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

A Proposal for the Health Care Strategies and Policy Contribution Program, Health Canada
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1. Primary Applicant Organization

This is a co-led initiative jointly developed by the Calgary Health Region, the University of Alberta, the University of Calgary, Capital Health, SAIT, Bow Valley College and Mount Royal College. All seven partner organizations will be responsible for the successful planning, implementation, evaluation and dissemination of the proposed project in accordance with the proposed timelines and budget. To meet Health Canada requirements of a single project lead, the partners have agreed that Dr. Esther Suter from the Calgary Health Region will formally represent the investigative team. She will be responsible for project management as well as coordinating regular updates on project progress and accounting to Health Canada.

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Calgary Health Region - Mission, Goals and Objectives

Our Mission - “The Calgary Health Region is committed to excellence in providing an accessible, accountable and integrated, community-based health system which promotes shared responsibility for improved health.”

The Region serves over one million or 34 percent of Alberta’s population. The core business is to ensure delivery of quality health services while managing the financial and human resources wisely and to encourage and promote healthy living. The four key areas of strategic focus are Healthy Populations, Innovative and Effective Services, People and Services, and Financial Stewardship. The Region is committed to research, which has a direct impact on the delivery of health care to patients. While clinical research has been the focus in the past, recent initiatives include research into population health, health services and policy, and knowledge translation. The Region has established strong links to academic researchers at the Universities of Alberta and Calgary and across the country. Current nationally funded research projects focus on innovation in health care delivery (i.e., telemonitoring of rural patients) and scope of practice of nursing (under the lead of Dr. Jeanne Besner).

Suitability to undertake project

The proposed research is a logical expansion of ongoing research initiatives within participating partner organizations and in keeping with the research mandate of the Calgary Health Region, the University of Alberta and the University of Calgary. The project is fully supported by the Calgary Health Region’s Senior Vice-President, Professional Practice, Research and Chief Nursing Office as well as senior executives from the University of Alberta, the University of Calgary and the other participating partner organizations. The project originates from discussions among researchers, educators, and administrative staff about the need to improve the coordination, comprehensiveness and quality of health education to enhance patient outcomes, while addressing staff development, retention and recruitment.
All partners in this project are highly committed to sustaining health education and practice research, and have stated that this research will make a critical contribution to student and practitioner education and quality patient care. Since educational institutions are committed to preparing the future health care workforce to meet changing practice needs, they support research in interprofessional collaboration for patient-centred care. Likewise, the partner practitioners and administrators have expressed interest in supporting and nurturing this research, recognizing its potential to improve patient care and the development of collaborative synergies.

Applications/grants or contracts related to project


Projects 1 and 2 focus on preceptorship for specific groups and settings (i.e., registered nurses in the cardiovascular area and licensed practical nurses in seniors’ health in project 1; nurses and medical students in population health in project 2). This is different from the current proposal which purposefully involves multiple health disciplines learning together in Communities of Practice. Project 3 focuses on views of cultural competence held by interdisciplinary mental health professionals and will inform the curriculum review and the conceptual model proposed in this initiative. Project 4 is piloting interventions to enhance learning in Communities of Practice, and project 5 aims to implement interprofessional teams in primary care. The findings from projects 4 and 5 will be helpful in the design and implementation of learning strategies for the Communities of Practice proposed here.

2. Partner Organizations

Partners’ roles and responsibilities

The partners are:

- **Calgary Health Region**
- **University of Alberta** (U of A); Faculties of Pharmacy, Rehabilitation Medicine (Occupational Therapy), Nursing, Medicine and Dentistry, Health Sciences Council
- **University of Calgary** (U of C); Faculties of Medicine, Nursing and Education
- **Capital Health (CH)**
• Southern Alberta Institute of Technology (SAIT)
• Bow Valley College
• Mount Royal College

This initiative is co-led by stakeholders in Calgary and Edmonton representing education, practice and research. All partners have been instrumental in the conception of the research project and the preparation of the proposal, and are highly committed to the initiative. The wide range of disciplines represented in the collaborative ensures the following: research questions are addressed from multiple perspectives and provide truly interprofessional solutions; the project will be successfully implemented across multiple settings; and the outcomes are beneficial to all stakeholders involved.

Each partner organization is responsible for allocating resources in the form of expertise and time to the project in addition to incorporating findings into current and future practices. Academic partners will ensure that the lateral mentorship training program and the curriculum recommendations will be incorporated into the health curriculum in a coordinated and timely fashion, therefore increasing sustainability of the project. Practice partners will facilitate the incorporation of learnings into the practice setting, and help to create positive environments that support interprofessional lateral mentorship and collaborative patient-centred care.

In order to move the project forward and ensure success, responsibilities for the project have been divided among partner organizations. While the Calgary Health Region assumes responsibility for the overall management of the project, the Professional Education Research Centre (PERC) at the University of Calgary will manage finances (see attached letter of support). Dr. Nancy Arthur, one of the Principal Investigators for this project, will represent PERC and ensure that financial management and overall project plans are in alignment.

Project lead

The project leads are:

- **Calgary Health Region**: Dr. Esther Suter, Research and Evaluation Consultant, Research Initiatives in Nursing and Health (RINH, Overall Project Management)
- **Capital Health**: Wendy Hill, RN, MN, Executive Nursing Officer and Chief Operating Officer for Community Hospitals and Regional Support Services
- **University of Alberta**: Liz Taylor, Associate Professor & Associate Chair, Occupational Therapy
- **University of Calgary**: Dr. Michael Clinton, Dean, Faculty of Nursing
- **SAIT**: Dr. Nancy Arthur, Associate Professor, Education, Canada Research Chair (Financial Accountability)
- **Bow Valley College**: Jaci Lindon (BA, MCE), Practice Development Specialist, Department of Health and Public Safety
- **Mount Royal College**: Dr. Pam Nordstrom, Chair, Undergraduate Nursing Studies
The people described below will take co-responsibility for the development, implementation and evaluation of this project. (Together with the Project Leads, they are described as the investigative group in this proposal. Members of the group will be involved in various aspects of the project.) They represent diverse health disciplines and have a wide range of experience in research, teaching, mentoring and clinical practice.

- **Besner, Jeanne** (RN, PhD); Director; RINH, Calgary Health Region
- **Cox, Cheryl** (BSP, MBA); Pharmacy and Pharmaceutical Sciences; U of A
- **Friesen, Steven** (BSc); Research Assistant, RINH, CHR
- **Hofmeyer, Anne** (MPHC, PhD); Dean, Undergraduate Educ., Faculty of Nursing, U of A
- **Hurlock, Debb** (PhD); Project Manager, Interdisciplinary Primary Health Care Initiative, Calgary Health Region
- **King, Sharla** (PhD); Academic Co-ordinator InterProfessional Initiative, U of A
- **Kipp, Jean** (MScN, MPH); Team Placement Coordinator, InterProfessional Initiative, U of A
- **Oelke, Nelly** (RN, BScN, MN); Research and Evaluation Consultant, RINH, CHR
- **Paton, Brenda** (BN, PhD); Assistant Professor, Nursing; U of C
- **Pimlott, Jan** (RDH, BScD, MSc); Director, InterProfessional Initiative, U of A
- **White, Debbie** (PhD, RN); Assistant Professor, Nursing, U of C
- **Casebeer, Anne** (PhD); Associate Director, Centre for Health and Policy Studies, U of C
- **Chatur, Fatima** (PhD); Research Coordinator, Ward of the 21 Century; U of C
- **Ghali, Bill** (MD, MPH, FRCP©); Associate Professor, Medicine and Community Health Sciences U of C; Government of Canada Research Chair/ Health Services Research

**Group trust and cohesiveness**

All partners are members of a larger research collaborative that has been formed under the initiative of the Calgary Health Region for the purpose of moving the interprofessional agenda in Alberta forward. The collaborative has been meeting regularly since June 2004 to discuss health education and practice issues and priorities. These meetings have provided an opportunity for partners to get to know each other and their different perspectives, thereby increasing trust and group cohesiveness. A central coordinator has acted as facilitator and mediator and has ensured that information is communicated to all members in a timely manner. The Health Canada project is the first in a series of projects that will be undertaken by the research collaborative. Meetings will continue, with the goal being to develop a 5-year research plan to support interprofessional education and practice in Alberta. The ongoing work of the collaborative will further enhance its effectiveness and collaborative skills, which will greatly benefit the Health Canada project.

**Communication strategies**

Dr. Suter’s responsibility as Project Lead is to maintain ongoing communication regarding the status of project activities. Email, regularly scheduled meetings via teleconference as well as face-to-face meetings with the investigative group will ensure that all parties are kept informed. Monthly progress reports will be provided to the Steering Committee.

A project website will be established with privileged access for the investigative group. We will also explore the possibilities of using the website to facilitate synchronous and asynchronous meetings.
Conflict resolution
Conflicts will first be addressed at the project team level, and if not able to be resolved there, the Steering Committee members will be consulted for direction.

3. Patients and Learners

Description of patient and learner groups
Patients and learners will be involved in all stages of the project. They will be recruited from multiple organizations and settings to ensure a wide representation of health disciplines, practice environments and health conditions. For example, students will be recruited through different health discipline programs (e.g. nursing, medicine, occupational therapy, pharmacy) at the University of Alberta, University of Calgary, Mount Royal College, Bow Valley College, and SAIT. Undergraduate and post-graduate students will be included as appropriate.

Patients will be recruited from clinical sites for acute care, long-term care, community-based care and mental health, from rural and urban locations, and from diverse ethnic backgrounds. The Procedures section of this proposal describes how patients and learners will be involved.

4. Steering Committee

Role
A Steering Committee has been established to include experts appropriate for the various aspects of the project. The Steering Committee is representative of the partnership and includes educators, learners, practitioners, patients, researchers and administrators. Two co-chairs lead the committee. The responsibilities of steering committee members include to:

- Provide scientific and practice input and advice as needed
- Communicate project progress and challenges to their respective organizations
- Participate in meetings as previously scheduled or as needed (or appoint an alternate)
- Facilitate the work of the investigative group throughout the research, implementation and evaluation phases of the project
- Address barriers to success as identified by project participants
- Facilitate communication with specific patient groups and information sources
- Identify and provide information from a broad range of sources that will contribute to innovative and practical solutions
- Engage and recruit additional project participants as needed
- Review reports and assist in interpretation of findings
- Search for opportunities to combine resources across stakeholders to support and sustain the project
- Assist with knowledge dissemination
Proposed members and role descriptions

- **Katherine Stansfield**, Director, Nursing Professional Resources, Calgary Health Region, is one of the co-chairs. Her main responsibility will be to lead the Steering Committee.
- **Dr. Jane Drummond, PhD.**, is a faculty member in the Faculty of Nursing and Acting Executive Director, Health Sciences Council at the University of Alberta. She has broad experience in partnership development in cross disciplinary and cross sector research initiatives and will act as co-chair for the Steering Committee.
- **Wendy Hill**, RN, MN, is Chief Operating Officer, Regional Support Services and Community Hospitals; Executive Nursing Officer with Capital Health. Her participation in the Steering Committee will be essential to facilitate access to clinical sites for the project. She will be sharing the second co-chair position with Jane Drummond.
- **Lori Anderson**, Director of Rural Health, Calgary Health Region, is Director of the Interdisciplinary Primary Health Care Initiative in Okotoks, a capacity enhancement project funded by Alberta Health and Wellness. Her experiences with the Okotoks project will be valuable for the design and implementation of the Communities of Practice model.
- **Lynn Basford**, Dean, Faculty of Health Sciences, University of Lethbridge, has years of interprofessional experience from the United Kingdom, bringing an international perspective to the project. As Faculty of Medicine Head, University of Sheffield, she examined all undergraduate and post-graduate health sciences programs to ascertain any common themes/subjects that could facilitate shared learning and teaching. She also chaired and directed The Trent Institute of Inter-professional practice learning and education (TIIPPLE).
- **Dr. Ann Casebeer**, PhD, Associate Professor Community Health Sciences and Associate Director of CHAPS, has over 20 years international experience including 10 years as a practice based policy analyst in the United Kingdom’s National Health Service. She also works closely with SEARCH (Swift Efficient Application of Research in Community Health) - a multi-disciplinary learning community dedicated to enhancing research use in health system environments for health improvement. Her expertise in designing and delivering multi-disciplinary and inter-professional learning programs will be accessible to the team. She will also assist with information dissemination through CHAPS and SEARCH.
- **Kylie Cassinat** is a 3rd year undergraduate student in Nursing at the University of Calgary and a Calgary representative of the National Health Sciences Student Association initiated by the University of British Columbia. Kylie will represent student interests and perspectives.
- **Dr. Sheila Evans**, PhD, Associate Dean, Research, Faculty of Nursing, University of Calgary is a longstanding promoter of interprofessional seminars at the University of Calgary. Her role will be to facilitate faculty dialogues and provide guidance for implementation and sustainability of the Communities of Practice.
- **Karen Jackson**, RN, BScN, Med is a Research and Evaluation Consultant in Research Initiatives in Nursing and Health, Calgary Health Region, with expertise in work redesign. Her nursing experience will be essential for validating emerging contextual barriers and facilitators and for developing strategies and pragmatic solutions to overcome these barriers.
- **Dr. Peter Jamieson**, Division Chief, Acute Care Family Medicine, Calgary Health Region and Clinical Associate Professor, University of Calgary is the practice representative on the Steering Committee and will facilitate access to patient populations for this project.
• Tracy Marsden, BSc, BScPharm, DHPh, FBIH, is the current President of the Alberta College of Pharmacists and has a special interest in holistic approaches to healing and integrative health care. Her perspective will be useful in designing the Communities of Practice from an integrative perspective.

