

REPORT

Building Western Canadian Partnerships between Health Human Resource Planning *and* Interprofessional Education

September 17 & 18, 2007
Calgary, Alberta

Sponsors

Canadian Interprofessional Health Collaborative



Health Workforce Research Network of Alberta



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EXECUTIVE SUMMARY

Health and human service providers are the cornerstone to Canada's publicly funded health system. Ensuring that these providers are healthy workers practicing to the full scope of their practice and appropriately distributed is key to sustaining cost-effective, safe, quality health care. The challenge is to educate and adapt health care providers today to work in more collaborative practice models that meet the needs of an ever-changing health care environment. Redefining 'how we work together' has become an important piece of health human resource planning and management.

On September 17 and 18 2007, the Canadian Interprofessional Health Collaborative and the Health Workforce Research Network of Alberta hosted [Building Western Canadian Partnerships between Health Human Resource Planning and Interprofessional Education](#). During this Calgary conference, participants from Manitoba, Saskatchewan, Alberta and British Columbia shared and examined outcomes and learnings from Health Canada-funded Interprofessional Education for Collaborative Patient-Centred Practice (IECPCP) projects. The goal was to explore the potential of a Western regional approach to health human resource planning in the context of interprofessional, collaborative, patient-centred practice.

Four key themes emerged from the various round-table discussions:

1. Outcomes and learnings must be evidence-based and brought forward in a way that is meaningful, action-oriented and ensures that an interprofessional approach is embedded in the health system.
2. Recognition and endorsement that it is critical to link interprofessional education for collaborative patient centred care (IECPCP) with the goals and priorities of health system reform and HHR.
3. Knowledge translation and communications is a priority. Proponents and experts in interprofessional collaboration should use existing communications materials (e.g. CIHC Dissemination Strategy) to broaden the awareness and understanding to a larger audience.
4. Support for continued regional discussion and expanding the group of stakeholders.

BACKGROUND

In June 2007, Western Canadian Steering Committee members for the Canadian Interprofessional Health Collaborative (CIHC) identified an interest in organizing a joint strategy session linking:

- Professional practice leaders
- IECPCP projects
- Policy leaders from Ministries of Health and Advanced Education
- Members of the Western & Northern Health Human Resources Planning Forum (HHR Forum)

This vision resulted in [Building Western Canadian Partnerships between Health Human Resource Planning and Interprofessional Education](#), held September 17-18 2007 in Calgary.

The Health Workforce Research Network of Alberta (Network) which has a mandate to undertake research across the spectrum of interprofessional practice (IP) and health human resources (HHR), agreed to co-host the session with CIHC.

Thirty representatives (combined) from British Columbia, Saskatchewan and Manitoba were invited. Alberta, as part of its broader agenda for Network members, had thirty-five representatives. In addition, representatives attended from the CIHC Secretariat, Health Canada, and the Western HHR Forum. Appendix A lists participating organizations and attendees.

The meeting was designed around the four meeting objectives:

- Share key messages about Health Canada funded Interprofessional Education for Collaborative Patient-Centred Practice (IECPCP) projects.
- Explore strategic linkages between HHR planning and interprofessional (IP) education and practice.
- Discuss strategies and structures for sustainability of IECPCP project initiatives and capacity building at provincial, western region, and national/CIHC levels.
- Discuss possibilities for a joint Western provinces proposal to Health Canada for years 6-10 of IECPCP funding and other potential sources.

SETTING THE STAGE

Participants explored strategic linkages between HHR planning and interprofessional education and practice.

Guiding principles to address HHR and health system reform interests need to:

- Be interprofessional, collaborative and patient-centred
- Be population and patient needs driven
- Optimize utilization of knowledge and skills of all providers
- Link staffing and staff mix to the intended patient, provider and system outcomes
- Be informed by evidence and context specific.

Key findings include:

- Although existing structures and policies can accommodate interprofessional education and practice, it often exists in small pockets or pilot projects. There is a need to come to consensus on approaches to IP implementation, standards and assessment to encourage broader uptake of interprofessional collaboration in both education and health sectors.
- With clearer evidence that interprofessional practice strategies demonstrate positive impacts on HHR priorities and patient outcomes, HHR leaders would be better equipped to promote more systematic IP uptake.
- Good models of successful intersectoral, multi-jurisdictional collaborations exist and are key examples of how to overcome organizational differences between the research, government, health care delivery and post-secondary education sectors.

