary care IP teams in post-licensure settings. A discussion of the results by objective of our interim review and the recommendations we made and followed for Year 2 follows.

- **Review and analysis of project documents, project team meetings and data collected from the CLE project teams, led to a number of lessons learned for implementation.**

  Team members still had an uneven level of understanding of the CLE project objectives; therefore the need for repeated communication presentations may have been under estimated. The project clinical lead may not have had the time or resources to provide ongoing project communication. A site facilitator from the project team itself may be required for complex projects such as the CLE. Our communication strategy may have been too focused on external partners and stakeholders at the expense of ongoing communication with the sites.

- **Assess how successful the implementation of the CLE shared-care model had been at the GAHSA site to date.**

  Data was collected and analysed from GASHA/St.Marthas from a number of sources: a needs assessment survey of change management and IP team competencies, regular self-reports by the team lead, observation of CLE team meetings, key informant interviews with the CLE team and other stakeholder groups, and clinic service delivery statistics. These provided formative knowledge for the CLE project team and lead to a series of recommendations for year 2 activities for the site.

  Findings indicate that there was an increase in the GASHA CLE team's general and formal understanding of IP competencies and an increased in recognition of the benefits of greater IP collaboration in primary peri natal care. Although a peri natal

team has been formed at St. Martha's Hospital in advance of the introduction of the CLE project, it had not formally identified itself as an interprofessional collaboration.

The on-site project communication activities provided a framework for identifying the benefits of adopting an IP lens on their pre-existing team. The needs assessment survey that specified particular competencies; the designation of a CLE clinical leader; provision of a model and supporting tools to further develop an IP shared-care service delivery model that included an extended group of IP care-providers (such as public health nurses, lactation consultants, social workers, family physicians) resulted in a number of immediate and short-term changes.

Referrals to public health nurses increased and one clinical team member had identified possible uses of nursing staff to address the unmet healthcare needs of specific target groups of patients such as First Nations women. There is however IP barriers to increased use of nurses in prenatal care that result from limits on recognized scopes of practice.

Practitioners within the team report that there has been an increase in understanding of professional scopes of practice and acceptance of MWs but family physicians are still not included in the team.

The CLE team at GASHA developed formal Terms of Reference that directly included the objective of increasing interprofessional collaboration as a goal and supported team cohesion. The CLE clinical team lead and other members of the team also began, during interviews, to identify specific challenges and barriers to IP collaboration, as such. They began to adopt an IP lens when clinical and policy challenges were encountered during weekly team meetings, which were held to review patient cases.

The evaluation proposed a number of benchmarks for assessing the level of successful implementation of the CLE project, on-site and during our Interim review.

These were used these to evaluate progress and continuing challenges. The results from the evaluation by benchmark are presented below:

- Understanding by team members and site participants of CLE project and objectives. ***This objective was partially met*** *- there are varying levels of understanding of the project objectives among members and participants. This, in part, is likely because new members joined and because this is a complex project and could have benefited from enhanced communication.*
- The CLE clinical data capture forms are in use on-site**: This objective was determined to be *non-compliant*** *–the team is not using many of the forms provided.*
- On-site facilitation of project data collection: ***This objective was partially met -*** *cooperation was evident based on team observations and interviews. Access to labour summary data was not made available. Clinical project lead reports are lacking detail, and the site did not adequately contribute to data collection despite direction of the signed project agreement.*
- Shared and equal rotation of patients in prenatal clinic, involving creation of a more even distribution of low-risk patient load across primary care provider team members: ***This objective was partially met-*** *midwives are seeing more patients however the distribution remains unequal. Reasons for the disparity include: issues around MW scope of practice, definitions of continuity of care, billing concerns, prior service delivery models and call schedules.*
- Identification by team members and administration of potential and/or current policy and/or pre-existing service delivery barriers to collaborative shared-care: ***This objective met with partial success-*** *individuals have recognized some barriers however this recognition has not yet reached the team level.*
- Development of IP shared clinical protocols and policies. ***This objective has been partially met-****work on shared care model has begun and there has been identification of the need for a more formal policy review to address various barriers to a collaborative care model.*
- Intra and inter-professional consistency of approach to care among team members: ***This objective was partially met -****differences were identified both*

within and between professions and conflict remains over perspective on best-practice.

