**Western and Northern**
**Health Human Resources Planning Forum**

# "Developing Sustainable Interprofessional Collaborative Practice and Learning Environments"

**SITE REPORT**

**Jurisdiction:** British Columbia.

## Site Names:

Seniors at Risk Integrated Network,
Vancouver Island Health Authority
**&**
The Lodge at Broadmead,
Broadmead Care Society

***Developing Interprofessional Collaborative Practice and Learning Environments across the Continuum of Care in Western and Northern Canada***

## Submission Requirements

Site reports should be submitted as soon as possible after June 30, 2011 and no later than July 15, 2011. The Project Final Report will be going forward to Health Canada, through the Forum, at the end of July 2011.

Please submit your report to Catriona Park (cpark@bcahc.ca) with a copy to BJ Gdanski (bjgdanski@bcahc.ca).

This report is intended to be brief and to complement data that are being collected through the overall project evaluation. If you have materials prepared for other purposes that address any of the questions outlined, please append and indicate within the body of the report rather than duplicating effort.

**Describe each of the CP&LE sites/teams that participated in this project. Please include:**

## 1. Profile of Sites

The project was undertaken at two separate sites as follows:

### 1.1 The Lodge at Broadmead (the Lodge), Broadmead care Society (BCS)

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| **DESCRIPTION:** | • Residential care facility operating within VIHA<br>• Includes 115 priority access beds for veterans and 110 community beds. |
| **POPULATION SERVED:** | • The Lodge provides service to seniors with impairments that may be physical, cognitive, or very frequently both, when care and assistance must be readily available at all times.<br>• Average age of resident is 87<br>• 75% have cognitive impairment + multiple co-morbid conditions<br>• Between 50% - 60% of all residents have a change in family physician when they move into the care facility.<br>• Near 100% of all people who move into the Lodge die there. |
| **PROGRAM OVERVIEW:** | • The Lodge is funded by the Vancouver Island Health Authority. Residents pay a daily rate that is set by the Ministry of Health, as well as optional service fees.<br>• Veterans may receive funding support for some services, equipment and supplies through Veterans Affairs Canada.<br>• Staff is made up of an interdisciplinary team providing assessment and care, nursing, social work, dietician, occupational therapy and physiotherapy<br>• Have been working with a small group of 10 - 12 local physicians who have been willing to increase the number of patients they care for at The Lodge; collectively they now provide medical care to over 80% of the residents. |
| **TEAM COMPOSITION:** | • Multidisciplinary care staff (Includes supervisory, administrative and clinical staff).<br>• Family physicians providing clinical consultations and interventions at BCS<br>. |

### 1.2 Vancouver Island Health Authority (VIHA): Seniors At Risk Integrated Health Networks -(SARIN).

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| **DESCRIPTION:** | • Innovative approach to keeping vulnerable seniors healthy and out of hospital.<br>• Integrated health network that links seven VIHA programs, 28 Greater Victoria and Saanich Peninsula physicians, and elderly patients.<br>• Aims to empower people to become partners in their own health care by maximizing function and independence. |
| **POPULATION SERVED:** | • Frail, elderly patients over 55 years of age living with 2 or more chronic conditions. |
| **PROGRAM OVERVIEW:** | • SARIN creates partnerships between primary care physicians, home and community care programs, mental health and addictions services, seniors health specialized services, End of Life services, community recreation centres and many other organizations that help delivery holistic primary and preventative care to seniors.<br>• Works around a clinical team approach where case managers collaborate with nurse practitioners, specialized nurses, social workers, pharmacists, dieticians, physiotherapists and occupational therapists.<br>• Provides enhanced access to services for frail seniors/families (falls prevention, medication management, CHF self management, dementia education programs).<br>• Linkage with Specialist Services (Geriatrics, Mental Health, Palliative Care)<br>• Access to community services that promote seniors independence. |
| **TEAM COMPOSITION:** | • SARIN Clinical Team: *Family physicians, Nurses, Case Managers, Occupational and Physiotherapists, Nurse Practitioner, Recreation Therapist, Dietician, Pharmacist, Administrative assistants, manager* |

## 2. Organizational Context (i.e. how situated within the broader organization, key linkages, etc.)

### 2.1 Broadmead Care Society

The service delivery team at BCS consists of Family physicians, Registered and Licensed Practical Nurses, rehabilitation professionals, care aides, leaders and support staff. The primary focus of this project was to explore the relationships and interprofessional practice between all of these disciplines with particular emphasis on the integration of a newly introduced Nurse Practitioner role. The Broadmead Care Society is a non-profit society that is affiliated to the VIHA through a service contract. The Lodge, operated by the society, is a complex care facility that provides service under the VIHA contract to clients who have been assessed as not being able to live safely in their own home. Clients are referred and approved for funded service by the VIHA.