CONVERSATIONS FOR INQUIRY & DISCOVERY

Participants engaged directly with one another to discuss topics linked directly to meeting objectives 2-4:

- Explore strategic linkages between HHR planning and interprofessional education and practice.
- Discuss strategies and structures for sustainability of IECPCP project initiatives and capacity building at provincial, western region, and national/CIHC levels.
- Discuss possibilities for a joint Western provinces proposal to Health Canada for years 6-10 of IECPCP funding and other potential sources.

A complete reporting of the discussions appear in Appendix B, Parts A and B. Summary highlights of these sessions are reported below.

Participants discussed the common ground between interprofessional practice and health human resources. Suggestions were to:

- Re-examine the notion of “shortage” and make links between productivity and role optimization
- Synthesize the IP research that informs HHR planning
- Increase IP education for students so they may better articulate their role and their profession
- Strengthen the linkages between education/ government/ workforce planning/ practice.

In order to effectively support system change, participants recommended:

- Fostering leadership development
- Influencing across sectors (IP leaders are primarily in education with limited connections to diverse practice environments)
- Developing better mechanisms to increase patient/family involvement in health teams
- Creating a unified vision and structure where IP is viewed as a mechanism to improve HHR productivity and quality
- Positioning current HHR shortages as a catalyst for new practice models
- Developing messaging that is clear, understandable, and patient-centred.
- Formalizing the collaboration between Ministries of Health and Advanced Education increases leverage, thus resulting in better planning.
- Shifting focus to the patient

A second round of discussions focused on a robust role for IP in HHR solutions, and stressed the importance of having IP and HHR planners at the same table. Participants suggested a regional collaboration that could build on existing relationships and use government priorities to move quickly and efficiently towards further embedding IP in HHR planning in order to realize benefits. This structure could recognize and reward new models of practice, model IP in student teams and promote professional development.

Sustaining a western regional collaboration would require a clear vision and goals, an inclusive structure, support from existing organizations at various levels, and long term resourcing. For example:

National:	CIHC
Regional:	Western and Northern HHR Planning Forum
Provincial:	Health Workforce Research Network of Alberta BC Academic Health Council Saskatchewan Academic Health Sciences Network

Funding proposals should integrate issues of quality service delivery, health system costs/risks, patient and provider outcomes, synthesis of existing IP research/evidence, knowledge transfer aimed at decision makers and consumers as well support for regional collaboration. Delegates recommended targeting five-year funding (or more) recognizing the length of time needed for change. External funding sources include CIHR and CHRSF.

PARTNERSHIPS AND PLANS

During the final session, participant-generated topics determined the best next steps for partnership between HHR planning and IP research, education and practice, meeting objectives 3 and 4:

- Discuss strategies and structures for sustainability of IECPCP project initiatives and capacity building at provincial, western region, and national/CIHC levels.
- Discuss possibilities for a joint Western provinces proposal to Health Canada for years 6-10 of IECPCP funding and other potential sources.

The session facilitated many important and diverse discussions. A complete reporting of *Partnerships and Plans* discussion appears in Appendix B, Part C. Summary highlights of these sessions are reported as four actions below.

1. Develop a **Western Regional Collaborative** to build on the strengths of the western provinces, translate concepts generated to date into action, and establish a formal link between IP and HHR planning. The mandate of this working group could be to collaborate, innovate and exchange knowledge.
2. Introduce a focused **Social Marketing Campaign** about IP activities, outcomes and key lessons learned. This could include re-educating all providers about their roles and the roles of others. This campaign would raise awareness, offer tools and use IP champions to support widespread behavior change.
3. **Align IP Strategies** with high priority HHR issues, such as rural health issues. Highlight IP as an integral part of how we do business – not as a separate (or additional) activity. Identify IP champions in the health system, align these champions with key service delivery projects and measure the outcomes at all levels: patient/ provider/ system and process.
4. Increase **Leadership Skill Development** to create interprofessional learning sites, establish new service delivery models and monitor impact. This includes: (a) engaging managers, physicians and practice leaders; (b) garnering additional support from national collaborations (e.g. IHI); (c) addressing issues of role clarity; (d) showcasing experiences; (e) addressing the needs of rural health; (f) linking funding to key outcomes; (g) linking costs, workforce productivity and patient experiences in future business cases.

