



SEARCH Networks...

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ABSTRACT BOOKLET

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LOCAL PROJECTS

Local projects are conducted by individual SEARCH Classic participants with local colleagues, and involve evidence synthesis and communication to inform local decision making.

How do Health Facilities Plan, Implement and Evaluate the People Centered Care Concept?

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BACKGROUND

People Centred Care is defined by the World Health Organization as “a balanced consideration of the values, needs, expectations, preferences, capacities and health and wellbeing of all the constituents and stakeholders of the health care system”. (WHO, 2007). Alberta Health Services (AHS) strives to provide high quality care that values patient safety. Developing partnerships helps to facilitate information sharing between stakeholders. This improves health outcomes and overall stakeholder satisfaction. The purpose of the literature review was to identify strategies that will assist health facilities to forward People Centred Care (PCC) momentum.

METHODS

A targeted literature review was used to determine the current state of knowledge and practices concerning PCC. This involved the critical appraisal of literature which met inclusion/exclusion criteria. Content, quality and transferability were assessed using a qualitative valid, important and applicable (VIA) model approach. The report includes both philosophical and concrete strategies to foster and support PCC.

CONCLUSIONS

Within the existing literature, two factors for successful applications of a PCC approach were consistently identified:

The importance and commitment of organizational leadership.

The feeling of ownership by the people.

AHS has indicated the importance of placing the patient at the center of health care service delivery. The Mission of AHS is, “To provide a patient-focused health system that is accessible and sustainable for all Albertans” and as such can be applied to all six dimensions of health and four areas of need, within the Alberta Quality Matrix for Health. The adoption of PCC into health environments can improve health outcomes at individual, organizational and system levels.

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Quality Performance Indicator Reporting to Surgeons: Is there Another Option?

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BACKGROUND

As of July 2007, there were 2,686 physicians working in the Capital Health region of which 1,481 were surgical or medical specialists. Over the last 10 years, initiatives involving reporting of Capital Health data elements to physicians, using clinical and administrative data accessible through Capital Health database systems, have been perceived by physicians as not useful with respect to improving the quality of surgical care. Recognizing the escalating costs of health care, and a growing emphasis on accountability, effectiveness and quality of clinical care, Capital Health identified the need to create a framework for appraising physician performance with ongoing quality analysis reporting to physicians. This issue is also of importance to physicians, being recognized as a priority in the 2005 Capital Health Medical Affairs business plan.

Purpose

The purpose of this systematic literature review is to determine if the reporting to surgeons of results from surgeon specific performance indicator systems, using clinical / administrative data, result in improved patient outcomes.

METHODS

A review of the literature from 1992 to 2007 was conducted between July 16, 2007 and January 24, 2008. A search of PubMed, MEDLINE and Healthstar through the Ovid interface, MEDLINE and CINAHL through the EBSCO interface, and HSTAT through the National Library of Medicine (NLM) electronic databases yielded a total of 49 retrieved articles and three text chapters. After a comprehensive analysis, followed by a critical appraisal of the three articles meeting the exclusion / inclusion criteria, it was determined that the study results did not suggest a true correlation between the studies' interventions and the outcome of interest. Given the lack of conclusive research findings, additional peer-reviewed and gray literature was reviewed with the goal of identifying key concepts and promising practices in this field. Experts in the field of quality improvement were also identified through this expanded search and interviewed.

CONCLUSIONS

As a result of this work, two key implications for surgical service performance management in Capital Health were identified. First, Donabedian's triad framework of structure, process and outcome should provide a foundation for measuring quality in healthcare, as these are integrally related and cannot be viewed in isolation. Second, because using performance indicator measurements to assess performance of a particular surgeon has not been shown to be effective, moving to performance management systems that target the whole surgical team and process is being increasingly recommended.

Opportunities exist for Capital Health to provide leadership and support by building on the experience of local services contributing to or using provincial / national service data bases. Another

opportunity is to explore possibilities to further the research linking measures of clinical, functional, and quality of life outcomes; as well as the connection between processes of care and outcomes.

