Meeting agenda
Presentation by Bev Ann Murray, Health Canada
Presentation by Lesley Bainbridge, CIHC, BC
Presentation by Liz Harrison, CIHC, Saskatchewan
Presentation by Ruby Grymonpre, CIHC, Manitoba
Presentation by Judy Anderson, CIHC, Manitoba
Presentation by Esther Suter, CIHC, Alberta
Presentation by Zahra Nurani, Health Workforce Research Network of Alberta
Presentation by Peter Gibson, Western and Northern Health Human Resources Forum
Presentation by Jeanne Besner, Health Systems & Workforce Research Unit, Calgary Health Region
Building Western Canadian Partnerships between Health Human Resource Planning and Interprofessional Education

Mon Sept 17/07 (11:30-4:30) and Tues Sept 18/07 (8:00-3:30)
Olympic Volunteer Centre at McMahon Stadium, Calgary

Attendees
Health Workforce Research Network of Alberta (Network)
members are professional practice leaders and health services researchers from health regions across Alberta and the Alberta Cancer Board [www.calgaryhealthregion.ca/hswru/phwrn](http://www.calgaryhealthregion.ca/hswru/phwrn)
(2 members from each health region)

Canadian Interprofessional Health Collaborative (CIHC) - Western provinces
members are involved in projects funded by Health Canada’s Interprofessional Education for Collaborative Patient-Centred Practice initiative [www.cihc.ca](http://www.cihc.ca) (for this meeting: BC, AB, SK, MB members); CIHC Steering Committee members

Western and Northern Health Human Resources Forum (HHR Forum)
members are from Ministries of Health and Advanced Education in the four Western provinces and the territories

Bev Ann Murray, Health Canada

BC Academic Health Council

Saskatchewan Academic Health Science Network (SAHSN)

Other stakeholders

Facilitator: Val Embree, planning consultant

MONDAY SEPT 17

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
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| 11:30-12:30| Networking Lunch  
CIHC poster set-up (posters will be displayed for the 2 days) |
| 12:30-1:00 | Welcome by Jeanne Besner (Calgary Health Region) on behalf of the  
Health Workforce Research Network of Alberta  
Opening remarks  
Bev Ann Murray from Health Canada on policy maker’s perspective on link  
between IP education and HHR planning  
Group discussion/questions |
| 1:00-2:00  | CIHC  
Introduction from Brenda Sawatzky-Girling  
Information from CIHC members about key findings from specific IECPCP  
projects (10 minutes each province=40 minutes)  
Group discussion/questions |
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<th>Time</th>
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<tr>
<td>2:00-3:00</td>
<td>Networking break and CIHC poster viewing</td>
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<tr>
<td>3:00-3:30</td>
<td><strong>Health Workforce Research Network of Alberta</strong></td>
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<td>- Information sharing from Zahra Nurani regarding greatest HHR challenges in AB today and the need to translate knowledge into action in order to move towards optimal utilization of our workforce</td>
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<td>- Group discussion/questions</td>
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<td>3:30-4:00</td>
<td><strong>Western and Northern Health Human Resources Forum</strong></td>
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<td>- Information sharing from Peter Gibson, Executive Director, about strategic priorities and initiatives for the Western provinces</td>
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<td>- Group discussion/questions</td>
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<tr>
<td>4:00-4:30</td>
<td>Summary of day (link to highlights of pre-meeting consultations) by facilitator Val Embree; preview of day 2</td>
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**TUESDAY SEPT 18**

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<tr>
<th>Time</th>
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<tr>
<td>8:00-8:30</td>
<td>Breakfast</td>
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<tr>
<td>8:30-9:00</td>
<td><strong>Opening remarks</strong></td>
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<td>- Jeanne Besner (Calgary Health Region) from the Health Workforce Research Network of Alberta on how IP practice fits as a strategy in HHR planning and workforce optimization</td>
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<td>- Group discussion/questions</td>
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<td>9:00-12:15</td>
<td><strong>Participant Dialogue</strong></td>
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<td>Participants meet regarding objectives:</td>
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<td>- Explore strategic linkages between HHR planning and interprofessional education and practice.</td>
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<td>- Discuss strategies and structures for sustainability of IECPCP project initiatives at provincial, western region, and CIHC levels.</td>
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<td>- Discuss possibilities for a joint Western provinces proposal to Health Canada for years 6-10 of IECPCP funding and other potential sources.</td>
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<td>12:15-1:15</td>
<td>Networking lunch for all participants</td>
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<td>1:15-3:30</td>
<td><strong>Next steps</strong></td>
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<td>- Discuss common interests among Network, HHR Forum, CIHC</td>
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<td>- Discuss possibilities for applying for joint funding</td>
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<td></td>
<td>- Summary and next steps</td>
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<td></td>
<td>- Closing remarks from Esther Suter (Calgary Health Region) on behalf of CIHC</td>
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At the heart of any health care system are the people who deliver care – health human resources (HHR).

2. IECPCP
   - a look back
   - “some” lessons learned
   - a look forward

3. Where to from Here?
   - The Framework for Collaborative Pan-Canadian HHR Planning
   - Pan-Canadian HHR Strategy Years 6-10 (2009-2013)
The Pan-Canadian Health Human Resource (HHR) Strategy seeks to respond to commitments made in the 2003 & 2004 First Ministers’ Accords by securing & maintaining a stable and healthy workforce in Canada.

