PHASE ONE ICP & LE Multi-Site Evaluation

Introduction

The ICP & LE Multi-Site Evaluation Framework, guided by the program theory and logic model, was used as the basis for the Phase One ICP & LE Multi-Site Evaluation. In addition to providing evaluation questions and indicators for the Phase One implementation evaluation, the framework also outlines an evaluation strategy for the long term project described in the original proposal. A copy of the evaluation framework, program theory and logic model can be found in Appendix XXX.

The Phase One evaluation focuses on the three primary areas of activity defined in the program theory: 1) jurisdictional programs focusing on collaborative practice, 2) the overall project activities created to support sites and jurisdictions, and advancement of collaborative practice, and 3) support for systems change at all levels. For each of these areas, common themes regarding implementation of the activities are discussed.

This chapter reports on the findings from the Phase One evaluation. It begins with a discussion of the evaluation methodology. In subsequent sections, the evaluation findings are presented followed by conclusions and recommendations.

Evaluation Methodology

The Phase One ICP & LE Multi-Site evaluation was developed and implemented by external evaluators with input from the ICP & LE Evaluation Working Committee (EWC) and the Provincial Steering Committee (PSC). The role of the EWC was to review and provide advice regarding evaluation activities. The committee was comprised of evaluation experts from each of the jurisdictions and the Project Manager. The committee provided advice regarding the evaluation framework and associated indicators, the evaluation methodology, gave feedback on interview questions, and suggested potential documents for the document review. In addition, committee members reviewed the preliminary evaluation and provided their insights into local contexts which contributed to the validity of findings. The PSC also approved the evaluation framework and Phase One Evaluation methodology.

The four jurisdictions operated independently to design, implement, and evaluate their programs which were designed to establish effective ICP & LE approaches to health care delivery. Projects were in a variety of practice settings within each province, operated across a range of clinical settings, and were meant to reflect the continuum of health care delivery. While it would have been ideal to conceptually compare data across jurisdictions and sites it was not feasible to do so, given the project timeframe.

The following section describes the evaluation methodology in more detail. It begins with a description of the tools used to collect data. This is followed by a description of the evaluation participants and the approach to analysis. This research received ethical clearance by the University of British Columbia Office of Research Services, Behavioural Research Ethics Board.

Evaluation Tools

Evaluation data were collected through: 1) semi-structured-telephone interviews and 2) project document review.

1. Semi-structured telephone interviews

Semi-structured telephone interviews were conducted with twenty-nine participants from both the jurisdictional and the overall project teams[1] (24 jurisdictional interviews and 5 overall project team interviews). The interview questions were qualitative in nature and were guided by the overarching evaluation questions. Table 1 identifies the primary areas addressed in the telephone interview. The areas included are based on the indicators listed in the evaluation framework. The EWC reviewed and provided feedback regarding the final set of interview questions. For a copy of the interview questions please see Appendix XX.

Table 1: Primary domains included in the telephone interview grid

Domain	Focus
Context	Role in project Description of ICP & LE model
Inputs	Resources dedicated to the project-human, material/training, political, financial as well as in-kind contributions Relationships/partnerships that played a role
Activites	Activities undertaken Factors that challenged implementation of activities Factors that facilitated implementation of activities
Outputs	Products produced Services produced Deliverables attained
Outcomes	Outcomes realized to date
Learnings	Lessons learned
Looking ahead	Requirements to sustain level of build on or sustain level of change.

2. Project document review

Project documents such as meeting minutes, evaluation reports, and general documentation were reviewed to provide additional information and context to the evaluation findings. Researchers, facilitators and the Project Manager were asked to identify potential documents for review, many of which were housed on the eCoP. The documents were reviewed to provide additional contextual detail and where applicable validate the findings. In addition, final site reports prepared by each jurisdiction were reviewed to confirm findings. Each site report was systematically reviewed to identify key

[1] Jurisdictional team refers to individuals in the four jurisdictions that were involved in developing and implementing project activities. Overall project team refers to individuals responsible for developing and implementing overall project activities (e.g., Project Manager, eCoP moderator and knowledge broker, contract mangers and SNA manager).

outcomes and pertinent information regarding the teams that participated in the project activities, the roles and responsibilities within the service delivery teams and the degree to which the roles and relationships were optimized throughout the project.

Interview Participants

The evaluation team worked with the researchers and facilitators from each of the jurisdictions and the Project Manager, to develop a list of potential interview participants (n=32). The aim was to identify potential participants who were significantly involved with project implementation and represented a variety of positions/organizations such as facilitators, researchers, health authority, project team etc. Once identified, potential participants were contacted via email and telephone and asked if they would like to participate in a 45-60 minute telephone interview. If interested the participant was asked to sign a consent form describing the interview process in greater detail and ensuring confidentiality and anonymity. All interviews were conducted over the telephone. Of the 32 individuals contacted 29 agreed to participate in the evaluation. Those not able to participate either had too many other commitments and were too busy (2) or were out of town (1).

Of the 29 interview participants, 14 participated on the PSC in addition to their various roles within the jurisdictions or on the project team. When interviewed, these individuals were asked to speak to activities both within the jurisdictions as well as overall project activities. Table 2 provides information regarding the number of interviewees from each province and their key roles on the project.

Table 2: Interview Participants

Jurisdiction	Total number of interviews	Representation
British Columbia	7	1 researcher, 3 site leads, 2 health authority, 1 Ministry of Health. 3 of the 7 were PSC members
Alberta	5	2 research/facilitators, 2 site leads, 1 Ministry of Health. 2 of the 5 were PSC members
Saskatchewan	6	1 facilitator, 1 researcher, 2 health region, 1 Ministry of Health, 1 University of Saskatchewan. 2 of 6 were PSC members
Manitoba	6	2 facilitators, 1 researcher (University), 2 Health Region, 1 Ministry of Health. 4 of the 6 were PSC members.
Project Team Member	5	Project Manager, Contract Manager for BC Academic Health Council, Chair of the PSC and Contract Manager for BC Provincial Government and Western and Northern Health Human Resources Planning Forum, eCoP moderator and broker, SNA Manager 3 of 5 were PSC members
Total number of interview participants	**29**	

Analysis and reporting

The interviews were audio-taped and transcribed for purposes of analysis. The key evaluation questions provided the framework for the analysis. The data were analyzed according to qualitative research methods including clustering and coding to determine respondent views and perceptions and uncover emerging themes. The data were analyzed according to jurisdiction and project team and then examined for common themes. Two members of the evaluation team analyzed the data separately and then compared findings to ensure consistency. In addition the results were reviewed by members of the EWC to help validate findings and provide insight into the jurisdictional and overall project context.

The data from the project document review was used to further develop themes and set the context for findings. This included the individual jurisdictional site reports that were reviewed to help ensure accuracy of findings.

Findings

The findings of the evaluation are organized according to the three primary areas of activity as outlined in the project theory: 1) jurisdictional activities focusing on collaborative practice 2) the overall project activities created to support jurisdictional efforts, and 3) support for systems change at all levels.