• Dr. Pam Nordstrom, PhD, Chair, Department of Undergraduate Nursing Studies, MRC; Dr. Rena Shimoni, PhD, Dean, Health & Community Care, Bow Valley College, and Marlene Raasok, Dean, Health & Public Safety Department, SAIT will all represent colleges on this project and ensure that the Communities of Practice model developed and implemented will be appropriate for their student populations.

• Dr. John Parboosingh, MD, is an Emeritus Professor, Obstetrics & Gynecology, and Medical Education, Faculty of Medicine, University of Calgary. His expertise in the area of medical education, workplace learning/practice-based learning has been acquired over many years in multiple public and private settings. He has extensive experience with Communities of Practice and his input and guidance will be essential for the development, implementation and evaluation of this project.

• Dr. John Toews, MD, is chair of the Council of Associate Deans Education, Faculty of Medicine. He is currently chairing the steering committee for the e-Learning in the Health Professions Alliance, a group composed of representatives of the University of Calgary, SAIT, Mount Royal College, Bow Valley College and the Calgary Health Region. His experience with e-learning will be essential for the development of the Communities of Practice model.

• Darlene Harris, Dr. Stewart Longman and Wendi Lokanc (all Calgary Health Region) are all experienced preceptors. Their input will be essential for the development and implementation of the Communities of Practice model.

• Dr. Albert Cook, PhD, Dean, Faculty of Rehabilitation Medicine and current Chair of the Health Sciences Council University of Alberta. The Health Sciences Council is comprised of the Deans of the six U of A Faculties that are involved in health sciences professional education and aims to champion interdisciplinary health sciences research, education and community service at the University of Alberta. Dr. Cook’s expertise and input as Health Sciences Council chair will be essential for the success of the current project.

• Dr. David Cook, PhD, Professor and Director of Studies in Medical Education, University of Alberta is a long standing member of the Interprofessional Initiative at the University of Alberta. His role will be to help with the development, implementation and evaluation of this project. He has published more than 150 papers in his original discipline of pharmacology and in medical education. The Division of Studies in Medical Education has expertise in several areas of statistics, assessment and evaluation that will be important to the success of the project. Dr. Cook is also a 3M teaching Fellow and was part of the team that won the Blizzard Award for Collaborative Education.

• Tiffanie Mo is an undergraduate student in occupational therapy, University of Alberta, who works with the Professional Development committee as well as the student interdisciplinary student group (ACHILI) at the University of Alberta.

• Dr. David Rayner is the Associate Dean of Undergraduate Medical Education at the University of Alberta. He has experience teaching in nearly all the health disciplines, and is an advocate of interprofessional and contextual learning. Dr Rayner's involvement will help
ensure broader faculty participation from Medicine and Dentistry, and provide guidance for implementation and sustainability of the project.

- **Dr. David Magee**, PhD, is a physical therapist and the Associate Dean of Professional Programs and Teaching in the Faculty of Rehabilitation Medicine, University of Alberta. He has clearly been a link between clinicians, students and the community. His role in this project will be to facilitate implementation of the theoretical models into practice.

- **Jelle van Ens**, Social Worker 2, Capital Health, Clip program, works in a city agency in mental health with a high prevalence of dual diagnosis patients. Often used as a clinical site for community placements, he supervises students from a wide variety of disciplines. Jelle clearly understands the importance of preceptorship from an interprofessional model and will help guide the development of a model, practical to a variety of community sites.

- **Dr. Rene Day**, Ph.D., Associate Dean (Executive and Partnership Development), Faculty of Nursing, University of Alberta, has had an extensive career in teaching, curriculum development, research on student learning, and student experiences in preceptored clinical courses and has been nationally recognized for her expertise in nursing education administration. Since the early 1990s, she has been involved in developing and implementing interprofessional educational opportunities for health science students at the University of Alberta.

- **Rosemarie Cunningham** retired from the Faculty of Medicine and Dentistry division of Medical Laboratory Science, University of Alberta. She continues to be active in the Interprofessional Initiative and with the Faculty of Medicine and Dentistry as a facilitator of small groups. Rosemarie will represent the clinical community interests in preceptorship.

- **Dr. Margaret Shim**, PhD, Practice Advisor of the Alberta Association of Registered Occupational Therapists has an extensive career working both as a clinician and academic. Her particular expertise is in cultural issues in health from studies and practice in Singapore, New Zealand and Canada. She will provide knowledge in practice issues around cultural competence in this project.

- **Garry Wheeler**, PhD, Executive Director of the Steadward Centre for Personal and Physical Achievement at the University of Alberta has an extensive career working both as an academic, clinician and researcher. His particular experience is working to develop interprofessional programs for Albertans with disability in order to enhance physical and mental well-being. Garry has developed interprofessional teams in this setting, and will contribute this knowledge to the team.

- **Donna and Rudy Cornet** have been consumers of the health care system on an ongoing basis. Donna lives with MS, and Rudy has experienced a head injury. They provide consumer input into courses offered by medicine, occupational therapy and human ecology at the University of Alberta. Always educating, they teach future clinicians from all disciplines the importance of working together and being client centred.

Additional members will be added as appropriate.
Co-chairs’ experience

*Katherine Stansfield*, RN, MN is the Director of Nursing Professional Resources (NPR) in the Calgary Health Region, with responsibility for nursing practice standards and professional development for more than 9000 nurses. The NPR has developed a preceptorship model for nursing with support for novice and experienced nursing preceptors. All of the policies developed within the NPR Department relating to nursing practice are developed in consultation with other professionals to identify areas of mutual concern or practice issues. Representatives from diverse health disciplines are part of the policy development working group. NPR also provides workshops for health practitioners in the Calgary Health Region focusing on scope of practice for nurses, which highlights the notion of overlapping scopes of practice with other disciplines under the current Health Professions.

Katherine is also part of the Regional Directors Advisory Committee. Within that committee, a standing agenda item is entitled “Developing Communities of Practice”. A different Director takes the lead each month to determine the topic of discussion related to an interprofessional practice issue; provides background on the topic and then chairs the discussion on various aspects of the topic from an interprofessional perspective. A recent example is a discussion focusing on primary health care. The goal is not necessarily to resolve an issue or even come to consensus but rather to gain a fuller and deeper understanding of the issue itself. Katherine’s experience with these Communities of Practice will be essential for providing direction for the development of interprofessional mentors, as culture, expectations and fears related to interprofessional preceptorship need to be explored from the views of all stakeholders.

Katherine’s previous work involved teaching and supervising nursing students at the undergraduate level and providing professional development in research and evaluation for nurses. In these capacities, and as a practicing clinical nurse and participant in interprofessional research projects, Katherine values the importance of interprofessional practice, as it forms the context within which all healthcare professionals practice. She welcomes this opportunity to build knowledge to enhance interprofessional collaboration and practice.

*Dr. Jane Drummond*, PhD, and *Wendy Hill*, RN, MN are sharing the second co-chair position. Dr. Jane Drummond is a professor at the Faculty of Nursing and current Acting Executive Director of the Health Science Council at the University of Alberta. She has been a nurse for 30 years. In her nursing practice she champions a capacity orientation where the strengths of children and families are emphasized and enhanced. She is the team leader of the Child and Family Resilience Research Program. That program of research takes a trans-disciplinary approach to knowledge generation and a multi-targeted approach to knowledge dissemination and uptake. The team is currently devising and testing approaches to enhance parenting in families with adolescent mothers. They are also engaged with the community in investigating the effectiveness of home visiting as a method of primary health care delivery.

Wendy Hill is Executive Nursing Officer and Chief Operating Officer for Community Hospitals and Regional Support Services for Capital Health in Edmonton, Alberta. Her Executive Nursing Officer responsibilities include identifying and acting on strategic priorities, policy development, impact analysis, workforce planning, response to legislation, and strengthening relationships with professional and educational nursing bodies. Wendy is a senior level health administrator with broad operational experience in acute and community care.
She is experienced in the planning, implementation and evaluation of health services and programming in a large health region of 29,000 employees. In her capacity as Chief Operating Officer, Wendy’s current portfolio includes six community hospitals and several regional support services departments including nutrition and food services, material management and patient information.

5. Project Description

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

Brief overview of project
This submission to Health Canada represents the launch of a voluntary collaborative dedicated to enhancing interprofessional health education and learning practice through a program of linked research initiatives and demonstration projects. The collaborative is comprised of about 30 researchers, practitioners, educators and administrators from across Alberta.

The project proposed here, the group’s first collective undertaking, involves collaborative research and program development in an important but understudied aspect of interprofessional training – lateral mentorship within Communities of Practice.

The project is derived from the need of both the Calgary Health Region and Capital Health to increase clinical capacity, establish greater links between health education and practice and respond more effectively to multicultural patient groups. Research has stressed the importance of collaborative, interprofessional teams as a way of optimizing health professionals’ skills and knowledge, thereby increasing capacity and efficiency. However, new graduates of health disciplines often lack collaboration and team skills. In addition, barriers to collaboration may exist at the organizational and practice levels.

This project proposes developing a Communities of Practice model to foster and support collaboration and interprofessional education. Traditionally, the mentor is an experienced practitioner who enters into a one-on-one relationship with a student for the purpose of advancing the student’s clinical experience and helping in the transition from training to practice environment. In this model, “Communities of Practice” will replace the individual mentor to allow shared lateral mentoring across disciplines. A group of health educators, researchers, students and practitioners will work together to identify and introduce the curricula and structural changes that support lateral mentorship in Communities of Practice. The new model will then be implemented and evaluated.

As outlined in Figure 1, the project will address five research questions or topics in three phases:

Research
1. What constitutes effective interprofessional lateral mentorship in Communities of Practice?
2. What competencies are required for multicultural Communities of Practice?
3. What are the contextual characteristics within education and practice environments that support effective interprofessional learning?

**Development and Implementation**

4. Create an interprofessional learning environment for students, faculty and practitioners through Communities of Practice

**Evaluation**

5. What are the impacts of interprofessional Communities of Practice on collaborative, patient-centred care?

**Figure 1. Proposed Research Project**

**Project Overview**

- **Research Phase**
  - Determine effective Communities of Practice models
  - Analyze competencies for multicultural Communities of Practice
  - Identify contextual factors supporting interprofessional learning

- **Development and Implementation Phase**
  - Develop and implement interprofessional Communities of Practice

- **Evaluation Phase**
  - Evaluate impact of Communities of Practice on collaborative, patient-centered care

**Evidence-Based Research**

Evidence from current research literature is presented to support the idea that interprofessional Communities of Practice can be used to develop and sustain collaborative patient-centered care.