- Increased inclusion/integration of extended care provider team members**: *This objective was partially met –****although the extended team is attending meetings, family physicians are not yet fully engaged with the CLE team. Social workers and public health nurses report increased perceptions of inclusion and numbers of referrals, as well as an increased understanding of team member's professional scopes of practice.*
- Participation in CLE recommended collaborative IP skills enhancement activities: ***This objective was partially met-*** *the team demonstrated a willingness to review materials and provide feedback but did not fully adopt for on-going use.*
- CLE model of call schedule developed and adopted for trial by site*:* ***This objective was not met*** *– this may constitute a barrier to more equal distribution of clients.*
- Team cohesion and participation by all professions*:* ***This objective was partially met -*** *Physicians initially dominated the team but shared leadership is evolving.*
- Full participation in CREW: ***This objective was partially met*** *–initial resistance by Physicians was noted however, recent CREW reports indicate positive impact on the workplace.*

3: Identify the specific presage/contextual challenges and specific implementation needs of CLE primary care IP teams in post-licensure settings.

It was predicted that a number of presage/contextual factors would be salient for the implementation of the CLE project. Below are the results of the interim review of findings by factor:

- Level of uptake/support from Provincial Government Advisory Group was not in the sphere of direct CLE influence. *This factor was important for helping to recruit sites in NL and NS. (See further discussion of this factor in Conclusions section of this Report)*

- Introduction of new care providers/new professions into the health care systems and into existing teams- *Professional issues: Family physicians (FPs) not participating-there was some evidence that they see Midwives (MW) as competition; Midwives encountering resistance from their regulatory body and other professions over scope of practice and specific professional polices such as 'continuity of care' that are affected by an Interprofessional Practice (IP) collaborative model. While these factors are not in the sphere of direct CLE influence- the evaluation may assist in clarifying MW scope of practice.*
- Presence or absence of champions and direct institutional support- *the CLE project had some direct influence here. The GAHSA administration and site coordinator are supportive of the CLE presence; however they were not proactive in identifying probable barriers or with problem solving of existing barriers. More and different kinds of advance information and communication materials might have increased the level and types of support offered by site champions. Other potential champions in additional stakeholder groups might be a consideration for future reference. Champions need not be from the project site and in fact sustainability of projects may be enhanced by recruiting external stakeholder champions*.
- Pre-existing institutional policies and guidelines that may present barriers to full inter-professional collaboration: *clinical and service delivery policies have been identified that create barriers, such as policies that prevent MWs from ordering certain tests or procedures despite being within the MWs scope of practice; lack of clear guidelines for defining low-risk creating inequitable distribution of clients among the practitioners.*
- Pre-existing service delivery models*: the arrangements for on-call schedule and prior clinic model of distributing clients between Obstetricians (OBs), MWs and FPs were possible barriers. Other barriers noted was the impact of the changes to the service model including: use and allocation of clinic space, changing clinical and administrative policies, financial compensation, and referral patterns and practices by the physicians external to the clinic.*

- Previous billing patterns: *There are pre-existing financial disincentives for Interprofessional Collaboration: Alternate Payment Plans and other billing patterns for FPs and OBs are an issue that will require government and professional association attention*.
- Time constraints experienced by team members may hinder activities to facilitate full IP collaboration: *competing projects and initiatives and staff shortages all have an impact on engagement with CLE activities.*
- Competing initiatives at the organization: *MoreOB, CREW and other projects compete for time and may appear to duplicate some CLE activities. A careful review of pre-existing projects and initiatives to determine how they might be used to leverage as opposed to replicate one another, should become a part of future CLE /IP project planning and implementation.*
- Constraints of physical space to support IP care delivery model and/or team activities: *space for CLE learning activities was not an issue but space did become a significant issue for moving toward a more collaborative service delivery model. Lack of clinic space at the site meant that only one provider at a time could hold clinic hours*.
- Lack of IT capacity at sites: *this is an issue for working from a distance with CLE teams and for communicating with team members. The cost of IT and the uneven access and support across sites limits the types and frequency of CLE activities that can be offered. This impacts the sites abilities to take advantage of CLE/IP resources that exist on-line.*
- Capacity of organization to facilitate system-level change: *An important factor affecting the success of implementation of IP collaboration is the degree of capacity of project planners and an organization's ability to appreciate strategic system-level impacts. (* see below in Conclusions for further discussion)

INTERIM REVIEW RECOMMENDATIONS FOR GOING FORWARD

CLE IMPLEMENTATION TEAM LEVEL

- **Communications**

  Designate site facilitators /coordinators for NL and GAHSA sites from the Project Team.
  Continue to collect data for presage factors and 'lessons learned' from all Project sites.
  Review NS 'Better Todays and Tomorrows' and respond to NS Government Advisory Board inquiries.

- **Scope of Evaluation & Data collection**

  Given reduced resources for evaluation in Year 2, reduce scope and prioritize project evaluation activities.
  Client and practitioner end of project data collection be completed by the CLE implementation team.
  Distribute patient satisfaction and practitioner surveys by e-mail.
  Cease formal observation of CLE team meetings and use resources to begin observation of IP Policy work by the GASHA team.

