Research expertise for health system solutions

Knowledge Transfer and Exchange (KTE) Plan and Report:
Interprofessional Collaborative Practice and Learning Environments Project

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Acronym Glossary

AACHHR: Atlantic Advisory Committee on Health Human Resources
BCAHC: BC Academic Health Council
CIHC: Canadian Interprofessional Health Collaborative
e-CoP: e-Community of Practice
Forum: Western & Northern Health Human Resources Planning Forum
ICP&LE: Interprofessional Collaborative Practice and Learning Environment
IPSC: Interim Project Steering Committee
JSC: Jurisdictional Steering Committee
KB: Knowledge Broker
KTE: knowledge transfer and exchange
PSC: Project Steering Committee
SNA: social network analysis
VMR: value management review
WCIHC: Western Canadian Interprofessional Health Collaborative

Project Overview

Project Description and Target Audiences

The vision and goal of the project as taken from the Project Charter is as follows:

> *…To establish and implement interprofessional collaborative practice and learning environments (ICP&LEs) in a variety of multi-jurisdictional sites across the continuum of care.*
>
> *The ICP&LEs will exhibit innovation in interprofessional patient-centred practice and workforce optimization, promoting high quality care and improved patient outcomes.*
>
> *The ICP&LEs will serve as capacity centres to provide the essential tools, resources, processes and learning opportunities to facilitate replication of the successful interprofessional and change management practices for other clinical sites and settings in the future, as well as to provide the opportunities for learning for future students and health care practitioners.*

This project was initiated by the Western & Northern Health Human Resources Planning Forum (the Forum), on behalf of the members, being the ministries of health and the ministries of advanced education from the four western provinces (British Columbia-BC, Alberta-AB, Saskatchewan-SK and Manitoba-MB) and the three northern territories (Yukon, Northwest Territories and Nunavut)[1]. Proposal development and implementation was done in association with the Western Canadian Interprofessional Health Collaborative (WCIHC) – a network of academics, applied researchers and decision-makers from across the four western provinces who work to improve interprofessional education and collaborative practice in health care.

In addition, discussion has been ongoing with the Atlantic Advisory Committee on Health Human Resources (AACHHR) which is also funded by Health Canada to do a similar project in their region. Each organization is committed to open collaboration wherever appropriate and possible to avoid duplication of effort and to facilitate success in the achievement of each project's respective deliverables.

As initially conceived, the ICP&LE project was to run for three years (three phases), however, funding was secured for only twelve months (phase one).

As stated by the Project Charter, the objectives for the project are as follows (for more detail on these, look to Appendix I):

1. Establish project structure and processes.
2. Build ICP&LE capacity:
    a. Define an ICP&LE and associated terms.
    b. Clearly describe the process for developing an ICP&LE including the change management processes and learning strategies & resources to be applied to each site.
    c. Develop and implement at least one innovative model of interprofessional collaborative practice in each participating jurisdiction.
3. Evaluate the ICP&LE models
    a. Establish a minimum set of evaluation and outcome indicators to be used in measuring the impact of the projects especially on patient outcomes and HHR issues.

[1] The territories were unable to participate in the project.

   b. Document the process of implementation, lessons learned, successes and challenges, barriers and facilitators, and recommendations for creation of new sites of interprofessional collaborative practice and learning environments.
4. Support Knowledge Transfer (KT)
   a. Develop a collaborative HHR Planning and Research Network facilitated and supported by an electronic platform or e-Community of Practice (e-CoP). This Network would comprise all key partners, stakeholders, ICP&LE site teams and others as appropriate to ensure the success of the project and the effective dissemination of all learning and tools that are derived during the project. The electronic platform will build on existing developments where appropriate.
   b. Develop an integrated KT plan that promotes application of evidence to improve long-term practice/behaviour, which is "generalizable" across project sites, as well as across other potential new sites with differing contexts.

The complexity of this project entailed the involvement of multiple target groups and project benefits were expected across these groups. The groups described below were engaged in and drove the KTE initiatives being designed and implemented at the site level. For example, in MB, an informational webpage is being established for use within the Winnipeg Regional Health Authority and SK is attending an international conference/workshop in the fall 2011 to present this work. The current report covers cross-jurisdictional KTE initiatives for the overarching project. For this reason, the individual site initiatives are not discussed in detail. For more information see the final project and evaluation reports.