**Need for Change**

Several trends are impacting the delivery of health care, including demographic changes, exploding health care costs, and actual and projected shortages in human resources. Health providers are being driven by an urgent need to address labour shortages, increase clinical capacity and optimize the use of staff expertise and skills. The way health services are delivered needs to be changed to meet patients’ needs and provide high quality services in an effective and timely manner (Bohmer & Edmonson, 2001).
Collaborative Teams as Solution
Health researchers have stressed the importance of collaborative teams as a way of optimizing the use of health professionals’ skills and knowledge (Mazankowski, 2001; Romanow, 2002; The National Academy of Science, 2000; Health Canada, 2004). The characteristics of a high functioning team include shared values and goals, diversity of skills and knowledge, mutual support and trust, effective conflict management and communication, interdependence, shared leadership, and mutual and individual accountability (Curry and Hollis, 2002). Self-managed, interprofessional teams are seen as a means of improving quality and reducing costs, staff turnover and absenteeism, while enhancing organizational adaptability and patient outcomes (Jones 2002, p. 2/3; Cashman et al, 2004, Horak et al, 2004; Robelin et al, 2002).

Barriers to Use of Collaborative Teams
The introduction and use of collaborative teams in the health care sector is complicated by several factors. First, collaboration requires a set of knowledge, skills and attitudes that are not necessarily being taught as part of the professional health education curriculum. Academic institutions have not kept pace with the demographic and social realities of health care. As a result, many employers believe that recent graduates do not meet the requirements of the new labour market (Chevannes, 2002). In particular, new graduates are seen to lack team problem-solving skills and the ability to communicate with diverse audiences (Jones, 2002, p11). This latter point is significant because patients are increasingly becoming more culturally diverse, and health care professionals must be able to demonstrate cultural competence in order to respond effectively (Arthur & Collins; in press; Brabeck, Walsh, Kenny & Comilang, 1997; Johnson, Steward, Brabeck, Huber and Rubin, 2004). Moreover, professionals need to learn how to leverage the advantage of cultural diversity within health care teams.

Second, cultural competence likewise requires a specific set of knowledge and practice skills, including self-awareness (Norr et al, 2003; Ramirez, 2003). However, the influence of culture on practice is only beginning to be recognized, and the way in which culture intersects with interprofessional education and practice has received little attention to date (Purden, 2004). Consequently, cultural competence is missing from the curricula of many health education programs.

Third, many barriers to collaborative team care have been identified at the organizational and environmental levels, including a lack of organization support and resources, counter-effective policies and procedures, or educational and professional systems that are not conducive to collaborative patient care (Curran, 2004). If service delivery by a collaborative team is to be effective and efficient, health care and educational organizations must adapt and adopt the infrastructure and systems necessary to support and sustain that approach (Drinka & Clark, 2000). In the absence of such structures, professionals are likely to revert to the traditional models of parallel practice (Cashman et al, 2004).

Health Care Setting as Learning Organization
Clearly, the changes required in the health care sector can only come about through reform of health education curricula and adjustments to the practice environment. The concept of the learning organization may be helpful in bringing about the adaptations needed to support collaboration. A learning organization is defined as the intentional use of learning processes at
the individual, group and system levels to continuously transform the organization in a direction that is more satisfying to its stakeholders (Dixon, 1994).

The focus is on collective learning – the knowledge, expertise and skills held collectively and in common by a number of people who work together to achieve a certain task. Learning organizations must demonstrate specific cultural and structural elements that facilitate and support team learning. The organization’s culture must be able to tolerate mistakes, encourage measured risk, foster trust among team members and recognize tacit knowledge as an important source of learning. Flattened hierarchies that foster teamwork, promote open communication and offer incentives for learning are also essential. Learning must be encouraged and acknowledged as an inherent part of every day practice.

Evidence is growing that the concept of a learning organization can work in health care provided that places and structures can be created where shared learning can occur (Rushmer et al., 2004a, b, c; Elwyn & Hailey, 2004; Bohmer & Edmonson, 2001). This may be done by offering staff protected time to learn and think reflectively, for example through informal work shadowing and mentoring (Elwyn & Hailey, 2004).

The Changing Face of Preceptorship

Preceptorship is a traditional way of combining learning and on-site practice, and there is a wealth of evidence to support the contribution of the preceptor in the education of health professionals. Preceptorship is typically characterized by a one-on-one relationship between an experienced practitioner and a novice that has been established to support the student's transition from classroom to workplace (Goldenberg, 1987). The preceptor’s role is seen as particularly important in providing opportunities for mentees to be active in decision-making and patient care delivery, and offering constructive feedback (Epstein et al., 1998). Positive outcomes attributed to preceptorship include support for the student, socialization, increased awareness of professional accountability and collegiality in the workplace (Morton-Cooper & Palmer, 2000). Students report increased confidence, more effective feedback on performance and decreased stress levels after a positive preceptorship (Morton-Cooper & Palmer, 2000).

Nevertheless, there are issues with traditional preceptorship. Recruiting qualified preceptors in clinical settings has become increasingly difficult, which limits the clinical placement sites available to health students. Preceptorship is perceived as burdensome and stressful by many health professionals, as it typically adds to their normal workload and puts them at risk of burnout (Speers et al., 2004; Yonge, Ferguson, Myrick & Haase, 2003; Lee, 1997). In addition, preceptors find it difficult to manage the conflicting roles and responsibilities they need to fulfill (Atkins & Williams, 1995). In a study by Allen and Simpson (2000), preceptors experienced tension between their workloads, the time available for their tasks and the expectations placed upon them.

Changes in the healthcare environment also have implications for preceptorship. For example, collaboration and team learning is not intrinsic to this approach. The relationship is vertical in nature and goal-oriented, with the expert guiding the student in practice and providing answers to questions. As organizations start to embrace teamwork and the idea of professionals learning from each other in the clinical environment, the role of the preceptor needs to be revisited.
(Hughes et al, 2004). The traditional relationship between preceptor and novice needs to be replaced with a "flatter" structure, in order to enable the type of workplace learning envisioned by organizations.

**Lateral Mentorship in Communities of Practice**
A new concept of preceptorship has evolved called “lateral mentoring” (Polin et al, 2001). Lateral mentoring is a group process that de-emphasizes hierarchies and occurs within a Community of Practice, which brings people together to work collaboratively towards a common goal (Wenger, 1998).

To function effectively, a Community of Practice needs commitment and a shared set of ideas. Members build relationships over time, eventually developing resources, such as tools, documents, or routines, and innovative ways of practice (Wenger, 1998). Participation is central to success, as it fosters a sense of mutual trust and interdependency, two factors essential for effective teams and communities (Curry & Hollis, 2002; Wenger, McDermott, Snyder, 2002). All members have the opportunity and responsibility to learn from and teach each other (Polin et al, 2001). Responsibilities for mentoring are shared by the group, and novice practitioners often serve as mentors for each other (Polin et al, 2001).

In addition to in-person meetings, Communities of Practice use multiple, often newer, methods of communication and learning, such as threaded discussions using online media, narratives, personal learning projects and reflective practices (Wenger, 1998). Learning is contextual. Lateral mentoring in Communities of Practice is served best by approaches that challenge underlying assumptions and values, promote shared learning and encourage a team culture.

Communities of Practice in health care have recently received attention through work conducted at the US Veterans Administration. The Veterans Administration’s Water Cooler Logic project systematically reinvents the way people think, decide, and work and learn together in communities of practice. The pilot project, which has received international acclaim, can be viewed at http://www.cme.umontreal.ca/copMultiCenter/. In the past six months, projects have also been initiated in Ontario (in Mental Health, Cancer) and Australia (Emergency Medicine). A pilot project to study information exchange among Community of Practice members is currently underway at the Canmore Hospital, Alberta. Titled, “A knowledge brokering model for rural health care decision makers,” the project is designed to make a difference to patient safety and quality of care.

These projects have led in the search for innovative ways to facilitate practice-based learning. By moving away from the traditional approach of experts delivering content in the classroom, the Community of Practice is consistent with the vision of workplace learning for professionals using online courses, traineeships and a range of other appropriate resources.

**Communities of Practice and Interprofessional Education**
The concept of Communities of Practice lends itself well to interprofessional practice-based education. Members of a Community of Practice may include health practitioners, students, and faculty from across health disciplines, all with the shared goal of improving patient outcomes.
Besides having the potential to address many of the issues associated with traditional preceptorship, Communities of Practice offers its own advantages, for example (Polin et al, 2001, Wenger, 1998):

- The shared responsibility of mentors within Communities of Practice eliminates the burden of responsibility for a single mentor. Since all members of the community work towards the same goal and share the responsibilities for problem solving, there is a broader base of experience and responsibility.

- The sharing of leadership and responsibilities addresses concerns of workload management, which has been a serious impediment to the recruitment and retention of traditional preceptors. Consequently, health professionals may perceive participation in Communities of Practice as less burdensome, which may result in a larger pool of mentors.

- By participating in an interprofessional Community of Practice, members learn from each other. This contributes to personal and professional development and is consistent with the concept of learning organizations. A Community of Practice can also empower students and new professionals by recognizing them as full members of the team – recognition that builds novices’ confidence in providing interprofessional team care (Berwick, 2003).

- A sense of team is fostered when all members are involved and their contributions acknowledged. The trust and interdependency that result will help to cross professional boundaries and eliminate turf protection (Boreham, 2004).

- An interprofessional Community of Practice allows more people to be mentored with fewer resources. Sharing responsibilities increases flexibility for all team members and allows the team to operate with fewer mentors.

- Integrating faculty members into the Community of Practice will give health practitioners access to support and expertise as needed. It will also improve the alignment between practice and education, thereby helping to equip students for the changing demands of the workplace.

- The flexible structure of Communities of Practice, where members can join and leave as needs change, offers an ideal format for ongoing learning in the workplace. Encouraging wide and continued participation, including beyond the official end of the student mentorship, will foster the acceptance of Community of Practice structures as essential components of organizational learning.

*Fit with D’Amour and Oandasan Framework*

The concept of Communities of Practice fits well with the framework on interdisciplinary education for collaborative patient centred care developed by D’Amour and Oandasan (2004).
The Communities of Practice proposed here:

- Can form a bridge between interprofessional education and practice and serve as the medium through which learners enter the professional system.
- Focuses on processes and contextual learning in the work place, thereby supporting the importance of practice settings in modeling interprofessional collaboration.
- Takes into account micro, meso and macro contextual factors that significantly impact (facilitate or impede) interprofessional education and practice.
- Makes learners central to the interprofessional education process and places patients at the centre of collaborative care.
- Includes cultural diversity and socio-cultural competencies that have been recognized as important factors for interprofessional education and practice.
- Recognizes the need for additional research and evaluation within the quantitative and qualitative domains to inform the teaching environment and help trainees become competent collaborative practitioners.

**A New Vision for the Clinical Workplace**

In summary, considering the changing requirements in education and clinical practice, there is a need to create interprofessional learning environments and training programs that are different from the past. The concept of Communities of Practice seems to have promise for interprofessional education and practice and deserves further exploration. According to Wenger et al (2002), learning and practice cannot be separated when professionals work in Communities of Practice – and this is its strong advantage. While there will always be a need to learn from experts, research indicates that practical or “tacit” knowledge (Eraut, 1992) and “practical wisdom” (Coles, 2000) are as important as specialized knowledge in patient-centered care delivery systems (Brigley et al, 1997). Any new model has to recognize informal modes of learning between co-workers (Marsick & Watson 1990), the value of the knowledge embedded in our own practice (Schon, 1978), and the empowering nature of learning. One of the objectives of change is to foster an environment where health professionals become “citizens in the improvement of their own work.” Creating interprofessional learning environments through Communities of Practice can support this goal and ensure that collective knowledge and competencies can be created and applied.