GO FORWARD ACTIONS TO DATE

The aims of **Building Western Canadian Partnerships between Health Human Resource Planning and Interprofessional Education** were to explore strategic linkages, strategies and structures for sustainability. The following 'go forward actions' are underway at the provincial, regional and national levels:

British Columbia

Negotiations are underway in BC with government to establish a provincial hub for IPE activity that will build upon the extraordinary work of In-BC, the interprofessional network that is the BC IECPCP project. A brief report of the Calgary regional meeting was distributed to In-BC members and there is strong support for further activity to participate in regional discussions.

Alberta

A brief summary report was given to the Clinical and Nursing Practice Leaders Network and the Health Workforce Research Network. Participants look forward to continued efforts to include interprofessional education and practice as part of their health human resource planning.

Saskatchewan

Members from P-CITE (the provincial Health Canada-funded IP project) in Saskatchewan are advancing a dissemination strategy as part of their commitment to the P-CITE goals. P-CITE will hold a meeting in January 2008 (to be confirmed) to bring projects together to showcase their work.

Manitoba

The Deans from eight health faculties within the University of Manitoba are meeting in December 2007 to discuss the creation of an IPE Working Group and outline the terms of reference for this committee. The working group will likely make an application to COPSE for funding to maintain the momentum of IPE within the University of Manitoba. Manitoba Health and the Winnipeg Regional Health Authority have expressed a keen interest in maintaining future partnerships.

Western Region

Another meeting of interested western regional individuals and organizations is under development – possibly for January 2008 in Saskatchewan, building on a P-CITE meeting.

National

CIHC continues to work together with national, regional and provincial partners to determine the best actions to further the interprofessional agenda throughout Canada.

APPENDIX A PARTICIPATING ORGANIZATIONS AND ATTENDEES

Organizations

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

Canadian Interprofessional Health Collaborative (CIHC) - Western provinces: members are involved in projects funded by Health Canada's Interprofessional Education for Collaborative Patient-Centred Practice initiative (*for this meeting: BC, AB, SK, MB members*); CIHC Secretariat members www.cihc.ca

Western and Northern Health Human Resources Planning Forum (HHR Forum): members are from Ministries of Health and Advanced Education in the four Western provinces and the territories. Contact Peter Gibson: Peter.J.Gibson@gov.bc.ca

Attendees

Name	Organization
Andrea Burton	Canadian Interprofessional Health Collaborative
Anne Sales	University of Alberta
Barbara Lowe	College of Registered Psychiatric Nurses of Alberta
Bev Ann Murray	Health Canada
Brenda Ashman	Palliser Health Region (AB)
Brenda Hendrickson	Mount Royal College (AB)
Brenda Paton	University of Calgary
Brenda Sawatzky-Girling	Canadian Interprofessional Health Collaborative
Cathy Giblin	Capital Health (AB)
Christine Ateah	University of Manitoba
Cornelia van Ineveld	St. Boniface General Hospital (MB)
Cory Galway	HBA Services (AB)
David Allen	Alberta Health and Wellness
Deborah Hull	BC Ministry of Advanced Education
Debra Barrath	Calgary Health Region
Don Philippon	Saskatchewan Academic Health Science Network
Esther Suter	Calgary Health Region
Genevra Beck	Aspen Regional Health (AB)
George Eisler	BC Academic Health Council
Gislind Moehrle	Aspen Regional Health (AB)
Glenda Hawthorne	Palliser Health Region (AB)
Grace Mickelson	Provincial Health Services (BC)
Grant Charles	University of British Columbia
Heather Dean	University of Manitoba
Holly Knight	Calgary Health Region