1. Patients, their families and communities benefit from improved quality of health care delivery in the ICP&LE project sites.
2. The health providers in the project sites benefit from improved understanding of team member roles, improved collaboration with other team members and increased provider satisfaction.
3. Health science students who fulfill their clinical placement requirements in the project sites will gain experience of positive collaborative care models.
4. Middle managers, senior managers and executives of the health facilities and health authorities will see improvements in care provider and patient satisfaction at the project sites. They will also see improved efficiencies and outcomes, including patient outcomes, due to the implementation of a collaborative model for health care delivery.
5. Jurisdictional policymakers and decision-makers will see the potential benefits for overall health system functioning if successful ICP&LEs are developed across their jurisdiction(s).
6. Other groups could indirectly benefit from this project based on the sharing of project learnings, use of ICP&LE development tools, access to the e-platform and participation in the HHR Planning and Research Network.

Barriers and Facilitators

The project had an incremental start across the four western provinces. MB and AB had their sites functioning ahead of SK and BC. This resulted in each province being at a different developmental stage, and thus communication and knowledge exchange among the jurisdictions was uneven. For example, MB was able to share implementation and evaluation material before BC had formally identified its sites; this was very helpful for BC and SK. As with many projects, each group joined the ICP&LE project with a different level of knowledge concerning the project topic. The staggered initiation increased the challenge of coming to a common understanding and increased the need to communicate and work together effectively, as did the context of each jurisdiction, i.e. some of the sites were embedded in an

environment where ICP&LE were already being addressed locally and in association with their universities, while other jurisdictions had less experience with ICP&LE.

Another barrier to sharing knowledge was the diversity inherent in the site projects. To a certain degree each site was chosen based on variation to allow for comparison and to offer the program to a broad range of care provision units. This approach does not lend itself to direct sharing of information as initiatives implemented in one site might not be explicitly relevant to another. The lessons learned and ideas put forth need a certain degree of "translation", to support good knowledge exchange for participants from diverse initiatives. Agreeing upon common frameworks to guide the work, and regular team meetings helped to mitigate this barrier and convert it into a benefit of the program.

One inherent challenge was building the governance structure, i.e. the Jurisdictional Steering Committees (JSCs) could not be established until the sites were chosen. Once the JSCs were formed, the governance structure was fully functioning allowing for communication to flow from the Project Steering Committee (PSC) through to the sites, which were at varied stages of development depending on the jurisdiction. With this communication, the nascent sites benefited from hearing about the sites which were further along, and all benefited from learning about the different approaches and challenges each faced. This barrier was overcome by initiating an Interim Project Steering Committee which became the Project Steering Committee at the Winnipeg face-to-face meeting when all sites had been established. Transitioning at the face-to-face meeting was optimal as it allowed PSC members to engage with each other, build relationships, and work on some key milestones, which helped to facilitate sharing and sustain effective communication and KTE across jurisdictions throughout the project. From this point, the project moved from communicating within jurisdictions to across jurisdictions. Another important factor for the project's success was having a WCIHC member within each JSC. These members acted as champions for ICP&LE. These people also played key roles in the evaluation process.

The core team was an important enabler of communication across sites and jurisdictions. This team included all jurisdictional researchers, facilitators and site leaders, members of WCIHC, project administration (business manager, project manager and knowledge broker), and consultants (SNA and evaluation).

About one third of the way into the project, at the first PSC face-to-face meeting in Winnipeg, the PSC accepted a project charter that was critical for building common ground on the governance structure, objectives and deliverables for the project. At the same time, the PSC adopted two guiding frameworks for the project: The World Health Organization's *Framework for Action on Interprofessional Education and Collaborative Practice*, and the Canadian Interprofessional Health Collaborative's *A National Interprofessional Competency Framework*. Together, these complementary documents formed a strong foundation for advancing ICP&LE and provided the common ground necessary for guiding the diverse project membership. Both documents were positively received and played a significant role in facilitating the work.

Geography was a challenge for this project, given that it spanned the four western provinces. Based on participant request, an electronic Community of Practice (e-CoP) was developed, in part, to help address this issue, however, a small number of project members do not use it for a variety of reasons, including limited access to computers, preferences for other communication methods, etc. For those who do use the eCoP, it has been a salient facilitator for knowledge exchange and by focussing on clinical practice, has helped to fill a perceived gap. Other communication methods used to address the geography challenge included bi-weekly core team teleconferences, one in-person core team knowledge exchange

event (once all sites were set up and running), and one in-person and monthly teleconference PSC meetings.