**Context**

Healthcare providers in the Calgary and Capital Health Regions are being driven by an urgent need for change – to address labour shortages, respond more effectively to multicultural patient groups, increase clinical capacity, and optimize the use of staff expertise. Health education holds the promise of being a catalyst for change, provided it is linked to practice and applied research so as to create a learning environment that facilitates collaboration, knowledge transfer and innovative thinking. Now a unique opportunity has come about in Alberta for health educators, practitioners and others to work together to determine how to achieve the required changes in the most effective ways.

The Calgary Health Region has committed to the development of a new hospital at the south end of the city, situated within a larger South Health Campus. Stakeholders from the Calgary Health
Region, Bow Valley College, SAIT, Mount Royal College, and the University of Calgary have come together regarding the development of a health education complex, the Health Learning Institute (HLI), to be located on the South Health Campus. The HLI will be designed to foster collaboration between educators, health providers, researchers and other stakeholders in healthcare. It will provide resources and education using a variety of learning settings – classrooms, lecture theatres, laboratories, patient care clinics, simulation centre – to a full range of disciplines from the partner institutions. A collaborative network of some 30 researchers, practitioners, educators and administrators from across Alberta will conduct research initiatives and demonstration projects to support the planning and visioning of the HLI. The collaborative has been meeting since June 2004 to identify research needs and priority projects. An investigative group has been formed to submit this proposal and conduct the activities described here. Several members of the group are also on the Steering Committee for the HLI, ensuring that the vision of the HLI and the research activities are aligned.

The University of Alberta, an important partner in this project, is in a unique situation to address the demands of educating health professionals in an interdisciplinary approach. Through its six health science faculties, the University of Alberta offers a total of fourteen health science programs, one of a small number of Canadian universities that offers such a wide spectrum. Since the 1990s, the University of Alberta has responded to external and internal demand by developing interdisciplinary educational opportunities for health science students. This led to the creation of the InterProfessional Initiative (IPI), the mission of which is to offer interprofessional experiences to health science students so that graduates of the University demonstrate exemplary behaviour, as health team members, in the provision of health services and in health promotion. In addition, a partnership between Capital Health and the University of Alberta to develop the new Health Sciences Ambulatory Learning Centre (HSALC) has created a unique opportunity to integrate patient-centred clinic care, education and research in an interdisciplinary model.

**External Drivers**

The project is being driven by changes in the demographic make-up of the Canadian population, labour shortages, gaps in the practice skills of health care professionals, and the need to find ways of employing limited resources more effectively, for example, through collaboration, interprofessional training and the transfer of knowledge.

**Internal Drivers**

The internal drivers include the opportunity to build on the advantages presented by the Health Learning Institute and the collaborative network, the desire to enhance practice and the commitment to use research to generate outputs that will benefit the healthcare system of the future. Stakeholders agree that new outputs can only be achieved by drastically changing the ways health professionals are educated and the way they practice.

**Opportunities**

As centres for innovation, the Health Learning Institute in Calgary and the InterProfessional Initiative as part of the Health Science Council in Edmonton, will create opportunities to conduct research and design models of education and practice that contribute to the best outcomes for learner and patient populations across the province. These outcomes are expected to include:
• For patients, increased safety by way of enhanced communication and collaboration between health care workers;
• For health care workers, greater confidence and ability to practice in an interprofessional and diverse environment, enhanced professional development, and higher job satisfaction;
• For educators, expansion of education programs with new results (teamwork, simulation centre), best-practice models being shared across disciplines;
• For the evolution of practice, interprofessional development activities and teaching clinics that combine education and practice;
• For healthcare provider systems (i.e., hospitals, clinics), innovation in workforce planning, education and care delivery, greater workforce effectiveness, safer environments and higher rates of recruitment and retention.

Contribution to Change
The project will support the development of competent professionals to enhance patient outcomes. The three parts of the Research phase (A-C) will facilitate discussions of discipline specific and interdisciplinary competencies and educational needs among stakeholders across disciplines, thereby creating a culture of trust and mutual understanding. This will open the way for interprofessional thinking and the envisioning of alternative interprofessional models for health student education and clinical practice. The project will also prepare a cohort of mentors, faculty, and students with the competencies to facilitate interprofessional education for collaborative patient-centred care and advocate for cultural changes in education and practice. It is anticipated that the learning communities formed will exist beyond the duration of the project, thereby contributing to the ongoing development of interprofessional competencies as well as an interprofessional culture.

Barriers and Challenges to Implementation
Potential barriers to the implementation of the project include current policies that support ‘unidisciplinary’ education; for example, the rotation of residents may impede access to sites that could, in principle, facilitate interprofessional education. Also, regulations with respect to the number and timing of student placements may affect whether students from more than one discipline can be present in the facility at the same time. Highly conservative interpretations of regulatory legislation, staff perceptions of their scope of practice, and concerns about patient safety and professional liability may impede both interprofessional education and collaborative practice. In addition to regulatory bodies, unions and other bodies may resist the changing work models and role functions that could emerge as a result of this project.

These challenges and potential barriers can be overcome by engaging stakeholders in discussions about the purposes of the project, by drawing on local expert opinion to resolve questions concerning scope of practice issues, and by involving stakeholders in shaping the implementation of the project. Throughout the project the investigative group will be sensitive to local requirements and concerns without altering the objectives and integrity of the project. In addition, the strategic direction of universities is to seek strategies to foster interprofessional education and practice and to develop strong clinical placements for students.
The involvement of students, faculty, health organizations and other decision makers in the planning, development and the implementation of the project will increase commitment to the process and products of these innovations.

**Primary Target Audience**

The target audiences are students, educators, health professionals in practice, leaders and decision makers in education, practice and regulatory bodies, and of course the patient who is the recipient of care.

**Process for Integrating Learning**

University, college and health agency educators have been and will continue to be involved in the development and implementation of this project. This will ensure a high degree of ownership, which will facilitate the integration of learning into educational curricula and practice settings.

The learning experiences of students, staff and mentors will be enhanced through the project, which will further encourage change within educational institutions and practice settings. The learning can be integrated in a number of ways: as threads in curricula (theory and clinical), as orientation for professionals, and by being built into continuing education activities. Working together on this project will build partners’ capacity for collaboration, which will foster an interest in taking on future projects that might emerge, such as joint curriculum development initiatives. The collaborative nature of the project and the rapport and good will established throughout will ensure that any changes that emerge are adopted in practice settings as well as educational institutions.

**6. Project Objectives**

**Overall Goal of the Project**

The goal of the project is to develop, implement and evaluate interprofessional Communities of Practice designed to foster interprofessional learning and collaborative patient-centred care. The Communities of Practice will be developed using research findings from existing Communities of Practice, the competencies required to work effectively in and with multi-culturally diverse teams and patient populations, and the contextual factors that impede or facilitate interprofessional collaboration.

**Specific Objectives**

The project objectives are:

**Research Phase:**

1. **Part A:**
   - To identify the attributes of effective Communities of Practice from the patient, mentor, student and faculty perspective
   - To develop a conceptual model of interprofessional Communities of Practice
Part B: To analyze existing curriculum models and practices in health care disciplines that support the development of cultural competencies
To identify professional education needs of students, practitioners and faculty to work effectively in culturally diverse contexts
To design a framework for inclusion of cultural competencies in interprofessional Communities of Practice

Part C: To identify contextual factors in education and practice that facilitate or impede interprofessional learning
To develop strategies for working effectively within interprofessional Communities of Practice given existing contextual factors

Development and Implementation Phase:

To develop and implement an interprofessional Communities of Practice model including health practitioners, faculty and students based on best practice and education principles, and the findings from research parts A, B and C.

Evaluation Phase: To evaluate the impact of interprofessional Communities of Practice on collaborative patient-centred care from a patient, health practitioner, faculty and student perspective.

**Relation to Health Canada Objectives**

The proposed project addresses all five of Health Canada’s objectives.

By involving health practitioners, educators, students and patients, the inquiry-based learning methods employed in Parts A-C will stimulate networking and the sharing of best approaches to interprofessional education and practice (Health Canada objective 2).

By identifying the contextual barriers and facilitators and cultural competency requirements for successful collaboration, Parts A-C will also help to facilitate interprofessional collaboration in both education and practice (Health Canada objective 5).

The Communities of Practice that are developed and implemented will increase the number of practitioners and students trained to provide collaborative patient-centred care (Health Canada objective 3).

They will also increase the number of educators prepared to teach from a multicultural, interprofessional patient centred perspective (Health Canada objective 4).

The evaluation of the impact of the Communities of Practice and the dissemination of the results will help to demonstrate and promote the benefits of interprofessional education on patient-centred care to patients, educators, students and practitioners (Health Canada objective 1).
7. Work Plan and Timelines

A detailed work plan reflecting the project objectives is provided on the following pages. The plan outlines the activities, timelines, measurements and outcomes for each phase of the project and identifies the team responsible. Three separate teams that are working closely together are responsible for conducting Parts A, B and C of the research. All research is timed to begin and conclude between May 1, 2005 and April 30, 2006. Development and implementation will begin in January 2006, using findings from the research. Pilot testing of the Communities of Practice will take place beginning September 1, 2006. The evaluation of the project will be concluded by November 30, 2007.
Research Phase

Table 1. Part A: What constitutes effective interprofessional lateral mentorship in Communities of Practice?

<table>
<thead>
<tr>
<th>Activities</th>
<th>Timelines</th>
<th>Measurements</th>
<th>Responsibility</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Project preparation, hiring staff</td>
<td>May 1/05 – June 30/05</td>
<td>Staff hired</td>
<td>Team A: members from Calgary and Edmonton under lead of Liz Taylor; hired project staff will conduct literature review and stakeholder interviews</td>
<td>Understanding of key elements that constitute effective interprofessional mentorship in Communities of Practice</td>
</tr>
<tr>
<td>Conduct key stakeholder interviews and focus groups to identify key concepts and analyze data</td>
<td>July 1/05 – February 28/06</td>
<td>Interview transcripts, narratives</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Review the literature for existing frameworks and models on preceptorship and Communities of Practice</td>
<td>July 1/05 – Feb 28/06</td>
<td>Documents summarizing results of literature review</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Integrate key concepts from interviews with frameworks in the literature</td>
<td>January 1/06 – March 31/06</td>
<td>Documents outlining the conceptual framework</td>
<td></td>
<td></td>
</tr>
<tr>
<td>First draft of conceptual model for interprofessional lateral mentorship in Communities of Practice</td>
<td>January 1/06 – April 30/06</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Knowledge transfer, attendance at conferences; project website</td>
<td>June 1/05 - April 30/06</td>
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</tbody>
</table>

Table 2. Part B: What competencies are required for multicultural Communities of Practice?