Name	Organization
Jana Lait	Calgary Health Region
Janet Bjornson	Winnipeg Regional Health Authority
Janet Lapins	Chinook Health (AB)
Janet Vas	Palliser Health Region (AB)
Jean Kipp	University of Alberta
Jeanne Besner	Calgary Health Region
Jerry Ross	Manitoba Health
Jim Lees	Alberta Cancer Board
Jo Ann Nettleton	Caritas Health Group (AB)
Joanne Maclaren	Vancouver Island Health Authority
Jon Pascoe	Pascoe Management Consulting Inc. (AB)
Joyce Vogelgesang	College of Physical Therapists of Alberta
Judy Anderson	University of Manitoba
Karen Martin	David Thompson Health Region (AB)
Karen Jackson	Calgary Health Region
Kathy Copeman-Stewart	Interprofessional Network for BC
Kelly Kuz	Peace Country Health (AB)
Kevin Veitenheimer	Saskatchewan Advanced Education & Employment
Lana Trojan	Calgary Health Region
Lesley Bainbridge	University of British Columbia
Libby Posgate	BC Ministry of Health
Linda Ferguson	University of Saskatchewan
Linda Fontaine-Tymchuk	Capital Health (AB)
Linda Moore-Martin	Red Deer College (AB)
Linda Sawchenko	Interior Health (BC)
Linda Stanger	College of Licensed Practical Nurses of Alberta
Linda Tessmann-Potvin	Palliser Health Region (AB)
Liz Harrison	University of Saskatchewan
Liz Taylor	University of Alberta
Louise Nasmith	University of British Columbia
Lynn Redfern	College and Association of Registered Nurses of Alberta
Marilyn Visser	Calgary Health Region
Marta Crawford	Manitoba Health
Mary Gibson	Mary Gibson Consulting (AB)
Michael Moffatt	Winnipeg Regional Health Authority
Murray Holtby	Calgary Health Region
Nancy Arthur	University of Calgary
Nelly Oelke	Calgary Health Region
Noreen Linton	Calgary Health Region
Olive Fast	Calgary Health Region
Pam Nordstrom	Mount Royal College (AB)

Name	Organization
Peter Gibson	Western & Northern Health Human Resources Planning Forum
Ruby Grymonpre	University of Manitoba
Sandra Cripps	Saskatchewan Health
Scott Fielding	Cross Cancer Institute (AB)
Sheila Achilles	Saskatoon Health Region
Siegrid Deutschlander	Calgary Health Region
Sinead McGartland	Health Quality Council (SK)
Sissel Bray	East Central Health (AB)
Susan Deane	Manitoba Advanced Education & Literacy
Teri Myhre	Chinook Health (AB)
Trish Picherack	Calgary Health Region
Val Embree	Embree & McBride Consulting
Zahra Nurani	Health Workforce Research Network of Alberta

APPENDIX B SUMMARY OF DISCUSSION TOPICS

Link to Meeting Presentations

Presentations can be found on the Canadian Interprofessional Health Collaborative website as well as the Health Workforce Research Network website:

http://www.cihc.ca/announcements/events_archives.php

<http://www.calgaryhealthregion.ca/hsrwu/phwrn/updates.htm>

A complete reporting of discussions throughout the meeting is reported below.