CLE SITE LEVEL

- Newfoundland
  Recruit and engage a new NL site to replace Jackman Memorial in Labrador.
  Prepare for new NL ethics approvals.
  Implement CREW in NL when site is fully secured.

- GASHA

  Present interim findings/recommendations for site to GASHA.

  Design and introduce the proposed IP policy development activity at GASHA.

  Continue to encourage, support and report on GASHA CLE TEAM work with IP service delivery model- particularly on-call schedule and patient rotation.

- Newfoundland and GASHA

  Review data collection responsibilities with sites.

  Propose IP policy process for Year 2.

  Designate site facilitators to introduce and move IP Policy work and activities forward.

  Develop supporting materials/tools for new activities at NL and GASHA sites.

  Plan data collection for new activities.

  Increase use of teleconferences and circulate meeting documents in advance.

PROJECT YEAR 2 RESULTS:

RESULTS OF GANDER AND GASHA YEAR 2 TARGETED ACTIVITIES:

Gander, NL

The strategic use of currently running and potentially competing projects at the NL site was successful and an IP process was developed that was integrated into the site's Action Plan for a change in nursing model of care in the maternity care unit. Although this site came into the project late (January 2012) rapid progress was made.

Over the course of 4 meetings the two project team site facilitators worked with an IP team to identify areas in the new care model that raised issues and potential opportunities

for increased IP collaboration. The CLE Implementation Team members were invited to review plans for physical renovation and reorganization of the ward.

The project site Action Review Team began immediately to think strategically about how to integrate IP principles with existing committees, such as the Maternal Quality Improvement committee, and how to leverage these committees to increase IP opportunities identified during the CLE working meetings. They also identified IP components and opportunities for increasing collaboration and cross-profession understanding in specific practices such as the new model's communication protocols, new nurse orientation, and patient rounds, at the hospital. These insights lead to further consideration of whether the hospital should review its vision and mission statements for inclusion of IP as a formal institutional goal and whether there could/should be a standing IP committee formed to review policies, initiate IP projects and act as a liaison with other provincial IP projects underway.

The CLE site facilitator at Gander provided support for this process by doing an initial review of the Action Plan and scheduling further meetings. Both the site and CLE Implementation Team facilitators contributed to and recorded the ongoing work done in working sessions and circulated updated drafts of the work to date before each working session. Additional information about collaborative practice in maternity care and cultural competence was also provided.

In their own words:

> The review of the action plan and support of the CLE researchers has, and will continue to, assist us with the identification of areas where IPC fits extremely well in this work environment. The team will use the information received through the CLE support to incorporate IPC in a variety of day-to-day situations. These include, but are not limited to, increased IP orientation to the program area; initiate IP educational rounds; policy development and/or revision to be carried out with an IP focus; and explore option for IP peer reviews. To facilitate some of these IPC opportunities, the Maternal Child QI Team which has an IP

composition, will be the chosen forum. These opportunities have a very good alignment with the mandate of this team. It will likely be necessary to expand the membership and utilize the leaders who have been involved in this project to champion IPC." *(See Appendix 5 for full report)*

Assessments of organizational capacity for system-level change was not completed at the Gander site prior to CLE implementation. They were already into a change process with their Action Plan for introducing a new model of nursing care. This meant that the starting point for CLE with the NL site was strategically placed within the organization's current activity. That acted as a catalyst for becoming engaged with the CLE IP learning activity and the two activities generated synergy and had greater benefit than predicted.

The goal of CLE was simply to secure a site and support the development of an awareness and understanding of the opportunities for system-level integration of IP learning and collaborative practice, but the team moved quickly from understanding to action with little prompting required from the site facilitators. The next step in system-level awareness would have moved the organization toward strategic positioning of IP within the provincial healthcare system. It is unfortunate the CLE Project has ended, but the Gander site will be provided with the evaluation report and some further materials that may be of use to them in making that next step.

Antigonish, GASHA

The introduction and facilitation of the IP Policy development process at GASHA lead to similar and related results with regard to increasing organizational understanding of the potential system-level benefits and impacts of IP collaboration.

In late January 2012 the GASHA CLE Team was provided with a template of a process to address and either revise, or create a new policy from an IP perspective. The Team agreed to engage in this activity and had mixed feelings about its likely success. They were currently working on a clinical policy and had become bogged down by differences in perspective. While curious to discover whether this process might prove more

successful they were not very optimistic. During the early meetings the Team reviewed the process, determined process details, choose a specific policy –induction and dating pregnancies-identified who needed to be at the table for work on this specific policy area and then began to work on the policy. *(See Appendix 6 for copy of the IP Policy process template)*

Attendance at the meetings was good and differences in practice and in perspective both intra-professionally and interprofessionally were identified and discussed. The team also identified complicating factors outside their control that would be a challenge for any clinic policy. These included the clinical practices of referring family physicians, recent changes within the demographic of their clients, and issues of resources –particularly the clinic's access to radiology resources.