Knowledge Translation Goal

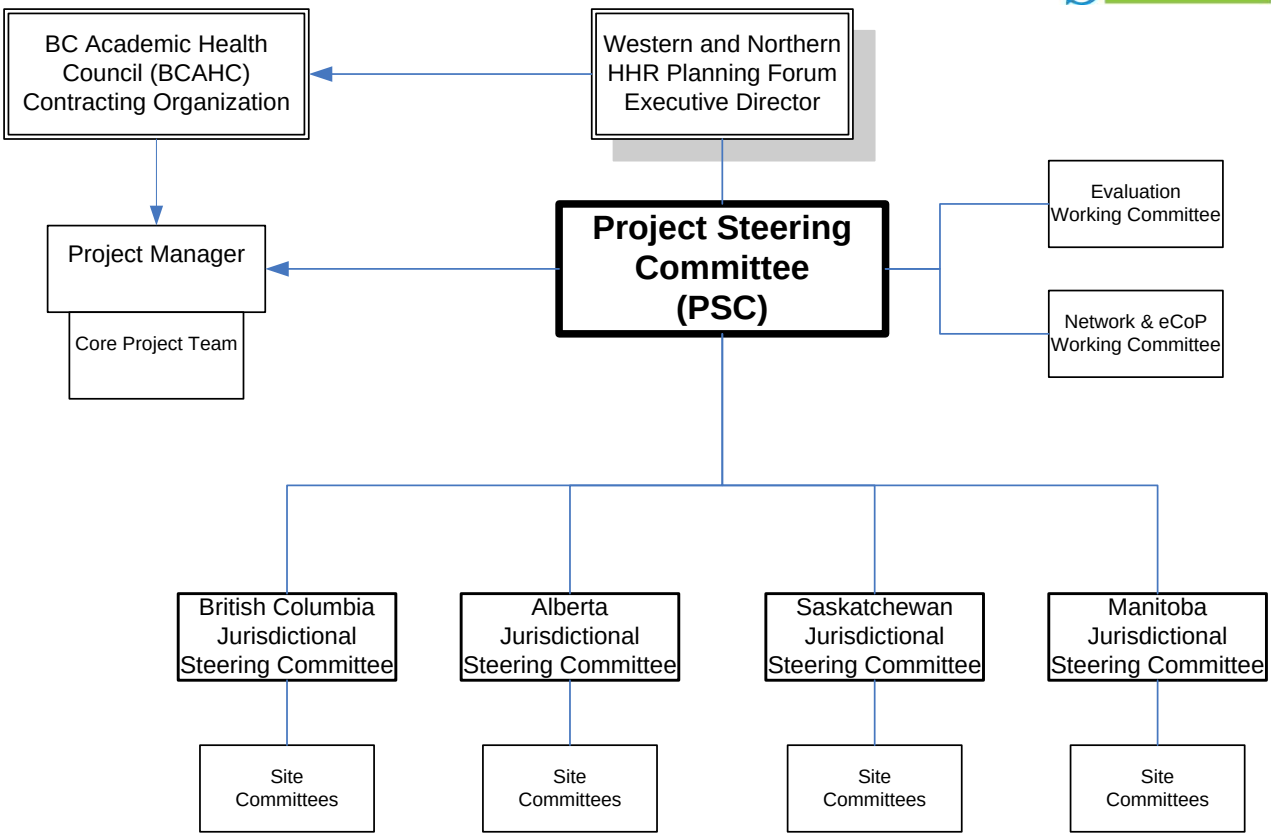
The overarching goal of the KTE component of the project was to integrate ICP&LE into the best practice design for new health services delivery initiatives and for revitalizing ongoing initiatives. Furthermore, the work done here is contributing to an existing body of knowledge on interprofessional collaborative practice. To assist with meeting this goal, the eCoP may be made public to encourage broader engagement across the country. There has been interest from the Western CEOs group around developing the eCoP into a broader, Models of Care site specific to clinical practice.

Although the target audiences listed earlier could benefit from this work, within the provincial ministries of health and regional health authorities, policy makers with the ability to direct how health care is delivered is a particularly strategic target group. If through the evaluation of this project it can be shown that working collaboratively is beneficial for patients and health care providers, then policy and decision-makers will be more inclined to integrate ICP&LE methods into policy, practice and education.

Setting the Stage

Development of the Project Teams (the Governance Structure)

Given this project was initiated by the Forum; project partners included their own members, with representatives from the ministries of health and ministries of advanced education from the four western provinces (BC, AB, SK and MB). Members of the WCIHC representing those provinces were also included to enhance continuity of the ICP&LE topic across the jurisdictions. Forum and WCIHC representatives made up the PSC. JSCs were created from jurisdictional members of the PSC and representatives from the project site committees who do the ground work. Supporting the structure was the contracting organization (the BCAHC), a project manager, a knowledge broker, the evaluation working committee and the eCoP/SNA working committee. Project membership successfully represented a balance of researchers, decision-makers and practitioners. See below for a diagram of the governance structure. For more detail on the membership of each group, refer to the project charter.