Part A – HHR & IP: common ground

1. Shared interests? What's being learned from IP projects that overlap with HHR concerns?
 - IP messages are not resonating with decision makers, not 'mainstream'; patient safety may be impetus to promote IP and teamwork; HHR and system crisis may lead to system redesign, but also prevents thoughtful response. Culture of 'busyness', territoriality, bio-medical focus, increasing system complexity.
 - Linking IP & HHR reveals system flaws, challenges; re-examine notion of a 'shortage', make link between productivity and role optimization. Need to synthesize IP research that informs HHR planning and the new vision / model of health care, strengthen linkage between education and HHR / workforce planning and policy.
 - IP education will help students define and articulate their role and profession, address stereotypes and preconceptions.
 - Some examples of IP promotion: Alberta primary care funding, Alberta Cancer Board culture
2. Approaches to influencing system change – how do IP and HHR leaders approach system change? What's different, what's not?
 - Foster leadership development and influence across sectors; IP leaders are primarily in education sector with limited connections from diverse health services practice environments with no united or systematic approach. HHR leaders are health system executives. Issues of scarcity can be catalyst for new system and practice models. Promoting a partnership between education and practice could take a business model approach to make IP important to HHR planners. Intersect IP with patient-centred model of care – shared vision helpful, e.g. patient safety model. Prepare and support leaders with an IP philosophy.
 - Create vision and structure via high level committees e.g. CHEA in Calgary, BCAHC in BC. This vision should view IP as a mechanism to improve HHR productivity / quality, achieve buy-in, identify steps for implementation, empower.
 - Ensure messaging / knowledge exchange is understandable, important and patient-centred. Start with core principles, understanding roles and dialogue –Link IP activities to pan-Canadian, regional, provincial frameworks and strategic priorities in health services, education, research as inter-sectoral impact may be greater.
 - Involve micro, meso and macro levels of organizations in IP change initiatives to address, 'We are afraid to move forward. We are comfortable with concepts but fearful of change'. Create principles, policies, structures.

- Engage unions and regulators from start to support restructuring around patient needs; create expectation of collaboration via regulations, expectations and advocacy by students.
 - Need role clarity before moving to IP – role clarity, rationale, principles and policy, rewards and recognition for IP. Support grass roots capacity, front line small ‘wins’ – immediate changes that make a big difference. Address fears, scope, enable local IP committees to manage process.
 - Incorporate better mechanisms to hear the patient voice and increase patient and family involvement in their health team(s). Focus on the outcome of better patient outcomes.
 - Practice in full scope adds to provider satisfaction but requires re-education of providers, marketing IP differently, highlighting benefits to patients and practitioners.
3. Cross-sector communication – understanding needs and translating knowledge

Issues:

- System direction
- Leadership driven by disciplines and political perspectives, traditional relationships;
- Collaboration seen as an ‘add-on’
- Culture of academia / collaboration lacks accountability
- ‘Patient-centred’ not well understood, not driving decisions
- Different ‘cultures’ at all levels – Ministries of Health (crisis driven) vs. Advanced Education (hands off)
- Gap between HHR planning and education planning – lack of data, language, priorities

Opportunities:

- Shift focus of discussion to the patient and have health professionals be responsive to this – highlight shared values and common vision
- Collaboration needs transactional resources and accountability
- Consolidate tables for proactive leadership and priority setting / focus on common issues
- Engage with and draw on diverse and new information technologies to enhance IP
- Start discussing / promoting the concept of ‘ready to practice interprofessionally by changing accreditation standards for education health to reflect IP expectations and ensuring preceptor and faculty training includes IP teaching and learning
- Regulators, professional associations and unions play a big role in creating and sustaining professional identities – need to work with union priorities and regulators to ensure their concerns about practicing interprofessionally are addressed (e.g. hold IP conferences)
- Formalize collaboration between Ministries of Health and Advanced Education – e.g. BC Academic Health Council as example of shared and broad mandate could host BC’s IP network (IN-BC); having participation of BC Ministries of Health & Advanced Education at the table increases leverage, results in better planning.
- Link IP to the local workplace e.g. IP Committee at hospital, in rural communities – ensure locally effective mechanisms; create critical mass of buy in. Need leaders and champions, engagement of middle managers, plus grass roots interest, support.