Comprised of 3 initiatives:

- Pan-Canadian HHR Planning
- Inter-professional Education for Collaborative Patient-Centered Practice (IECPCP)
- Recruitment & Retention

$20M in annual funding has been allocated to support work under the 3 initiatives.
IECPCP – a look back

OBJECTIVES of the IECPCP Initiative

- Promote & demonstrate the benefits of IECPCP;
- Stimulate networking and the sharing of the best approaches;
- Increase the number of health professionals trained in collaborative patient-centred practice, pre- and post-licensure;
- Increase the number of educators prepared to teach from an interprofessional, collaborative patient-centred perspective; and
- Facilitate interprofessional collaboration in both education and practice.
IECPCP – a look back

What has been done to advance the IECPCP agenda across Canada and across education and practice settings?

- Conducted a Literature Review & Environmental Scan (Oandasan, D’Amour, Zwarenstein et al. Report 2004)
- Developed a Conceptual Model (Oandasan & D’Amour, 2004)
- Commissioned 10 research papers re: IECPCP
- Created the National Expert Committee (NEC) to guide the IECPCP Initiative
IECPCP .... a look back

20 Learning Projects (Building the evidence)


• Involve nursing, medicine and at least 1 more health profession – many projects involve 5-6 professions
• Many projects focus on both pre- and post-licensure education
• Involve a variety of health care settings
• All projects focus on a priority health care issue: e.g. primary health care, palliative care, rural/northern, chronic disease, Aboriginal, mental health, and patient safety.
IECPCP ... a look back

Complementary projects

Completed
• Legislation/Regulation
• Liability
• Clinical Placements
• Leadership
• Academic Barriers

Ongoing
• Canadian Interprofessional Health Collaborative (CIHC)
• Accreditation
IECPCP – “some” lessons learned

Three themes:

1. Moving mountains (achieving culture change)

2. Creative mountain climbing (effective learning strategies)

3. Mountains left to climb (real and perceived barriers)
IECPCP – Lessons learned

Moving Mountains

1. Early & sustained engagement of interprofessional faculty is essential to change traditional practices within faculties and to build IECPCP champions. (e.g. interprofessional curriculum development committees have been particularly effective)

2. Organizational infrastructure in educational institutions is necessary for sustainability & growth
IECPCP – lessons learned

Moving Mountains

3. More specific research re. effective approaches to seek & incorporate patient & community insights into redesign of IPE & collaborative care is needed

4. Health Canada funding has enabled recipients to lever $ and other resources as well as buy in from others

5. IECPCP initiatives have engaged academic, practice & policy stakeholders and contributed to the creation of “communities of practice” on this topic.
Creative Mountain Climbing

1. Clinical placements are ideal settings to teach & model IPCPCP; Interprofessional clinical placements attract students to “hard to fill” settings.

2. E learning projects produced interesting, well received teaching tools…… these learnings must be reinforced by face to face learning opportunities to solidify IP values & behaviour.

3. Many versions of IP competencies & associated curriculum are developing across the country. Harmonization of these variations may be important to establish a core set of IP practice competencies.
IECPCP – lessons learned

Mountains left to climb

1. Fundamental logistical barriers (e.g. space, scheduling) for team-based learning must be addressed and conquered.

2. While liability is not the barrier to collaborative practice that some health care professionals perceive it to be, effective strategies to change these perceptions are still needed.

3. Current legislation and regulations do not prohibit collaborative practice, but neither do they require or endorse it.
IECPCP – lessons learned

Mountains left to climb

4. IECPCP champions must keep abreast of changing government policy priorities & be prepared to advance IPE and collaborative practice as effective ways to achieve results related to these priorities (e.g. wait list management & reduction; patient safety; ER staffing crisis)

5. Policy makers, employers, academic & professional leaders will continue to require demonstrable evidence that IPE and collaborative practice result in improved outcomes for learners, patients and the system to continue to support this approach.
IECPCP – a look forward

What do we expect will happen next?

• Champions will continue to champion IECPCP
• Learning projects will implement sustainability plans in many sites
• Canadian Interprofessional Health Collaborative (CIHC) will coordinate ongoing information gathering, exchange and analysis as well as strategic planning with stakeholders
• “Communities of practice” will continue to emerge and thrive
• Strategic funding opportunities to enhance, expand and/or customize Interprofessional Education and Collaborative Practice will emerge through Health Canada, provincial/territorial jurisdictions; research organizations; etc.
Context for IECPCP in the Future

The Conference of Deputy Ministers of Health requested the F/P/T Advisory Committee on Health Delivery and Human Resources (ACHDHR) to develop a Framework for Collaborative Pan-Canadian Health Human Resource Planning.

This Framework:

- was approved by the DM’s in October 2005
- is a major output of the Pan-Canadian Strategy (Years 1-5)
- recognizes the jurisdictional responsibility for health system design & HHR Planning
- Affirms that jurisdictions cannot plan in isolation & realizes the value of a pan-Canadian approach to HHR planning
Goals of the Framework Action Plan

1. To improve all jurisdictions’ capacity to plan for the **optimal number, mix, and distribution of health care providers** based on system design, service delivery models, and population health needs.

2. To enhance all jurisdictions’ capacity to work closely with employers and the education system to **develop a health workforce that has the skills and competencies** to provide safe, high quality care, **work in innovative environments, and respond to changing health care system** and population health needs.

3. To enhance all jurisdictions' capacity to achieve the **appropriate mix of health providers** and deploy them in service delivery models that make **full use of their skills**.