The need for participation of Diagnostic Imaging personnel in development of the particular IP policy had been identified. A radiologist attended the final CLE meeting held during the project's time span and because of his input an important move forward occurred. Through discussions regarding whether the hospital had the resources to use ultrasounds to date all pregnancies where due dates were uncertain, thereby reducing incidences of unnecessary inductions; the question of whether there might be areas for reduction of ultrasound use by the clinic overall was raised. This focused the discussion on the evidence–base for use of ultrasound during pregnancy and highlighted the weak support and even contra-indications for several specific uses. The radiologist indicated that it was not his place professionally to challenge senior individual practitioners about their respective use of radiological tests in particular clinical contexts, but that tests that were not supported by the current evidence-base were indeed being ordered. The two hospital administrators attending this meeting noted at this point that a hospital-wide review of the allocation of radiology resources was about to begin and committed to addressing the issue. They also committed to work with the CLE site team to move the IP dating and induction policy forward.

This was an important step forward for the clinic CLE team. The discussion of differences between professional points of view and interpretations of evidence –base

provided a concrete demonstration of the way IP policy review and IP policy development are connected to issues of system-level change through resource allocation. It highlighted the need for consistency of clinical care across an IP shared care team and the impacts on health outcomes for clients.

It is unlikely that the CLE site team would have tackled an IP policy development process in a systematic way, without the facilitation of the CLE project. The sequence of meetings and sustained work of CLE helped them to reach this point relatively quickly. Facilitators question if it would have happened as quickly or at all, without the support of the CLE project.

Year 2 evaluation targeted CLE policy work with the Gander NL and the GAHSA NS sites. Results suggest that facilitation of policy review and organizational level change processes has an important impact on the development of IP teams. This is true both from the level of individual practitioners and IP teams to the organizational and healthcare system-level. This is an under-explored area of IP research that bears more scrutiny.

The CLE Project team is sorry that the project ended at this point in the process and will explore ways to offer continued support to the GASHA team.

Results for Presage and Contextual Factors:

The results of the Interim review as detailed above have been confirmed. Two new presage factors were identified.

Presage Factors

- Lack of Internet Technology (IT) capacity at sites: *IT access issues were either infrastructure or policy based. The IT issues limited the ability of the CLE project to work from a distance with CLE Teams across the region. The cost of using IT, the irregular access to IT, and varying levels of support across sites limits the*

types and frequency of CLE activities that could be offered. Sites were sometimes unable to take advantage of CLE/IP resources that exist on-line. At one site a nurse does not even have a computer of her own! Better access could have improved communication with site CLE teams and individual team members. IT supports need to be considered when planning for implementation of CLE projects.

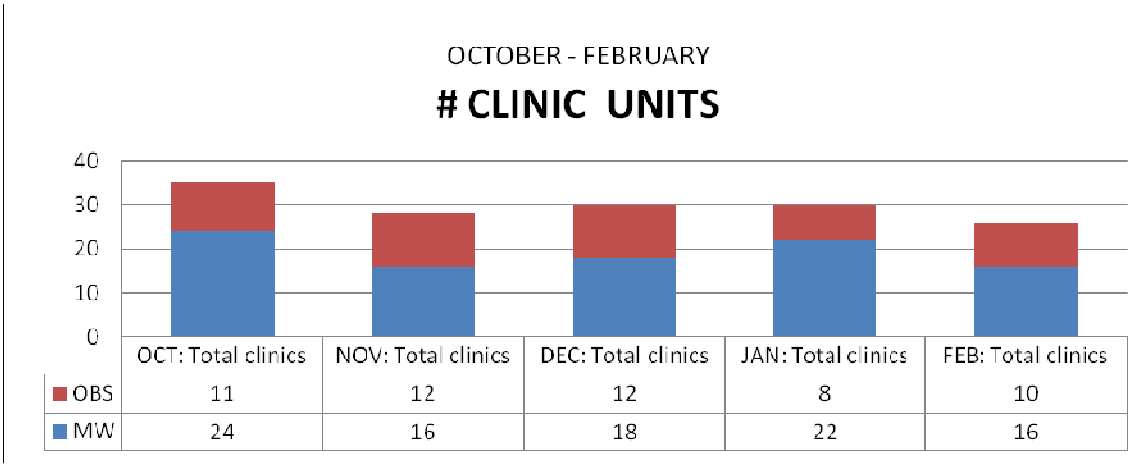
- Capacity of leaders within the organization to think in terms of system-level change: *the full benefits of IP collaboration are only realized once they reach the level of organizational, system changes. An important factor affecting the success of implementation of IP collaboration is the degree of capacity of the project planners themselves, and the leaders of the specific site organization(s), to think in terms of strategic system-level impacts. (* see below in Conclusions for further discussion)

Updated Results for GASHA service delivery model and Results from Patient, Practitioner Surveys.