Jurisdictional Activities

The findings reported in this section focus on the implementation of jurisdictional activities and represent common themes across the four jurisdictions which are further illustrated by quotes (see Tables 3 & 4). Jurisdictional activities refer to the project activities undertaken in each of the four jurisdictions which are the formation of a jurisdictional steering committee and ICP & LE interventions undertaken at each of the sites within the jurisdictions.

Results are reported according to the evaluation questions described in the evaluation framework:

- Were **jurisdictional** activities implemented as intended?
- What were the factors that facilitated implementation of activities at the **jurisdictional l**evel?
- What were the factors that challenged implementation of activities at the **jurisdictional** level?

Some early short term outcomes were identified in the data and are presented. Although they should be considered tentative, they shed some insight into short term outcomes and address the evaluation question:

- Was there an increased capacity for ICP & LE and change management practices among site level participants?

It is important to note that results represent common themes across jurisdictions rather than commentary specific to individual jurisdictions. As mentioned previously, we did not use Jurisdictional Evaluation Reports for purposes of comparison in this part of the evaluation; however, we did review

jurisdictional site reports to ensure there was continuity with implementation findings. For individual jurisdictional site reports please see Appendix X.

Were jurisdictional activities implemented as intended?

Multiple intervention activities were implemented within each of nine health care settings across Western Canada. The sites represented a variety of settings across the continuum of care ranging from long terms care clinics to wellness centres. All four jurisdictions created a jurisdictional steering committee to guide site activities within their province. For a detailed description of the sites and associated activities please refer to Part II of this report.

All the interview participants believed that site activities were implemented as intended though many participants were quick to comment that implementation was an "*iterative process*" with project activities building on one another. Thus, plans were initiated as intended but changed in response to local context. A comment from a facilitator illustrates this point: "*As knowledge and experience was gained and issues came up with staff turnover and new team members coming on site, our activities and the way they were implemented changed continuously."* As a result, though activities were implemented as intended team members recognized the need to be flexible and responsive to unique circumstances at the site level. For example, in one of the jurisdictions, the researcher met with the teams to identify their goals and vision for the project. From there, she drafted a work plan that addressed the goals identified. However, as the team began engaging in learning events they "*started to realize that they wanted to focus in a different area or that they really knew less about working in a team than they originally thought."*

Learning Education Opportunities for Students

With regard to the student learning education component of the ICP & LE project, one of the jurisdictions implemented ICP clinical student placements. Of the remaining three jurisdictions, one did not have learning education opportunities for students; another offered a range of ICP practice learning opportunities embedded within the profession specific clinical/fieldwork/practicum placement such as opportunities for health care students to shadow other health care professionals and observe team functioning; and the third jurisdiction developed a relationship with an academic institution to facilitate learning education opportunities in the future. Thus, this component was not implemented with equal intensity across the four jurisdictions. As one respondent stated the "*student piece was hit and miss*" and another commented that *"the student piece wasn't the main focus of any particular project (site). It was more about working with the teams to help promote ICP."*

In the jurisdiction where ICP clinical student placements were implemented, six students participated in the process through an ICP mentoring model. The facilitator spent time with the staff and students at bi-weekly meetings, created numerous resources and materials to support learning and students participated in a wide range of ICP related activities. The student preceptors were encouraged to explicitly discuss the ICP competencies with the students informally and during student assessment. In general, the ICP clinical student placements were implemented as intended however, were viewed as "*moderately successful*". It was challenging for the facilitator to engage preceptors to work with students from an ICP perspective. In one instance, two of the students were not aware that they would be participating in an ICP clinical student placement as they did not receive any project information from the preceptor.

The variety in approaches to implementing learning education opportunities at the sites may have been a result of differing philosophies about the integration of student learning education in the ICP & LE project. Some members of the team believed that it would be more advantageous to work with the sites to become reflective of ICP prior to integrating student learning education opportunities while others believed that student learning education opportunities should be implemented at the beginning of the project so that students would act as learning change agents within the team.

What were the factors that facilitated implementation of activities at the jurisdictional level?

There were a number of factors which supported implementation of site activities, many of which speak to the strength of the existing infrastructure in the jurisdictions. The strongest themes to emerge from data were provision of funding, collaboration and partnerships within jurisdictions, and engagement of senior management. Other themes, of moderate strength, include linkage to provincial strategies and communication and collaboration between jurisdictions. Table 3 provides quotes to support themes related to factors that facilitated implementation of activities at the jurisdictional level.

<u>Provision of Funding</u>
A significant facilitator to project implementation which was noted almost unanimously was having additional funding to support ICP&LE activities. The funding provided the opportunity for these individuals to fully focus on project activities rather than "*conducting the work off the side of their desks*" which they noted has been the case in the past.

Funding was also utilized "*to help with the engagement piece*" for staff development and persuasion of team members to participate in project activities (e.g. stipends, refreshments etc). Funds were also used to pay for speakers and other consultants such as writers and facilitators. Funding was particularly useful in recruiting fee for service health care providers such as physicians and psychiatrists, sites noted that these professionals are often limited in terms of time availability because they are generally fee for service providers, and are not paid when participating in volunteer activities. The resources from this project provided remuneration for their participation. The following comment by one of the participants supports this premise: "*There is no way we could have gotten the physicians involved if we didn't pay them."*

<u>Collaboration and Partnerships within Jurisdictions</u>
Each of the jurisdictions reported tapping into significant partnerships to implement project activities and in many cases strengthening or developing new partnerships. The partnerships were broad and included representatives from: education, government-Ministry of Health, health regions, Western Canadian Interprofessional Health Collaborative (WCIHC), health regions, site staff and managers, other provincial health related organizations and networks and the BC Academic Health Council.

The role of these partners varied, some were directly involved with implementation, others sat on the jurisdictional steering committee while others provided support in a manner that was relevant to the mandate and functioning of the particular organizations. In one the jurisdictions, a key partner contributed additional project funding enabling the timeline of the project to be extended. Partners contributed significantly to the project primarily in terms of human resources, the majority of which was in-kind.

There were "*previous relationships and a history of collaboration"* among many of the project members within each of the jurisdictions. Interview participants spoke of this history and how it provided for an environment in which there was the "*willingness of team members to work together in a respectful manner* "that was engaging, cooperative, and welcoming. Some project members had worked together on previous projects related to ICP and as a result could share their previous experiences and expertise. For example, one of the project researchers for the ICP & LE project was involved in a previous ICP related initiative and was able to bring her knowledge about ICP to the project.

Participants also commented on how previous experience working together on other provincial working groups or committees such as other health related collaboratives, networks and education councils or groups was beneficial as a working relationship was already established. In one of the jurisdictions, a provincial interprofessional health collaborative compiled a number of relevant ICP resources for project facilitators and researchers to use and share with other jurisdictions.