Part B – Imagining a robust role for IP in HHR solutions

1. Promoting knowledge exchange – how can IP learnings translate into useful evidence for HHR planning?
 - Data exists but need more transparency and relevance; find common language, vision, goals. Explicitly link government/employer priorities to research groups/research funding.
 - Have IP & HHR planners at the same table – linkages promote dialogue. E.g. joint conferences, initiatives, education, jointly funded positions across education / employers / professional bodies. Involve unions / associations from the outset.
 - Promote and build on existing IP settings and opportunities – provide a flood of information; embed IP education at all levels of student training; increase the patient voice in knowledge exchange.
 - Collaborate on IP training across regions / provinces with focus on competencies which influence relationships and outcomes; build structures for reflective practice; make IP education relevant to individual’s professional practice.
 - Lessons for IP:
In a position to assist with knowledge translation – close the gap between education about research methods and translation of research – e.g. clinical scholars embedded within practice environment.
Understand variety of target audiences; translate findings into specific implications; make very tangible and concrete recommendations.
 - Don’t wait for perfect evidence/research – implement improvements as we identify opportunities. Acknowledge crisis as a basis to change practice; acknowledge current weaknesses. Use student interest, expectations as opportunity to promote change.
2. Is regional collaboration a good idea? What are the facilitators and barriers?
 - Pros: sharing expertise; building on existing relationships, use western provincial government priorities to move more quickly; more manageable, efficient, relevant
 - Possible drawbacks: could dilute provincial initiatives; could be threatening; provincial priorities may get lost; may have unrealistic expectations
 - Overall conclusion: yes, a good thing to do – inclusive, with vision, governance, clear goals, clear added value and unique contribution
3. Options for sustaining collaboration – what structures/processes would support collaboration? What funding sources might enhance collaboration?
 - Shift IP focus: shift from ‘end in itself’ to where it makes a difference for patients, HHR, health system – address system level, but also report ‘good stories’. Link sustainability of IP to productivity; affordability and accountability will possibly drive development of a new worker. Optimizing utilization of skills in teams will create sustainability.
 - Get to the table on EHR/ EMR with IP perspective
 - Strengthen formal links between education & practice e.g. via research network, funding requirements
 - Funding links to knowledge translation - pursue funding by connecting across IP, HHR, others on common issues of quality, costs, risks, outcomes, EHR; use plain language – drop jargon, connect the dots; get support of senior health system executives via clear business case
 - Include pursuit of funding to support collaboration and sustainability – plan for 5 years or more, recognizing time needed for change. Standardize key messages, share ‘fact sheets’, other resources among ‘champions’

Funding sources:

- CIHR / CHSRF – for synthesis of existing IP research & evidence, with KT aimed at decision makers, public
- Provincial governments/ health authorities (in-kind supports) / regulatory bodies – insert IP requirements in programs, provide leadership for change in attitudes and collaborative skills development

Steps / processes:

- Common vision – national / regional / provincial
- Role clarification – template or framework
- Professional development – address existing front line & senior leadership include unions, regulators, public

Structures:

- Strengthen working relationships between health services and academic institutions – recognize and reward new model practice sites;
- Ensure academic faculty are good IP role models, and promotion and tenure reflect updated professional role clarification and care models (psycho-social + biomedical);
- Model IP in student teams

Part C – Best Next Steps: Partnerships and Plans

- i) Education & Health Care - Collaborative Forums in Alberta & Manitoba
- ii) Developing a Western Regional Collaboration - Who, What, How, When
- iii) Social Marketing Campaign
- iv) Key Messaging to Various Stakeholders
- v) Aligning IP Strategies with High Priority Health Services Issues
- vi) Job Redesign Process
- vii) Leadership Skills Development to Cultivate IP Learning Sites
- viii) Rural Health
- ix) Embedding IP into Existing Workforce

A full report of the topics convened is included below:

i) Education & Health Care - Collaborative Forums in Alberta & Manitoba

Discussion: Representatives from BC, Alberta and Manitoba met to discuss the development of a 'high level' organizational structure, similar to the BC Academic Health Council and the Saskatchewan Academic Health Science Network. There are differences between the existing two organizations but representatives were willing to work with groups from AB and MB to create a similar council.

Action: BC and Saskatchewan representatives to provide input to discussions in Alberta and Manitoba.

ii) Developing a Western Regional Collaboration - What, Why, How, Who

What?

- A working group for collaborative innovation and knowledge exchange (formal structure) See Figure 1 below.
- Focus on research, education and practice
- Develop a vision for IP and HHR
- Resource for IP and HHR planning in a western context
- Stimulate action and application
- Action to be taken in focused areas
- Facilitate joint research applications
- Align priorities with the provincial workforce action plans
- Advisory committee for the western provinces
- Work closely with the Western and Northern HHR Planning Forum – opportunity to leverage support/advice and influence

Why?