### 2.2 The SARIN Team:

SARIN is a Ministry of Health / VIHA demonstration project operating in the South Island that provides interdisciplinary services to support GPs in the management of seniors with multiple chronic conditions. Participating physician practices have access to services within the Network, integrating existing VIHA geriatric services with those offered by VIHA community clinicians/services. The objective of SARIN is to proactively meet the needs of seniors in the community at risk of admission to acute or residential care, improving health and maintaining independence as long as possible. The team reports to the Director of the Seniors and Spiritual Health program which has the responsibility within the VIHA, to deliver specialised seniors medical and psychiatric care

## 3. Degree of Student Involvement

No direct student involvement in either site project.

## 4. Briefly describe the roles and relationships within your service delivery team(s) and the degree to which you feel you had the opportunity to optimize roles through the course of the project.

### 4.1 The Lodge at Broadmead:

The service delivery team at BCS consists of family physicians, Registered and Licensed Practical Nurses, rehabilitation professionals, social workers, dieticians, care aides, leaders and support staff. The primary focus of this project was to explore the relationships and Interprofessional practice between all of these disciplines with particular emphasis on the integration of a newly introduced Nurse Practitioner role.

Through the Future Search workshop “The future of Interprofessional collaborative practice at The Lodge at Broadmead”, the team was able to explore the impact, challenges and opportunities of the team at The Lodge, which has evolved to include:

1. Implementation of a nursing staff mix which now includes LPN’s in direct care roles, RNs and RPN’s in leadership/supervisory roles, and advance practice nurses in CNS and NP roles
2. Implementation of the Nurse Practitioner role working in collaboration practice with several family physicians
3. Other interdisciplinary team members.

The workshop allowed the team to focus on past highlights and milestones, present reality and trends, and imagine and plan for our ideal future. Four action projects were identified related to:

1. Information technology
2. Nurse Practitioner
3. Person-centered end-of-life care
4. Community outreach for the frail elderly.

### 4.2 SARIN

| Team Member | Roles & Relationships: |
|---|---|
| Physician | Referral to SARIN Service indicated.<br>Primary care provider to patient.<br>Interacts mainly with Case managers and Nurse practitioner but has contact with other team members. |
| Team Leader | Responsible to coordinate service and staff to ensure project goals and care gaols are met. |
| Case Managers | Work directly with physician to determine most appropriate service to meet client needs. Liaises with all other clinicians and home support providers to facilitate required services. |
| Nurse Practitioner | Works primarily with team and physician to support clients with in depth, short term management of chronic health conditions. Participates in the development of interdisciplinary care plan with other team members as indicated. |
| Physiotherapist | On referral from physician manages falls prevention and strengthening program to improve clients ability to self manage chronic conditions. Participates in the development of interdisciplinary care plan with other team members as indicated. |
| Occupational Therapist | Focussed on the assessment of complex cognitive disabilities. Provides expert assessment and treatment options for cognitively impaired clients. Participates in the development of interdisciplinary care plan with other team members as indicated. |
| Rehab. Assistant | Works at direction of Physiotherapist delivering seniors specific falls prevention education and exercise classes. |
| Pharmacist | Works with physicians and other team members to optimize medication profile for clients with chronic health conditions. Participates in the development of interdisciplinary care plan with other team members as indicated. |
| Heart Failure Nurse | With appropriate clients manages telehealth program aimed at promoting self management of chronic COPD.<br>Participates in the development of interdisciplinary care plan with other team members as indicated. |
| Dietician | Promotes client specific and group orientated education on nutritional topics to support improved client self management of chronic conditions. Work is centred on group medical visits with physicians.<br>Participates in the development of interdisciplinary care plan with other team members as indicated. |
| Recreation Assistant | Coordinates a community Wellness education program designed to support client self management of chronic conditions.<br>Participates in the development of interdisciplinary care plan with other team members as indicated. |
| Advanced care Planning Nurse | Works with groups and individuals through physician referral to assist older adults understand and complete advance directives |

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| | to support delivery of appropriate when client is unable to self direct care.<br>Participates in the development of interdisciplinary care plan with other team members as indicated. |

The Future Search technique that was utilized to support the SARIN team led to extensive conversations that enabled all team members to gain a greater understanding of each other's roles and the day to day difficulty each encountered in fulfilling those roles. The power of these conversations has led to small and large changes in how many team members function with each other. In particular, an exercise on day one of the Future Search session required the team to explore the "land" inhabited by others (See "Future Search Appendices 1" below). This exercise was very powerful in exploring myths about other team members and bringing the team to a closer understanding of each others roles.