The structure functions and communication flow are both top down and bottom up. For example, the sites were selected and the initiatives were planned at both the JSC and the site committee levels with Ministry of Health decision making, whereas the underlying framework for the site selection and initiative design was determined by the PSC. The complexity is inherent in the project design, which crosses jurisdictions and health service categories and includes front-line workers, managers, researchers, administrators and policy-makers.

Partnership Incentives and Buy-in

The main incentive for participation in the project is the desire to improve practice through enhanced collaboration. The aim of this approach is to ensure the right person is providing the required service at the right time (i.e. workforce optimization). Further incentives range from improving practice at the ground level and maximizing use of each individual's training, to developing policies supporting more efficient use of resources. The outcome could result in greater job satisfaction for individual practitioners, an improved experience and health outcome for patients, and increased public confidence in the health system with the knowledge that health resources are used efficiently.

Another key incentive for partners was the rich learning opportunity inherent in participating in a multi-jurisdictional project, e.g. the benefit of cross-jurisdictional exchanges of lessons learned with respect to challenges and successes.

To encourage buy-in and stimulate discussion across the groups, a knowledge broker (KB) was hired. The KB has a strong background in health research and academia, balanced by an understanding and ability to work effectively within the practice environment. Specifically, the KB was hired to:

1. Assess the information needs of defined CP&LE project stakeholders and determine the most effective/efficient methods for engaging those stakeholders and providing them information.
2. Facilitate the mobility of information (translation and exchange) within the developing project network.
3. Improve access to knowledge, facilitate learning, link those in the network, and facilitate the implementation of knowledge in new settings.
4. Facilitate the implementation of the eCoP, assist users of the eCoP, moderate the site and manage communication and KTE within the site.

KB tasks include: organizing meetings, forums and special interest discussions; liaising between decision makers, practitioners and other constituents/stakeholders; synthesizing and presenting information/evidence to facilitate decision-making. It took a few months for ICP&LE members to understand how the KB could facilitate the work, however, the role and the effective application of it grew and improved alongside the formation of the ICP&LE community. This maximized compatibility between the KB and project functions as they developed over time.

In addition to the formal KB role, some organizations informally engaged in sharing information and facilitating dialogue among project members (in some cases this was indicated in the social network analysis), as did the executive director of the Forum and the ICP&LE project manager, especially prior to the hiring of the KB.

The KTE Framework

The ICP&LE project approached KTE from two perspectives (a hybrid approach), following definitions provided by the Canadian Institutes for Health Research (CIHR). The primary focus for the project was "integrated KT," with a secondary focus on the more traditional "end-of-grant KT" perspective. (See text boxes for CIHR definitions of these perspectives).

> ***Integrated KT***
> *In integrated KT, stakeholders or potential research knowledge users are engaged in the entire research process. By doing integrated KT, researchers and research users work together to shape the research process by collaborating to determine the research questions, deciding on the methodology, being involved in data collection and tools development, interpreting the findings, and helping disseminate the research results. This approach, also known by such terms as collaborative research, action-oriented research, and co-production of knowledge, should produce research findings that are more likely be relevant to and used by the end users* *(http://www.cihr-irsc.gc.ca/e/39033.html)*

The integrated approach was implicit in the core functioning of the project and its governance structure, providing collaboration opportunities during the project for partners to determine direction, facilitate changes necessary for effective project completion, engage in data collection and interpretation, and share in the dissemination of results. Mechanisms for this included a value management review (VMR), bi-weekly core team teleconferences and one in-person core team knowledge exchange event (once all the sites were set up and running), one in-person and monthly teleconference PSC meetings, conducting a social network analysis (SNA), evaluating the project, and the development of an eCoP (detail of these mechanisms can be found in the table below).