Members of the WCIHC were part of project teams in each of the jurisdictions. Participants noted that WCIHC members and colleagues brought a wealth of knowledge regarding ICP & LE to the project and also had a history of collaborating with one another across jurisdictions. While this certainly was an asset at the jurisdictional level, some interview participants did not believe the potential of this group was "*fully realized in terms of contributing to the intellectual development"* at the overall project level.

Engagement of Senior Management

Nearly every jurisdiction indicated that engagement of senior management was instrumental to the implementation of project activities and their continued success. Senior management was represented on all jurisdictional steering committees and these individuals provided insight and linkages between project activities and other strategic primary health care initiatives in the jurisdictions. For example, "*The Director of Primary Health Care was on the jurisdictional steering committee and could share the strategies in this area and how the ICP & LE project could complement that."*

The participation in project activities by senior management also helped to break down communication challenges between other senior managers and project stakeholders. For example, in one of the jurisdictions, senior management and physicians had an opportunity to talk about each others roles and responsibilities and lay the foundation for further communication.

Link to Provincial Strategies

Some interview participants commented on the importance of jurisdictional activities being linked to provincial frameworks or strategies that address health and healthcare service delivery redesign. The following quote from a project member supports this finding*: "Consistency with the overall strategy of the province in terms of primary health care services was also very helpful to this project."*

Many of the jurisdictional ICP & LE activities at the sites aligned nicely with the healthcare service delivery redesign strategies occurring in the provinces. For example, in one of the jurisdictions, one of the key result areas for the Ministry is focused on community integration of health care and community services. The project activities at the site led to discussion around this area and some identified steps for action.

Collaboration and Communication between Jurisdictions

There was recognition among participants about the importance of communication and collaboration between project members across jurisdictions. The overall project team provided opportunities for project members to communicate and collaborate through a number of platforms, including regular conference calls for the Core Team and PSC; face-to face meetings; and an electronic community of practice (eCoP). A face-to-face meeting in Calgary was frequently mentioned by interview participants as a tremendous opportunity to share experiences and discuss implementation plans. As one respondent stated: "*I really enjoyed the face-to-face meeting in December that was probably one of the highlights.*" The regular conference calls with Core Team members were also mentioned as a useful communication mechanism, though a few interview participants commented that the conference calls should have started at project onset.

The eCoP was increasingly being used as a repository for information that could be accessed by project members. Project members posted meeting minutes, tools, evaluation reports and other types of information for other team members to access. However, there was limited communication on the discussion board component of the eCoP; over the course of the project there were 13 subjects posted to the discussion board. There were also a few project members who did not use the eCoP at all and made it clear that they had no plans to utilize the website in the future. The reason for this is not clear though there was some discussion among project members about the potential duplication with the eCoP with other ICP related websites.

While all the communication mechanisms utilized facilitated some level of communication, participants did not perceive that collaboration between the jurisdictions was realized to its greatest potential with the exception of some sharing of project ideas and materials. In general, the jurisdictions operated relatively independently. Project members indicated that if the project time frame had been extended, closer working relationships would have developed across jurisdictions. We noted in project documents and through our own observations that toward the end of the project, team members were beginning to share similarities related to implementation and outcomes across their jurisdictions.

Table 3: Quotes to support themes related to factors that facilitated implementation of activities at the jurisdictional level

Provision of Funding
"It was helpful to have funding for staff development because I think that was a big perk for them. You can't underestimate the impact of those pieces."
"I think the hook (for the site team) was that they had some dollars they could put to the team to provide some education and learning opportunities. That was something that provided the buy-in for the team to continue."
"We brought in outside facilitators and luckily we had the budget to do that."
"We would not have had any where near the people (at our event) if they weren't paid to be there. "
Collaboration and Partnerships within Jurisdictions
"We (the jurisdictional steering committee) have a mutual respect and we are collaborative and work very well together. I can't minimize the importance of that because it just makes things so much easier."
"The collaborative tradition in our province helped move the project forward."
"Everybody sitting at the table was willing to listen and learn from each other and take advice from past experiences."
"It is really critical to tap into them (those with previous experience in the area) for their expertise and knowledge."
"When we look at it from a provincial perspective, important partnerships are being developed (as a result of the ICP & LE project)."

"One of the really positive things that came out of this is that we have a stronger relationship with one of our key partners."
"We had on our jurisdictional steering committee the director of primary care services so we were aware of what their strategies in this area are and how this project could complement that."
Engagement of Senior Management
"The whole area around collaborative practice and care has been accepted by the senior administration as a major strategic piece and this is very helpful."
"Senior management actually spent time in some of the workshops."
"It was important to have management support at the sites."
"Having commitment and support from high level people was really critical."
There is now a relationship at a systems level (through relationship with senior management)."
"Senior management said to the doctors, "hey you can phone us anytime" and the doctors were saying, "we didn't know you had a phone."
Link to Provincial Strategies
"There is a provincial framework with an action plan for interprofessional education and collaborative practice which we linked to. This (project) has helped establish our relationship provincially and I think that is one of the big wins."
"I think one of the things that made it easier is that it (the project) was such a good fit with the work we are doing in the province currently around primary health care. Our foundational piece is interprofessional work and it was a great fit."
Collaboration and Communication Between Jurisdictions
"The meeting we had in Calgary was probably one of the most helpful things from a overall project perspective in my eyes. We were actually able to see people face-to-face. I came away from the meeting feeling a lot more confident about things."
"The core team meetings were a really great opportunity to link with others."
"I found the bi-weekly meetings that I was able to attend were quite valuable, hearing what other sites were doing and how they were dealing with their challenges."
"The face-to-face meeting in Calgary was good, we really got a good sense of what the project was meant to be and the juices started to flow when we were interacting with the other provinces."

What were the factors that challenged implementation of activities at the jurisdictional level?

Interview participants identified a number of challenges to project implementation, though they also commented that in most cases, they were able to implement strategies to overcome the challenges. The most frequently expressed challenges were the compressed time frame and lack of common project elements. These were followed by differences in readiness for site selection, team dynamics and lack of clarity around extended project options.

<u>Compressed Time Frame</u>

All the interview participants believed that time constraints posed a significant challenge to the amount of work that could be completed during the 12-month project period. Several participants commented that although a great deal of work was accomplished, in all actuality, the work was only just beginning.

The time frame for the ICP & LE Project was compressed. The project proposal was based on eighteen months, however, by the time the contribution agreement was signed and the money from the funder arrived, it left 12-months for project implementation. A 6-month, no-cost extension was received; however, there was a substantial reduction of committed funding ($152,000) which seriously compromised the project.

The shortened project time frame allowed for the planned activities related to inputs. That is, engaging with communities to build relationships, engaging health care professionals in a meaningful way and beginning to implement intervention activities. This time frame did not allow for further work with teams to embed changes and achieve (or reliably measure) even short term outcomes related to improved workforce optimization.

Lack of Common Project Elements

Many interview participants commented that there was a lack of direction and communication about key project elements to support a common approach among jurisdictions. Project members "*struggled along the way about what were the common elements across the projects and the things that actually linked the jurisdictions together*."