## 5. Briefly describe the key outcomes that your site targeted for improvement with respect to:

### 5.1 Patient/family

SHORT TERM

- Increased satisfaction with healthcare provision and healthcare experience.
- Improved self-care capacity, reduced healthcare service utilization.

LONG TERM

- Improved Health outcomes.

### 5.2 Providers

- Positive change in attitude, knowledge and skills related to ICPLE; positive attitude toward healthcare team; increased skill in patient centred care.

- Increased life/work satisfaction; improved work quality and safety increased attitude, knowledge and skills toward healthcare team

### 5.3 Broader organization and/or system

- Increased team cohesion, efficiency and collaboration
- Increased staff recruitment and retention, efficient utilization of healthcare workforce.
- Improved productivity leading to cost effectiveness, reduced sick leave taken and patient centred care.
- Increased capacity for ICPLE and change management practices among site level participants (providers, patients, an workforce optimization).
- Increased access to technology to support cross jurisdictional/site role collaboration.
- Increased Knowledge Exchange related to ICPLE between all project participants.
- Increased awareness of relationships involved in ICPLE network and activities by all project participants.

- Increased capacity and evidence of cross jurisdictional/site role collaboration.
- Awareness of the importance of mechanisms identified by WHO framework for Framework for Action on Interprofessional Education & Collaboration Practice as essential for support system change at the national jurisdictional and site levels (institutional support, working culture and environmental mechanisms).
- Improved team effectiveness in ICPLE at practice sites (providers, patients, workforce optimization).

## 6. Briefly describe the interventions you introduced (to work on question 2 and 3 above). Please identify all tools, resources and/or processes used.

### 6.1 INTERVENTION GOALS:

**SARIN TEAM:**

1. Enhance the current high functioning of the SARIN team, and position them for future challenges.
2. Explore the challenges/opportunities of engaging physicians in SARIN.
3. Develop a roadmap for the next 18 months that has SARIN aligned with physicians.
4. Document the processes/tools used so they can be shared with others.

**TLAB**

1. Enhance collaboration among staff at TLAB (staff is the term being used until we clarify exactly who will participate).
2. Explore the impact, challenges and opportunities of the “nurse mix” that has evolved at TLAB over the past several years.
3. Enhance understanding among everyone of the roles each other play.
4. Maximize staff effectiveness through role clarity.
5. Document the processes/tools used so they can be shared with others.

**Evaluation Plan**

| **Activity** | **Timeline** |
|---|---|
| Prepare Ethical Review | End Nov |
| Confirmation of ethical review | January |
| Prepare pre-intervention survey | Dec |
| Finalize survey participants, processes for collection | January |
| Administer survey to SARIN docs | Jan 7 |
| Administer survey to other SARIN participants (electronically) | Finish by Jan 7 |
| Administer survey to TLAB participants (electronically) | Finish by Jan 7 |
| Analyze survey data | February |
| Collect additional data from intervention (TBD)- could include analyzing facilitator journals, interviewing facilitators, analyzing intervention design. | Feb-June |
| Administer post-intervention surveys to SARIN and TLAB | March-June |
| Analyze surveys and prepare final evaluation report | March-August |
| Final Evaluation report | August 2011 |

**Intervention Plan**

| **Activity** | **Timeline** |
|---|---|
| Select interviewees and prepare interview questions for SARIN and TLAB - at this point we are thinking of using appreciative inquiry as an overall framework for the interviews | Dec 2010 |
| Recruit SARIN docs for interviews | Jan 7 2011 |
| Interview other SARIN participants | Jan 10 – Feb 28 |
| Interview TLAB participants | Jan 10 - 21 |
| Review interview data and prepare interventions | Jan 24 – 28 |
| **SARIN i**ntervention -<br>1. Present results of interviews, review results of Team Effectiveness Survey, and introduce activities from Senge's ideas around team | 3 day workshop divided up into full day and jalf |