<table>
<thead>
<tr>
<th>Activities</th>
<th>Timelines</th>
<th>Measurements</th>
<th>Responsibility</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Project preparation, hiring staff</td>
<td>May 1/05 – June 30/05</td>
<td>Staff hired</td>
<td>Team B: members from Calgary and Edmonton under lead of Nancy Arthur</td>
<td>Better understanding of competencies required to practice in culturally diverse settings</td>
</tr>
<tr>
<td>Conduct key stakeholder interviews and focus groups to identify key concepts and education needs and analyze data</td>
<td>July 1/05 – February 28/06</td>
<td>Interview transcripts, narratives</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Review of existing curriculum</td>
<td>July 1/05 – February 28/06</td>
<td>Curriculum outlines, best practice guidelines and procedures</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Review of best practices</td>
<td>July 1/05 – February 28/06</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Review existing frameworks and models on cultural competencies in the literature</td>
<td>July 1/05 – February 28/06</td>
<td>Literature review of multicultural frameworks</td>
<td></td>
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</table>

Calgary Health Region
Integrate interview data and curriculum information with frameworks in the literature
Implement cultural competencies framework into conceptual model for interprofessional lateral mentorship in Communities of Practice
Knowledge transfer, attendance at conferences, project website

<table>
<thead>
<tr>
<th>Activities</th>
<th>Timelines</th>
<th>Measurements</th>
<th>Responsibility</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Project preparation, hiring staff</td>
<td>May 1/05 – June 30/05</td>
<td>Staff hired</td>
<td>Team C: members from Calgary and Edmonton under lead of Esther Suter</td>
<td>Increased understanding of contextual barriers and facilitators that affect effective collaborative learning and practice</td>
</tr>
<tr>
<td>Conduct key stakeholder interviews and focus groups to identify key concepts and analyze data</td>
<td>July 1/05 – February 28/06</td>
<td>Interview transcripts, narratives</td>
<td>Results will be discussed with the investigative group and Steering Committee to create conceptual model</td>
<td>Strategies and solutions that help to address key contextual factors and can be incorporated into the overall Communities of Practice framework developed from Part A</td>
</tr>
<tr>
<td>Review the literature regarding contextual facilitators and barriers to collaborative practice and learning in Communities of Practice</td>
<td>July 1/05 – Feb 28/06</td>
<td>Documents summarizing results of literature review</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Develop strategies and pragmatic solutions about how to work with contextual factors</td>
<td>January 1/06 – March 31/06</td>
<td>Document outlining strategies and solutions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Incorporate strategies and solutions into conceptual model for interprofessional lateral mentorship in Communities of Practice</td>
<td>January 1/06 – April 30/06</td>
<td>Documents outlining the conceptual framework</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Knowledge transfer, attendance at conferences, project website</td>
<td>June 1/05 - April 30/06</td>
<td></td>
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</table>

Table 3. Part C: What are the contextual characteristics within education and practice environments that support effective interprofessional learning?
### Development and Implementation Phase

#### Table 4. Create an interprofessional learning environment for students, faculty and practitioners through Communities of Practice

<table>
<thead>
<tr>
<th>Activities</th>
<th>Timelines</th>
<th>Measurements</th>
<th>Responsibility</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review of best practice and education principles</td>
<td>Jan 1/06 – March 31/06</td>
<td>Outline of learning curriculum, strategies, vignettes and other learning materials</td>
<td>Development Team with members from Calgary and Edmonton under lead of Michael Clinton</td>
<td>Interprofessional learning environment within Communities of Practice that fosters lateral interprofessional mentorship</td>
</tr>
<tr>
<td>Development of learning environment (content and processes) for interprofessional mentorship in Communities of Practice</td>
<td>April 1/06 – July 31/06</td>
<td>Documentation of established communication medias/strategies (e.g. website, meeting schedules etc)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Work with partner organizations to recruit participants (students, faculty, health professionals) for first 3 Communities of Practice</td>
<td>July 1/06 – August 31/06</td>
<td>Team member lists for Communities of Practice</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recruit and train facilitators for Communities of Practice</td>
<td>July 1/06 – August 31/06</td>
<td>3 hired facilitators</td>
<td>Steering Committee members will be consulted regularly to verify conceptual framework and Communities of Practice educational components</td>
<td></td>
</tr>
<tr>
<td>Pilot testing of Communities of Practice learning program with first three teams – Cohort 1</td>
<td>September 1/06 – December 31/06</td>
<td>Documented Communities of Practice activities such as meeting notes, documented learning problems, threaded online discussions etc.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Work with partner organizations to recruit participants for second 3 Communities of Practice</td>
<td>October 1/06 – Nov 30/06</td>
<td>Final report; manuscript preparation</td>
<td>Development team will work with partner organizations to recruit faculty, students and health providers for pilot testing</td>
<td></td>
</tr>
<tr>
<td>Pilot testing of Communities of Practice learning program with second three teams – Cohort 2</td>
<td>January 1/07 – April 30/07</td>
<td>Final reports and manuscripts</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Revise learning program (content and processes) based on participant feedback</td>
<td>September 1/07 – Jan 31/08</td>
<td>Documentation of revised learning program/curriculum</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Final report; manuscript preparation</td>
<td>September 1/07 – Jan 31/08</td>
<td>Final reports and manuscripts</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Knowledge transfer, attendance at conferences and invitational workshops</td>
<td>Jan 1/06 – Jan 31/08</td>
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</table>
### Evaluation Phase

#### Table 5. What are the impacts of Communities of Practice on collaborative, patient-centred care?

<table>
<thead>
<tr>
<th>Activities</th>
<th>Timelines</th>
<th>Measurements</th>
<th>Responsibility</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recruit evaluation consultant</td>
<td>April 1/06</td>
<td></td>
<td>Steering committee</td>
<td>Committee</td>
</tr>
<tr>
<td>Develop measurement instruments and tools</td>
<td>May 1/06 – Aug 30/06</td>
<td></td>
<td>External consultant in collaboration with an evaluation team with members from</td>
<td>Evaluation tools</td>
</tr>
<tr>
<td>Complete baseline assessment with each Community of Practice with data</td>
<td>Sept 1/06 – Sept 15/06 and Jan 3/07 – Jan 18/07</td>
<td>Assessment tools for stakeholder attitudes skills and behavior change</td>
<td>Calgary and Edmonton</td>
<td>Projects make program adjustments or improvements as required</td>
</tr>
<tr>
<td>Conduct process evaluation with each Community of Practice to determine if</td>
<td>Oct 15/06 – Nov 15/06 and Feb 15/07 – Mar 15/07</td>
<td>Interview transcripts, narratives</td>
<td>Evaluation results will be discussed with evaluation team and Steering Committee to make program changes as appropriate and address emerging issues</td>
<td>Documented impact of lateral mentorship within Communities of Practice on students, mentors, faculty and patients</td>
</tr>
<tr>
<td>Complete outcome or impact assessment for each Community of Practice based</td>
<td>Dec 15/06 to Dec 20/06 and April 15/07 – April 29/07</td>
<td>Assessment tools for stakeholder attitudes skills and behavior change, and for team functioning</td>
<td></td>
<td>Increased understanding of how contextual factors and team components affect success or failure of Communities of Practice</td>
</tr>
<tr>
<td>Complete long term impact assessment</td>
<td>Completed by Nov 30/07</td>
<td></td>
<td></td>
<td>Revised concept of interprofessional lateral mentorship within Communities of Practice that can be adopted by larger audience</td>
</tr>
<tr>
<td>Distribute evaluation reports following baseline, process evaluation and</td>
<td>April 1/06 – Nov 30/07</td>
<td></td>
<td></td>
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<tr>
<td>outcome evaluation assessments; produce overall evaluation report</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Knowledge transfer, attendance at conferences and invitational workshops</td>
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Project Procedures

Research Phase

Data collection: Research teams representing different disciplines and paradigms of thought will collect and analyze the data. Focus group and individual interviews will be used to capture the perceptions and points of views of multiple stakeholders. Open ended questions and prompts will guide the discussions and interviews. Data collection and analysis will occur simultaneously and iteratively, with earlier collection and analysis informing future data collection. Focus groups and interviews will be complemented by observation to understand how the concepts of interprofessional preceptorship are operationalized within the sites.

Data analysis: Focus group and interview transcripts will be coded for themes. The themes will be identified and categorized by two independent researchers, and differences in interpretation reconciled. Discourse analysis of the data will examine the use of language and how it reflects interprofessional preceptorship in education and practice, and the characteristics that construct and perpetuate preceptorship practices. This will allow capturing contextual and cultural facilitators and barriers inherent in the predominant organizational discourses (e.g., how professional attitude or organizational culture is reflected in the language of faculty and sessional instructors).

Vignettes will be constructed from critical incidents and narratives emerging from the focus groups and interviews. The vignettes will help to understand the cultural and contextual factors (interactional, organizational, and system levels) that shape practice. Vignettes will be presented to focus groups of patients, students, preceptors, faculty, and system administrators for the purposes of verifying the barriers and facilitators identified and initiating further discussion. The responses and discussions are the starting point for developing strategies to overcome cultural and contextual barriers or to leverage facilitating factors to promote interprofessional preceptorship and collaborative patient care.

Several steps will be taken to establish trustworthiness of the data:

- analytic triangulation (i.e., data coding by two independent researchers to reduce bias);
- member checking (i.e., themes from focus groups/interviews reviewed by selected participants);
- audit trail (i.e., data collection and analysis processes documented to facilitate reproducibility and verification of the findings); and
- reflexivity (i.e., the researchers adopt a self-critical attitude on how preconception may bias their observations and interpretations).

Data from all three parts of the research will be integrated to develop a comprehensive framework of interprofessional mentorship in Communities of Practice and to inform the development of quantitative assessment tools.

Subjects: Participants for the research will be drawn from patients, health practitioners, students and faculty. Students and faculty members will be recruited from all partner organizations and across disciplines that include nursing, social work, pharmacy, dentistry, medicine and others. To maximize learning, health practitioners and patients will be recruited from three different types of practice settings:
1. Those that have already functioning interprofessional teams e.g., Bone and Joint group (Calgary Health Region); Mental Health (Boyle Street Coop in Edmonton), Palliative Care (Grey Nuns in Edmonton), Acute Care (e.g. Compu at the Misericordia in Edmonton, Ward 21C Calgary); Long Term Care (e.g. Lynnwood in Edmonton); rural (Okotoks, Canmore Hospital) or North East Health Unit, which serves a special needs population.

2. Practice settings with no history of or developing interprofessional teams; and

3. Settings with high diversity in health care teams and/or patient populations.

Sampling will be based on the needs of the study and the themes that evolve and will continue until no new themes emerge. It is anticipated that about 10-15 focus groups of 3-10 participants each and 10-15 interviews will be conducted for each of the three parts of the research phase. All participants will be required to provide informed consent before participation in the project.

The focus group and interview topics addressed in the research phase are outlined by Part below:

Table 6. Focus group and interview topics

<table>
<thead>
<tr>
<th>Subjects</th>
<th>Potential Topics of Focus</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Part A</strong> Effective interprofessional mentorship</td>
<td></td>
</tr>
<tr>
<td>Patients</td>
<td>• Experiences with team care and with student-mentor care teams and how these affected patient care</td>
</tr>
<tr>
<td></td>
<td>• Examples of effective or ineffective interprofessional care and mentor-student relationships</td>
</tr>
<tr>
<td>Students and health practitioners</td>
<td>• Definition of interprofessional mentorship and Communities of Practice</td>
</tr>
<tr>
<td></td>
<td>• Experiences with/ expectations of interprofessional mentorship and Communities of Practice (roles, responsibilities, the student-mentor relationship and interactions)</td>
</tr>
<tr>
<td></td>
<td>• Examples (positive and negative) of how teams affect patient care</td>
</tr>
<tr>
<td></td>
<td>• Preparation needed for interprofessional learning and lateral mentoring in Communities of Practice</td>
</tr>
<tr>
<td>Faculty</td>
<td>• Definition of interprofessional mentorship and Communities of Practice</td>
</tr>
<tr>
<td></td>
<td>• Preparation needed for interprofessional learning and lateral mentoring in Communities of Practice</td>
</tr>
<tr>
<td></td>
<td>• Supports necessary to create interprofessional Communities of Practice</td>
</tr>
<tr>
<td></td>
<td>• Critical incidents in interprofessional mentorship</td>
</tr>
<tr>
<td>Managers, supervisors, administrators in sites using interprofessional teams</td>
<td>• Factors that contribute to the success of these teams</td>
</tr>
<tr>
<td></td>
<td>• Impact on patient care and the organization itself</td>
</tr>
</tbody>
</table>
### Part B: Multicultural competencies

**Patients**
- Cultural competencies of an interprofessional team important for patients’ health care

**Students and health practitioners**
- Cultural competencies needed for working effectively on interprofessional health care teams or with diverse populations
- How mentor’s role can facilitate cultural competence
- How practice-based learning and lateral mentoring in Communities of Practice can facilitate cultural competence

**Faculty responsible for interprofessional and/or multicultural education**
- Barriers to multiculturally competent practice
- How curricula support students for future roles on interprofessional and diverse teams and with diverse patient populations
- Barriers and enablers for integrating interprofessional and multicultural content into curricula
- How educational programming can improve cultural competence during interprofessional lateral mentorship in Communities of Practice
- Critical incidents in interprofessional and/or multicultural learning

### Part C: Contextual characteristics

**All cited above**
- Experiences with mentorship and Communities of Practice at an interactional level (e.g. team composition and dynamics, leadership, professionalization)
- Organizational level (e.g. organizational culture and support, regulations and procedures)
- System level (regulatory barriers, professional and educational system) level
- Facilitators and barriers to implementation of Communities of Practice within education and practice settings

### Additional Research Step

All three parts of the research phase will follow the procedures outlined above. In addition, the following specific procedures will be used for Part B.