An example of this, raised by an interviewee, was the common evaluation framework that was developed by the external evaluators several months into project implementation. Participants felt that rather than develop an evaluation framework that was a synthesis of their projects, they would have preferred to work together on a common evaluation framework prior to project implementation. The common evaluation framework could have been used as a resource for their jurisdictional evaluations and ensured consistency in data collection at the jurisdictional levels. Other examples of key common project elements provided are the provision of a common approach for implementation, definitions and an overall timeline. The perceived lack of sufficiently common elements, identified at an early phase, may have deterred jurisdictions motivation to collaborate on a more extensive basis.

Differences in "Readiness" for Site Selection

The four provinces were at varying levels of "readiness" for site selection and this posed significant challenges in terms of how quickly they were able to move forward with project activities. This in combination with the compressed timeline, made it challenging to build cohesion across jurisdictions as "*each of the jurisdictions seemed to be in a different place of readiness in terms of site selection…and the work became more focused on what was happening at the sites*."

Two of the jurisdictions had a delayed project start as a result of change in project leadership and internal bureaucracies (e.g. procedures for hiring staff). The other two jurisdictions had the opposite experience as they were ready to implement project activities well before official IPC & LE project start-up. This meant that two of the jurisdictions had close to a year to plan and implement activities and the other two jurisdictions had less than 5 months to implement activities.

Recognizing Team Dynamics

While overall site teams participated enthusiastically in project activities there were a few challenges associated with the team dynamics that influenced implementation of activities. In two of the site teams, the team perceived that they were already functioning well as an ICP team and as a result it was more difficult to engage them in significant ICP intervention activities related to team building. The following quote illustrates this point: "*They all came into the project thinking they were pretty darn good teams*" and "*they were already doing a good job*." Interestingly, at the end of the project, these teams commented that by participating in the ICP process they developed a greater understanding into ICP and areas for potential improvement.

Additionally, a few of the site teams had challenges in terms of overall team dynamic/functioning and this hampered engagement. This is illustrated by the following comment from a facilitator: "*On the surface one of the teams looked like it was a highly functional team but the better we got to know them we realized they had quite a challenging team dynamic. I think that hampered the engagement*." Facilitators at these sites commented that in hindsight, they could have spent more time on team building up front before trying to get the site to change without making sure they were ready to make changes as a team.

Finally, a few of the sites experienced staff turnover during the course of the project which required additional work and time in developing a cohesive team. The staff changes ranged from site personnel to facilitators to the co-leader of the jurisdictional steering committee.

<u>Lack of Clarity Around Funding</u>
The proposal that was funded was written on the assumption of a three phased, multi-year plan. The project team were told that additional phases would not be funded during their first official meeting of the PSC.

Further, the project was cut back from 18 months to 12 months. A no-cost time extension of 6 months was negotiated. However, at the same time a $152,000 reduction in funding was announced. The 6-monthextension was announced well into project implementation when two of the communities were preparing for wrap-up of project activities.

Project members expressed considerable disappointment and discouragement at the way in which these events unfolded. This was evident by the conversations and meeting minutes from the Core Team and PSC conference calls. These events were distracting and the team spent considerable time discussing whether or not there would be an extended time frame and if additional funding became available for subsequent phases, what activities would be undertaken.

Table 4 below provides additional quotes to support the themes noted above.

Table 4: Quotes to support themes related to factors that challenged implementation at the jurisdictional level

Compressed Time Frame
"The shortened time frame has certainly been a challenge. We have really just begun to be honest."
"We worked under very tight timeframes and challenges."
"The jurisdictional steering committee felt strongly that we were just really getting our sleeves rolled up and getting some good outcomes and having to close it all down."
Lack of Common Project Elements
"If the overarching piece had been stronger, we would have been able to deliver more because we would all be on the same page."
"I think the coordination between the jurisdictions and the overall project from an evaluation perspective was the biggest difficulty."
"We felt there was a lack of clarity overall. We were supposed to be doing things in a similar way across the jurisdictions."
"The communication was problematic; the jurisdictions just didn't have information about key elements like evaluation and that sort of thing. That was very, very problematic."
Differences in "Readiness" for Site Selection
"Where we ran into some difficulty was because every project was at a different part of its evolution."
"Each of the jurisdictions seemed to be in a different place of readiness in terms of site selections."
"If all the sites had come on board at the same time it would have been a little bit easier because they would have

been able to support one another."
Recognizing Team Dynamics
"One of the teams believed that when they were selected to participate they thought they had won an award because their team was such a good team (ICP team)."
"The fact that there was a lot of staff turnover on the teams made it difficult. It is hard when you have people leaving and coming in and some people not being replaced."
"There were a lot of staff changes which were quite disruptive to the process."
Lack of Clarity Around Funding
"Through the entire time of the project there was uncertainty as to how much money there was and how long it was going to last."
"Throughout the project until right up to the very end there was no indication from the funder that they would not comply with their extended options for funding for the next two years. The project was under that shadow of uncertainty the entire time."

Was there an increased capacity for ICP & LE and change management practices among site level participants?

While it is not possible to measure short term outcomes within the timeframe of this project, a number of early indicators of success were identified in interviews and project documents. These can be organized by: 1) broader organization and or system 2) providers/students and 3) patient/family. The reader is reminded that these early indicators of success represent common themes across the four jurisdictions. For information on outcomes from each jurisdiction and sites please refer to the jurisdictional site reports located in Appendix XXX.

1. Broader organization or system

Institutional Support

In all of the jurisdictions, there was evidence of institutional support for ICP & LE. Examples of institutional support include but are not limited to:

- ICP curriculum/orientation packages for employees
- A guide to building an effective ICP health care team.
- IP mentoring strategy (ICP clinical placement approach)
- Creation of IP student seminars
- Online ICP & LE toolkit
- ICP student placement guide for management
- ICP language is integrated into regional job descriptions
- Protocols for co-sharing complex clients between two therapists
- ICP Policy paper-*Strategies for organizational planning/sustainability of integrating inter-professional collaborative competencies in an organization*.
- Sites are looking at practice change to support ICP in areas such altering discharge procedures and emergency room functioning.
- Conversations about unattached clients that resulted in a solution for increasing access of those clients to family physicians.
- Increased number of sites for ICP clinical student placements as a result of the project.

Working Culture Mechanisms

During project implementation all of the jurisdictions began to see changes in working culture. Some examples include:

- Teams met regularly and engaged in regular dialogue about ICP.
- Teams developed "simple rules" to guide behaviour
- There was shared decision making about action plans, team goals and visions for the future.
- ICP became a regular agenda on team meeting agendas
- Internal processes were revised to support ICP such as an ICP folder on shared drive
- One team evaluated how information was shared with support staff. Currently, this team is working on improving processes for knowledge translation and access to educational materials for rehabilitation assistants.