4. To enhance all jurisdictions’ capacity to build and maintain a **sustainable workforce in healthy safe work environments**.
Future direction of the Pan-Canadian HHR strategy:

- ACHDHR is providing strategic direction, support and guidance to Health Canada on the next phase of the HHR Strategy which is to assist in the implementation of the Pan-Canadian Planning Framework;

- The Year 6-10 strategy will:
  - guide future Federal HHR planning priorities;
  - be grounded in the goals and objectives of the Framework for Collaborative pan-Canadian HHR planning Framework and Action Plan;
  - build upon the successes of Years 1-5 (2003-2008); and
  - engage our partners to realize sustainable outcomes.
The Pan-Canadian HHR Strategy (2009-2013)

3 Proposed Funding Streams:

- **Federal Obligations- $3M**
  - Recognizing the federal government’s obligations and commitments to its partners (e.g., official language minority communities, Aboriginal, etc.).

- **Jurisdictional - $4M**
  - More flexibility for PT’s to identify and fund HHR initiatives.
  - Focussed on top 9 priorities but may address remaining objectives under the Action Plan to meet a specific identified jurisdictional need.

- **Pan-Canadian Implementation of HHR Planning Framework - $8M**
  - Focussed priority objectives to maximize long-term outcomes and build on previous momentum generated from years 1-5.

*Note: All three funding streams address objectives and actions under the Framework and Action Plan*
Health Canada is committed to:

- **Implement the Framework and Action Plan**, which set out an innovative approach that is driven by population health needs and health system design and provides the flexibility to deploy health human resources differently in new health care delivery models; and

- Seek **ongoing engagement of stakeholders**, including ministries of education, research entities, national Aboriginal groups, health sector organizations, health professional associations, and professional regulatory bodies, to provide their input and determine how they can support and contribute to the Framework’s Action Plan.
Lesley Bainbridge

Associate Principal
College of Health Disciplines

Director, Interprofessional Education
Faculty of Medicine
University of British Columbia

Co-PI, In-BC
What is In-BC?

- A unique provincial network.
- A blend of top-down, bottom-up and cross-sectoral approaches.
- A collaboration of practitioners, educators, clients, students, decision makers, and policy makers/government.
- A small central hub.
- A strong consortium of specific projects.
In-BC projects

- **CMNH**: The Collaboration for Maternal & Newborn Health
- **GIFS**: Guided Interprofessional Field Study
- **IRPbc**: Interprofessional Rural Program of British Columbia
- **VCHIC**: Interprofessional Collaboration
- **PF**: Patients First
- **UHC**: UBC Healthcare Clinic
- **VIIEP**: Vancouver Island Interprofessional Education Project
Key messages/lessons learned for health human resources

• **Innovation/Evaluation**
  – Align IPE and CP with strategic priorities
  – Grow local champions
  – Use qualitative and quantitative evaluation

• **Health Systems Benefit/Sustainability**
  – Position IPE and CP as catalysts for other priorities
  – Embed IPE and CP into education and practice
  – Introduce early and “make it matter”
Key messages/lessons learned for health human resources

- **Communication/Dissemination**
  - Communicate widely in different ways
  - Make the information applicable and relevant

- **Health Care Provider Experience**
  - Provide workshops and social events
  - Make IPE and CP worth their while
  - Be patient and try co-location

- **Patient Experience**
  - Involve patients/families actively in many different ways
  - Inform patients about the value of CP (e.g. posters in waiting areas)
Key messages/lessons learned for health human resources

• **Learner Experience**
  – Create learning environments that create conditions for learning together
  – Make the “team” experience real in real locations
  – Develop space for learners to be together

• **Educator Experience**
  – Demonstrate value of IPE activity
  – Recognize faculty and preceptors
  – Provide training
Barriers to interprofessional education and collaborative practice

- Scheduling logistics
- Change management
- Strategic priority placement
- Time
- Reward system
- Training
- Financial support
Changes required to increase capacity for IPE and CP

- Accreditation standards (education and service provider)
- Training in PSE and health authorities
- Policy changes in support of IPE and CP
- Tangible and intangible reward system
- More evidence of effectiveness through research
- Development of champions
- Ongoing development of links between education and practice
- Clear competency definition, learning outcomes and performance indicators
Forward is a direction, not a speed......

- Fund
- Collaborate
- Test
- Evaluate
- Value
- Reward
• In-BC website [www.in-bc.ca](http://www.in-bc.ca)

• The following posters are displayed for more In-BC details:
  – In-BC overview - provincial activities and projects
  – Collaborative Learning Units
  – Rural Academic Health Project
  – Vancouver Island Project
Acknowledgements

• Committee and project leads and participants

• All partners of In-BC - health authorities, post-secondary education institutions, Ministries of Health and Advanced Education, College of Health Disciplines, BCAHC, Health Match BC

• Health Canada
Building Western Canadian Partnerships
Health Human Resource Planning & Interprofessional Education
Calgary AB  September 17-18, 2007
Main Elements of P-CITE Project

- Provincial Project
- Interprofessional education of health science students
- Program funding supports:
  - Development of faculty, clinical supervisors, community preceptors in IPE
  - Evaluation/research
  - Innovative projects throughout the province
- Links with other IECPCP programs
- Advancing partnerships between academic and community partners
P-CITE Steering Committee

- Academic and Community Co-chairs
- Battleford Tribal Council Indian Health Services
- College of Education, U of S
- First Nations University of Canada (FNUC)
- Health Science Deans Committee, (U of S)
- Northern Health Strategy
- Prince Albert Parkland Health Region
- Regina Qu'Appelle Health Region
- Sk Academic Health Science Network (SAHSN)
- Sk Advanced Education and Employment
- SK Health
- Sk Institute of Applied Science and Technology (SIAST)
- Student Wellness Initiative towards Community Health
- Students
- U of Regina
Project Themes

#1 Child & Youth Mental Health
#2 Chronic Disease in Middle Aged Adults
#3 Elders in Transition from Acute to Community Care
#4 Health in Aboriginal Communities

