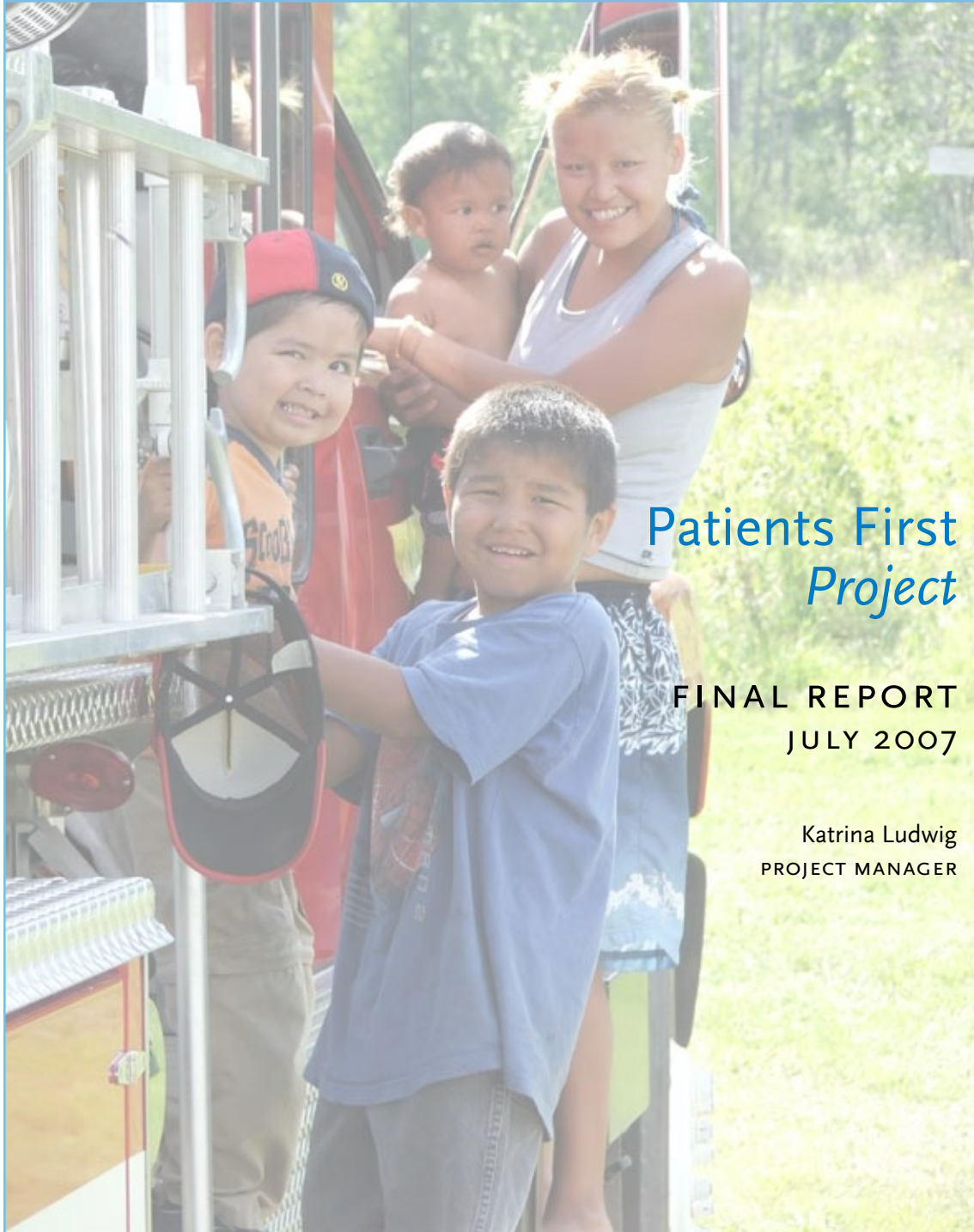




Interprofessional  
Network of BC



## Patients First *Project*

FINAL REPORT  
JULY 2007

Katrina Ludwig  
PROJECT MANAGER



Central Interior Native  
Health Society

## Acknowledgements

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The success of the Patients First Project was due to the co-operation of many individuals and agencies. I would like to thank the partners of this project for all of the time, input, and support they provided. To the sites that volunteered to participate and provided space, staff and time, thank you. My unlimited gratitude must also be given to Sandra Ritchot, Mabel Louie and Mary Teegee from Carrier Sekani Family Services; without their support and guidance this program would not have been able to have the richness of the First Nation voice and experiences. Thank you goes to Peter Martin for his support, encouragement, and “grammar expertise”. Finally, to the students and participants – thank you for sharing your voices and bringing an energy and excitement to not only Patients First but to the future role of interprofessional education and practice.

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## Executive Summary

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The Patients First project was initiated to explore the status of interprofessional teams working within a rural First Nation context in northern British Columbia (BC). Patients First also explored what was needed to optimize current team function and preparation requirements for health science students to work within interprofessional teams in target communities. Structured as a twenty-four month project, Patients First was funded by a Health Canada initiative administered by the Interprofessional Network of British Columbia (IN-BC).

The five partners of Patients First were the University of Northern British Columbia, Northern Health, Carrier Sekani Family Services, the Southside Wellness Clinic, the Central Interior Native Health Center, and eleven Carrier Sekani communities. The steering committee developed four overall goals for the project:

1. improve the quality of care provided by interdisciplinary teams of health professionals;
2. prepare health sciences students to work as members of interprofessional teams providing collaborative patient-centered practice;
3. encourage the development of interprofessional teams in First Nations/Aboriginal communities in northern British Columbia; and
4. demonstrate the impact of collaborative patient-centered practice on patient care outcomes

The first phase of the project evaluated the current interprofessional teams, health science student knowledge, and their interaction with the First Nations rural practice.