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Moving Stroke Rehabilitation Guidelines into Clinical Practice

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BACKGROUND

The province of Alberta is embarking on a provincial stroke strategy to ensure stroke care is consistent across the province. Chinook Health is in its first phase of stroke implementation. Stroke represents the leading cause of adult disability and is a leading cause of death in Canada. Most stroke rehabilitation is disjointed and does not flow across the care continuum in Alberta. Through research, inpatient and community rehabilitation has been shown to be effective in reducing disability post stroke, reducing ongoing care costs and improving quality of life for stroke survivors. Effective stroke strategies will build networks, capacity, and services across Chinook Health's stroke rehabilitation care continuum.

Question

What strategies have been shown to be effective in implementing evidence-based clinical guidelines into stroke rehabilitation practice?

METHODS

A systematic literature review was conducted. The initial search in EBSCO, PubMed and Google Scholar produced 330 articles. Search terms and key words included: guidelines, implementation, dissemination, stroke rehabilitation, practice and strategies. Consideration was given to articles specific to strategies that promoted the movement of evidence-based guidelines into stroke rehabilitation or clinical practice. To draw conclusions effectively to the data on the promotion of evidence-based guidelines into stroke rehabilitation practice, articles selected addressed specific strategies within the health care system. Although many articles identified strategies, seven articles met the criteria and were included in this review.

CONCLUSIONS

"As decisions in health care are influenced by a whole range of cultural, organizational, systemic, educational, interpersonal and individual factors, it is important to have different strategies for different groups for the implementation and dissemination process." (Barosi et al., 2006) The literature points to several strategies that support moving evidence-based guidelines into stroke rehabilitation practice. Five of the seven articles had themes which were duplicated.

Of the seven articles analyzed, the following common themes were noted:

- the need for project champions, leaders, stars and experts
- the provision of stroke education before and after the project implementation
- the building of networks on a local, regional and provincial level
- the promotion of culture and interest of research within an organization
- strong links between academics and clinical staff
- the need for policy/procedure development-throughout project implementation.

Strategies are needed to move evidence-based guidelines forward.

Through research investigation, research promotion, discipline specific evidence-based focus groups, development of evidence-based clinical pathways and appropriate allocation of resources, Chinook Health's stroke rehabilitation plan is following many of the recommendations reviewed in this critical appraisal. Adherence to these strategies will assist organizations with the promotion and implementation of evidence-based guidelines into stroke clinical practice.

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Young Adults in Care – ‘Finding Our Voice’

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BACKGROUND

Question

What factors contribute to quality of life for young disabled adults living in long term care?

In May 2004, Bethany Care Society (BCS) CollegeSide in partnership with the DTHR opened the first young disabled adult residential care home in this health region. Since that time, BCS has identified challenges in providing quality care to this unique population within the environment of a

long term care setting. Specialized and segregated services for younger adults requiring long term care is a relatively new concept. In an effort to guide future service delivery and decision making this local research project sought to discover quality of life indicators for this challenging population.

METHODS

A systematic review of the evidence related to quality of life indicators for the young adult population living in long term care. Databases searched include Cochrane Library, National Guideline Clearinghouse, ABI Inform, PubMed, EBSCO, and CINAHL resulting in 14 articles. Search Engines explored include Google Scholar, Google Canada and Ask.com resulting in 58 articles. After the application of the inclusion and exclusion criteria a total of 17 articles met the requirements of this study.

The study articles were assessed and primary results or key themes were highlighted then contrasted across articles. Eight **key themes** emerged. The literature implied that Young adults with disabilities living within a long term care environment often struggle with increased depression and dissatisfaction. Incorporating these key factors into service delivery may enhance quality of life:

CONCLUSIONS

Key Themes

- Community Inclusion
- Age-Appropriate Recreational/Leisure Programs
- Social Contact
- Mental Health Support
- Enhanced Rehabilitation
- Family Collaboration and Inclusion
- Specialized Staff Training
- Self-Determination

Implications and Applications

There is a lack of empirical data and scarcity of available programs for young adults with disabilities in institutional environments. Consequently, facilities offering services to this unique and challenging population lack the research to identify and recommend best practices in relation to service delivery. This literature review informs decision makers of specific areas of need that if incorporated into their service delivery has the potential to improve quality of life for the target population, increase caregiver work satisfaction and increase the retention of staff. DTHR/BCS have the potential to be leaders in the development of services to the young adult population in long term care.