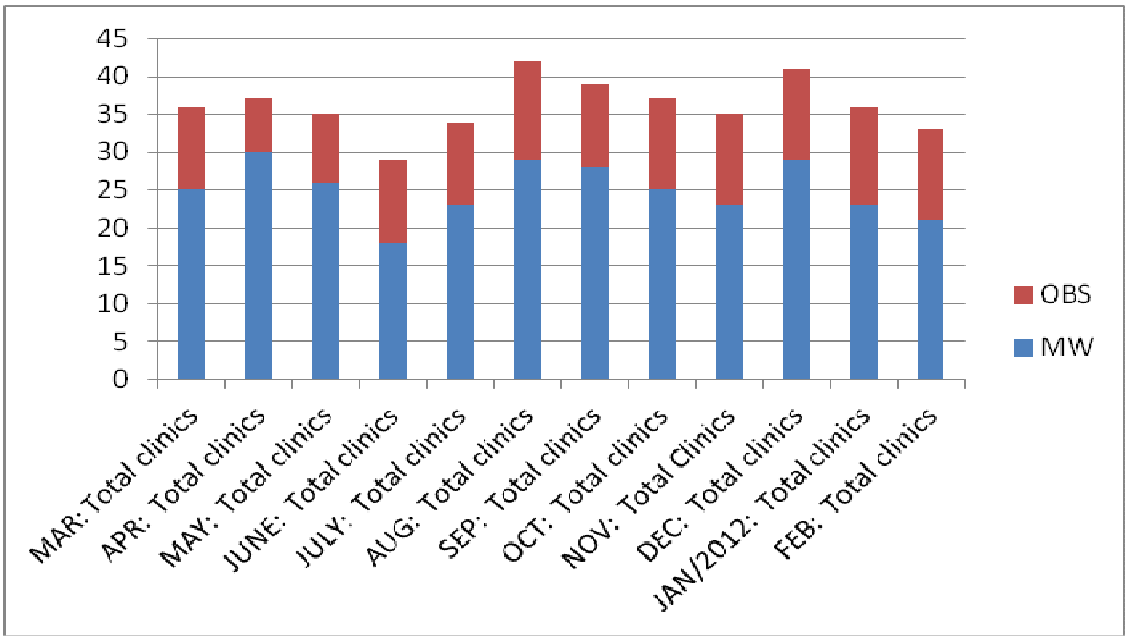
GAHSA CLE Service Delivery Model

The interim review of GASHA's service delivery model indicated that there had been partial success in balancing the distribution of low –risk clients across the IP primary care team. The first three tables below show the distribution of clients and births for year 1 and the second table shows the distribution at project end –March 31, 2012.

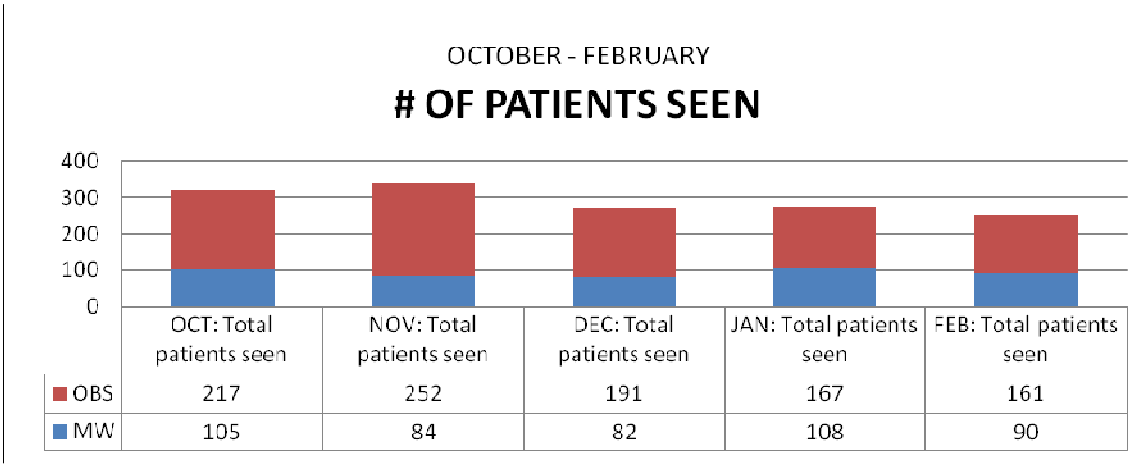
Total # of Clinic Units: October 1 to February 28, 2011