> ***End-of-Grant KT***
> *In end of grant KT, the researcher develops and implements a plan for making knowledge users aware of the knowledge that was gained during a project. Therefore, end of grant KT includes the typical dissemination and communication activities undertaken by most researchers, such as KT to their peers through conference presentations and publications in peer-reviewed journals.*
>
> *End of grant KT can also involve more intensive dissemination activities that tailor the message and medium to a specific audience, such as summary briefings to stakeholders, interactive educational sessions with patients, practitioners and/or policy makers, media engagement, or the use of knowledge brokers. The commercialization of scientific discoveries is another form of end of grant KT* *(http://www.cihr-irsc.gc.ca/e/39033.html)*

The eCoP was built half-way through the project once all the sites were established. It was built to specifications outlined by potential users to facilitate KTE and as such, had immediate uptake by some of the core team members as it directly addressed the need of the users. Formal planning for integrated KTE at the outset of the project did not appropriately mesh with the nature of the work, the busy schedules and the complexity of the project model. Beyond the VMR, planned meetings, the SNA, the evaluation process and the eCoP, other opportunities for KTE were ad hoc and responded to specific needs as they became apparent. These "organic" opportunities included two in-person presentations to the Forum members, the Core Team In Person Meeting in Calgary and the core team meetings. The work of the KB is also organic and based on the needs of the membership. These KB activities thus far have included topic-focussed teleconferences, 'spot lights' (specific topics highlighted with relevant information made available on the eCoP), and informal dialogue.

Although outside of the scope of this report, it is important to make reference to the integrated KTE efforts at the site level between the project and patients/families. Many of the site initiatives had the

patient and/or family at the core and included them in their teams. These initiatives will be captured and discussed in detail in the evaluation report. Many of the patient- and family-focused tools developed by the site initiatives are available on the eCoP.

The end of project KTE will include dissemination of the final report, including the SNA report and the evaluation report. This will be initiated by the Forum, who will disseminate the final report to its members and then to other provinces. Reporting on the project will become an agenda item at strategic forums and jurisdictional committees such as the BCAHC Board of Directors and the Forum. Other dissemination will include circulation via informal email networks of all the project partners, and postings on the eCoP (which may go public at the end of the project). One final KTE activity which was cancelled while in the planning stages was a knowledge exchange event for the core team members. This was intended to be an in-person gathering to share learnings in a workshop format and to discuss sustainability. JSCs, the PSC and the Forum were to be invited as well as external stakeholders. Due to funding cuts, this event was cancelled.

KT Activity	Nature of the Activity*				Target Audiences	Purpose	Stage of Project for Implementation
	1	2	3	4			
Administrative Team Meetings		x	x	x	Internal project team; project director, BCAHC rep, project manager, KB (once hired about half way through).	Exists for the purpose of meeting project deliverables, keeping on track and on schedule.	Beginning and ongoing through project
Project Steering Committee (PSC) meetings		x	x		Members of the Project Steering Committee	Members provided guidance and oversight to the project.	Beginning and ongoing through project (one of the meetings was face-to-face)
Value Management Review (VMR)		x	x		Forum members, IPSC members and other external stakeholders	A VMR is a process to confirm the deliverables and ensure that the project would be of value to the identified stakeholders.	Beginning, one time event
Working Committee Meetings	x	x	x		Members of the Project Steering Committee, project administration and consultants.	The working committees accomplished the tasks of a) designing the social network protocol and guiding the design and development of the eCoP, b) designing and guiding the evaluation process.	One third of the way through and ongoing through project

*Nature of Activity Codes:

1. Passive dissemination of results
2. Knowledge exchange opportunities
3. Activities designed to improve uptake of the results
4. Follow up activities to determine the impact of the work

KT Activity	Nature of the Activity*				Target Audiences	Purpose	Stage of Project for Implementation
	1	2	3	4			
Social Network Analysis		x	x		PSC and JSCs (top down orientation primarily due to the fact that not all the provinces had site level activity. Other 'levels' in the network were slated for SNAs in phase 2 and 3. The SNA that was done, was used at the knowledge exchange event as a learning tool for future planning.)	Engaged members in dialogue around identifying gaps, brokers and hubs in the network. Plays a role in strategic planning for development of the network, thus laying the foundation for KTE channels. The results also informed the development of the eCoP.	One third of the way through
Core Team In Person Meeting		x	x	x	Core team: Jurisdictional researchers, facilitators and site leaders, some members of the WCIHC, project administration (business manager, project manager and knowledge broker), and consultants (SNA and evaluation).	To discuss progress of site initiatives and share lessons learned along the way. Also to engage the core team in the design of the evaluation protocol and future planning for a phase 2 SNA.	Half way through.
Core Team Teleconferences	x	x	x		Core team (as above)	To discuss progress of site initiatives and share lessons learned along the way.	Regular bi-weekly meetings that began half way through the project.
Two In-Person Presentations to Forum Members		x	x	x	Western and Northern Health Human Resources Planning Forum Members	Report progress, share information, seek recommendations and buy-in	One third and two thirds of the way through.
Development of an Electronic Community of Practice (eCoP)	x	x	x		ICP&LE members, possibly will be made public in the future (developed from the bottom up, and initially that is where the activity has begun, yet it is anticipated that the administrative level participation will increase over time). Discussions are underway to expand the membership to include the Atlantic and Ontario ICP&LE projects.	The eCoP was established for the use of all members to share information and as a document repository and contact list.	Middle of the project and ongoing beyond the project end date.