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What are the Indicators of Staff Readiness for Organizational Change?

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BACKGROUND

Organizational Issue/Question

New technology is being introduced to Community Health Services which will impact the way staff document client records.

Background Information Context

eClinician is a comprehensive clinical information system that will support Community Health Services' clinics through two integrated applications; including eClinician electronic medical record (EMR), an electronic patient charting and clinical decision support tool.

In the next eighteen months, Planning and Support is working to implement the EMR at 22 health centre sites in urban, rural and suburban areas. There are varying levels of computer competence and comfort amongst staff.

METHODS

Comprehensive literature review was conducted to determine indicators for staff readiness.

In reviewing both qualitative and quantitative studies, findings indicate that much of the research on organizational change is from an organizational or systems perspective. As well, readiness, which implies a proactive approach to positive staff change, is distinct from research that identified ways to reduce staff resistance.

Readiness for change models, which combine organizational and individual models, were identified. Work variables are predictors of readiness for organizational change. Staff perception of their competence with new skills required, impacts readiness for change. Employees in positions with more control over their jobs reported higher readiness for organizational change scores, and were more likely to participate in organizational redesign.

CONCLUSIONS

Readiness for organizational change implies a proactive approach so staff are supportive of organizational change. Management and the project team are integrating the following to ensure implementation of the EMR is successful:

- Facilitated discussions are being held at all health centres and team meetings;
- Staff feedback and participation is being encouraged;
- Multiple approaches to training will address staff competency issues;
- Ongoing, multiple communication strategies are being developed.

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What are the Current Admission Practices for Pediatric Patients in Settings Where Both Tertiary Care and Community Hospitals Exist?

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BACKGROUND

The hospitals in Calgary are responsible for providing comprehensive health services to residents within the city and rural areas surrounding Calgary and tertiary level services to the population in Southern Alberta. Given this, the population growth through in-migration and the increasing birth rate is predicted to put a strain on existing paediatric inpatient services. These pressures are within the context of the normal seasonal variation of paediatric inpatient activity (peak activity from November through April due to high levels respiratory and infectious illnesses). For planning purposes, the winter peak activity is used for capacity planning.

In Calgary paediatric inpatient care occurs at two sites, the Alberta Children's Hospital (ACH) and the Peter Lougheed Centre (PLC). This current bed compliment has been primarily adequate, although activity has been increasing. With the increased birthrate (5% per year) over the past several years and the in-migration of families there is a projection that additional beds will be required.

From a service delivery perspective, the ACH will continue as the single tertiary site and any new beds will be at the community or secondary level of care. It has become clear that the definition of community or level II patient populations and service delivery models is not well defined in practice. While capital planning proceeds, there is a pressure to confirm a paediatric care model that addresses the best practice within a tertiary/secondary level of care service model. This initiative can support current models of patient care across the ACH and PLC as well as inform service delivery and expectations for future capital growth.

METHODS

Systematic Review of the Literature

A systematic, comprehensive literature search was conducted in both the academic and grey literature fields using the key words: "paediatric" and "patient admission"; "tertiary care" and "community hospital" and "admission"; "appropriateness" and "admission"; "criteria for admission"; "admission" and "algorithm"

The few articles that were found were analysed based on content and those describing how decisions made around where patients (preferably paediatric) were admitted were included.

Key Informant Information

After the literature review generated a low yield, the SEARCH participant contacted the Canadian Association of Paediatric Health Centers (CAPHC), whose members are the 16 Paediatric Tertiary care teaching centers across Canada. Via the Canadian Pediatrics Decision Support Network (CPDSN), all the 16 centers contacted were asked how decisions were made around Paediatric admissions with a focus on choosing between Tertiary care and Community Hospital beds. Seven of 15 centers responded, and of those, this question was only relevant to three hospitals. The SEARCH participant contacted these specific hospitals and a 45 minute semi-structured interview was conducted to explore their established admission processes.