In addition, most of the interview participants believed that project activities could be easily replicated in other settings. When asked, "To what extent to you believe the ICP activities can be replicated in other setting (1-low and 5-high)?" interview participants were very confident that the activities could be replicated (4.7 was the mean response). However, participants were quick to add that a number of contextual factors such as funding, leadership and commitment would need to be in place for the activities to be successful. This is promising at one of the objectives of the ICP & LE Project was to create sites that could *serve as capacity centres to provide the essential tools, resources, processes and learning opportunities to facilitate replication of the successful interprofessional and change management practice for other clinical sites and settings in the future…."*

2. Provider/Students

Increase in provider knowledge related to ICP & LE competencies

There was an increased awareness, reflection and knowledge about ICP competencies among providers at the sites. Project members reported an increased comprehension and understanding of ICP. Interestingly, some providers at the sites believed they were already high functioning in the area of ICP and as a result of participating in the project realized they have more work do to do enhance ICP within their respective teams.

Improved understanding of respective roles of team members and changes to team composition potentially contributing to enhanced workforce optimization

There was an increased understanding among health care providers of the roles and responsibilities of other health care providers. In some instances, this led to realignment of positions and professionals at the sites reassessing how they work and how they could work "*even better*." The following comment illustrates the increased understanding of one another's roles: the ICP & LE intervention *"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 one another*." Examples of changes in understanding of respective roles of team members and changes to team composition include but are not limited to:

- Senior management and general physicians having an increased understanding of each other's roles and responsibilities.

- Implementation of a nursing staff mix which now includes LPN's in direct care role, RNs and RPNs in leadership/supervisory roles and advance practice nurses in CNS and NP roles.
- Implementation of nurse practitioner role working in collaboration practice with several family physicians.
- Evaluation of team composition in order to address the need for managing onsite resident care when the physician is not available. This resulted in the addition of a nurse practitioner to the team.
- Organizations experiencing greater communication between internal "silos"

Improved team functioning

Some of the sites reported improved team functioning as a result of project activities. Examples include:

- Increased staff awareness of team dynamics
- Increased cohesion and team functioning

Enhanced student understanding of ICP

In the jurisdiction that implemented ICP clinical student placements, students reported an increased knowledge about ICP competencies. In addition, the students reported gaining a greater awareness about how other practitioners work and that collaborative practice is an important part of client care.

3. Patient/Family

Due to the compressed time frame, the project activities were primarily focused on ICP practice assessment and training for health care providers. There was little to no focus on tracking patient/family outcomes with the exception of one jurisdiction that planned on mapping 2 patient experiences and another jurisdiction that has identified increasing their satisfaction survey to patients as an ongoing action item.

Overall Project Activities

The purpose of the overall project activities was to link all sites *"through the development of an integrated project framework and the creation of an infrastructure that will promote shared learning throughout the duration of this 'action research' based initiative."* Numerous activities were implemented to create and support the jurisdictions. The evaluation findings in this section report on the implementation of these activities. More specifically, the evaluation questions ask:

- Were the ***overall project*** activities (SNA, eCoP, KE, evaluation framework and operational activities) to support site, jurisdictional and national advancement of ICP & LE established?
- What were the factors that facilitated implementation of the ***overall project*** activities?
- What were the factors that challenged implementation of the ***overall project*** activities?

In addition, although the time frame for the project was compressed, some early short term outcomes were also identified. These shed some insight into the question:

- How effective were the **overall project** activities in advancing ICP & LE?

Were the overall project activities to support site, jurisdictional and national advancement of ICP & LE established?

Despite the compressed timeline and uncertainty of extended project options, a significant amount of work was undertaken to create overall project support for the ICP & LE project. As with the jurisdictional activities, implementation of overall project activities was "*a bit of an iterative process*" as the activities evolved in a way that was responsive to the project members. For example, activities at the face-to-face core team meeting in Calgary contributed to the enhancement of the eCoP and the creation of a definitions document.

All of the deliverables identified in the Project Charter were implemented, however many of the deliverables, such as the eCoP and Social Network Analysis (SNA), may not have reached their full potential. For example, while there was some activity on the eCoP, the level of engagement was limited. There were varying levels of interest, comfort with technology and perceived value of the eCoP among project members. When asked about utilization of the eCoP, project members commented that they had limited time in their busy day to access the site. As noted earlier, a few project members did not use the website at all and "*selectively chose not to participate and were very clear they were taking a stand against the eCoP."*

The SNA was conducted at the onset of the ICP & LE project and provided a snapshot of the network in the project. However, the majority of interview participants who commented on the SNA did not consider the results of the SNA to be integral to their network development. A few participants commented that the findings from the SNA were misleading as there was confusion among some survey participants about which organization they were representing on the survey (e.g. Forum, WCIHC, Health Authority). Despite efforts of the SNA project team to educate project members about SNA through in-person meetings and webinars, there were varying levels of understanding about SNA and the underlying concepts among project members.

Much of the work to implement the overall project activities was undertaken in consultation with project members through the PSC, working committees and the Core Team. The activities associated with establishing overall project support are described in detail in Part I of this report.

What were the factors that facilitated implementation of overall project activities?

There were two primary factors that the data suggests facilitated implementation of the overall project activities: support from the overall project team and communication and collaboration between jurisdictions. Table 5 provides quotes to support themes related to factors that facilitated implementation of activities at the overall project level.

<u>Support from Overall Project Team</u>
The support from the overall project team (e.g., contract managers, project manager, eCoP moderator and knowledge broker, SNA manager and evaluation consultants) was a facilitator to project implementation. The project team worked together collaboratively to implement overall project activities such as the development of the common evaluation framework, social network analysis, eCoP,

knowledge exchange and administrative functions such as transfer of funds and development of the Memorandum of Understandings. As one of the team members commented, "*The project team was pretty easy to work with and that was a bonus… The working relationship was good."*

Collaboration and Communication Between Jurisdictions

One of the most important supports that the overall project team provided was the opportunity for communication and collaboration between jurisdictions. The majority of project members indicated that sharing and collaborating with one another through the PSC, Core Team and working committees facilitated their work. ICP & LE is a concept that project members are passionate about. They view ICP as having great value and potential for a positive impact on health care service delivery redesign and "*there was lots of commitment to the actual vision of the project*." Thus, they were dedicated to the project and saw value in collaborating across jurisdictions. A variety of mechanisms for project members to communicate and collaborate were provided by the overall project team these included: regular conference calls for the Core Team and PSC; electronic platforms, in-person meetings and a knowledge broker who was responsible for facilitating communication among team members.

The hosting of face-to-face meetings for the Core Team in Calgary and the PSC in Winnipeg were viewed as extremely beneficial to project members. The meetings provided an opportunity for team members to meet one another in-person, discuss implementation and share experiences and viewpoints. At these meetings, key items were discussed such as the adoption of the CIHC and WHO frameworks, the Multi-Site ICP & LE Evaluation Framework, Logic Model and Program Theory, definitions, Project Charter, and the SNA.

