Appendix 3: Interim Review of Findings and Recommendations for Year 2

GASHA-ST. Martha's Site:

- **Data Collection Issues:**
  - Amanda's (site coordinator) monthly reports are very schematic-in depth reflection from the midwives would be useful but is difficult to get
  - Cooperation for key informant phone interviews has been good
  - We don't have a way to contact nurses directly via email-IT system at GASHA is poor
  - Site has been resistant to collection of patient chart data. If we do it we will require an amendment to our ethics agreement. It is fairly time intensive. We need to review what data s needed from the charts-how will we use it—do we actually need it for our evaluation purposes?
  - Do we continue meeting observations at GASAH site-do we keep doing them-for what purpose-if the case review format is adopted then we recommend yes, but with clear /modified data collection tool
  - Patient satisfaction surveys –clinic does their own, but we need to do our independent survey as well. It was difficult to work out a reliable method for collecting these on site so we have decided to do mailings
  - NEW data identified as relevant: Costing model: details of APP and MW employment contracts- this data also will be needed to figure out rotation-on call hours—need to find out which polices, if any, concerning on-call have been changed –identified as a challenge

Communication with site and at Project level:

- Communication of CLE project objectives-has the site lead fully informed the site clinical team of the terms of the partnership agreement? Site Responsibilities for data collection do not seem to be recognized.

- How well do the individual clinical team members understand the CLE objectives? Uneven levels of understanding. We assumed that the site coordinator would continue to inform new members, those with questions—this has not happened.

- CLE Implementation Team meetings have not been held regularly for past few months. We need to hold regular TCs.

- **Implementing the CLE Model of shared-care and collaborative learning: GAHSA**
    - Education/IP facilitation: Sent supporting materials for IP policy development-this may have prompted their review of policy; provided CASE REVIEW to clinical team for possible use(we need to have a look at what activities the team are engaged in through MoreOB-are there case reviews? what do they look like? Do they address IP issues?)
    - Rotation of patients in a shared care IP service delivery model: has not been fully implemented
    - Recommended CLE call schedule not implemented-rejected by clinical team as unworkable-explore this resistance further as it hinders full IP collaboration
    - IP protocols and protocols Have any been developed-the policy for epidurals an example of a clinic protocol-how IP was its development-what other IP protocols or policies might be useful? For example : Determination of high vs low risk; Informed Consent, induction policy

The Presage-Contextual factors we predicted would be salient were, in fact, all relevant:

- Level of uptake/support from Provincial Government Advisory Group-not in our sphere of direct influence
- Introduction of new care providers/new professions into the healthcare system and into existing teams- Professional issues: Family physicians not participating; MWs confronting resistance from their regulatory body and other professions –while these factors are not in our sphere *of direct influence*- we can assist in informing CLE Team of MW scope of practice—there are clear misunderstandings in this area
- Presence or absence of champions and direct institutional support-we have some influence here-although the GAHSA administration and site coordinator are supportive of our presence at site they are not proactive in predicting barriers or in problem solving
- Pre-existing institutional policies that may present barriers to full inter-professional collaboration: there are a number of clinical and service delivery policies that create barriers
- Pre-existing service delivery models: on-call and patient distribution between OBs, MWs and FPs are a barrier
- Previous billing patterns- pre-existing financial disincentives for IPC: APPs and other billing patterns are an issue
- Time constraints experienced by team members which may hinder activities to facilitate full IP collaboration:
- Competing initiatives at the organization: MoreOB and other projects are competing for time
- Constraints of physical space to support IP care delivery model and/or team activities: not a big issue
- Lack of IT capacity is an issue for working from a distance and for communicating with GASHA team members. One nurse does not even have a computer of her own!

Interim findings: Project-level Process Implementation Factors:

- Ethics process is time consuming and requires that detailed project plans be determined in advance of submission. Projects often begin before project plans are fully formed but this is not possible for projects that require ethics approval. It was a challenge for us to fully detail and coordinate our plan which added time to an already lengthy ethics submission process.
- Recruiting sites for CLE project has proved to be a challenge. Weak provincial government support and competing demands on practitioner time and organizational resources at site is a major factor. We need a new strategy that capitalizes on, rather competes with, pre-existing projects at potential sites.
- Co-ordinating multiple components of a project across multiple sites is a challenge. Regular project team meetings for updates and discussion of project prioritization of activities are a must.
- Prior circulation of documentation of issues to be discussed would be helpful.
- Use formative evaluation results to revise/improve implementation strategies: recruitment approach for NL should directly address and build on any existing projects at potential site; activity/intervention to engage GASHA team in review and development of policies to directly support IP should be introduced.
- If new activities are mounted at NL site and GASHA site facilitators from our project Team will necessary.

CLE PROCESS EVALUATION :

- To date no evaluation plans have been established for directly including NB activities in the process evaluation

- In order to proceed with data collection for NL site we will need more detailed information about the site objectives and participants. Have the CPAT results been reviewed?

- Data collection remains a challenge –we will need to collect more of the data ourselves

Recommendations for Year 2:

Project-level Implementation:

Data collection:

Collect Patient and practitioner satisfaction data ourselves. Mail out of patient survey.

Cease formal observation of CLE team meetings-will need to begin observation of IP Policy work by the team

Project Lead should review data collection responsibilities with sites

Designate site facilitators for NL and GASHA to move IP Policy work and NL activities (TBD) forward.

Present interim findings/recommendations for site to GASHA team and propose IP policy process for Year 2

Increase our project TCS and circulate documents in advance

Prepare for NL ethics as soon as we have site secured and project activities planned. Plan data collection for activities.

Start CREW as soon as NL site is secured

Review NS 'Better Todays and Tomorrows' and respond to NS Government Advisory Board question about why we didn't use it.

Develop the supporting materials for new activities at NL and GASHA

GASHA and NL sites:

Recruit NL site by building on any existing site project or activity that could benefit from review of opportunities for IP learning/policy lens.

Propose IP policy development process at GAHSA. Continue to support CLE TEAM work with IP service delivery model-call schedule and patient rotation

Interim formative evaluation

Review of findings from extended needs assessment and data on presage factors and process of project and activity implementation:

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