**Curriculum review:** Course outlines pertaining to professional education for interprofessional and multicultural topics will be collected and reviewed. A content analysis of themes will be conducted to examine dominant content and teaching and learning processes in individual discipline and interdisciplinary curricula. Results will be compared against recommendations derived from theoretical sources of literature and integrated with data from stakeholder interviews to develop a conceptual framework of cultural competencies in multicultural and interprofessional education and practice.
Particular focus will be paid to the three domains self-awareness, knowledge, and skills. It is generally accepted that professionals’ awareness of own assumptions, values, and biases is a foundation for the development of competencies in other domains. The knowledge domain refers to understanding the worldview of individuals with culturally diverse backgrounds. In order to work effectively across cultures, health practitioners require skills in developing appropriate interventions strategies and techniques. In recognition that professional practice occurs in cultural contexts, a fourth domain will be added: multicultural organizational competencies. These refer to an organization’s structures, policies, and practices that influence the delivery of health care to patients from culturally diverse backgrounds. As practitioners improve their multicultural expertise, they are better positioned to promote organizational competencies that benefit all.

**Development and Implementation Phase**

**Development**

The investigative group (described under Project Leads) will oversee the development of practice-based learning strategies to be used within the Communities of Practice. Patients will be consulted as appropriate.

The educational objectives for the Communities of Practice will focus on creating an interprofessional learning environment for students, faculty and health practitioners that fosters collaborative team care. Specifically, the learning environment will be designed to promote the critical competencies identified in the research phase A, B and C and the resulting conceptual framework. In addition to specialist knowledge and traditional procedural skills, it is anticipated that the research will show a need for “softer” competencies. These include improvisation, experimentation, respect for practice wisdom and clinical judgment, and practice reflection. Particular focus will be paid to the multicultural competencies of self-awareness, knowledge, and skills and the multicultural organizational competencies identified in Part B of the research phase.

Methods grounded in best practice and education principles will be used to design the learning environment. Learning will be contextual and include discussion of professional and interprofessional identity, and communication of shared goals for patient care. Examples may include system analysis of patient care issues such as how to share and examine errors and near misses, and how to deal with unknowns. It is envisioned that the Community of Practice will use learning activities that specifically foster the softer skills discussed above. Approaches such as narratives, journaling, vignettes and simulations, threaded discussions, personal learning projects, and other reflective practices that enable both personal and professional development will be considered. Communication and learning strategies that remove hierarchies, challenge underlying assumptions and values, promote shared learning and encourage a team culture will be employed using face-to-face meetings and innovative online resources. (These interventions are currently being piloted in the project in Canmore, Alberta described earlier.)

Reporting structures will be developed and educational objectives for the Communities of Practice will be detailed in the following areas:
1. **Individual learning**: interprofessional knowledge, skills and competencies acquired by participants. It is anticipated that participants will demonstrate shifts in attitudes and behaviours as they related to views of collaborative care within a multicultural context.

2. **Community of Practice functioning and learning**: including cohesiveness, ownership and identity with the Community of Practice, satisfaction with the process of learning from practice and from other members and with the opportunities for professional development. The focus is on group processes. Participants are expected to demonstrate team behaviours that promote effectiveness and success of the Community of Practice.

3. **Organizational learning**: Participants will report how their participation in the Community of Practice (i.e. group discussions, personal learning projects) has resulted in some specific changes in policies, procedures, practices, structures, or curricula at their work site and the impact on patient wellbeing and safety.

There are no tools that would allow assessing these three dimensions in the context of Communities of Practice. However, there are some tools that cover specific aspects and might be useful for this project. These include the Team Anomie Scale, which measures the degree of team functioning; the Communities of Practice tool, which measures group functioning, knowledge and information sharing, participation in the group, and access to information; and the TOSCE, which has been modified from a tool evaluating clinical competency. Additional tools will be developed and tested as part of this project.

**Implementation**

It is anticipated that a total of six Communities of Practice will be created to test the proposed model. Each Community of Practice will include faculty members, health practitioners and students. (Patients will be included as appropriate.) Members will be recruited from across health disciplines, educational institutions and practice settings to maximize diversity and learning. The development team will closely work with clinical placement coordinators, faculty members and participating clinical sites to recruit suitable members and implement the Communities of Practice.

The first three Communities of Practice will be implemented in September 2006 and learning activities will be conducted and monitored through December 2006. The second cohort of three Communities of Practice will be implemented in January 2007 and learning activities will be conducted and monitored through April 2007.

Workshops will initially be held to introduce members to the concept and characteristics of Communities of Practice, and the learning strategies and communication media that are available. The workshops will also assist members to be aware of, and value, their already existing skills of practice reflection and the value of sharing. At the workshops, Community of Practice members will be encouraged to use their skills of practice reflection to generate questions or ideas that have the potential to enhance care practices.

The Community of Practice will engage in the activities outlined above. Facilitators will be hired to provide support, for example, by assisting with the collection of evidence-based information relating to practice questions or with information sharing.
A summary of the development and implementation activities is listed in Table 7.

Table 7. Summary of development and implementation activities

<table>
<thead>
<tr>
<th>Develop curriculum for Communities of Practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Review findings and conceptual models from parts A, B &amp; C</td>
</tr>
<tr>
<td>• Develop new curriculum models (content and processes; learning objectives)</td>
</tr>
<tr>
<td>• Define competencies for Communities of Practice</td>
</tr>
<tr>
<td>• Develop innovative strategies to incorporate new curriculum into Communities of Practice</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Establish Communities of Practice (Cohort #1)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Recruit first semester Communities of Practice (three sites)</td>
</tr>
<tr>
<td>• Recruit students, health practitioners and faculty to participate in the pilot project</td>
</tr>
<tr>
<td>• Recruit and train facilitators</td>
</tr>
<tr>
<td>• Implement curriculum in Communities of Practice</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Establish Communities of Practice (Cohort #2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Recruit second semester Communities of Practice (three sites)</td>
</tr>
<tr>
<td>• Recruit students, health practitioners and faculty to participate in the pilot project</td>
</tr>
<tr>
<td>• Implement curriculum in Communities of Practice</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Review curriculum and strategies</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Review process evaluation findings</td>
</tr>
<tr>
<td>• Adapt curriculum and implementation strategies as appropriate</td>
</tr>
</tbody>
</table>

**Evaluation Phase**

This phase of the project is covered in the evaluation plan that follows.

**8. Evaluation Plan**

**Overview**

The evaluation is built on the approach outlined by Health Canada (2000) and the W.K. Kellogg Foundation (1998). Both approaches focus on a participatory approach and place a high value on the following guiding principles.
Evaluation must:

- Strengthen programs for the well-being of people;
- Apply both multidisciplinary and flexible approaches to problem solving;
- Be useful to the people who are doing the work being evaluated;
- Encourage participation in the evaluation process and build capacity; and
- Recognize the progression of change in knowledge, attitudes, skills and behaviour.

The evaluation framework designed for this project focuses on both processes and outcomes to ensure a comprehensive understanding of the project. Both qualitative and quantitative methods that draw upon multiple data sources such as interviews, narratives, documents, and assessment tools will be used.

**Process evaluation:** A process evaluation provides insight into how the different project components have been implemented to achieve specific outcomes and assists in identifying emerging issues. Information will be collected through interviews and focus groups with staff, students, health practitioners, patients, facilitators and other stakeholders, and review of meeting minutes and group memos.

**Outcome evaluation:** The Kirkpatrick (1998) model for evaluation training programs is based on a four-step protocol where each step addresses different training outcomes. These are:

i) Participant reaction to the training experience (immediate outcomes);
ii) Participant learning (immediate and intermediate outcomes);
iii) Participant behavior change (intermediate outcomes), and
iv) Impact on patients, health practitioners and the health delivery system (intermediate and long term outcomes).

Unanticipated outcomes will also be captured. The schematic in Figure 2 illustrates the evaluation plan from an outcome perspective. The outcome shown for each stakeholder is one example of the type of outcomes that will be measured. The evaluation involves six Communities of Practice (1-6), four key stakeholder groups (patients, health practitioners, faculty/students, and the health system), three time periods and multiple outcomes.

Outcomes are assessed at three time periods as follows: immediate – within 30 days of training, intermediate – within six months of training, and long term – within one year of training. The measures used in this period will focus on sustained changes among participants and within settings as well as on the impact of the training program on care delivery from a patient perspective.
Figure 2. Outcome evaluation schematic

Procedures
The basic outline of the evaluation phase is shown in Table 8. Six Communities of Practice, three in each semester, will be assessed at start up (baseline), midway through the project (process evaluation) and at the end of the project (outcome evaluation). The outcome evaluation includes immediate, intermediate and long-term impacts.

Attitudes, knowledge and skills, participant reactions, satisfaction, and behavioural changes of Community of Practice participants will be measured pre and post implementation of the Communities of Practice. Assessment instruments will be developed or adapted from existing tools in the four months leading up to the launch of the first Communities of Practice. A formative, process assessment will be undertaken at the midpoint to determine if the project is being delivered as intended and to identify areas for improvement. The evaluation protocol will be completed twice, once for Communities of Practice in the first semester and again for Communities of Practice in the second semester.
Table 8. Evaluation design

<table>
<thead>
<tr>
<th></th>
<th>Communities of Practice 1 to 3 in Semester 1</th>
<th>Communities of Practice 4 to 6 in Semester 2</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2006</td>
<td>2007</td>
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<tr>
<td>May - Aug</td>
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<td>Sept</td>
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<td>Apr</td>
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<tr>
<td>May - Nov</td>
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</tbody>
</table>

Instrument Development
Baseline Assessment*
Process Evaluation
Outcome evaluation – immediate and intermediate
Outcome evaluation – long term

Success Indicators
Success of the overall project will be reflected by:

i) A comprehensive conceptual framework for interprofessional lateral mentorship within Communities of Practice that includes contextual and multicultural considerations;

ii) Six interprofessional Communities of Practice successfully implemented and pilot tested

iii) Documented positive changes in satisfaction, learning and behaviours of all Communities of Practice stakeholders, and positive impacts on the organization and on patient care.

Medium and Long-term Impacts
Creating an interprofessional learning environment for students, faculty and health practitioners through Communities of Practice will help to better prepare mentors, students, and faculty for interprofessional patient centred care. It is anticipated that the interprofessional Communities of Practice will have a significant impact on quality of patient care, staff workplace satisfaction and long-term retention of staff.

Responsibility for Evaluation and Measurement
An external evaluator will be commissioned for the evaluation. Members from the investigative group will collaborate with the evaluator in developing a template detailing the evaluation data requirements and timelines, and drafting data collection tools, such as questionnaires and interview guides, to capture stakeholder experiences and issues.
They will also assist the evaluator in designing or selecting assessment tools to measure levels of satisfaction, learnings (knowledge, skills and attitudes), behavior change among stakeholder groups and impact on the organization and patient care. The evaluation team will work closely with the evaluator to facilitate data collection and ensure recording occurs in a timely manner according to the specified requirements.

**Use of Evaluation Information**

Evaluation results will be used to improve the Community of Practice framework and make curriculum changes as appropriate. Evaluation results will be of value to clinical sites developing interprofessional teams and to other academic departments involved in health student training and education. The Steering Committee will identify key target audiences across the province and Canada and select appropriate media to disseminate the evaluation findings.