*Nature of Activity Codes:

1. Passive dissemination of results
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KT Activity	Nature of the Activity*				Target Audiences	Purpose	Stage of Project for Implementation
	1	2	3	4			
KTE teleconferences		x	x		all ICP&LE members	Initiated by the KB, these teleconferences were designed to address specific topics as desired by the membership (e.g. workforce optimization).	Half way through and ongoing as needed and/or requested.
KB informal engagement		x	x		all ICP&LE members	KB would respond to requests and/or initiate communication to facilitate knowledge exchange among the members.	Half way through and ongoing as needed and/or requested.
Ongoing dialogue with the Atlantic ICP&LE projects (informal via email and phone, plus one in person meeting)			x		Senior administration of the Two projects	The ED of the Forum would engage in discussion with the other projects to share lessons learned and plans for the future. At the in person meeting, a common evaluation framework was discussed along with reviewing the various approaches to the work and sharing lessons learned.	
Evaluation (results will be posted on the eCoP)				x	The evaluation results will be available to all project members, and external stakeholders.	The Evaluation addresses the question: "Were project activities implemented as intended? What were the lessons learned?" A logic model guides the work and provided a base for the questions being asked.	Latter half of the project

*Nature of Activity Codes:

1. Passive dissemination of results
2. Knowledge exchange opportunities
3. Activities designed to improve uptake of the results
4. Follow up activities to determine the impact of the work

KT Activity	Nature of the Activity*				Target Audiences	Purpose	Stage of Project for Implementation
	1	2	3	4			
Report dissemination *via* eCoP posting, email distribution, and being present and on the agenda for key board and committee meetings across the country • Final report • SNA report • Evaluation report	x				Other stakeholders not included in the ICP&LE project	To disseminate the results of the project as widely as possible and to stimulate interest and commitment to continuing the work.	Post project

*Nature of Activity Codes:

1. Passive dissemination of results
2. Knowledge exchange opportunities
3. Activities designed to improve uptake of the results
4. Follow up activities to determine the impact of the work

As the project progresses, key messages are developed by the core team during meetings, within discussion boards on the eCoP and within their own jurisdictions. These are then collated by the project manager who will present them to the ICP&LE members within the final report in the form of working guidelines for developing an ICP&LE. Once feedback from the members has been incorporated into the report it will be disseminated broadly, as described above.

Beyond the ICP&LE Project:
Plans for the Future

The following is a collation of ideas discussed during the project. Each item requires development and further detail prior to implementation and will be presented in the final report. A business case for more resources or in-kind contributions is required if much of this work is to continue. Success for each item will be enhanced if senior level champions come forward from each participating province.

1. Health Canada to facilitate a national teleconference bringing together the senior administration from the three ICP&LE projects (Western, Atlantic and Ontario). This meeting would be to discuss each of the projects and to strategize ideas for how to move forward in future.
2. eCoP
    a. Expand the eCoP to include the Atlantic and Ontario ICP&LE project members.
    b. Link to universities and health authority websites as a resource (do an environmental scan to see what everyone is doing and who would be best to link with to prevent duplication and maximize use, i.e. ensure uniqueness).
    c. 'Reface' the eCoP site making it accessible to the public and health care providers as a IP clinical practice resource site.
    d. If eCoP is expanded or maintained, funding will be needed to cover the costs of managing and moderating the site. It has been indicated that a moderator is essential to keep the site fresh and current for this complex multi-stakeholder network, therefore for the importance of the moderator role would increase if the eCoP membership were to grow and become more complex.
3. Merge the work done around models of care across Canada. There has been some discussion between the Forum and Western CEOs, but it is unknown at this time if these discussions will continue and what form they will take. The eCoP could provide one mechanism for merging the models.
4. Continue core team dialogue by whatever means are feasible. Minimal funding is required to cover a teleconference line for meeting. Enhanced interactions (e.g. in-person KTE events, webinar capabilities, etc.) could be initiated with additional funds.
5. Conduct an environmental scan for the purpose of linking to other related initiatives.
6. Have the final report broadly disseminated by the organizational members of the Forum, PSC and JSC's to maximize exposure of the work. Make sure each organization representative has the information circulated to their membership where appropriate, e.g. WCIHC.
7. Create a common PowerPoint presentation that project members could use and adapt to their context for presenting at various events. For example, the SK team will be presenting at the *Collaborating Across Borders* conference in Arizona this year. This could be an opportunity to present something specific on the ICP&LE project.
8. Secure external funding for a knowledge exchange event inviting external stakeholders, core team members, PSC, JSC, the Forum to share learnings on developing and sustaining an ICPLE