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| learning. (this session focused on SARIN without GPs present).<br>2. Complete a Future Search workshop with SARIN staff, physicians and selected others over 3 separate days.<br>3. See link for Future Search details FUTURE SEARCH<br>4. Prior to the Future Search workshop:<br>The participants completed the National Interprofessional Competency Framework Assessment via online survey<br>Most participants were also individually interviewed by the Future Search workshop facilitators. | day sessions in Feb & March, at least a week apart |
| **The Lodge At Broadmead:** Future Search Workshop: an intensive, large systems approach to change that includes representatives from every part of TLAB*. Session covered:*<br>1. Understanding the Past and Exploring Current Reality - Participants review key events that have shaped where they have come to in order to build collective understanding. They then map the trends/challenges facing them. This also serves to build collective understanding.<br>2. Owning the Present - Participants collectively own the current realty, each acknowledging the role they play in the organization's successes and challenges. They realize they need to shift from us/them to we.<br>3. Common Ground and Future Vision - Participants engage in future visioning with the intent to come to understand they have more common ground than differences.<br>4. Action Planning - Participants self select into teams to put into action what they have learned. This is where a team around role clarity or collaborative practice, for example, would likely emerge.<br>5. Prior to the Future Search workshop:<br>The participants completed the National Interprofessional Competency Framework Assessment via online survey<br>Most participants were also individually interviewed by the Future Search workshop facilitators. | Weekend retreat or<br>4 half days in February, ideally within a 1-2 week period |

**ADDITIONAL SARIN ACTIVITIES**

| Activity | Brief Description (e.g. scope, target audience, purpose/objectives, format, Timing). | Resources |
|---|---|---|
| A. Learning sessions & Dialogue (X3) re: IP practice competencies, dialogue | Three small group sessions for up to 15 participants. Sessions will provide staff/physicians, health authority leaders and community partner's opportunity to understand and imagine the future of IP collaborative practice.<br>Costs related to staff backfill costs, physician sessional fees and educator preparation and delivery time. | • 6 staff backfill<br>• 5 staff no cost.<br>• 3 physicians sessional.<br>• Contracted |

| Activity | Brief Description (e.g. scope, target audience, purpose/objectives, format, Timing). | Resources |
|---|---|---|
| and future opportunities. | Timing; January & February 2011. | educator.<br>• Room booking costs. |
| B. Patient Experience Maps. | 1. To map at least two SARIN patient experiences:<br>A. As the patient describes their experience.<br>B. Clinicians and physicians describe their experience related to selected patients care.<br>2. Half day workshop to identify improvement opportunities related IP collaborative practice. | • QI Consultant led activity.<br>• Up to 3 physician sessionals.<br>• Up to 4 staff backfill.<br>• Room rental. |
| C. Org. Strategies Consultant | To hire a consultant to attend and monitor intervention with a view to identifying system structures processes that impede collaborative practice. Consultant will develop a discussion paper re: strategies for organizational planning/sustainability of integrating inter-professional collaborative competencies in an organization (e.g. job descriptions, new employee selection criteria, performance expectations/feedback, learning needs, etc).<br>Cost: Consultant time.<br>(See 7 Below for final report) | • HR Consultant |

7. **Please list all documents used and produced by your site, with a brief description of each, the rationale for using them and how each was used (i.e., baseline scans and analysis, evaluation reports, notes/results from interventions, etc.).**

| Tool | Description |
|---|---|
| National Interprofessional Competency Framework Self Assessment | NIC Framework was converted to an electronic survey and administered to all participants in both projects pre and post interventions.<br>  <br>CIHC_IPCompetencies_Feb1210.pdf |
| In person interview questions. |  <br>Interview Questions Revised.docx |
| Future Search Strategy Final Report Broadmead Care Society |  <br>TLABFSReport.pdf |
| Future Search Strategy Final Report SARIN |  <br>SARINFSFINAL.pdf |
| Research Ethics Submission – as provided The Vancouver Island Health Authority. |  <br>CPLE VIHA Ethics Submission.pdf |
| Ethics Certificate of Approval |  <br>Lesley Bainbridge H2011-03.pdf |
| SARIN Future Search Appendices |  <br>SARINFSAppendices.pdf |
| SARIN Work Plan progress Notes |  <br>SARIN CPLE WORK plan may-June.pdf |
| Organizational Strategies Report: David Creelman |  <br>Creelman_VIHA_white_paper_on_Collabor |