White Buffalo Youth Lodge
P-CITE
Projects must demonstrate:

- collaboration with academic and community partners
- sustainability past the funded project
- integration of best practice evidence
- mix of health professional students (2 or more student professions)
- emphasis on active learning methods
Deliverables Proposed
(completed June 1\textsuperscript{st}/2007)

- 2500 Classroom experiences for students (2865)
- 1200 Problem-based learning exercises for students (806)
- 250 Interprofessional clinical experiences for students (319)
- Evaluation and Research into IPE
- Knowledge translation
Increased capacity and adoption

- 31 Funded Projects
  - Students from 13 disciplines and/or professions
  - 326 health care providers, 315 educators, 141 external stakeholders
P-CITE Committees

Faculty Development
- Workshops, conferences, resources to better equip educators to teach interprofessionally

- Evaluation
  - Evaluation of funded projects
  - Support to projects
  - Identifying issues related to sustainability
Lessons Learned

- Short timeframe
- Good momentum but human resources being pulled in many directions and concerns re long term sustainability
  - Need for dedicated attention/resource
- Structural challenges
  - Institutional, health system
- IP clinical practice for student experiences
  - Resource intensive
  - Practice settings limited
Highlights

- Champions
  - Commitment crosses: Institutional, health system, govt, PCITE committees, SAHSN and Individuals!

- Innovative projects

- Changes already happening
  - Curriculum planning in health professional programs
  - New models being explored/tested
Questions?

• Visit: www.pcite.ca

WHAT’S NEW?

UPCOMING WORKSHOPS:
Evaluating Interprofessional Education (IPE) & P-CITE projects: Did it work?
Date: Friday January 5, 2007
Location: Sasktel Theatre, Royal University Hospital Saskatoon, SK
Time: 8:30 am - 4:30 pm
Workshop Brochure: click here
Online Registration: click here

Spring 2007 Call for Proposals
P-CITE is excited to announce the Spring 2007 Call for Proposals!
Grant applications are now available. Click here for $3,000 application (227kb .doc)
and click here for $20,000 application.
Deadline for grant application submission is January 19, 2007.
The funding allocation will occur in the new fiscal year - April 2007.
Interprofessional Education in Geriatric Care (IEGC) Program

IEGC

Key HHR messages

Presented by Ruby Grymonpre
September 17, 2007
Primary Goal of IEGC

Advanced trained learners
5 different health care professions
Simultaneous clinical placements
Shared IP learning in clinical context
Secondary Goals of IEGC

Build capacity and promote culture change:

- Within University of Manitoba
  - Faculty Champions
  - Students
  - Council of Health Deans
- Within 3 clinical practice sites

Riverview Health Centre
Day Hospital

St. Boniface Day Hospital

Deer Lodge Day Hospital
Student/Preceptor anecdotes

“It was interesting to see the students learn and improve their skills. I think it enabled each team member to be more aware of the students within day hospital.” — Clinical team member

“LOVED IT! I think all health care students should do this, it really gives a sense of interdisciplinary importance.” — Student

“I appreciated having the opportunity to integrate with the staff and truly become a team member. I liked being able to present material.” — Student
#1 - Support simultaneous clinical placements of multiple disciplines that offer shared learning experiences in IP teaming

Positive clinical placement experiences =

Improved recruitment

Improved retention
IPE clinical placement process

Academic institution

WRHA

IPE placement coordinator

Health care institutions

Students

patients
#2 – Continue to develop & implement HSPnet

Health care institutions

WRHA

HSPnet

Academic institution

Students

patients
#3 – Sustainability requires organizational commitment

Academic institutions

Health care institutions
Manitoba Initiative: IECPCP
Mission Possible!
Dr. Judy Anderson, PI
Dr. Christine Ateah, Co-Lead

Sponsors: Faculty of Medicine, Faculty of Nursing, Faculty of Dentistry, Faculty of Pharmacy, School of Dental Hygiene, School of Medical Rehabilitation
Partners: Northern Medical Unit, Winnipeg Regional Health Authority

c/o Dept of Medical Education, S204-B Medical Services Building, Faculty of Medicine

Funding: Health Canada RFA on IECPCP
Study design: Mission Possible!

**GOAL: to improve care via IECPCP**

**EDUCATION PLATFORM:**
- **Demo project:** 51 students from 7 professional schools
  1. Orientation Group: ½ day
  2. Education Group: 2 ½ days
  3. Full-Participant Group: 8-9 days immersion at practice site
    - Northern Medical Unit: Repulse Bay, Garden Hill
    - Winnipeg Regional Health Authority: DER-CA, Mt Carmel Clinic
    + 1 day wrap-up + Follow-up (pending)

**RESEARCH PLATFORM:**
  1. Graduate-level coursework
  2. Graduate training/research support
Key messages for workforce planning

GENERAL
• Commitment, partnerships, administrative support
• Collaboration is more fun than working alone
• Keep focused on the “patient” experience

TRAINING:
• Take opportunities for IPE training (UofT course valuable)
• Early experiences effective for faculty, staff, students

RESEARCH:
• Collect lots of data: evidence-based practice requires evidence
• Use pedagogy & validated tools to test ideas
• Immersion experiences in setting of patient care
Limitations of IP collaboration

Historical cultural silos
- Academic-professionals
- Supervision (accreditation of trainees)
- Graduate studies

University vs. workplace distinctions:
- Affiliation agreements, contracts, unions, reporting lines
- Budgetary procedures/policies, governance structures
- Expectations affect activity, remuneration, equity, commitment