Lessons Learned[2]

One of the keys to KTE success for the ICP&LE project has been having dedicated funds to support a KB. Alongside the KB skills, the person hired also had content knowledge and history with some of the project partners. This proved to be advantageous to the functioning of the KB. Furthermore, the KB role included eCoP moderation which has proven essential to the effective running of the site. Not only does a moderator initiate discussions and remind members about the site via email and other methods, they also screen posted documents for copyright issues and relevancy, as well as ensure that the documents are loaded under the most relevant categories. The eCoP is a concrete, tangible, practical and easy-to-use tool for KTE. Project members were impressed with the visual presentation of the eCoP and saw value and potential for making it something that could be sustained as an ongoing KTE tool for exchanging ICP&LE information.

Conducting a social network analysis at the outset was a useful exercise to highlight current communication links and identify gaps and ways to strategically develop the network. Plans are in place to continue the discussion regarding network development on the eCoP. If the project had continued past the first year, one or two follow-up SNAs would have been conducted to measure change in how members of the network communicate and with whom, and to inform strategic network development.

Another critical success factor for KTE was a nimble and effective administrative project team including a dedicated chair, who provided a solid functional link to the PSC and the Forum. This team was able to respond quickly and make significant adjustments to the work plan in order to meet the needs of the partners, in particular the site-level participants. An example of this was the design and implementation of the inaugural, in-person Core Team Meeting event, which was not originally in the plan. People invited to this event were those at the site level (research assistants and facilitators) as well as project contractors (the KB, evaluators, and SNA specialists). This formed the Core Team, who after this in-person meeting continued to meet bi-weekly by teleconference. This event was pivotal for enhancing the success of later KTE opportunities.

Other success factors included regular face-to-face and virtual meetings which helped maintain momentum and build trust and comfort among the players. The following examples are particularly worth mentioning with respect to enhancing the KTE functions of the project:

1. The VMR at the outset helped to set the direction for the project.
2. The in-person PSC meeting in Winnipeg provided the opportunity for the administration of the project to get a feel for what was happening at the site level, which helped guide the work moving forward.
3. The creation of the core project team and the implementation of bi-weekly meetings following one in person meeting were significant enablers for the continuation of effective KTE across jurisdictions and among practitioners and academics.
4. Establishing common tools and definitions to be used across jurisdictions, such as the competency frameworks, and project charter

Central to the success of the KTE functions for this project was the full integration of relevant and diverse stakeholders, from senior administrators to ground-level health care providers. This level of integration

[2] This section will be more fully explored in a systematic way by the formal evaluation process of the project that was underway at the time of writing.

supported with a systems-oriented approach, allowed for a natural, flexible process while addressing the complexity of the project's partnership model involving diverse regions and jurisdictions.

The project was challenged by its inherent complexity and foreshortened time frame (it was initially envisioned as a three year, three-phase project, but only one year of funding was secured for the first phase). This created challenges for building the necessary teams quickly and allowing adequate time for implementation and reporting.

The learnings from this project provide useful guidance for any similar initiatives in the future. In that respect, the following suggestions are offered:

1. At the outset, make sure the expectation for knowledge sharing is explicit and understood by all participants. In some cases, members were reticent to share their work. This could be due to a reluctance to share anything but final-version documents, or because they are simply too busy. Hesitancy to load documents to the eCoP could be due to a fear that the site will become public. For this reason, decisions regarding public access to the site must be made collaboratively, and communication about this needs to be clear.
2. eCoP
    a. Emphasize that there will be a sustainability plan for the eCoP so that members will not view their participation in it as wasted once the project is officially over; or communicate from the beginning that it is a project tool meant for sharing during the life of the project and note that project documents developed will be put into a repository afterwards for use.
    b. Set up the eCoP early in the process so that members can take advantage of it as soon as possible. As participants join the project they should be encouraged to use the eCoP. For the ICP&LE project, having the eCoP online sooner might have facilitated the participation of the territories by giving them access to a streamlined and effective communication tool. Note though that this was meant to be a three-phased project and developing project infrastructure i.e. the eCoP, was an activity scheduled for phase-one.
    c. Consider making it mandatory that members use the eCoP as the sole mechanism for project communication between meetings. Be prepared for different levels of acceptance for this proposal, with some members embracing it and others resisting it.
3. Set project site selection criteria early, along with a timeline for doing the selection. Ideally, all project sites should come online at the same time. This did not happen for the ICP&LE project due to its complexity, multiple stakeholders and politics. Some of the critical, 'shining' moments of the project did not occur until all the sites were at a certain stage of implementation. Had they been online earlier in the project and at a similar time, there could have been more of those moments.