**9. Knowledge Transfer, Networking and Dissemination**

**How Information Will Be Shared**

The key principles of knowledge transfer (Lomas, 1997) will be applied in raising awareness of the project findings. Key stakeholders, such as the Council of Chief Executive Officers, will be involved in introducing policy or workplace changes that result from the project. The Communications Departments in the Calgary Health Region and Capital Health will help to ensure that the messages are tailored appropriately to the target audiences in policy and practice as well as to the public. Members of the Steering Committee will identify the mechanisms for communicating information about the project within their respective organizations. The following strategies will be used to ensure ongoing transfer of knowledge:

- A project web page will be developed in the first year with links to the web sites of all partner organizations and other IECPCP projects funded by Health Canada. Regular updates will occur to document project progress.
- E-letters will be distributed four (4) times per year to practitioners, educators, students, policy developers and others identified by the Steering Committee. The letters will be posted on the project web page.
- Decision makers in policy, administration and education, researchers and other knowledge purveyors will be invited to workshop during year 2 and 3 to share the research findings and identify the mechanisms for translating the findings into practice and education.
- A water-cooler videoconference will be developed through the Health Research Transfer Network of Alberta (RTNA) to share the findings RTNA members during the final project phase.
- The website and existing Regional Health Authorities, Universities and College newsletters will be used to inform the public as appropriate. A storyboard or poster display will be created for use at public forums.
- Starting in year 2, articles will be prepared for professional research journals.
Follow-up Activities
The Health Learning Institute Steering Committee will meet regularly with the research team and Steering Committee of this initiative to discuss how to apply learning from the project to practice and planning. Similarly, faculties of the partner institutions will meet to discuss the implications of the findings for curriculum development. The evaluation of the program is designed to help to determine who is applying the findings, with what audiences, and the outcomes.

Through the IECPCP, we are committed to fostering a network across the western provinces (Alberta, British Columbia, Saskatchewan and Manitoba) in the following key areas:
- to explore potential linkages regarding curricula for pre-licensure and post-licensure;
- to advance dissemination of knowledge across our respective projects; and,
- to discuss evaluation approaches and explore opportunities for common measurement tools
A meeting to further explore these linkages among the four provinces is being planned for February 2005.

10. Sustainability Plan

Barriers and Challenges to Sustainability
Potential barriers and challenges to sustaining the project include losing momentum or continuity, issues of communication and collaboration arising between the partners due to a lack of trust or protectionism, and the project being derailed due to a lack of time or resources.

Methods to Overcome Barriers and Challenges
The following methods and supports will help to prevent these barriers and challenges from occurring or to overcome them should they occur.

- A high caliber Steering Committee representing all key stakeholders is charged with the responsibility of overseeing the project. Members’ expertise in interdisciplinary education and practice will assist in developing strategies that support sustainability of the project.
- Steering Committee members have agreed on a structure and process involving regular meetings, individual responsibilities, clear lines of communication, and various channels for exchanging information.
- A communication and reporting process will be developed between the Steering Committee and the investigative group.
- Support for and commitment to the project comes from the highest management level in the partner organizations. The project is a priority, and time and resources have been allocated accordingly.
- Since support comes from the partner organizations, rather than individuals, if one person leaves, the larger organizational support remains.
Factors Contributing to Sustainability
The partners have been working on the challenge of sustainability since first developing the idea for this project. All components of the project will be purposefully designed to support sustainability. For example, key partners are represented at all levels of design, implementation, and evaluation, as well as on the Steering Committee. Ongoing discussions and consultations with academic partners, regional representatives, health practitioners and students will ensure that the project is implemented on a mutually agreed basis that will contribute to its long term sustainability. There is much evidence in the literature to support the use of research networks as a way of improving multidisciplinary collaboration, creating and transferring knowledge, encouraging research uptake and building research capacity (de Bruyn, 2001; Thomas & While, 2002; Griffiths et al, 2000). Given the resources committed to the Health Learning Institute and the Interprofessional Initiative, and the interest and excitement the present initiative has generated in the health-education-research community, the drive to demonstrate results is strong.

Activities to Increase Sustainability
The collaborative network has been meeting informally for five months to discuss issues, identify research priorities and explore opportunities, so members have already built a working relationship and a shared understanding of what they wish to achieve. The group will be formalized to carry out this proposed project. This will involve developing structures and processes to successfully move this project forward. The collaborative will be self-sustaining at the end of the project.

Key Stakeholders in Sustainability
The partner organizations described in this proposal will be the key stakeholders in sustainability.

Resources
Resources needed include knowledge, expertise, people, space and financial resources. Steering Committee members will have an essential role in identifying and securing resources. Partner organizations have committed to supporting this project by providing resources as outlined in the support letters, for example, in-kind contributions such as staff time, space for meetings, research assistants, and knowledge and expertise to develop and implement the project.

Link to Evaluation Plan
Information generated through the evaluation plan provides a focal point for the key stakeholders to stay apprised of all developments so they can provide the resources and support required to ensure optimal conditions for the success of each phase. Evaluation results will contribute essential information for management decisions regarding the future of each Community of Practice.
11. Project Budget

The budget is detailed in Appendix A

Personnel
The following staff will be hired for this project: project manager ($75,000/yr, 1 FTE) through Calgary Health Region; administrative assistant ($35,000/yr, 1 FTE for year 1; 0.5 FTE for years 2 and 3); financial administration through University of Calgary ($21,725 year 1; $23,700 year 2; $19,750 year 3; total $65,175); Masters trained research assistants ($40,300/yr; 4 FTE year 1, 2 FTE year 2, 1 FTE year 3); Note: 18 percent benefits are added to all salaries.

Travel and accommodation
Steering Committee: 5 Steering Committee meetings per year: 4 by teleconference (expenses $50/person for 10 people; total $2,000/yr) and 1 face-to-face meeting in Edmonton or Calgary (expenses $500/person for 5 people; total $2,500/yr).
Expenses for team meetings: local trips for team members (including parking) for meetings and site visits: year 1 $4,500; year 2 and 3 $1,500; distance trips (Edmonton and Calgary) for team members: $500/person; 4 trips for 5 people; total $10,000/yr
Distance trips for interviewers: in year 1 to travel to Edmonton/Calgary to conduct site interviews: $350/trip, 5 trips each for parts A, B and C; total $5,250.

Rent and utilities
(Described under In-kind contributions.)

Materials and supplies
Costs for materials and supplies relate to interview transcribers, tapes and recorders (total $1,800 year 1); paper, photocopies, fax, postage ($3,000 year 1; $ 1,500 year 2 and 3); a small amount has been budgeted for focus groups/team meeting refreshments/meals ($2,250 year 1; $750 years 2 and 3). Materials and supplies for the development and implementation of the learning strategies are estimated at $20,000 (year 2).

Cost of Services and equipment
Computers: 4 computers are required to conduct parts A, B, and C of the research and to support the development, implementation and evaluation phase ($3,000/computer, including software; total $12,000 for year 1). Consulting services will be required for developing the instructional design and multimedia component of the Communities of Practice learning environment ($100,000 in year 2). Three facilitators will be contracted to act as resource persons and work with the 6 Communities of Practice for the duration of the pilot (3 facilitators in year 2; total $170,000).

Evaluation
Evaluation consultants will be contracted to conduct the process and outcome evaluations. Estimated costs are $80,000 for year 2 and $40,000 for year 3.

Dissemination
Conference costs are based on $3,000 per person per conference; it is anticipated that 3 people will attend national/international conferences during year 1, 6 people during year 2, and 6 people
during year 3. A project website will be created for project member communication and for information dissemination; initial development costs are estimated at $10,000 (year 1); operational costs at $1,500 (year 2 and 3). Watercooler sessions, reports etc will be produced during year 2 and 3 ($2,000/yr). Invitational workshops with key stakeholders will be hosted during year 2 and 3 to share findings and discuss implications ($10,000 in years 1 and 2).

In-kind contributions by Partner Organizations
In-kind contributions will be made by all participating partner organizations and will mainly consist of expert knowledge, time commitment, and office space as listed below:

- It is planned that among the partner organizations, 4 office spaces will be created and donated as in-kind to this project; estimated at $12,000/year
- Staff time allocated by the partner organizations have been estimated to amount to approximately 1 day/wk for the Calgary Health Region (estimated costs $40/hour, total $18,200), 1 day/wk for the University of Calgary ($18,200), 1 day/wk for the University of Alberta ($18,200), and 1 day/week together for SAIT, Bow Valley College, Mount Royal College and Capital Health ($18,200 together); total $72,800/year
- Steering Committee time for meetings (5 per year), project consultations, document review, and dissemination activities is estimated at 40 hours per year for each Steering Committee member; estimated costs (at $40/hour) are $1600 per person and year. Total costs for Calgary Health Region (7 Steering Committee members) $11,200, for University of Calgary (5 members) $8,000, for University of Alberta (7 members) $11,200, Capital Health (2 members) $3,200; other members (6) $9,600; total $43,200/year.

12. Ethics Review

Ethical Considerations

Ethical considerations and requirements will be handled through the well-established codes of ethical conduct to which participating investigators and partner organizations adhere. The principle foci will be on ensuring no harm is done in the conduct of this proposed program of work, and that emphasis is placed on the capture of benefit within the context of social justice and fairness. During the focus groups and interviews, particular attention will be paid to encouraging and respecting participants’ diverse views and to integrating these into the overall conceptual framework of interprofessional Communities of Practice.

All data will be collected with appropriate consents; all data will be handled and stored in alignment with ethical approval protocols. All personal identifiers will be removed from data prior to reporting findings outside the study. All members of the investigative group will strictly uphold the principle of confidentiality of information.

Ethics Approval

Ethics approval for this project will be the primary responsibility of the Conjoint Ethics Review Committee at the University of Calgary, which applies well-established ethical and scientific processes to health research. In most cases, reciprocal agreements are in place with other relevant
ethics boards and practices, such as those of the partner institutions. Subsequent to approval by the Conjoint Ethics Review Committee, review will be sought from these partner institutions.

**Bibliography**


Appendix A: Application Form / Demande de financement

FOR DEPARTMENTAL USE ONLY
USAGE DU MINISTÈRE SEULEMENT

Reference Number/Numéro de référence\(^1\): 111529

Health Human Resources / Ressources humaines en santé
Health Policy Branch / Direction générale de la politique de la santé
Please refer to the Guide for Applicants before completing this form.
Veuillez vous référer au Guide du requérant avant de compléter la demande

1. Language Preferred for Correspondence/Langue préférée pour correspondance
   - English/Anglais X
   - French/Français

2. Name of Primary Applicant Organization/Nom de l'organisme qui assume le rôle de soumissionnaire principal
   - Calgary Health Region, Research Initiatives in Nursing and Health

3. Mailing Address (Street Address and/or PO Box, Postal Code)/Adresse postale (rue et/ou B.P., code postal)
   - Calgary Health Region
   - Research Initiatives in Nursing and Health
   - 10101 Southport RD SW
   - Calgary AB
   - Canada T2W 3N2

4. Contact Name/Nom de la personne-ressource: Dr. Esther Suter

5. Telephone/Téléphone: (403) 943-0183

6. Fax/Télécopieur: (403) 943-0180

7. E-mail address/Courrier électronique: Esther.Suter@calgaryhealthregion.ca

8. Project Title/Titre du projet
   - Creating an Interprofessional Learning Environment through Communities of Practice: An Alternative to Traditional Preceptorship

9. Amount Requested/Somme demandée: $1,295,244

10. Duration of Project (months)/Durée du projet (mois): 33 months

11. Are funds being received or applied for from other sources for these activities? If yes, please identify the funder(s).
    Le projet a-t-il demandé ou reçoit-il du soutien financier d'autres organismes pour les activités proposées? Si oui, précisez la (les) source(s).
    - No/Non X
    - Yes/Oui __________________________