Initial team assessments indicated that interprofessional team work has been undertaken with varying degrees of success at all sites. Each team's ability to practice interprofessionally has been complicated by access to funding, competing mandates among health care agencies, lack of consistent staffing, and the transient nature of the clients/patients served. Community based teams also were subject to inter-community challenges and member burn out – leading to the dissolution of teams. Health science students expressed a lack of interprofessional knowledge and limited knowledge of rural First Nation practice. In addition, the ability of students to gain experience and knowledge of interprofessional team work was complicated by a lack of collaborative education opportunities.

Phase two involved meeting the goals of the project through training and education. In order to prepare, and build interprofessional knowledge and skills, the Patients First project developed and implemented an interprofessional team training curriculum. As a way of encouraging interprofessional in First Nations communities, health care practitioners and health sciences students were invited to the Unity Learning Circle in which community health representatives from rural communities presented their experiences, expectations and knowledge.

Goal Four was not fully accomplished due to the transient nature of many of the people who accessed the study sites. In order to address the patient outcome aspects of interprofessional

team work, it is critical to have a more stable and involved patient.

Further, dissemination of the findings of the Patients First project was accomplished through conferences, education sessions, and presentations, as well as three reports: Optimizing Interprofessional Team Work; Community Perspectives, and the Unity Learning Circle.

The Patients First project ended with four lessons learned:

1. The community based approach of First Nation's interprofessional team work has the potential to be an anchor for health care services at the community level. Fundamentally, merging health care into an interprofessional First Nation practice can be a catalyst for cumulative healing in a community – a rallying point – a safe place – a stabling force that can move the community to positive health.
2. In order for healthcare services to be sustainable within First Nation's communities there has to be support for interprofessional practice. Health care agencies and providers, government ministries, and educational institutions must commit to engaging the community and working beyond the concept of boundaries and limitations.
3. First Nation communities have the knowledge of what they want to address but battle the issue of being dependant on “outsider” tools. Consequently, many of their issues remain unaddressed or in adequately addressed.
4. There has to be direct relationship between 1) interprofessional education – that all health science students take together and 2) the community practice – collaborative work centers that actively practice interprofessional team work.
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# Project Summary

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## 1.0 Background

### 1.1 THE CHANGE INITIATIVE (PROVINCIAL)

Prompted by the increase in health care costs, more complex health care needs and patients becoming more involved in their health care, primary health care services throughout Canada are undergoing a period of significant transformation. The Canadian health care system is responding to these changing needs by transforming from isolated top down, disease/professional focused health services to patient-centered multi-disciplinary services.

One of the methods of achieving the change goal is to adopt the approach of interprofessional care. The concept of interprofessional is one of a fully integrated practice by a team of service providers from a diverse background of disciplines. Each member of the team has knowledge of the other team members' roles, and each works from an equally valued team mandate.

Within this model the services are patient-centred and cross the boundaries of health care determinants.

The *Royal Commission Report on the Future of Health Care*, also known as “the Romanow Report” of 2002 made several recommendations that focused on the need for collaborative, integrated interprofessional practices and education. The research presented in support of collaborative, interprofessional practice and education stated increases in

- \* patient-centered services,
- \* efficiency,
- \* sustainability,
- \* continuity of care

Further benefits of the interprofessional method were noted and included shorter wait times, more culturally appropriate services, and a prevention oriented approach to health care delivery (ref).

Building on the Romanow report, the *First Ministers Accord on Health Care Renewal* (2003) identified collaborative, interprofessional services and education as key components to increasing the effectiveness and sustainability of the Canadian health care system. Health Canada formed the Interprofessional Education for Collaborative Patient-Centered Practice (IECPCP) initiative to determine how the Canadian Health System could support interprofessional practice. The subsequent IECPCP reports and analysis substantiated the Romanow findings and also found that there was a distinct lack of systemic structures, at the practice and education levels, to currently support a patient-centered interprofessional collaborative mandate. In order to encourage the development of interprofessional care, Health Canada made available two cycles of funding to each of the provinces to develop IECPCP initiatives.

During this same time period, professional associations and universities also began to address the disconnect between education and practice. In 2004 and 2005, the College of Family Physicians of Canada and the Royal College of Physicians and Surgeons of Canada, prioritized the issue of interprofessional patient-centered care, resulting in changes in curriculum and other training directions. Throughout 2004-2006, *Enhancing Interdisciplinary Collaboration in Primary Health Care* (EICP) brought together 10 major health care associations and 1 coalition “to determine if there are ways to get more out our health care system, by encouraging interdisciplinary collaboration among health professionals”.

The Health Canada direction is clear on its commitment to interprofessional practices and education. In order to support this massive systemic change, commitment must be made by those at the policy, education and decision making levels in order to meet the primary goals of:

1. “50% of Canadians having 24/7 access to multidisciplinary teams by 2011.” (First Ministers Accord on Health Care Renewal, 2003)
2. To address the discontinuity between interprofessional knowledge at the education and practice levels.
3. To increase patient-centered collaboration.

In BC, the BC Academic Health Council supported the formation of several interprofessional initiatives, one of which has been the Interprofessional Network of BC (IN-BC). Funded through the cycle one funding, (see appendix 1), IN-BC formed as a collegial collaboration to increase interprofessional education and practice through the implementation of interprofessional projects in each of the health care regions of BC.

Health care in northern BC is mirroring the changes taking place at the federal health levels through the adoption of the interprofessional health care model of integrated and patient-centered practice and service delivery. Several initiatives have been developed in the North such as: chronic disease collaboratives and inter-agency partnerships with First Nations and Aboriginal organizations. Northern Health (NH) has taken a leadership role in working with health care professionals, educational institutions, provincial incentives, and communities in developing resources and training that support interprofessional integration. NH has also been part of the IN-BC initiative with the Patients First Project.