Collaboration
- Time
- Communication across jurisdictional boundaries
- Perception that commitment requires $

Complexity: programs, options, schedules, distances
Changes needed to raise IP capacity

- Respectful clarification of roles
- Education & immersion in collaboration, teamwork
- Reflections (~rounds) as IP group not by profession
- Acknowledging need for trust to enable collaboration
- Coordinate placements to use IP opportunities
- Coordinate accreditation standards for IECPCP
- Expectations for collaboration b/w university & workplace
Ways to foster cultural change

- Use IECPCP evidence/expertise toward clinical innovation
- Focus on function & workplace design to improve care
- Design policy and governance to be flexible
- Leverage student expectations toward education & practice
- Engage patients/consumers as political drivers
- Engage people who “gather” teams; force can’t build teams
- Focus on learning together to build capacity (research)
- Make small changes iteratively to accrue change
- Value and reward synergies and team success
  - In the workplace, the academy, professions
Mission Possible!

Change is fun!
A small change can make a huge difference
“It takes a village…”
interprofessional education & practice

Creating an Interprofessional Learning Environment through Communities of Practice: An Alternative to Traditional Preceptorship
Creating an Interprofessional Learning Environment through Communities of Practice

PIs: Esther Suter, Nancy Arthur, Liz Taylor

Joint Western Meeting, Calgary
September 17, 2007
Overview of Our Project

- Goals of the project:
  - Foster interprofessional (IP) collaboration through communities of practice (CoPs)
  - Replace traditional preceptorship with “IP mentoring”:
    - Students are mentored by not only professionals from their own discipline, but also by professionals from other disciplines
3 Characteristics of CoPs

1. Community: A self-motivated and voluntary group of experts who find innovative/dynamic ways to generate knowledge (including tacit knowledge)

2. Domain: an area of interest that creates a sense of identity and cohesiveness in the community
   - Pilot Sites: Focus is on enhancing IP practice as a shared interest

3. Practice: the common knowledge that the community develops to work together effectively
   - Includes ideas, tools, protocols, information, stories, shared documents
Clinical Sites

- 7 sites across Alberta (rural, urban, acute care, community care)
- Facilitator support
- Our pilot sites’ communities of practice focused on:
  - how to enhance or improve the current IP practice
- Focused on interprofessional mentoring where applicable
Results

- **Practice changes** fell into 2 main areas:
  - Improved communications
    - Joint meeting
    - “purple pen”
    - Targeted communication
  - Streamlined admissions/discharge processes
    - One person designated as intake staff to reduce involvement of multiple professionals in admissions
    - Eliminate duplication of information
    - Expanded information on discharge form
As a result of above practice changes, and of the process of making these changes, there were impacts on:

- **Relationships**
  - E.g. Increased awareness of importance of clarity in communication; greater team cohesion

- **Patient Care**
  - E.g. greater continuity of patient care, reduced admission time

- **Integration**
  - E.g. Greater integration between programs/providers/sites; feeling more informed

- **Work environment**
  - E.g. Project provided ‘permission’ to explore, more positive work environments
Key Aspects of CoP Development

- Flexibility of the CoP participatory approach creates ownership
- Support from facilitators
- Opportunity for reflection on existing processes
- Permission to explore
- Create local champions
- Integrate students in the process
Educational Sites

- 2 Undergraduate Nursing Senior Practicum Courses at two institutions
- Students added an IP focus to their placements (as outlined in course syllabus)
- Facilitator support
- IP activities included:
  - IP mentoring at clinical sites
  - Blackboard/online discussions
  - In-class presentations/discussions
  - Attendance at IP workshops
  - Readings on IP practice
  - Reflective writings
**IP Competencies Developed**

- **Attitudes:**
  - Trust and respect for the roles of others
  - Willingness to collaborate

- **Knowledge:**
  - Other professionals’ roles and approaches to client care
  - Own and others’ boundaries
  - IP principles and “how to do” IP practice

- **Skills:**
  - Communication with professionals outside their profession
  - Critical thinking
Project Learnings: Education

- Addition of IP component does not require major curriculum change
- IP should be embedded in curriculum – not an add-on
- Education and practice settings should work together to provide IP experiences for students
Project Learnings: Clinical

- CoP is a useful approach to create IP practice
- Potential impact on continuity of care and patient safety through improved communication
- Get leadership on board
- Integrate students in the process
- Celebrate successes

“From a patient safety point of view, well functioning teams have a great promise to deliver superior care. Poorly functioning, in particular poorly communicating teams, increase safety risks for patients”.

(The Canadian Medical Protective Association, 2006)
Acknowledgements

Production of this material has been made possible through a financial contribution from Health Canada. The views expressed herein do not necessarily represent the views of Health Canada.
Health Workforce Research Network of Alberta

Linking Research to HHR Planning and Management

September 17, 2007
Background

- Joint proposal by the Clinical and Nursing Practice Leaders Network of Alberta and the Health Systems and Workforce Research Unit (Calgary Health Region)
- Funded by Alberta Health & Wellness
  - 2 year commitment with possibility of renewal
- Involves 9 Health Regions and the Alberta Cancer Board
- Brings focus and structure to a provincial workforce agenda
Expected Outcomes

- Evidence informed HHR planning & management
  - Optimal utilization of HHR
  - Needs based data to support HHR planning for Alberta
- Research relevant to employer needs and priorities
- Potential for western Canadian HHR network at some future point
Progressive Strategy

- Put evidence-based knowledge into action
- Link practice, education, information, human resources, research and other resources
- Build capacity for HHR management and evaluation
- Garner support from administrative, practice and operational leaders
- Build collaborative relationships
- Facilitate communication, coordination and access to resources
- Align with patient safety, quality work place, interprofessional, and health IT initiatives
Where are we now?