The role of knowledge broker and eCoP moderator was "*instrumental*" in creating and facilitating communication and collaboration. She spent a significant amount of time working directly with project members determining information needs and facilitating communication and sharing of information. In addition, she moderated the eCoP site, encouraged its use and organized and posted information relevant to ICP & LE.

The most active component of the eCoP site was the resource section which was utilized as a repository for information. Over 184 different resources including: meeting minutes, presentations, ethics reviews, resources/tools and reports, were posted on the site with some jurisdictions posting significantly more resources than others.

Though there were some challenges in terms of engaging project members to utilize the eCoP, access to and use of the web site grew over the six months since its launch in December 2010. Web analytics show that as of July 2011, there were 54 registered project partners on the eCoP and 536 visits to the site with 77% of those visits representing returning visitors.

Table 5: Quotes to support themes related to factors that facilitated implementation of overall project activities

Support from Overall Project Team
"The whole concept of the project is a good one that has great value to all the various stakeholders. This is the cutting edge of where the health system is today…it is a very current issue for health managers across the country."
"There was good collaboration, good cooperation and good representation."
Collaboration and Communication Between Jurisdictions
"Every time I talked to someone (project member) they were generous with their knowledge and time and sharing of everything. They were really engaged and really supportive."

"The in-person workshops were good because we could really work with both those teams at in person meetings. I think we got a long way in September and with the Calgary group. Those meetings were really helpful."
"The knowledge broker was invaluable. I think that would be a big lesson out of the project. You have to have someone who is playing that role and linking people together and I think that has been really helpful."
"Getting the eCoP up and running in a timely way also helped with the collaboration and communication. That was a real tangible piece."

What were the factors that challenged implementation of overall project activities?

While a significant amount was accomplished to support the overall project activities, the work was not without its challenges. The primary challenge interviewees identified was the project governance and to a lesser degree the links with other ICP&LE focused organizations.

As might be expected some of the factors that challenged jurisdictions were also challenging for the overall project. The compressed project timeframe and the fact that provinces were at different stages of "readiness" for site selection were noted at both levels. These two areas have been discussed in detail in the previous section on jurisdictional activities and are not repeated here.

<u>Complicated Project Governance</u>
In the judgement of many interview participants the governance structure consisted of "*too many layers*". This led to confusion and lack of clarity around the various roles and responsibilities associated with governance. For example, several interview participants commented that they were not sure if the mandate of the PSC was well understood, despite articulation of the terms of reference for the group in a document. In one of the jurisdictions there was concern about accountability and the communication pathway between the sites and the overall project team which bypassed the jurisdictional steering committee. They were concerned that reports were going directly to the overall project team and this meant that "*the jurisdictional steering committee didn't know what was going on and what the challenges were.*"

A few participants commented that the composition of the PSC was challenging. They believed that PSC members were at "*varying stages of engagement with the project*" and some were "*not aligned with the mandate of the committee*" and had "*differing agendas*." As a result the PSC did not feel like a "*cohesive group with a clear sense of overall direction*."

<u>Ineffective Use of Organizational Links</u>
There were varying opinions about the role of the WCIHC and their contribution to overall project activities. Some project members recognized the strength of WCIHC as a collective group and were disappointed that there was not a stronger link with WCIHC as a collective group to develop various project components; rather "*they functioned as individual representatives within their jurisdictions*."

Other project members indicated that some WCIHC members felt frustrated by the project process and perceived lack of communication during the development of the proposal. They commented that while WCIHC was involved with the development of the proposal to Health Canada, they were not involved with the final stages of the proposal and the negotiations with Health Canada. Several members believed that the final proposal "*changed quite substantially from what we had intended it to be*" with little input from WCIHC. In addition, a few interview participants commented that if members from

WCIHC had been asked to provide input on the process for development of the evaluation framework and take the lead on its development, the process would have moved along more quickly.

Although not mentioned in interviews, it was originally intended that this project and the Atlantic Advisory Committee on Health, Human Resources (AACHHR) would collaborate, particularly around the evaluation, however this link was not effectively utilized. Members from the Atlantic group participated in an early meeting with the overall project team to discuss plans. The two groups did not develop a formalized collaborative relationship during the 12-month period of this initiative, however, there has been considerable discussion regarding the benefit of bringing the two groups together to discuss results and lessons learned.

Table 6 below provides additional quotes to support the themes noted above.

Table 6: Quotes to support themes related to factors that challenged implementation of overall project activities

Complicated Project Governance
"It was sometimes frustrating on the PSC calls because the kinds of questions that the larger project team needed directions and answers from, sometimes the people representing the jurisdiction needed to go back and get the answers from people who were a little closer to the project. I think you need to find that balance between the political need for people to be involved and what is actually helpful."
"The other challenge we faced in terms of implementation of this project was the lack of communication and coordination on the part of the PSC."
"I struggled with the fact that the PSC members were at varying stages of engagement."
"The committee structures were redundant. If you look at the levels, it is basically the same people. I didn't think it was a very good use of people's time. I think it actually impaired communication because people assumed you were on all the committee but you might not be."
"I found the governance structure to be cumbersome at times. I think there were maybe too many layers to it sometimes. The same players showed up at different places sometimes. That made it hard to sort out what hat you were wearing at the table."
"The governance model and some of the roles and responsibilities were a little bit fuzzy. I think it made it more challenging for implementing the activities."
Ineffective Use of Organizational Links
"We really hoped that the WCIHC would be a real partner and be able to lend a lot of expertise, particularly in the area of evaluation."
"The WCIHC was supposed to be the key organization to help drive the intellectual development of the project and they didn't perform as a group at all."
"We could have had a bigger role in working with our colleagues (WCIHC) across Western Canada relating to the framework and evaluation piece but that didn't become our role…"
"I would say we (WCIHC) that there would have been a substantial contribution we could have made, especially around the evaluation and framework, providing background information and the expertise we have."

How effective were the overall project activities in advancing ICP & LE?

While it is far too early to tell how effective the overall project activities will be in advancing ICP & LE, there are a number of significant outputs that will be useful to other groups working to advance this area. These outputs have the potential to serve as building blocks for the next generation of ICP & LE.

<u>Development of Project Charter</u>

The development of the Project Charter was a significant accomplishment. The Project Charter, which is described in greater detail in Part 1 of this report, is an agreement among the various project partners

participating in the ICP & LE project to work collaboratively in achieving the project vision and objectives. A copy of the Project Charter can be found in Appendix XXX.

ICP & LE Multi-Site Evaluation Framework

The Multi-Site ICP & LE Evaluation Framework was a key outcome of the overall project activities. The EWC, in collaboration with the PSC, worked to develop the Evaluation Framework which contains: 1) a program theory 2) logic model and 3) a common evaluation framework including short, intermediate and long term outcomes. The framework extends well beyond the frame or the existing project and can easily be adapted for use by other multi-site projects engaging in ICP & LE activities. A copy of the ICP & LE Multi-Site Evaluation Framework can be found in Appendix xxx.

eCoP

The eCoP was created to support exchange activities between the network of project partners across all four western provinces engaged in the project. Its potential for building and facilitating a larger interprofessional or models of care community may not have been fully realized. The PSC is considering options for the future of the eCoP.