Total # of Clinic Units: April 1-March 31, 2012

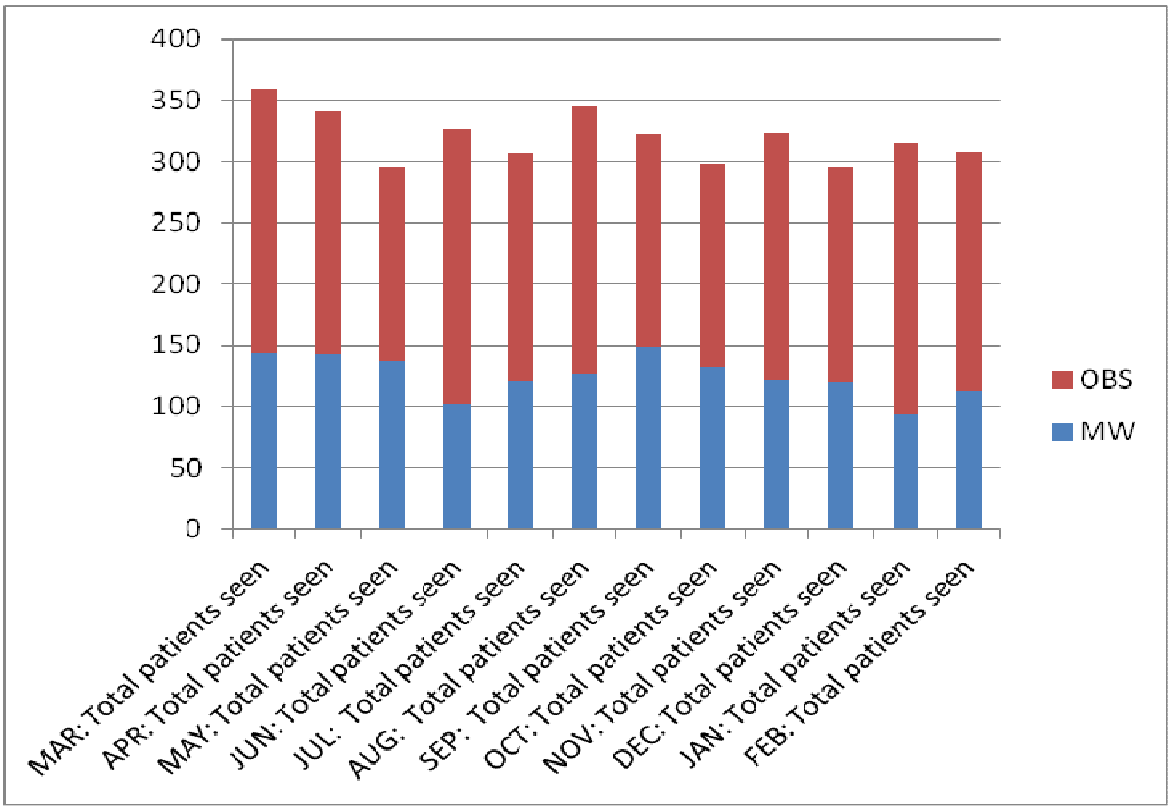


Total # of Patients Seen: October 1 to February 28, 2011

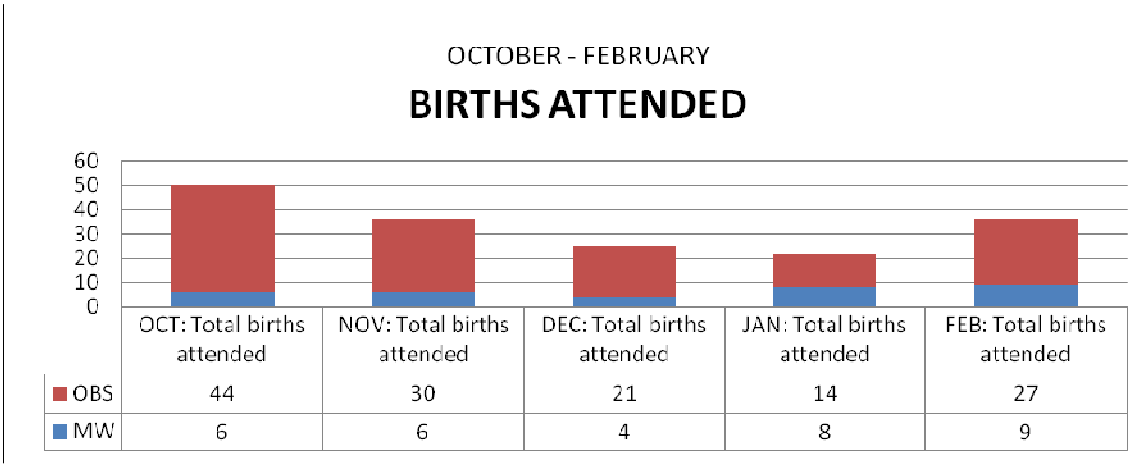


	OCT: Total patients seen	NOV: Total patients seen	DEC: Total patients seen	JAN: Total patients seen	FEB: Total patients seen
OBS	217	252	191	167	161
MW	105	84	82	108	90

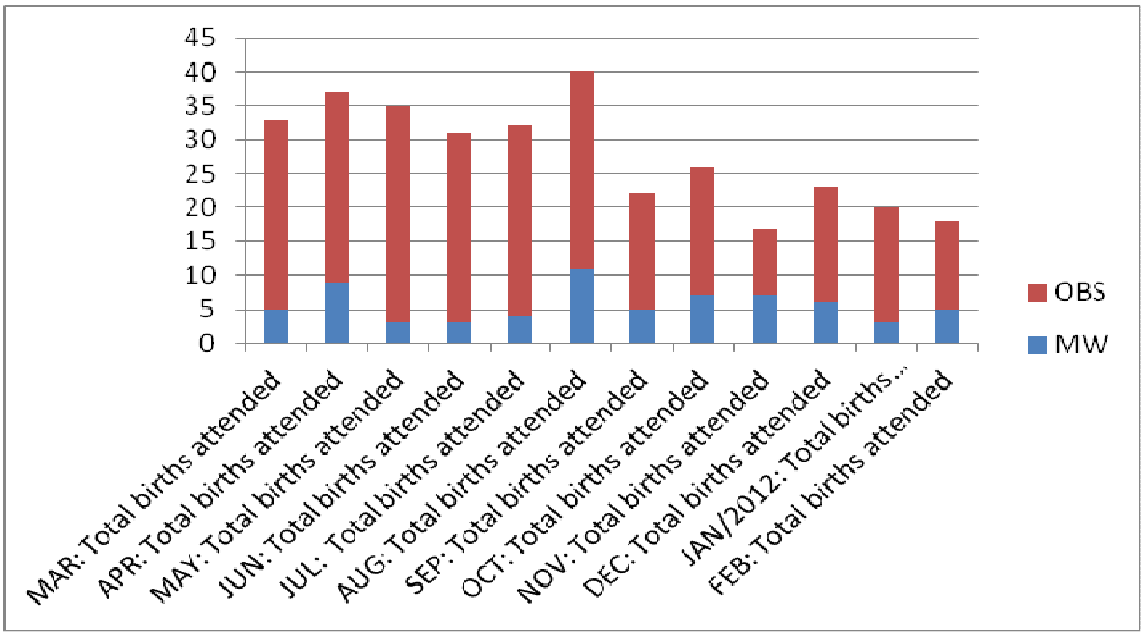
Total # of Patients seen: April 1 to March 31, 2012



Total # of Births Attended: October 1 to February 28, 2011



Total # of Bbirths Attended: April 1 to March 31, 2012



There has been an increase in number of clients seen by MWs. There are still no Family Physicians on the team.

There has been a small movement toward more balanced distribution of births across the IP team, but MWs continue to attend far fewer births. In the absence of IP team agreement on the definition of low risk birth and interpretation of continuity of care this situation is unlikely to change.

Reduction of Clinical Interventions

The Clinic expects, over time, to see a reduction of clinical interventions and hospital readmissions, as a result of the IP team approach; however a review of the data does not indicate a clinically significant change in the induction rate. No other clinical intervention data was provided.

Aggregate Results of Patient/Client Satisfaction Survey

Over all responses, demonstrated in survey answers, regarding care by the CLE/prenatal team were positive. Some dissatisfaction about community postpartum care was reported. While a number of women felt they could easily access post partum care at St. Martha's, some women strongly expressed a need for more extensive information and community care following hospital discharge. *(See Appendix 7 for aggregated survey scores by question)*

Prenatal Care

Most respondents were generally satisfied with the prenatal care they received at the prenatal clinic. This was also reflected in the comments, given by approximately 20 percent of patients, who expressed satisfaction with the model and quality of the care. A few patients specifically commented on the shared care model and felt it was a "great idea" and a benefit to pregnant women. Interestingly positive comments were made about the midwives and nurses whereas comments regarding OB involvement were absent.