Current HHR Challenges:

- Maintaining standards of service because of staffing shortages
- Using outdated models of care
- Reduced FTEs with increased overtime
- Collective agreements that reduce flexibility and may make it difficult to introduce new models of practice
- Lack of trained support workers
- Meeting needs of rural settings
- Managing the expectations of a younger workforce, aging workforce and changed public awareness
Current HHR Challenges continued

- Retaining and rewarding experienced professionals
- Decreased ability to mentor students/staff due to workload and lack of resources
- Large span of control of managers
- Gaps in knowledge about professionals’ scopes of practice
- Leaders have no time to plan and to generate alternative solutions to problems
- Ineffective at implementing change – not evaluating and revising processes
- Environment doesn’t facilitate building relationships between staff, managers and departments
- Lack of collaboration among professionals
- Increased sense of “panic” in the system
Looking ahead…

Where will our system be in 1 year or 5 years?

• Less experienced/expert staff
• Net loss of workers
• Demands on the system increase as the population and workforce ages
• Leadership/management vacuum
• Volatile health system
Hope

- In 1 year, our challenges will likely be the same
- In 5 years, our challenges may be the same BUT we will have different answers and different solutions
Innovation in staffing solutions

“High quality, effective, patient-centred and safe health services depends on the right mix of health care providers with the right skills in the right place at the right time.”

- Need to respect regional differences while looking for key opportunities for change – facilitate a shift in organizational culture
- Rethink how we practice and how we deliver service
- Try new things, evaluate, revise and implement
Key innovations in Alberta

- Alberta Nursing Knowledge and Education Project – develop a replicable model and tools to analyze educational program content and types/levels of knowledge acquired across three nursing groups
- Nursing Practice Readiness – support the retention of entry-level nurses through addressing issues related to practice readiness of new grads from the 3 nursing occupational groups in AB (gaps in expectations)
- Leadership Capacity – development of leadership competency model and leadership profiles for Executive Leaders, Senior Directors and Front Line Leaders as well as creation of an implementation guide to integrate competencies into region’s HR processes
- Front Line Leaders Initiative – Role clarity and organizational supports needed to enact role fully
Innovations continued

- OWLS (Optional Work Life Strategy) – retention strategy for the older workforce
- Hiring high school students who completed their Health Care Aide Certificate at school
- Comprehensive Health Care Certificates – skills in nutrition, housekeeping and as an aide; credits used for future upgrading
- Simulation Centre in Calgary – disseminated model for experiential learning; 10 000 sq ft central centre with a wet laboratory and smaller sites at the hospitals
- Region wide interprofessional education strategy for collaborative patient-centred practice
How can we help?

- Common/regional decision making frameworks, evaluation tools and change management tools
- Synthesized data that can be used across regions with similar challenges
- Consistent application of evidence-based practice – frontline, management, administration, ministry
- Communication networks – ways to share easily among regions
- “How to” models regarding system redesign and lessons learned
Help…continued

- Common plan regarding the utilization of research data
- Ways to integrate information from various sources to reduce duplication and bridge gaps
- Information on interprofessional practice, job redesign options, and utilizing staff to full capacity
- Dissemination strategies regarding clarification of roles, managing expectations (individual and employer), collaborative practice
- Tools to build competencies in staff (coordination, facilitation, conflict resolution, mentorship, leadership)
- Mechanisms to share stories and recognize outstanding staff
- Onsite assistance with change management and implementation
What’s next?

- Linkages between educational institutions and employers
- Create quality workplaces and collaborative working environments - where staff feel they contribute, they are valued and have work-life balance
- Need to understand our current workforce – what staff think/feel, why do staff stay/leave, how do younger workers differ
- Promote increased enrollment of rural students in health care education – thus returning to the rural setting
- Ambulatory HHR challenges – impact in the community
- New marketing strategies for recruitment of students and staff
- Ability to identify strengths and weaknesses in staff so that they can be placed in “the right position at the right time”
Priorities continued

- Work with other sectors to support the whole family
- Maximize technology for learning and practice (i.e. desktop learning and an evaluation of the impact)
- Knowledge of patient care and system outcomes related to staff issues (i.e. shortages, overtime)
- Impact of new/different staffing models on team functioning, relationships among professionals and staff retention
- Focus on implementation of interprofessional practice
- Does appreciating the value of diverse professionals improve communication between colleagues
- Use of broader skilled professionals – ability to practice in different sites or settings (i.e. support staff in continuing care)
- Impact of an HHR strategy on administration – cost savings?
Contact

For further information:

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Strategic Priorities and Current Initiatives in HHR Planning – from the Western & Northern HHR Planning Forum

Presented at the Building Western Canadian Partnerships between Health Human Resource Planning and Interprofessional Education, in Calgary September 17 and 18, 2007.

by

Peter Gibson
Executive Director
Western & Northern HHR Planning Forum
FORUM TORs

To provide a forum where western provincial and northern territorial Ministries of Health and Advanced Education can explore opportunities for co-ordinated planning and joint initiatives in the area of health human resources.
MEMBERS

The western provinces and northern territories include:

- British Columbia
- Alberta
- Saskatchewan
- Manitoba
- Yukon
- Northwest Territories
- Nunavut
ACTIVITIES

- Regular communication and information exchange on jurisdictional developments & initiatives in HHR.
- Establishment of interjurisdictional task groups.
- Organization of HHR Planning conferences
- Co-ordination of representation on national working groups and committees.
- Identification, development and implementation of opportunities for interjurisdictional collaboration in HHR.
HISTORY