## 1.2 THE CHANGE INITIATIVE – PATIENTS FIRST

In 2004, a steering committee was formed with the goal of enhancing interprofessional care for First Nations and Aboriginal people in rural, remote, and urban areas in the North. Northern Health (NH), the University of Northern British Columbia (UNBC), Central Interior Native Health Society (CINHS), and Carrier Sekani Family Services (CSFS) collaboratively developed the Patients First project. Based on a twenty-four (24) month time frame, the Patients First initiative was designed to improve the quality of care provided by health professionals and prepare health sciences students to work interprofessionally in order to provide collaborative, patient-centred care. The overall goals of the project were to:

1. Identify and build on best practices provided by interdisciplinary teams of health professionals through knowledge and skill development.
2. Prepare health sciences students to work as an interprofessional team providing collaborative patient-centered practice;
3. Encourage the development of interprofessional teams in First Nations/Aboriginal communities in northern British Columbia; and
4. Demonstrate the impact of collaborative patient-centered practice on patient care outcomes

The project plan defined each of the goals within a logic model template (See Appendix 2).

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## 2.0 Steering Committee Members

The following is a list of steering committee members.

Peter Martin, *Manager of Education*, NHA, [Peter.martin@northernhealth.ca](mailto:Peter.martin@northernhealth.ca), 250-565-2101, F. 250-565-2251

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## 3.0 Sites

Three sites were involved in the Patients First Project:

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1. The Central Interior Native Health Center (CINHC) – a multi-disciplinary medical clinic and social service agency serving the needs of First Nations/Aboriginal and non-Aboriginal clients and patients living in Prince George. CINHC also provides placement for students from a wide variety of disciplines at both the college and university levels
2. The Southside Wellness Center (SWC) – a multi-disciplinary center located in a rural area south of the community of Burns Lake. The Southside Center serves First Nations/Aboriginal and non-Aboriginal clients and patients. SWC is just beginning the process of providing student placements. The clinic is operated by the Southside Wellness Society and is a collaborative involving Carrier Sekani Family Services (rural health, family services and mental health), three First Nations Bands, community members, and NH.
3. Carrier Sekani Family Services (CSFS) – a health and social service agency serving the needs of Aboriginal communities and families in the central interior of British Columbia. Service delivery is provided through three divisions with mandates for physical health, mental health, and individual/family support. The original CSFS participation was with its contracted mental health team, Brazzoni and Associates. This later changed to the Community Based Teams that provide service to the 11 member bands belonging to Carrier Sekani Family Services.

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## 4.0 *Informing Populations*

The ability to assess the level of knowledge and education around interprofessional practice was foundational to the development of curriculum and training. A mixed method of evaluation was used. Surveys, focus groups and interviews were undertaken with the health science students at UNBC and CNC to develop the baseline data for entry level knowledge of interprofessional practice. An assessment of curricula relating to interprofessional care was also undertaken. The participating health science students were: Medical, Dental, Home Support, Social Work, Nurse, and Nurse Practitioner.

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The second level of knowledge was to determine the degree to which interprofessional practice was used within the actual teams. The same mixed methodology was used to develop the baseline assessment for existing interprofessional teams. The practitioners within each of the participating sites included: mental health, addiction, nurses, administrative support, medical professionals and community health representatives.

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## 5.0 Knowledge Exchange & Translation

Sustainability and knowledge exchange were key components for the Patients First Project. Throughout the life span of the Patients First project several venues were utilized to promote, educate and share the interprofessional message.

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- \* Conference Presentations
- \* Education Presentations (within classes)
- \* Poster Presentations
- \* Reports (Milestones)
- \* Information Fair
- \* Committee involvement
- \* Newsletters
- \* Training sessions
- \* Brochures & Publications (promotional)

In these knowledge exchange forums or venues or activities increased the potential for interprofessional team building through education, case scenarios and resource sharing.

Four knowledge exchange forums, which formed part of the milestones of the Project, were held in Prince George.

1. DR. JOHN GILBERT – introduced students, communities and educators to the theory underlying interprofessional practice.
2. INFORMATION FAIR – a booth which provided an introduction to the Patients First project, its partners, and opportunities for interprofessional practice. Target population health science students and instructors.
3. INTERPROFESSIONAL SKILL BASED TEAM WORKSHOP – Introduction to skills necessary to support positive interprofessional team work among community agencies, students, and professionals.
4. UNITY LEARNING CIRCLE – interactive learning forum on interprofessional team work within First Nation practice, education and expectations.

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## 6.0 Project Organization and Goals

Patients First was organized into two phases each with specific activities that led to the achievement of the project's goals. Phase one activities included:

1. An examination of best practices of collaborative, patient-centred care;
2. An analysis of team function with regard to interprofessional collaborative, patient-centred care;
3. A case study project to demonstrate the effectiveness of interprofessional care in terms of improving patient-care outcomes and fiscal sustainability; and
4. The development and delivery of a workshop on interprofessional and collaborative care in First Nations/Aboriginal communities. Areas of concentration were the world views and conceptions of health care of Aboriginal/First Nations people as well as the dynamics of interprofessional team care and community development.

Phase two activities included:

- \* The development of a course on collaborative, patient-centred interprofessional health care practice in northern communities for eventual delivery to UNBC students in nursing, social work, and medicine. It was intended that the course would form part of program graduation requirements.
- \* Expanding interprofessional student placements where clear benefits for students and health service sites could be demonstrated.