Labour and Birth

Again, women were mostly satisfied with their labour and birth care. It seems approximately half of the women felt they did not receive enough information regarding when to call in labour and when to go to the hospital. There were no comments provided by women in this section.

Hospital Post-Partum

Of the 32 respondents, included in patient satisfaction statistics, 30 indicated that their babies were roomed-in with them while 2 did not provide answers to this question. About half of these women utilized the services of a lactation consultant at St. Martha's. Comments mostly reflected a deep satisfaction with post partum nursing support and midwifery while in hospital. Some women expressed a desire for increased support by public health once they were back in their community.

Community Post Partum

The vast majority of women indicated satisfaction with their community post partum care including the timing of, length of and information provided. They felt they had good access to post partum care at St. Martha's.

One woman expressed a great dissatisfaction with being sent back to the family doctor at 12 days post partum. She felt that she received inaccurate and conflicting information from her family doctor compared to the information she had received from the prenatal clinic team.

Patient Record Binder

It is clear from survey responses the patient record binder was under-utilized, if at all, in most cases.

Community CLE Members

A third of the respondents indicated they saw a community CLE member or specialist during the course of their care. Most of the community care in this section was provided by a lactation consultant. Women clearly felt deeply satisfied with their experience with a lactation consultant.

Trainee Involvement

About half of the respondents reported trainee involvement during their care. The vast majority of trainees were nursing students. Women indicated a deep level of satisfaction with the nursing trainees'. Comments also supported this satisfaction.

Although there was some concern expressed by various stakeholder groups regarding the public's response to the shared –care prenatal model at GASHA and about whether women who were expecting midwifery exclusive primary care would be satisfied with this model the survey results suggest that women found the team model a positive experience. It is not known whether, or to what extent, the midwives are assigned clients that specifically or insistently request that they see a midwife.

Practitioner/Team Member Satisfaction Survey:

Although three reminders were sent out, the response rate was very low –only 3 members from the extended participant group which included administrators as well as clinical team members responded to the survey. Of the three that responded two were administrators and one was a clinical practitioner and not a member of the core CLE IP Team. This may reflect the time of year this data was requested. To allow the IP Policy Process maximum time to develop, project data was not collected at the end of March. Some members of the CLE Team were on vacation and others indicated that it was a very busy period at the clinic.

SECTION 5: CONCLUSIONS AND RECOMMENDATIONS

CONCLUSIONS:

Multi-component and multi-site IP projects are challenging to plan and implement but much can be learned from projects of this type. Multi-component and multi-site IP projects encounter, perhaps ironically, the perils and productive gains of IP and interdisciplinary work within the project implementation team itself. And just as it is crucial for IP teams in healthcare to take the time to arrive at common definitions, language and understandings before tackling more ambitious tasks, so too must Project

Teams. This is likely the most important lesson learned at the project-implementation level.

While further study of the interactions between presage/contextual factors is needed to determine which factors are most important for impacting the implementation and sustainability of collaborative IP change, it is clear that they play a large role in the success of such efforts in post-licensure contexts.

There is a need to study further the ways in which IPC projects and facilitators might increase capacity for organizational and systems thinking for teams and leaders of healthcare organizations. Teams cannot effectively form and perform in new ways without this form of recognition of how professional perspectives and practices are embedded in the structures of an organization and the healthcare system more broadly.

New and extended forms of change management support must also be developed and applied to IPC change initiatives. Focusing on supporting change for individual team members or even for whole teams in isolation from change management support for the organizational change process will not provide full benefits of IPC, nor is the change created in the short term likely to be sustained.

RECOMMENDATIONS:

Develop planning and implementation guides for IPC projects based on past evaluations and lessons learned.

Develop assessments of organizational readiness for IPC learning and change to be used by funders, potential sites, and project planners.

Develop IPC organizational level change-management support materials to increase capacity for system-level change.

Support further study and evaluation with current CLE sites that are now moving into the phase of IPC organizational and system-level change. This can identify how presage factors and other influences impact the full integration and sustainability of increased IPC within post-licensure contexts.

SECTION 6: APPENDICES

Appendix 1**:** Data Collection Tools

Appendix 2: CLE Process Evaluation Power Point

Appendix 3: Interim Report (internal to Project)

Appendix 4: Interim Report (for GASHA) Power Point

Appendix 5: Report from Gander, NL

Appendix 6**:** IP Policy Process Template

Appendix 7: Action Plan Review template

Appendix 8: Patient Satisfaction aggregated responses