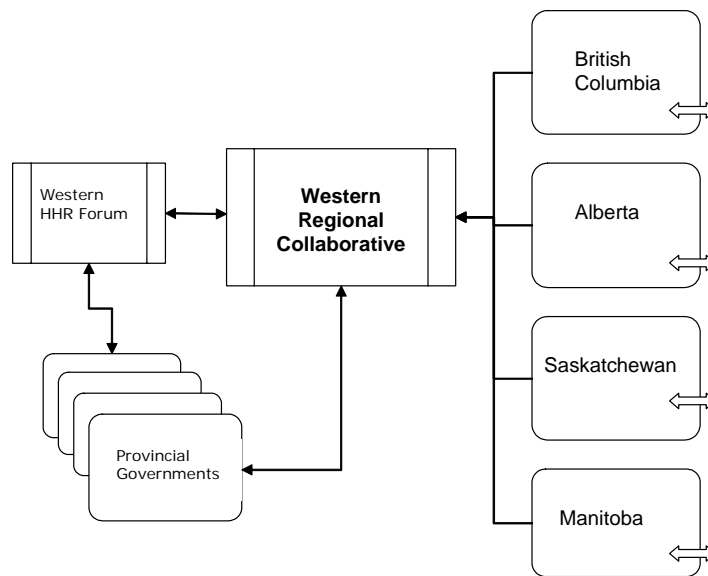
- Build on strengths of the western provinces
- Share learnings, knowledge
- Focus on specific regional approaches
- Take idea and concepts to action
- Build on existing relationships
- Need a formal link for IP to HHR

How?

- Feed into Western and Northern HHR Planning Forum and provincial ministries
- Two way exchanges
- Clear, defensible message and communication strategy
- 3-5 year strategic plan – listing priorities while allowing flexibility to respond to emerging issues

Who?

- Representatives from each of the four western provinces (may include individuals from existing provincial structures and networks)
- Representative to inform the Western and Northern HHR Planning Forum



iii) Social Marketing Campaign

Recommendation: as part of collaboration with the Western and Northern HHR Planning Forum, develop and implement a social marketing campaign about IP, its activities and outcomes.

The campaign would:

- **First:** raise awareness and offer tools (handouts, fact sheets, presentations, etc) to IP champions.
As provincial networks grow, teams deliver care differently, patients speak out, and IP gains momentum and sustainable support
- **Second:** use IP champions to support widespread behavior change.
Those engaged or interested in IP would have the communications strategies in place to support their vision and mission as they engaged more IP champions.
- See CIHC dissemination strategy, p. 21, on www.cihc.ca.

iv) Key Messaging to Various Stakeholder Groups

Discussion: Overwhelming numbers of key messages and stakeholder groups; challenge of how messages unfold and to what groups

Effective messaging can be used to lever agenda, get buy-in, support of change agents and champions.

Challenge:

- Get clear on message – across agencies, across sectors
- Reduce buzz words, such as evidence based and sustainability
- Marketing approach often provokes more questions

Recommendations: Review CIHC dissemination strategy, on www.cihc.ca, and then consider the following:

- What do we know? Back messages with synthesis of evidence for decision-makers;
- Link messages to workforce planning; link to population/ public / patient best interests; system; structure; highlight that IP is integral part of how we do business, not separate, quality and safety agenda; accreditation processes,
- Give targeted, refined answers that address specific agendas

- Use plain language
- Approach stakeholder / partner groups (as per CIHC Dissemination Strategy) and align with their strategic planning agendas (see v)

Thoughts on criteria and process:

- Who decides what the key IP messages are?
- Should they be standardized?
- Advise CIHC what's needed to drive change

v) **Aligning IP Strategies with High Priority Health Services Issues**

Recommendations: Overall support for aligning IP strategies with priority health services issues does exist:

- Identify IP champions in the health system
- Raise awareness at senior leadership levels
- Don't associate IP with only new initiatives, rather need to see this as a way of doing business - HHR has to be driven by future model of health services delivery
- Align IP champions with key projects in health system
- Measure outcomes at all levels – process, outcomes, staff satisfaction

vi) **Job Redesign Process**

This topic was identified as a “best next step” but did not produce a written action strategy.

vii) **Leadership Skills Development to Cultivate IP Learning Sites**

Discussion: IP education alone won't be successful in advancing IP. Students can't sustain it alone.