### 6.1 GOAL ONE – TEAM PRACTICE

The first step, in meeting goal one of the Patients First project was to determine the knowledge and experience of site teams that provide interprofessional care. The participant site locations: CINHS, Southside and Brazzoni and Associates filled out surveys, and participated in several on-site interviews, focus groups, and observation sessions. The data was formulated within a customized analytical evaluation model based on the works of Tuckman (2001); Drinka and Clark (2000), and Heinmann & Zeiss (2002). These three models provide recognized benchmarks regarding team function (See appendix 3). Team evaluations were broken into the categories of practice, interpersonal relationships, team structure, and actions/productivity. After all the data was formulated, the information was further assessed determine challenges and strengths unique to each team and its context.

The detailed process and results of the examination and analysis of interprofessional team function was compiled into the first milestone report of the project: *Interprofessional Team Work – Report on current practices*.

### 6.1.1 Primary Site Findings

1. The three site locations were at distinctly differing points on the team status continuum (see Appendix 3). The placement on the team continuum is not positive or negative, but is a reflection of the team's status and level of function. Teams are not static and are in a constant state of flux. The ability of the team to move smoothly through its developmental stages and rebound back after change denotes the strength of the team.
2. Brazzoni & Associates is a uni-discipline team and does not practice interprofessional team work. Indeed, the team has very restrictive protocols on maintaining client confidentiality and file disposition. The Brazzoni site did not fall within the scope of the project and Community based teams sponsored by CSFS were included in its stead.
3. Southside services are based on collocation and do not practice interprofessionally. During the time of this evaluation, there were several employers with staff working at this site and no agreement among them on how they would work together. There were no protocols for sharing information, work space, or accountability within the team. Many of the services were provided off site. Staffing was provided by the agencies with no joint selection. Services provided were meant to be culturally integrated; however, most of the agencies on site were mandated to only work with First Nation reserve communities.
4. The CINHS site does have an interprofessional mandate, but the opportunity to practice interprofessionally is influenced by the lifestyle of those assessing the service. Very few of the clients fully access the team even though it is available to them – those that do tend to be under some form of court orders or intervention services such as Ministry for Children and Family Development. This site does have protocols regarding information sharing and has interprofessional communication expectations. The CINHS site also has working relationships with community and government organizations. Staff was selected based on a best fit premise. Patients at CINHS were all First Nation or of Aboriginal heritage and were predominately considered high risk.

Fundamentally the ability to function as a team was subject to systemic issues of mandates, funding, and management support. Members of all teams did not have a background in interprofessional team training, communication, or conflict resolution. Indeed, there was an underlying belief that once all the professionals got together, they would just be able to work together – a misconception which limited team function in some cases.

### 6.1.2 Final Recommendations

Based on the evaluation, research and the participants input, twelve recommendations were made that support the development of a cohesive interprofessional team:

1. Creation of a shared vision – critical for team foundation is to share a common directive.
2. Hold regular meetings – to maintain communication, build trust and insure vision maintained
3. Develop an onsite single decision making ability – supervision and support is direct and immediate.
4. Develop an integrated approach – all team members and the patient work together with an knowledge of each others roles and expectations.
5. Develop a shared data system and a protocol on information sharing – clearly defined communication.
6. Support a patient-centred approach – the foundation of the team is the patient and his/her involvement directs services.
7. Support a single entry service model – based on collocation
8. Flexibility in service options – to involve services that include traditional/no, across all of the health determinant factors, and in environments that may include in home.
9. Be selective over team members –Team members need to believe in interprofessional methods and be prepared to practice within a integrated mandate.
10. Develop expectation agreements – Clearly outline what is expected between all parties and that it supports the shared vision.
11. Provide regular team building/education/cross training opportunities – Strong teams are ones in which the team members have developed a relationship with one another; this increases commitment and trust.
12. Provide team involvement incentives – Engaging team members in the process ensures that they are involved and increases commitment, trust and accountability.

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### 6.2 GOAL TWO – HEALTH SCIENCE STUDENTS & INTERPROFESSIONAL EDUCATION:

The provision of a learning environment that supports interprofessional practice is another area of focus for the IECPCP initiative. Northern Health has taken a leadership role in meeting this area of focus through the inclusion of students in the Patients First project. Goal two of the project explored the current status of interprofessional – patient-centred education knowledge, supportive curriculum, and interprofessional opportunities for practice education.

### 6.2.1 Findings

1. Health science students currently do not have any courses on interprofessional care or interprofessional learning opportunities.
2. The social science students have an understanding of team based work within an integrated, community based model of care.
3. The social science programs have a core of community work, team communications methods and a longer exposure to interprofessional practice (practica are months long). The medical science programs have some communication courses but they are not as focused and the perceptorships are days rather than months.
4. There are strong discipline silo knowledge with a significant lack of knowledge across disciplines. Students have a basic idea of what other disciplines do, but their knowledge tended to be superficial i.e.: Social Workers deal with poor people or people with addiction issues; Nurses help doctors and provide hospital care.
5. There is a stated assumption of power, authority and prestige based on discipline – with the medically based disciplines being ascribed an assumption of greater credibility.
6. Patient-centered was often conceived as a top down provision of service in which the patient was not directly involved with the plan or direction of care. In other words, patient-centered care meant care in the best interest of the patient as determined by the professionals. .
7. Students expressed lack of knowledge regarding team work, information sharing, rural practice, or conflict resolution skills
8. Students expressed a lack of knowledge regarding culturally sensitive practices of First Nations peoples and other minority groups.
9. Students were not provided with practical examples of interprofessional team work in action.
10. Students were willing to mentor in rural and remote but funds, housing, and appropriate supervision were cited as barriers.