ICP & LE Tools and Resources

As a result of project activities a number of tools and resources were sourced and/or documented. The majority of these resources, which are incredibly valuable to those working in ICP & LE, are presently housed on the eCoP.

Linking Workforce Optimization to the Competencies required for effective interprofessional practice

Due to the compressed timeline, the majority of project efforts were placed on ICP assessment and training and not as much on workforce optimization. However, although workforce optimization may not have been fully realized, there was excellent progress made on articulating a common definition of workforce optimization ,and linking it to the competencies required for interprofessional practice.

Knowledge Exchange and Translation Plan

To support knowledge exchange and translation, a detailed Knowledge Exchange and Translation Plan was created. A copy of the Knowledge Exchange and Translation Plan can be found in Appendix XXX.

Generic Site Intervention Plan

The Project Manger developed a generic site intervention plan which describes the common processes used at each of the sites to plan and implement project activities. A copy of the Generic Site Intervention Plan can be found in Appendix XXX.

Support for System Level Change

One of the principles underlying the proposal and the program theory for this project is that system-wide support and change are needed to fully realize effective ICP & LE. This perspective is one of the principles underlying the WHO Framework for Action on Interprofessional Education and Collaborative Practice.

To bring a systems perspective to the evaluation findings, we began by identifying different levels of the system represented in the data that influence the larger goal of the project which is, "*effective ICP&LE in*

a variety of settings, across a range of clinical settings and multiple jurisdictions, reflecting the continuum of health care deliver". The idea is to work simultaneously in these different parts of the system recognizing that different patterns of change will occur within each, but that all are necessary in order to fully realize the potential of ICP & LE in impacting workforce optimization. Five basic levels of system influences were identified, including:

1. National, provincial and organizational policy context
2. Site teams in clinical practice settings
3. Health care personnel
4. Students in the health care professions
5. Patients/family/community

Based on the findings from this evaluation and drawing from the WHO Framework, as well as the CIHC competencies we developed a framework (Table 7) that shows how a focus on multiple levels of the system influence the ultimate goal of this initiative[2].

We then identified aspects of change over time for each subsystem beginning with a baseline assessment, identification of potential intervention approaches, the "tipping point" needed within that system to facilitate ICP &LE, and finally the actions needed to sustain gains. It is important to note that although all levels of the system need to progress, there is not an expectation that they will change at the same rate or time frame.

[2] This approach is derived from the work of Beverly Parsons, a recognized expert and author in systems evaluation- Parsons B, Hargreaves M. Evaluating Complex System Interventions. Presented at American Evaluation Association Conference, Orlando FL, November 2009.http://www.insites.org/pub_AEA2009.html

Parsons B, Evaluating Patterns of Change in Complex Systems: Strengthening Families Example. Presented at American Evaluation Association Conference, Orlando FL, November 2009.
http://www.insites.org/pub_AEA2009.html

Table 7: A systems perspective on factors that support development of ICP & LE

POINTS OF INFLUENCE	BASELINE ANALYSIS Extent to which:	ACTION/ INTERVENTION	TIPPING POINT FOR CHANGE	SUSTAINING CHANGE
Policy Context (national, provincial, organizational) Examples: Health Canada, Provincial Ministries, Universities Health Authorities, clinical sites, relevant NGO's	Current policies/strategic plan encourage and support collaborative practice as a means to enhance workforce optimization. Resources available to support development of knowledge and knowledge exchange in collaborative practice.	Policies adjusted with stakeholder input and valuing of multiple perspectives.	Policies clearly encourage implementation and evaluation of collaborative practice across different types of practice settings, a range of clinical settings, and across the continuum of care.	Review and update policies to ensure they support best practices in ICP &LE that contribute to workforce optimization. Ongoing support and funding for development of new knowledge, evaluation of programs, and an infrastructure to support knowledge exchange.
Clinical practice setting Examples: mental health clinic, long term care facility, women's wellness centre, health care for seniors, community care programs, health care clinic	Health professionals at the site are at a level of team readiness that will make collaborative practice feasible. Support for ICP &LE from senior management and supervisors at all levels.	Team development activities to raise awareness of CIHC competencies, group dynamics, and enhance communication. Increase awareness of at organizational level regarding ICP & LE.	Multiple communities of practice that collaborate and function at a high level. Organizational culture is positive and supportive regarding ICP & LE.	Work with teams on an ongoing basis to maintain high functioning working relationships. Maintain infrastructure for ICP & LE, communications, support development activities.
Professional development for health care personnel Examples: Physicians, nurses, nurse practitioners, social workers, occupational and physiotherapists, pharmacists, case managers	Attitudes, level of awareness and skill related to competencies for interprofessional collaboration. Understanding regarding the link between collaborative practice and workforce optimization.	Professional development and continuing education on collaborative practice competencies and concepts related to collaboration, workforce optimization and patients outcomes	Professional development for collaborative practice is readily available and accessible for vast majority of health care personnel who have not been exposed to the approach.	Ongoing improvement and updating of professional development and continuing education (build on best practices, incorporation of new knowledge).
Student Education & Training	Student Attitudes, level of awareness and knowledge and abilities	Training and clinical experience in collaborative	Training in collaborative practice is embedded within the curriculum.	Ongoing improvement and updating of curricula (build on best

Examples: Physicians, nurses, nurse practitioners, social workers, occupational and physiotherapists, pharmacists, case managers	related to competencies for interprofessional collaboration. Mentors are committed to ICP, have knowledge and skill, knowledge regarding the competencies, skills in student assessment and feedback. Institutions' training health professionals incorporate ICP competencies framework into their curriculum. Understanding regarding the link between collaborative practice and workforce optimization.	practice that is supported by educational institutions and clinical training sites. Faculty Development Initiatives to advocate and support educational institutions in adopting the ICP competencies framework in education and training.	 Faculty development is readily available and accessible for vast majority of health care personnel who have not been exposed to the approach. Vast majority of training programs have curriculums that address the competencies.	practices, incorporation of new knowledge). Ongoing improvement and updating of faculty development (build on best practices, incorporation of new knowledge). Ongoing improvement and updating of curricula (build on best practices, incorporation of new knowledge).
Patients/family/community*	Patients and their families aware of what collaborative practice means. Patients engaged with their caregivers in supportive ways.	Patient education on collaborative practice and their role on the team.	A critical mass of patients and their families are familiar with collaborative practice and know what to expect from a practice team and are an integral member of the team.	Work with staff and patients/family to ensure meaningful engagement of patients/family in care decisions and appropriate role on collaborative team.

*Results do not include "Patients/Family/Community"; however, this category was included in the systems analysis based on the logical extension of intervention to these groups and the fact that they are the primary target group.