- Began in 2001
- Initially involved information exchange and networking on HHR Planning
- Has now matured into implementation of collaborative multi-jurisdictional projects
- First 25 projects have been completed using funding from Health Canada.
STRATEGIC ADVANTAGES

- Active Liaison & Networking between jurisdictions
- Active Liaison & Networking between Health and Post Secondary Education
- Genuine Collaboration & Sharing
- Guided by National Agreements e.g. FM Accord
- Consistent with Provincial Priorities & Plans
MORE STRATEGIC ADVANTAGES

- Forum represents 1/3 of Canadian population
- Considerable potential influence
- Driven by innovation & best practice
- Not limited to western & northern collaboration
- Capacity to collaborate with other jurisdictions & organizations e.g. with Ontario, Atlantic Provinces, Health Canada, HRSDC, CIHI, etc
- Capacity to remove interjurisdictional barriers to reform
- Increases capacity for all members, both large and small
COMPLETED PROJECTS (1)

- Western Alliance for Assessment of Internationally-educated Physicians (WAAIP)
- Ongoing Evaluation of Medical Education Initiatives
- Standardization of Description of LPN Competencies
- Extension of System of Matching Clinical Placement Capacity with Needs
- Development of Mentorship Program for Aboriginal Health Science Students
COMPLETED PROJECTS (2)

- Development of Curriculum for Behavioural Interventionists for treatment of Autism
- National Meeting on Physician Compensation (2 years)
- Development of HHR Indicators (Yukon)
- Student Placement Capacity Building in Rural Communities
- Development of Evaluation Framework for HHR Initiatives
- Development of HHR Plan (Nunavut & Yukon)
- and many more projects
CURRENT INITIATIVES (1)

- Health Canada funded 4-year project for collaborative development of products and services for IEHPs
- 8 priority professions - physicians, nurses, pharmacists, OTs, PTs, med rad, med lab + midwives.

2007/8 Workplan

- IEN Assessment and Bridging Project with Mt Royal College – (3 years)
- Assessment and Bridging Program for IE Midwives – CMRC – (3-years)
- Development of EE Study Guide for International Pharmacists (1year)
CURRENT INITIATIVES (2)

- Western & Northern HHR Regional Strategy
- Establishment of Web Page
- HHR Collaborative on Research & Knowledge Transfer and Exchange
RESEARCH PRIORITIES

- Undertake Synthesis of quality research
- KTE – Knowledge Transfer and Exchange Dissemination
- Identify gaps
- Develop new research
- Enhance Evaluation Capacity for program evaluation
- Improve data definitions/common collection processes/analysis/dissemination
- Enhance uptake of research findings
- Enhance Change Management Capacity
STRATEGIC PRIORITIES

- Productivity
- Entry to Practice
- Rationalization of Education Capacity
- Aboriginal HHR issues
- Rural and Remote Issues
- HHR forecasting & modelling
- Northern Issues
- Labour Mobility
- Centres of Excellence
PRODUCTIVITY - Top Priority

- Need to define Productivity in health care terms
- Analyse current work practices – impact on patient outcomes – *E McGlynn et al*
- Impact of remunerative practices on patient care
- CQI Patient Outcomes and Patient Safety
- Effective Models of Health Care Delivery
  - **INTERPROFESSIONAL PRACTICE**
  - Optimizing Skill Mix and Scopes of Practice for Future models of health care delivery
- Appropriate Adoption of Technology
- Impact of New Professions
- Productivity has greatest potential for gains
HHR and IECPCP

- Need to evaluate current initiatives
- Need clear evidence to confirm positive impact of IP on Patient care and HHR
- Need to confirm value for money option
- Need to disseminate evidence
- Need long term commitment to IP
- Need change management strategy and managers/politicians capable of implementation
KEY FEATURES OF SUCCESS IN FORUM PROCESS

- Open Communication Process.
- Commitment to Genuine Collaboration.
- Consensus Driven Decision-Making.
- Development of Trust among members.
- Collective courage is conducive to Innovation.
- Commitment to Capacity Building amongst all member jurisdictions, small & large.
- Development of Links to Other Key Players.
A REGIONAL COLLABORATIVE APPROACH

- Building on Best Practice from one jurisdiction and extending to others.
- Makes best use of scarce resources
- Expands limited capacity
- Assists in removing jurisdictional blockages
- Creates an effective & dynamic approach
THE “FORUM”

AN EFFECTIVE COLLABORATIVE PARTNERSHIP IN HHR PLANNING

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Workforce Optimization

The Relationship between IP, HHR Planning & Workforce Optimization

A summary of the evidence

Senior VP Operations, Professional Practice, CNO
Calgary Health Region
September 18, 2007
Optimal Utilization of IP Team Members

**Guiding Principles:**

- Population/patient needs driven
- Optimal utilization of knowledge and skills of all providers
- Link staffing and staff mix to intended patient, provider and system outcomes
- Evidence informed, context specific
Who are the people being served?
### Some Examples

Patients 65+ years, IP admissions, fiscal 2005 (365 day period)

<table>
<thead>
<tr>
<th># Stays</th>
<th># People</th>
<th>% Visits</th>
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<tbody>
<tr>
<td>1</td>
<td>14,126</td>
<td>66.4%</td>
</tr>
<tr>
<td>2</td>
<td>4,637</td>
<td>21.8%</td>
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<tr>
<td>3</td>
<td>1,552</td>
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<tr>
<td>4</td>
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<tr>
<td>7</td>
<td>40</td>
<td>0.2%</td>
</tr>
<tr>
<td>&gt;8</td>
<td>22</td>
<td>0.1%</td>
</tr>
<tr>
<td>TOTAL:</td>
<td>21,263</td>
<td>100.0%</td>
</tr>
</tbody>
</table>
Overview of the Population on One Medical Unit

- ~70% of patients d/c during the year clustered into 10 or fewer ICD-10 codes
  - Anemia, Atrial Fibrillation, COPD, Dementia, Diabetes, Heart Failure, Hypertension, Neoplasms, Pneumonia & Urinary Dx.
- Many patients have multiple co-morbidities
- 63% over 70 years of age
  - Consistent with data from Seniors Health strategic plan
- 46.5% discharged with no support, 26.3% with (i.e. referral to Home Care, etc.)
- Median LOS 6.1 days, Average LOS 10.7 days
Are we achieving intended outcomes?