## 6.3 GOAL THREE – DEVELOPMENT OF INTERPROFESSIONAL TEAMS IN FIRST NATIONS/ABORIGINAL COMMUNITIES

A review of relevant research demonstrates that First Nations/Aboriginal peoples experience barriers in accessing health care due to geography, discrimination, jurisdictional boundaries, program mandates, and staffing inconsistency in services specifically for them (NAHO,2004; INAC, 2005; Simcoes Report, 2003). The consequence is that the populations of rural First Nations communities have higher rates of tuberculosis, diabetes, HIV, arthritis, physical disabilities, addiction/mental health issues, and suicide than that of the general population. Ambulatory care has been stated to be 4-5 times higher hospital admittance for First Nation

populations, with the authors arguing that while the conditions could have been managed in the community – lack of funding, access and cultural stereotyping may lead to compounding of issues or issues not addressed until more critical stages.

Goal three of the Patients First project was to “encourage the development of interprofessional teams in First Nation/Aboriginal communities in northern British Columbia”. After the initial team review was completed, it became apparent that the Brazzoni site did not practice interprofessionally and removed from the study. Subsequently, the community based teams (CBT) located in the communities served by CSFS were invited to participate in Patients First.

In order to gain an understanding of the uniqueness of the community based teams, a community profile was completed on each of the communities inclusive of demographics, on site services, economic profiles and on/off reserve populations. Through community visits, round table meetings, team member interviews and service surveys several key questions were presented:

1. What services are offered on site, off site?
2. What services are periodical?
3. What are the roles, responsibility and membership of the CBT?
4. What are the staffing, schedules, turnover and training of CBT members?
5. How are services integrated into the community?
6. What are the strengths of your CBT?
7. What are the challenges?
8. How does the community address the challenges?
9. What are the gaps between current services and your community needs?
10. How have health science students worked with the CBT?

Of the other two Patients First sites; CINHS do not provide off site services and do not work with the rural communities so they were not included in this evaluative stage. Southside services were provided to some of rural First Nation services, but had limited interaction within the clinic site – off site services were provided by CSFS staff. The three First Nation communities within the Southside are all part of the CSFS membership so their information was captured.

The results of the community-based environmental scan, the focus groups, and the community meetings were presented in the report: *Patients First Exploring Community Based Teams: Community perceptions, capacity and relationships within Carrier Sekani Family Services*.

### 6.3.1 Summary of Findings

The results of the focus groups, research, and participant interviews demonstrate that the development of health care teams in rural and remote First Nation communities is subject to several unique factors:

- \* Young and mobile population with few opportunities for education or work while living on-reserve
- \* Respondents experienced discriminatory treatment by health care providers
- \* The widely held belief that seeking care/treatment outside the community would lead to community abandonment.
- \* Issues of discrimination, mental health, addiction and poverty were defined as the primary factors in determining the health of individuals.
- \* Distance from care, poverty, and agency mandates presented were factors which created community wide challenges with regard to population health and access to care particularly for reserve communities.
- \* The protectionist attitude demonstrated by some health care services in reserve communities limited continuity of care for some patients/clients.
- \* Higher rates of co-morbidity than found in the general Canadian population.

The community based teams recognized that an integrated interprofessional/community approach fits within Aboriginal conceptions of health and wellness; however, they struggle with issues of

1. Access
2. Funding
3. Commitment of team members and their organizations
4. Developing culturally services within program guidelines
5. Integration & Collaboration (jurisdictional, communication and transition issues)
6. Staffing
7. Politics and relations (governmental, local and internal)

Students are regularly included in service placements, however they are mentored by specific agencies that providing services and are not selected or responsible to the CBT. Students are not based in the communities themselves.

When all of these issues intersect, the community based teams breakdown and are no longer able to provide service. During the course of this project, all of the teams experienced various degrees of breakdown and significant lack of staffing (nurses, mental health, and addiction and family services). At the time of writing, none of the teams have returned to a functional level.

### 6.3.2 Recommendations:

In order to encourage interprofessional health care teams in rural/remote First Nation communities several recommendations are presented. All of the recommendations are based on the need to increase access, trust and communication while ensuring that First Nation communities define their needs and direct service provision.

1. Build on the concept of community based teams augmented with periodical services (traveling teams).
2. Work out agreements for transportation to service.
3. Use tele-health more frequently for medical advice and education.
4. Develop community specific protocols between Federal and Provincial governments with leadership from community members.
5. Provide educational support for health care professionals working in First Nations communities.
6. Hold regular meetings with First Nation communities to review progress on addressing health care needs.
7. Include CBT members in hiring and student placements in order to increase recruitment and retention of staff
8. Incorporate students in multi-supervisory models of practicum so that they can be placed in a variety of forums with exposure to other disciplines on rotation. Have a central discipline specific supervisor to work with the interprofessional frame work.
9. Have cultural representatives help to develop curriculum for the health science students.
10. Develop a community “broker” to mentor students and new professionals. For example, this might be an elder who is able to explain cultural and community dynamics).
11. Adopt a service model that specifically seeks to strengthen the relationship between health professionals and the community.
12. Foster collaborative and integrated services that include community members for in their administration and governance.
13. Design innovative compensation plans to encourage the participation of health care providers who normally work on a fee for service basis.
14. Develop strategic plans that make the most of short stay professionals that include specific relevant recruitment schemes.
15. Utilize an interprofessional format that leverages existing services into multi-related approaches (i.e. pair addiction with mental health).

#### 6.4 CASE STUDIES: GOAL FOUR

The final goal of the Patients First Project was to explore the patient care outcomes of 10 case study participants involved in interprofessional health care services within the selected location sites. During the time period of September 2006-May 2007 a concentrated effort was made to recruit these 10 case study participants. Several methods of recruitment were utilized:

1. Information letters were provided to the study site leads
2. Ongoing telephone contact with organizations and community leads
3. Ongoing emails to organizations and community leads
4. Several site visits and meetings

In order to support participant involvement; daycare, meals, transportation and participant meeting site selection was provided. An expectation of three interactive interviews (over a ten month period) and the completion of regular survey were minimum requirements for participation. Participants were referred to the project from the study sites. The base line criteria for participation included involvement with two or more interprofessional team members and two or more health concerns, one of which was medically based.