Summary and Recommendations

The ICP&LE project successfully established a governance structure with formal and informal mechanisms for engaging in integrated and end-of-project KTE. This was achieved despite a truncated project timeline and the inherent complexity of working with a diverse group of participants across multiple jurisdictions and health service categories (including front-line workers, managers, researchers, administrators and policy-makers).

To maintain the momentum developed by the ICP&LE project, it is recommended that strategically positioned senior champions be engaged (if they are not already) to influence the flow of resources (financial and in-kind) for continuing the work of this project. Include the territories at this stage if they are interested. Funding needs to be secured quickly in order to ensure continuity for the current governance structure and project sites. Secured funding would facilitate taking this work into a second phase as initially intended. Based on the learning from its first phase, the second phase of the project would ideally be launched by a KTE event and would include the following:

1. An overview of what was done and learned in phase 1, and how these learnings inform the direction for phase 2.
2. Small group discussions to design and set the criteria for selecting the next generation of project sites. Prepare for these discussions prior to the event by comparing the Western and Atlantic project evaluations and methods for site selection, i.e. the Atlantic project administration selected all the sites at the outset, whereas this project allowed each jurisdiction to do their own selections. If possible, determine which worked better and present that knowledge prior to breaking into small groups.
3. Begin to design a sustainability plan for continued effort once the dedicated funding ends. For example, the current model funds an external facilitator to guide the sites. A sustainable model might phase this role into more of an internal function.
4. Showcase the efforts and involvement of the patient and families involved in phase 1, along with the related tools and KTE mechanisms designed for this purpose. Ensure this remains an integral and continued effort during the planning of phase 2.

Appendix I: ICP&LE Project Objectives

(Reproduced here from the Project Charter)

Establish project structure and processes

1. Sign-off on Project Charter by all partners.
2. Document project processes and results.

Build ICP & LE capacity

3. Define an interprofessional collaborative practice & learning environment (ICP & LE) and associated terms (teams, sites, IP, CP, patient-centred care; learning environments; collaborative competencies; HHR outcomes, e-Community of Practice, etc).
4. Clearly describe the process for developing an ICP & LE including the change management processes and learning strategies & resources to be applied to each site.
5. Develop and implement at least one innovative model of interprofessional collaborative practice in each participating jurisdiction. This objective, as a minimum, would include the following:
    a. Formally describe the target population to be reached by the collaborative practice and learning model. (PATIENT / POPULATION)
    b. Describe the service delivery model (e.g. staff mix, education, experience) and context (e.g. organizational supports, leadership, policies) within which the collaborative model is to be implemented. (STRUCTURE)
    c. Describe current roles and relationships and examine degree to which roles are to be optimized. (PROCESS)
    d. Determine patient/family, provider and system outcomes to be targeted. (OUTCOME)
    e. Describe the learning and change management strategies to be used to achieve the new service model, the optimized roles and the multi-target outcomes. FINAL DRAFT CP & LE Project Charter Page 6

Evaluate the ICP & LE models

6. Establish a minimum set of evaluation and outcome indicators to be used in measuring the impact of the projects especially on patient outcomes and HHR issues. Describe the evaluation process that will be established to enable ongoing monitoring and evaluation of the development process.
7. Document the process of implementation, lessons learned, successes and challenges, barriers and facilitators, and recommendations for creation of new sites of interprofessional collaborative practice and learning environments.

Support Knowledge Transfer (KT)

8. Develop a collaborative HHR Planning and Research Network facilitated and supported by an electronic platform or e-Community of Practice (e-CoP). This Network would comprise all key partners, stakeholders, ICP&LE site teams and others as appropriate to ensure the success of the project and the effective dissemination of all learning and tools that are derived during the project. The electronic platform will build on existing developments where appropriate.
9. Develop an integrated KT plan that promotes application of evidence to improve long-term practice/behaviour, which is "generalizable" across project sites, as well as across other potential new sites with differing contexts.