What else is required?

- Engagement of managers
- Physician practices
- CIHI (Canadian Institute for Health Improvement) Collaborative
- Business Case – linking costs, workforce and patient experience
- Key indicators – linked to funding
- Role clarity issues addressed – shared understanding of scope, roles
- Senior leaders education – MBA vs. professional development
- CIHI - governance structure
- Leadership challenge – vision, modeling the way, enabling others, celebrating

Opportunities:

- Sharing the IP team – showcasing the experiences
- Small trials; customize it; 'achieve global' – stellar service
- Structure – geography
- IP PMC sites with physician leads
- Embed IP champions

viii) Rural Health**Discussion of issues:**

- Not enough health professionals to fill jobs in rural communities
- Recreating job descriptions
- Nurses afraid of liability
- Challenges for student placements
- Concern of some senior staff to preceptor (outdated knowledge, lack of confidence)
- Reality of number of students to capacity of rural communities
- Need to define “rural”

Opportunities:

- 75% of those placed in senior placements return as staff
- Accommodation is key to attracting students; housing an integral part of rural HHR
- Some communities willing to take students but there is no central mechanism to foster rural placement; HSPnet – opportunity to coordinate across rural communities
- Opportunity in rural community to experience teamwork – however challenge of some hierarchical approaches in some communities
- IP learning for rural practitioners; ex. MOREOB Program (a continuous patient safety improvement program for physicians, midwives and nurses, as well as all other stakeholders within obstetrical care units)
- Students being overseen by other health professionals – needs to be further explored (lateral mentoring)
- Saskatchewan – studying the preparation of preceptors for rural settings
- Simulation for rural practitioners (travel unit) – good tool for IP practice
- Use of technology

Recommendations:

- Students should be required to have rural placements – well functioning rural sites are IP collaborative teams

ix) Embedding IP into Existing Workforce

This topic was identified as a “Best Next Step” but did not produce a written action strategy.

APPENDIX C MEETING EVALUATION RESULTS

Participants were asked to complete and return a four-question evaluation form. Overall, responses were very positive. Participants were also invited to provide comments at each question or on the back of the evaluation sheet. 19 evaluation forms were returned. Based on 80 participants, excluding the 8 member planning committee and support staff, this represents a 26% return.

Evaluation questions, scores and comments

Scoring range was 0 to 4, with 0 being “No” or “Not at all” and 4 being “Yes” or “Very Clear” or “Very Good”. *Comments are recorded in italics.*

1. Were the meeting objectives clear?

Mean: 3.1 Median: 3.0 Range: 2 – 4

I could not find explicitly stated objectives for this meeting in any of the material distributed in advance nor on Sept 17.

2. Was the information provided by speakers on Sept 17 appropriate and sufficient to support the work expected of participants on Sept 18?

Mean: 3.4 Median: 4.0 Range: 2 – 4

Excellent opportunity to network & hear reports from other provinces

Would be great to have copies of slides presented by speakers.

I did not pay enough attention ahead of time

3. Was the meeting format appropriate?

Mean: 3.6 Median: 4.0 Range: 2 – 4

Open space concept fabulous & truly engaging

Yes - the second day was especially good.

Yes, I'm pleased that presentations will be forwarded

Need to have dedicated time for provincial groups - hard to get together at home!

The change to new table hosts & new topics was rocky. New hosts did not arrive, and the step-in hosts did not report on the notes they took. I would suggest #d tables & host assignments to ensure that the role was enacted & the table [sic].

4. Were the objectives for the meeting met?

Mean: 3.4 Median: 3.5 Range: 2 – 4

Hope so! Depends on next steps.

Very encouraging - laying groundwork for next steps

The ambiguity was part of the fun, I learned a great deal & it stimulated lots of thinking re: new ideas & strategies.

Not sure. See #1. Clearer on day 2.

Time will tell.

Thank-you for a very beneficial 2 days