#### 6.4.1 Method

Sites to identify appropriate participants

1. Select indicators and measures
2. Establish core questions
3. Meet with participants and explain process and reasoning
4. Obtain informed consent
5. Record the person's story – document their perceptions and experiences with team.
6. Frame information within evaluative methodology (qualitative/quantitative).
7. Follow participants from August 2006-July 2007 (Monthly visits with participants)
8. Provide information back to participant for approval

Patients First developed and provided to all participants: a consent form, an information booklet, a recording journal, service information listings, and contacts to provide them with further clarification before they agreed to participate. Standardized interview questions were developed for each of the three interview stages. Consultation with the research review committees at Northern Health and CSFS were included at all stages.

CSFS sites provided contact to 17 potential participants with a verbal commitment of 10 more. However, only 5 attended more than the initial meetings. In factor order, the primary barriers influencing follow up with the case studies were as follows:

1. Transients (participants could not be located for follow up)
2. Team break down and lack of referrals
3. Participant lifestyle (involvement in social crisis)
4. Removal of one of the study site locations

#### *6.4.1.1 Mobility of Population*

The populations involved in this evaluation have a high rate of mobility due to a variety of economic and lifestyle factors. Within this time period 12 of the 17 participants were unavailable beyond the initial referral meeting. The key factor for the 5 remaining participants was that they had maintained a consistent residence for longer than the one year period prior to evaluation.

#### *6.4.1.2 Team Break Downs*

The primary challenge for this evaluation was the breakdown of the interprofessional teams within the study site locations. During the evaluation time period, all of the teams experienced various degrees of staff turnover and management change. None of the participants had regular enough team involvement to develop a cohesive outcome evaluation. Due to team breakdowns, there were not enough referrals from the study sites.

#### *6.4.1.3 Participant Lifestyle*

The lifestyle factors influencing the referred participants were primarily drug/alcohol and mental health issues. The combination of these significant lifestyle factors resulted in participants personal and community instability. For one participant – while she was stable – the influence of the lifestyle of other family members had a direct correlation on her ability to be involved in this evaluation. In this particular situation, she ended up as the primary care provider for her grandchild and then for another new born grandchild. The responsibility of the children, court orders, social worker visits and the ongoing conflict of her daughter’s addiction created family instability. The other participant struggled with ongoing addiction and mental health issues, pregnancy, and loss of her pregnancy. These two were the most consistent case study participants, and both were under mandated court orders from Ministry for Children and Family Development.

#### *6.4.1.4 Removal of the study site location*

During the course of the project, the Southside clinic – one of the primary study sites – was removed from the study. The reason for the removal of the Southside was based on the increasing conflict among the member agencies operating at the site and the absence of a clear commitment to interprofessional practice. The removal of this site excluded the opportunity to recruit four potential participants and resulted in a significant burden of referrals from the remaining evaluation sites.

As a result of the factors mentioned, the case study goal could not be met within the scope of the Patients First Project. Any results from the participants which were more involved can not be considered valid as the participants did not have regular site team contact. On a positive note all of the participants considered the site locations as positive “supports” in their lives but did not really consider them as teams.

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## 7.0 Project Deliverables

### 7.1 INFORMATION SESSIONS (PHASE ONE: GOALS ONE, TWO AND THREE)

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Throughout the project, several information sessions were held to encourage the development of interprofessional knowledge and education. Although the primary audience of the information sessions were the health science students; community and the health professionals were also included. The first of the sessions was that by Dr. John Gilbert, Dean of the College of Health Disciplines at UBC and lead of the IN-BC project. Dr. Gilbert explained interprofessional practice and education from provincial, federal and global perspectives.

Throughout the project, regular information sessions led by the project manager were provided to health sciences students in social work, nursing, dental studies, home support/residential care, and medicine. Patients First also presented at approximately twelve conferences on various health and wellness, rural and remote and First Nation health issues. Poster presentations were also made to six conferences. Audiences ranged from health science students and academics to currently practicing health professionals, community members, and government officials.

An information fair was held at UNBC to promote interprofessional education and practice and also to promote the role of collaborative partnerships like Patients First. The full day involved posters on the Patients First project, UNBC health science programs, CSFS programs, Southside services and CINHS services. Representatives from the project and the evaluation sites were in attendance to answer questions; promotional materials were provided as prizes. The fair was also a promotional opportunity for students to sign up for the upcoming Patients First team building training and the Unity Circle. One professor from College of New Caledonia also used the session as a fact finding opportunity; all of the students had to fill out a questionnaire she developed on how to practice interprofessionally.

Promotional material for the project included: brochures, power point presentations, posters, and handouts folders.

### 7.2 DEVELOPMENT OF INTER- PROFESSIONAL CURRICULUM (PHASE ONE & TWO: GOALS ONE, TWO AND THREE)

Phase two of the Patient First project was to see the development of a course on inter-professional practice applicable to students in all health science disciplines. However, all programs have demanding course schedules designed to meet the standards of professional licensing bodies and an additional course could not be developed and integrated easily. Similarly, there was no way to integrate interprofessional concepts throughout existing course curricula within the life-span of the project.

Instead, project staff developed a two-day workshop on interprofessional practice that was piloted with health sciences students and health professionals. The workshop addressed the following topic areas:

- \* The theoretical foundation of interprofessional teams and teamwork
- \* Interprofessional team leadership
- \* Communication and conflict resolution
- \* Interprofessional, patient-centred planning

The workshop was formulated as a collaborative experience using various methods of instruction such as: experiential learning, lecture, group and individual work, and case studies. The workshop was limited to fifty (50) participants who were all divided up into groups – in which they were not generally known to each other and representing various professional disciplines and patients. There was a further wait list of 15 established for the training. Each participant was also provided with the workshop binder and a series of case study profiles. Introduction surveys and follow up surveys were provided for each of the days.