Conclusion

The vision of the ICP & LE project was *to establish and implement interprofessional collaborative practice and learning environments in a variety of multi-jurisdictional sites across the continuum of care*. All four jurisdictions successfully implemented intervention approaches designed to establish practice and learning environments, however, it is too early to conclude whether or not these approaches have been established to the extent that they will be sustained for any period of time.

The 12-month project timeframe is inadequate to make any conclusions regarding sustainability or achievement of anticipated outcomes. However, there were some early indications from qualitative data that short-term outcomes were being achieved (e.g., provider and student knowledge of competencies, improved team functioning). Had the interventions been implemented for a longer period of time, it is feasible that there would have been measureable short-term impacts leading to intermediate and long term outcomes (e.g., improved team effectiveness in ICP & LE, enhanced health and human resources planning and supply, and improved patient health outcomes).

Despite these limitations there are important gains that have been made in terms of insight regarding factors that facilitate and hinder implementation of an ICP&LE intervention in clinical settings. There have also been important lessons learned from implementing this multi-site project, as well as key products that will provide a foundation for the next generation of multi-site projects.

A number of factors were identified as important to supporting sites in implementing intervention components. The strongest themes to emerge were availability of resources to pay for items such as training and facilitation of teams, collaboration that occurred within jurisdictions, partnerships, and support from senior management. Another important factor was consistency of the project with provincial strategies.

Implementation of jurisdictional activities was supported by a number of overall project activities which aimed to enhance collaboration and communication among the jurisdictions. This role was identified as important to the success of jurisdictions. The factors perceived to hinder the success of the overall project included what was perceived as a cumbersome governance structure and ineffective linkages with other initiatives working in the same area (i.e., AACHHR and WCIHC).

The factors that hindered success of jurisdictions included the compressed time frame and what projects perceived as a lack of common project elements. The fact that the four provinces were at different stages of “readiness” for site selection, team dynamics and lack of clarity around extended project funding were also barriers to success.

A principle underlying the proposal and the program theory for this project is that system-wide support and change are needed to fully realize effective interprofessional collaborative practice and learning approaches, a perspective integral to the *WHO Framework for Action on Interprofessional Education and Collaborative Practice* and consistent with the CIHC competencies. We found that a systems framework was useful in bringing together the results from this evaluation. This approach identifies important indicators for monitoring success and determining potential gaps in the system that should be addressed to achieve the long term vision of contributing to workforce optimization through ICP &LE.

This multi-site project provided opportunities for a wide range of stakeholders to share information, collaborate on the challenges they faced and compare their experiences in different contexts. Among the factors that hindered success was "a lack of common project elements". It is important to recognize that there are different types of "multi-site" projects ranging from tightly controlled studies using a randomized controlled design, to initiatives that have a common goal but use different approaches and disparate measures. In the later case, evaluation focuses primarily on qualitatively identifying common themes and lessons learned. Somewhere in between these two extremes is a third approach in which multi-site projects apply different intervention approaches, but use a common set of core measures. The work that was conducted in this project would allow for this third approach. For future projects it will be important to specify the type of multi-site project being funded, roles and responsibilities of all stakeholders, and anticipated gains from this approach.

While the findings presented in this chapter will be useful and provide valuable insight for program planners and decision-makers, the reader is cautioned when interpreting the findings. The applicability of these results to similar initiatives in other contexts is unknown. Additional studies in other locations, with similar programs, will add to this body of knowledge.

Though long-terms outcomes were not achievable in the life of this ICP & LE project, the jurisdictions and their related sites appear to be well positioned to achieve one of the project goals which was for the sites *to serve as capacity centers to provide the essential tools, resources, processes and learning opportunities to facilitate replication of successful interprofessional and change management practices for other clinical sites and settings in the future.* In order for this to be realized, continued leadership, resources and integration into existing service delivery redesign will be required.

Recommendations

There were a number of lessons learned that are perceived as being important factors to successful implementation of similar ICP & LE programs. These lessons are based on the themes discussed in the challenges and facilitators to project implementation. One exception is the recommendation for jurisdictions related to developing intervention approaches that are theory-based and reflect best practices. Though this item did not emerge as a facilitator or barrier, participants voiced their strong belief that these two elements are the necessary foundation for a successful program.

Overall Project

- Ensure adequate time and funding to implement project activities and realize short and long term outcomes. ICP & LE is a complex intervention that requires change at multiple levels of the healthcare system. This twelve month project provided a reasonable amount of time to ensure inputs were in place (e.g. team development, educational sessions). However, the twelve months, combined with a decrease in funding was inadequate to achieve even the short term outcomes necessary to realize the potential impact of interprofessional collaborative practice on health care service delivery redesign.

- Fund multi-site projects with an overall project infrastructure. This will be a beneficial way to accelerate the generation of knowledge in ICP. An overall project infrastructure allows people to connect in an efficient manner and provides opportunities for collaboration. This can be

accomplished by implementing the kind of communication activities that were implemented in this project such as the provision of a knowledge broker to stimulate and facilitate communication and coordination and establishment of a variety of communication mechanisms such as in-person meetings, eCoP, and conference calls.

- For future projects it will be important to be clear about the type of multi-site project being funded, roles and responsibilities of all stakeholders, and anticipated gains from this approach. It is important to recognize that there are different types of "multi-site" projects ranging from rigorous studies, to projects that have a common goal but use different approaches and disparate measures. Somewhere in between these two extremes is a third approach in which multi-site projects apply different intervention approaches, but use a common set of core measures. The work that was conducted in this project would allow for this third approach.

- For multi-site projects create a governance structure that is efficient and provides opportunities for project members to participate in a way that makes the best use of their time and expertise. Be certain that everyone understands their roles and responsibilities and that there are clear lines of accountability. Review the governance structure at key points in the process to ensure the project it is serving the needs of the project.

Jurisdictional

- Incorporate best practice and theory based interventions into planning, implementation and evaluation of project activities. This will strengthen project activities by enabling efforts to *build* on lessons learned and previous experiences in ICP & LE rather than *recreating* ICP activities.

- Conduct a baseline assessment at the onset of project activities to understand the dynamics of participating site teams before engaging team members in change activities. This includes understanding how the teams function, as well as their level of understanding about ICP. It is important that teams understand the concept of ICP so they are able to gain the most value out of ICP interventions.

- Engage a broad range of stake holders in the development and implementation of project activities ranging from front-line mangers to community members to high level decision makers. This broad engagement allows stakeholders to work and learn together to facilitate change at all levels of the system. Where possible, capitalize on existing relationships and identify leaders/champions within the group of stakeholders.

- Facilitate and encourage engagement of senior management in project activities. These individuals can provide insight and linkages between project activities and other strategic primary health care initiatives in the jurisdictions as well as provide political support. Activities that clearly align with existing or planned healthcare service delivery and/or strategic directions at national, provincial and regional levels are more likely to gain support and be successful.