Calgary Health Region 43
### 12. Budget

<table>
<thead>
<tr>
<th></th>
<th>Federal fiscal year is April 1 to March 31.</th>
<th>Contribution from the IECPCP Initiative² Contribution provenant de l'initiative FIPCCP²</th>
<th>Income from other sources</th>
<th>Total Budget total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Year/Année 1</td>
<td>Year/Année 2</td>
<td>Year/Année 3</td>
<td>in-kind</td>
</tr>
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<td>Personnel</td>
<td>Research assistant, project management, clerical, financial administration /overhead U of C</td>
<td>345,078</td>
<td>228,030</td>
<td>150,336</td>
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<tr>
<td>Investigators and steering committee</td>
<td>Time spent by investigative team and Steering Committee (in-kind)</td>
<td>116,000</td>
<td>116,000</td>
<td>116,000</td>
</tr>
<tr>
<td>Travel &amp; accommodation / Déplacements et hébergement</td>
<td>Team meetings, Steering Committee meetings</td>
<td>24,250</td>
<td>16,000</td>
<td>16,000</td>
</tr>
<tr>
<td>Rent and utilities/Loyer et services publics</td>
<td>4 offices (in-kind)</td>
<td>11,000</td>
<td>12,000</td>
<td>10,000</td>
</tr>
<tr>
<td>Materials and supplies/Matériel et fournitures</td>
<td>Tapes, transcribers, recorders, office supplies, focus group refreshments/ meals, learning materials</td>
<td>7,050</td>
<td>22,250</td>
<td>2,250</td>
</tr>
<tr>
<td>Costs of services or equipment/ Coûts de services ou de matériel/ matériel</td>
<td>4 computers incl. software, instructional design expert, facilitators</td>
<td>12,000</td>
<td>270,000</td>
<td>0</td>
</tr>
<tr>
<td>Evaluation and dissemination/ Évaluation et diffusion</td>
<td>Evaluation Consultant, Conferences, project website, watercooler sessions, reports, workshops</td>
<td>19,000</td>
<td>111,500</td>
<td>71,500</td>
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<tr>
<td>Total</td>
<td>534,378</td>
<td>775,780</td>
<td>366,086</td>
<td>381,000</td>
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<tr>
<td>In-kind</td>
<td>127,000</td>
<td>128,000</td>
<td>126,000</td>
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<tr>
<td>Total requested</td>
<td>407,378</td>
<td>647,780</td>
<td>240,086</td>
<td>1,295,244</td>
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</table>

I declare that
- All the information in this application is accurate and complete;
- The application is made on behalf of the organization named on the first page of the form with its full knowledge and consent; and
- I acknowledge that should this application be approved, I will be required to enter in a formal contribution agreement that will outline the terms and conditions.

### 13. Name and Title of the Officer Authorized by the Organization/Nom et titre de l'agent autorisé par l'organisme

### 14. Telephone/Téléphone:

### 15. Fax/Télécopieur:

### 16. E-mail/Courrier électronique:

### 17. Signature of Authorized Officer

### 18. Date
Appendix B: Primary Applicant Organization Endorsement

I certify that, to the best of my knowledge, the information provided in this application is accurate and complete, and that this funding request is endorsed by the organization/agency I represent.

I also certify that if funding is approved, the organization/agency I represent will provide programmatic accountability and the required financial and narrative reports.

Authorization by Organization/Agency's Executive Director/Department Head

Name (please print): _____________________________________________________________

Title: _________________________________________________________________________

Telephone: ___________________________

Date: ________________________________

Signature: ____________________________

Authorization by Chair/President of Organization/Agency's Board of Directors

Name (please print): _____________________________________________________________

Title: _________________________________________________________________________

Telephone: ___________________________

Date: ________________________________

Signature: ____________________________
Appendix C: Executive Endorsement

Julie A. Gravel
Policy Analyst
Interprofessional Education for Collaborative Patient-Centred Practice Initiative
Health Human Resource Strategies Division
Health Canada
Room D 1894, AL 1918C
Jeanne Mance Building
Tunney’s Pasture
Ottawa ON K1A 0K9

Dear Ms. Gravel:

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

The undersigned support the application by the Calgary Health Region for funding to plan, implement and evaluate the project Creating an Interprofessional Learning Environment through Communities of Practice: An Alternative to Traditional Preceptorship.

The undersigned have reviewed the attached proposal and are fully aware of the roles and responsibilities of their respective organizations/agencies in the project Creating an Interprofessional Learning Environment through Communities of Practice: An Alternative to Traditional Preceptorship. To the best of their ability, the undersigned will work to ensure that the required visioning, leadership and administrative support are in place throughout the life of the project.

The undersigned have carefully reviewed the attached sustainability plan and are committed to working with project partners towards project sustainability.

Sincerely.

<table>
<thead>
<tr>
<th>Partner Organization</th>
<th>Department</th>
<th>Signature</th>
<th>Support letter</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calgary Health Region</td>
<td>Research Initiatives in Nursing &amp; Health</td>
<td>Dr. Jeanne Besner</td>
<td>Dr. F. Girard Senior Vice President</td>
</tr>
<tr>
<td>University of Alberta</td>
<td>Rehabilitation Medicine</td>
<td>Dr. Albert Cook</td>
<td>Dr. Carl G Amrhein</td>
</tr>
<tr>
<td>University of Alberta</td>
<td>Pharmacy and Pharmaceutical Sciences</td>
<td>Dr. Franco Pasutto</td>
<td>Provost &amp;Vice-President (Academic)</td>
</tr>
<tr>
<td>University of Alberta</td>
<td>Nursing</td>
<td>Genevieve Gray</td>
<td></td>
</tr>
<tr>
<td>University of Alberta</td>
<td>InterProfessional Initiative</td>
<td>Dr. Jane Drummond</td>
<td></td>
</tr>
<tr>
<td>University of Alberta</td>
<td>Health Sciences Council</td>
<td>Dr. Albert Cook</td>
<td></td>
</tr>
<tr>
<td>University of Alberta</td>
<td>Medicine and Dentistry</td>
<td>Dr. David Rayner</td>
<td></td>
</tr>
<tr>
<td>University of Calgary</td>
<td>Education</td>
<td>Dr. Tim Goddard</td>
<td>Dr. Ronald Bond Provost &amp; Vice-President (Academic)</td>
</tr>
<tr>
<td>University of Calgary</td>
<td>Nursing</td>
<td>Dr. Michael Clinton</td>
<td></td>
</tr>
<tr>
<td>University of Calgary</td>
<td>Medicine</td>
<td>Dr. Richard Hawkes</td>
<td></td>
</tr>
</tbody>
</table>

Calgary Health Region
<table>
<thead>
<tr>
<th>Organization</th>
<th>Position</th>
<th>Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>University of Calgary</td>
<td>Centre for Health and Policy Studies (CHAPS)</td>
<td>Anne Casebeer</td>
</tr>
<tr>
<td>University of Calgary</td>
<td>Professional Education and Research Centre (PERC)</td>
<td>Dr. Robert Stamp</td>
</tr>
<tr>
<td>Capital Health</td>
<td>Executive Nursing Officer</td>
<td>Sheila Weatherill</td>
</tr>
<tr>
<td>Mount Royal College</td>
<td>Undergraduate Nursing Studies</td>
<td>Dr. Brenda Hendrickson</td>
</tr>
<tr>
<td>SAIT</td>
<td>Department of Health and Public Safety</td>
<td>Marlene Raasok</td>
</tr>
<tr>
<td>Bow Valley College</td>
<td>Health &amp; Community Care</td>
<td>Dr. Rena Shimoni</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Dr. Rena Shimoni</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Dean, Health &amp; Community Care</td>
</tr>
</tbody>
</table>
Appendix D: Project Summary

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

1. **Mandate of the primary applicant organization**
   This project is co-led by the Calgary Health Region, University of Alberta, University of Calgary, Capital Health, SAIT, Bow Valley College, Mount Royal College with the Calgary Health Region acting as formal lead. The Calgary Health Region’s mandate is to provide high-quality accessible health services.

2. **List of partners with whom the organization will work on this project and their roles**
   All partner organizations listed above are jointly responsible for the development, implementation, and evaluation of the proposed project.

3. **Objectives of the project**
   The goal of the project is to develop, implement and evaluate interprofessional Communities of Practice designed to foster interprofessional education and collaborative patient-centred care.
   
   **Major activities required to achieve these objectives are:**
   - Determine the requirements (including contextual and cultural components) to create effective interprofessional Communities of Practice
   - Based on findings from the research, develop and implement interprofessional Communities of Practice (content and processes)
   - Pilot test the Communities of Practice model in 6 pilot teams
   - Evaluate the impact on students, health practitioners, faculty, patients and organizations

4. **Expected results of the project**
   - A comprehensive conceptual framework for interprofessional lateral mentorship within Communities of Practice that includes contextual and multicultural considerations;
   - Six interprofessional Communities of Practice successfully implemented and pilot tested
   - Documented positive changes in satisfaction, learning and behaviours of all Communities of Practice stakeholders, and positive impacts on the organization and patient care.

5. **Methods that will be used to evaluate both the process and the outcomes of the project**
   Both qualitative and quantitative methods that draw upon multiple data sources such as interviews, narratives, documents, and quantitative assessment tools will be used.

6. **List of the project deliverables with timelines**
   - Conceptual model of interprofessional lateral mentorship (including multicultural and contextual considerations) in Communities of Practice (April 30/06)
   - Interprofessional learning environment within Communities of Practice developed (including learning content and strategies (July 31/06)
   - Evaluation tools developed (August 31/06)
   - 3 Facilitators to support Communities of Practice recruited (August 31/06)
   - Members for first three pilot Communities of Practice recruited (August 31/06)
   - Pilot testing of first three Communities of Practice completed (December 31/06)
   - Members for second three pilot Communities of Practice recruited (November 30/06)
   - Pilot testing of second three Communities of Practice completed (April 30/06)
   - Short-and long-term impact of Communities of Practice completed (November 30/07)
   - Revised learning program based on participant feedback (January 31/08)

7. **Dissemination plan**
   - Results will be disseminated to educators, researchers, administrators, policy makers, the public and other stakeholders interested in interprofessional education and practice.
   - Dissemination will depend on target audience and include a project website, e-letters, invitational workshops, water-cooler videoconference and articles prepared for professional and lay journals.
   - Information dissemination will be ongoing and will be supported by all participating partner organizations
Appendix E: Provincial or Territorial Statement of Support

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

Name of Primary Applicant Organization: Calgary Health Region

Project Lead: Dr. Esther Suter E-mail Address: Esther.Suter@Calgaryhealthregion.ca

Mailing Address: Research Initiatives in Nursing and Health; Calgary Health Region; 10101 Southport RD SW, Calgary AB T2W 3N2

I have reviewed the proposal named above and conclude the following.

1. The proposed project complements or supports provincial or territorial work, goals, objectives and priorities. Please explain: ___Yes ___No_

2. The proposed project does not duplicate existing provincial or territorial work. Please explain: ___Yes ___No_

3. The outcome and impact of the proposed project will be beneficial to the province or territory. Please explain: ___Yes ___No_

Additional comments:

Name (please print): ________________________________________________________________

Title: _____________________________________________________________________________

Organization: _______________________________________________________________________

Address: __________________________________________________________________________

Telephone: _________________________________________________________________________

Date: __________________________ Signature: ___________________________________________
Appendix F: Conflict of Interest

In order to prevent conflicts of interest with respect to former federal public office holders or former federal public service employees, the organization submitting a proposal must provide the following information to confirm its compliance with the Conflict of Interest and Post-Employment Code for Public Office Holders and the Conflict of Interest and Post-Employment Code for Public Service Employees.

Has your organization, in the last 12 months, employed a former federal public servant or a federal public office holder at the EX minus two levels or higher in the Health Human Resource Strategies Division, Office of Nursing Policy and First Nations Inuit Health Branch of Health Canada who is subject to the Conflict of Interest and Post-Employment Code for Public Office Holders and/or Conflict of Interest and Post-Employment Code for Public Service Employees and therefore could potentially be perceived as having a conflict of interest with the project?

YES ________
NO  X

If so, the former employee or public office holder must contact the Health Canada Conflict of Interest Coordinator to obtain written confirmation, that he/she is in compliance with the relevant provisions of the Conflict of Interest and Post-Employment Codes and that his/her functions/responsibilities with your organization do not result in real, potential or apparent conflict of interest situation.

Conflict of Interest Coordinator
Conflict Resolution and Compensation Unit
National HR Service Division
Human Resources Services Directorate
6th floor, Jean Mance Building
AL 1906C
Tunney's Pasture
Ottawa ON K1A 0K9

The same requirement applies to a major shareholder or member of the Board of Directors.

Signature: __________________________
Date: __________________________
Name and title of signing officer: (Please Print) __________________________