### 7.3 UNITY LEARNING CIRCLE (PHASE ONE & TWO: GOALS ONE, TWO AND THREE):

The Unity Learning Circle was developed to strengthen communication and to increase the knowledge exchange between First Nation community members and non-First Nation health professionals and students. The Unity Learning Circle was structured as a double circle format, in which the guest speakers were in an inner circle and the participants formed a ring around them. The 15 guest speakers were the Community Health Representatives, nurses, nurse practitioners, family workers and other health/social community members who live and work extensively within their First Nation Communities. Two facilitators, Lucy Mattess and Nancy Tom, provided the history of a learning circle and explained the process.

Members of the circle introduced themselves, their clan/family membership, and the role they hold in the community. The speakers also introduced their unique community and protocols and the success/challenges that they face working in rural and remote practices. Each member presented what they expect from those who plan on working their rural/remote communities.

The Unity Circle follow up was synthesized in a report which included the evaluation results – with a finding that 80-88% of participants stated they had gained knowledge in:

1. Building collaborative (respectful) relationships
2. The uniqueness between communities
3. How interprofessional teams can work within First Nation communities
4. How to practice in a manner that focuses on the First Nation health and wellness perspective
5. The challenges & strengths for practice confronting these communities

## 7.4 PREPARING STUDENTS (PHASE ONE & TWO: GOALS ONE, TWO AND THREE)

Patients First developed education and information opportunities in order to address the gaps between knowledge, education, and practice. These were:

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- \* Several instructional presentations within each of the Health Science (Nursing, Nurse Practitioner, Dental, Social Work, Medical) classes
- \* An information seminar lead by Dr. John Gilbert
- \* An interprofessional information fair held at UNBC (105 participants)
- \* A Unity learning Circle (56 of the 110 were students)
- \* A two-day, interprofessional team building workshop (25 of the 50 were students)
- \* A listing of interprofessional team based services within Northern Health, CSFS and CINHS were provided to the practicum / preceptor coordinators at UNBC and CNC for student placements.
- \* Curriculum for team based education provided to chairs of UNBC health science for consideration

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## 8.0 Project Review

The scope of the Patients First project was developed, in principle, by the steering committee during 2004. The following is a review of the scope as the project unfolded.

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### 8.1 ACCOUNTABILITY

Patients First provided accountability through several venues:

1. Regular contact with Steering Committee through four face to face meetings
2. Monthly and bi-monthly update reports to: Steering members, IN-BC, NH management reports and supervisor meetings with Peter Martin (NH onsite supervisor)
3. Monthly involvement with IN-BC committees
4. Three on site presentations to IN-BC
5. Fiscal reports and financial outcomes: NH and IN-BC
6. Formal application through NH and CSFS research review committees
7. Ongoing co-operative sharing and disposition disclosure of information between sites, First Nation communities, and Patients First
8. Ongoing consultation with management of First Nation communities, Patient First partners, and NH.

### 8.2 CHALLENGES AND LIMITATIONS:

As with any project, the manner in which goals are able to be met are often subject to systemic and environmental issues that can not be fully pre-determined. When developing the scope for the project there was a fundamental lack of information, among steering committee members, about what an interprofessional team looked like. Indeed, the assumption that team work was generic influenced the selection of sites. As the project became more informed, the criteria and best practices of interprofessional work became more clearly defined. Subsequently, the project soon discovered that the selected sites were not best candidates for evaluation.

The Brazzoni and Associates site which was originally selected did not practice interprofessionally. It was withdrawn from the project and the community based teams sponsored by CFSF substituted in its place. Yet another site, the Southside Clinic, which was originally considered to be an interprofessional service provider actually housed a number of collocated but isolated services. Although Southside had a mandate to provide interprofessional service, the member agencies had not worked out an understanding of “how” they would work together. Essentially, all the staff and agencies worked out of the same building but did not share information, clients, or supervision. The lack of shared direction seriously impacted the services and the staff commitment.

The lifestyles of the patients/clients seriously impacted their ability to fully access the interprofessional services which were available. Patients/clients tended to have high-risk and transient lifestyles with multiple barriers to maintaining wellness including: homelessness, mental health, addiction, violence and health crisis. Patients/clients accessed health care services on an episodic or crisis by crisis basis that addressed their immediate needs but did nothing resolve underlying issues. Typically, they would access service for their immediate need and then disappear for several months – reappearing only when again in crisis. Episodic patient/client contact made it impossible to assess the effectiveness of interprofessional practice by assessing patient care outcomes.

### 8.3 STRENGTHS

The Patients First project was able to establish strong community relationships which strengthened the potential for long term sustainable practices between rural and urban sites. The ability to develop creative learning forums such as the “Unity Learning Circle” created a communication opportunity that can progress beyond the project.

Having stable funding for the project was a primary strength for planning and involvement. Indeed, the budget was built to allow for supporting participants in the process through facilitation of being able to provide travel, daycare, meals and supports. As the rural and remote First Nation communities tend to have access and transportation issues the ability to travel into the communities provided for opportunities to broaden the project into areas that contributed a completely different view to the project.

Finally, the strength of the project was due in large part to the partners and the participants in the communities. The willingness to share and participate is strong foundations for future interprofessional endeavors.