Evidence related to Outcomes
Predictors of Re-hospitalization (within 90 days)

- Lack of adequate support (social, financial, familial)
- Premature discharge from hospital
- Non-adherence with medication (lack of knowledge about)
- Non-adherence with follow up procedures or instruction
- Substance abuse
- Homelessness
- Events external to patient’s control
- Limited control over dietary restrictions or activity level
- Delay in seeking treatment at first sign of recurring symptoms

  - (Anthony, Chetty, Kartha et al. Advances in Patient Safety, Vol. 2.)

- Most of these predictors associated with comprehensive assessment by RNs and others
  - Suggests we could prevent some readmissions by focusing on improving assessment at the time of admission
31% of patients are returning within 90 days

- 368 patients represented 659 “readmissions”
- 44% of those within the top 10 cluster of diagnoses are returning within 90 days
A majority of in-patients are re-admitted through ED
What do Patients Say?

Key Themes:

1. **Social Support (from family, friends, providers)**
   - Contributes to ability to cope, less utilization of services

2. **System Navigation**
   - Depends on previous experience with system, relationships with & genuineness of providers. Communication & caring are key enablers
   - Lack of continuity between acute care and primary care

3. **Access to Services**
   - Facilitated by inclusion of client/family in discharge planning, communication among providers
   - Patients generally do not know what they don’t know; providers need to anticipate needs & issues
   - Social isolation common among elderly, complex chronic patients
   - Providers must increase assessment of risk factors

(Source: Patient Journey Study - 2007)
What have we learned about providers: Utilization, satisfaction, perceptions?
At the cusp of change, but a ways to go
- No system wide policy or vision for IP practice
- Need structural and functional system changes to move us forward
- Need to educate current workforce
  - Confusion about IP
    - Some think they’re there and they’re not’
    - Some think they’re not there, but they’re close
  - Professionals, administrators, faculty & students realize change is needed, but uncertain about how to move forward
**Barriers**

– *Perceived lack of support / leadership*
– *Not all professionals included*
– *Issues with communication*
– *Changing team players*
– *Physical distance of team members*
Facilitators

- *Dispel myths related to “others’ “ roles*
- *Role models*
- *Inclusion of all professionals*
- *Consistent “rules”*
  - *Create IP culture*
    - *Team building*
    - *Time for getting to know each other*
  - *Create Space*
    - *Joint space for work & socializing*
    - *Accommodate growth in number of professionals*
The Reality

Professional roles:

- **Role ambiguity and confusion within nursing and across professions**
  - Gaps between optimal and actual practice endemic
  - In part related to pre-regionalization differences in practices/policies and to lack of evidence base for practice

- **Roles = Sum of tasks/activities performed**
  - Overlap in tasks across professions contributes to frustration, confusion, tension

- **Optimal Utilization (“working to full scope”)**
  - Only 50% of RNs, 73% RPNs, 20% LPNs report working to full scope
  - Majority of PCMs and specialized nurses feel RNs, LPNs **NOT** working to full scope
    - Stereotyping contributes to sub-optimal utilization
  - (Sources: Clinical Nutrition Review; Scope of Practice and Interprofessional research)
What are some of the issues?
Efficient Utilization of Staff

Themes emerging from Research

• **Duplication**
  – data collection (e.g. assessment data); data entry (e.g. multiple forms & data entry)
  – Fragmentation across continuum of care

• **Information flow**
  – Lag time in data entry, data retrieval
  – Content of messages, information overload (too much unimportant, irrelevant data)
  – Lack of integration b/w institutional and community services

• **Time Pressures**

• **Team cohesion (some integrated, cohesive; others not)**
  – Need for clear mandates and priorities

• **Gatekeepers, information hubs (contribute to fragmentation, delays in care)**

• **Resource limitations (e.g. SLPs, pharmacists, SW)**

• **Lack of comprehensive client assessments (focus on bio-medical)**
  – Need to focus on patient versus provider needs

• Sources: Scope of Practice, Process Mapping, Interprofessional research, Clinical Nutrition Review
The Importance of Context

Barriers to Optimal Workforce Utilization

• **Poor interprofessional relationships**
• **Lack of data about allied health professional roles**
  – Research to date primarily within nursing
• **Perceived lack of professional autonomy**
• **De-valuing of own & other professional roles, power struggles**
• **Lack of trust among team members**
• **Lack of involvement of all team members in decisions about work redesign**
• **Work environment**
  – Time, workloads, patient acuity, lack of organizational supports, lack of access to continuing education, space/physical layout, administrative structures,
  – **LEADERSHIP**
  – (Source: Scope of Practice 2005; Interprofessional research 2006)
Recommendations

• Clarify roles, establish clear vision for optimization
• Re-educate staff for interprofessional practice that optimizes roles
• Establish new service delivery models and monitor impact