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## 9.0 Recommendations

The following are recommendations to sustain interprofessional practice in First Nations communities:

- 1. HOLD A UNITY LEARNING CIRCLE BI-ANNUALLY**  
The Unity Learning Circle was successful in promoting education, knowledge and First Nation practice in a unique manner. The opportunity to make the connection between those who intend to work in First Nation communities and those who live and work in those communities should be expanded. The potential to increase communication and trust is further extended to opportunities to recruit staff and practicum students and to develop networking. This event would also be suitable for sponsorship by the Aboriginal Health Division within Northern Health.
- 2. OFFER INTERPROFESSIONAL TEAM BASED WORKSHOPS**  
The feedback from the Patients First project clearly indicated a need for focused interprofessional team based education and training. The team workshops must be interprofessional in nature and include health professionals from a variety of disciplines, community members, and health sciences students.
- 3. CONTINUE TO DEVELOP RELATIONSHIPS WITH FIRST NATIONS COMMUNITIES**  
Patients First has developed positive working relationships with the First Nation communities within the CSFS region. It is recommended that the good will continue with the offering of other collaborative opportunities to work together and ongoing inclusion of First Nations representatives in health and wellness initiatives, projects, and training.
- 4. GAIN PATIENT OUTCOME RESULTS**  
The population involved in the Patients First project was not stable enough to access interprofessional team services on a consistent basis. The report recommends that the effects of interprofessional teamwork on patient care outcomes are explored with a more stable population. Suggested populations include residents of care facilities, geriatric patients, and the clients of chronic disease teams.
- 5. BRING EDUCATION, PRACTICE AND POLICY TOGETHER**  
A three prong approach to developing a commitment towards interprofessional practice and education is critical. The final recommendation of the Patients First project is to gain a clear commitment from stakeholders in education, healthcare and government to develop further interprofessional initiatives. Holding a forum to begin the conversation on how this can be done is an important first step.

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## Appendix 1

### IECPCP Funded Projects

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#### 2.1 CYCLE 1

- \* [Creating an Interprofessional Learning Environment through Communities of Practice: An Alternative to Traditional Preceptorship](#)
- \* [Structuring Communication Relationship for Interprofessional Teamwork \(SCRIPT\)](#)
- \* [Queen's University Interprofessional Patient-centred Education Direction \(QUIPPED\)](#)
- \* [Collaborating for Education and Practice: An Interprofessional Education Strategy for Newfoundland and Labrador](#)
- \* [Interprofessional Education for Geriatric Care](#)
- \* [Patient-Centred Interprofessional Team Experiences](#)
- \* [Patient-Centred Care: Better Training for Better Collaboration](#)
- \* [The McGill Educational Initiative on Interprofessional Collaboration: Partnerships for Patient-Family Centred Practice](#)
- \* [Building Capacity and Fostering System Change](#)
- \* [Institute of Interprofessional Health Sciences Education](#)
- \* [Seamless Care: An Interprofessional Education Project for Innovative Team Based Transition Care](#)

## Appendix 2

CHART ONE: THE CONTINUUM OF TEAM DEVELOPMENTAL STAGES

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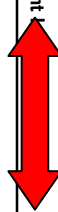
<b>INTERDEPENDENCE &amp; Functional (Performing)</b>	Free expression of "feelings"	Flexibility Negotiating	Supportive Good Communication	<b>Stage Four : Effective Team</b>	TURNOVER - Leaving Stage 	STUDENT IMPACT 
<b>COHESION &amp; Consensus (Norming)</b>	Tightly Knit Trust" we-ness"	Harmony Cooperation	<b>Stage three: Sharing Group</b>	Ownership Safety		
<b>CONFLICT (Storming)</b>	Resistance Leadership Struggle disagreement	<b>Stage two: Fractionated Group</b>	Encounter Task-Oriented Confrontation	Issue-Oriented Polarization		
<b>DEPENDENCY &amp; Testing (Forming)</b>	<b>Stage one: Immature Group</b>	Inefficiency Search for procedures	Telling-Asking One way communication	Experting Leader-centered Decision making		
	<b>ORIENTATION Context</b>	<b>ORGANIZATION Structure</b>	<b>OPEN DATA FLOW process</b>	<b>PROBLEM SOLVING productivity</b>		
<b>TASK BEHAVIOURS</b>						

(Based on Models proposed by Tuckman, as outlined in Farrell et al. , 2001; Drinka & Clark, 2000; and Heinmann & Zeiss, 2002)

CHART TWO: A TEAM IN CONTEXT OF ENVIRONMENTAL VARIABLES

Overlapping the model of team developmental stages are also the evaluative measures as outlined in this chart.

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Values - Socialization	Issues that directly affect Practice Process		Intra-Team Issues Context		Organizational Issues Structure		Actions necessary for Team Maintenance Productivity		
	Personal	Professional	Team Structure	Team Process	Internal	External Organization	Team	Organization	
	Age Gender culture Communication skills Energy Styles of relating Willingness to risk Flexibility Leadership styles Openness to new knowledge Personal knowledge Maturity Awareness of personal conflict styles	Expertise in specialty Dedication to an ideal Respect for professional differences Broad knowledge of health determinate Willingness to share client Professional maturity Knowledge of roles of others Knowledge of systems Knowledge of ways different professionals problem solve	Formal leadership Norms Composition Formal roles Team culture Professional status Physical placement Structured for interaction Structured for innovation	Negotiating informal leadership Goal setting Appreciating values Negotiating team roles Building trust Communicating Problem solving Problem solving influences Managing conflict	Team Philosophy Resource allocation Rigid vs. flexible rules Simple/complex structure	National policy Funding sources Philosophy Inter-disciplinary values	Use power for decision making All free to disagree Evaluates and manages itself Mentorship leadership to new members	Communicates a clear mission statement Team feedback to develop and ongoing revise mission Team to manage itself Gives constructive feedback to team Responds in a problem solving manner to the teams' requests	Student 
<b>Meanings – Language – Priorities (Directness – Elimination of Jargon)</b>									

(Based on Models proposed by Tuckman, as outlined in Farrell et al., 2001; Drinka & Clark, 2000; and Heinmann & Zeiss, 2002)