CONCLUSIONS

Systematic Review of the Literature

Very little consensus was documented in the literature and most of the literature dealt with physical requirements of Emergency Departments and hospitals, risk of admission assessment measures, or were not describing the paediatric population but were valuable in general terms. Two articles were from a major Canadian center describing their admission practices and were directly applicable to the project.

Key Informant Information

Two centers described their systems of diverting Level II patients to outlying paediatric units in community hospitals while retaining the Level III patients at the Tertiary care paediatric center. The third center described a reduced need for community hospital paediatric beds and inferred a potential bed reduction in these hospitals.

Implications and Applications

The results of the study was used as background research by a clinical working group to establish clinical guidelines to be used when a child presents in one of the Emergency Departments and the decision is made to admit the child. The guidelines will be evaluated at regular intervals.

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Strength is Not in the Numbers: The Influence of Social Support on Postpartum Depression

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BACKGROUND

Approximately 13% of mothers are at risk of developing postpartum depression (PPD) after giving birth. In 2007, Northern Lights Regional Health Centre (NLRHC) delivered 940 babies. Fort McMurray, AB is the major centre within the Northern Lights Health Region. Located approximately 440 kms north of Edmonton, Fort McMurray, home of the oilsands, has become one of Alberta's largest boomtowns. Given a 13% incidence, it is expected that over 120 mothers each year are at risk of developing PPD within Fort McMurray alone (Dennis & Ross, 2006).

Within NLRHC, more mothers are being referred to Mental Health Services by Family Health during their infants' two-month immunization. During initial assessments with therapists, mothers are noting a lack of adequate social support as one factor contributing to their inability to cope. As such, it would be useful for professionals to determine whether social support is related to the onset of PPD. This question is important to answer since identification of a link between PPD and social support may lead to practice changes within NLRHC, particularly related to prevention and treatment.

METHODS

To determine the relationship between social support and onset of PPD, a systematic review of primary studies from 1997 to 2008 was conducted. Eighteen studies were retrieved for the review, with only two articles being classified as providing high quality evidence.

CONCLUSIONS

The review indicated that social support was not the only factor influencing the development of PPD and was often embedded within a multi-factorial framework (income, age, ethnicity, etc.). Despite this finding that a number of factors are related to the onset of PPD, in the general population, social support single-handedly accounted for approximately 13% of the variability in PPD. Furthermore, it was found that mothers perceived importance and satisfaction with social support received as the strongest determinants of PPD.

Given that this review has addressed an area of need for expectant and new mothers, NLRHC is currently investigating services that could possibly prevent or mitigate the risk of developing PPD. It is this author's hope that a PPD prevention program will be developed which assesses expectant mothers' risk for developing PPD. At risk mothers would be provided with early interventions which have a fundamental focus on PPD with the added component of developing an adequate social support system prior to baby's arrival. Many prenatal courses are focused on pregnancy and delivery and fail to address postpartum issues. Through the program expectant mothers could develop an awareness of PPD and develop a plan to minimize their risk; a plan that may be as simple as seeking the support that they organized during the preventative program. This would allow NLRHC to provide services which are acceptable, appropriate and subsequently mitigate risk to mothers and their babies.

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What are the Current Best Practices for Conduct Disorder Within the Adolescent Population? Does the Current Programming in Palliser Health Region (PHR) Need Changing?

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BACKGROUND

In 2007, stakeholders and partners had identified that there was increased identification of conduct disorder in the school system consistent with current Canadian averages. There was interest in determining how the Palliser Adolescent Service (PAS) program could assist with building capacity and resources to address this issue within both the school and health systems while not increasing the burden on these systems.

METHODS

A literature search was conducted, using key search terms (“conduct disorder”, “therapy”, “adolescent”, and “behavior”).

Randomized control trials, nonrandomized comparison groups, quasi-experimental designs studies dated from 2002 to 2007 were reviewed and filtered pertaining to treatment modalities and efficacy of outcome measurements with interventions to produce change in adolescent behaviours.

453 articles were identified in the literature search, 11 meeting the inclusion criteria. Evidence that was generated was of good quality despite limited research for the population in regards to therapy outcomes.

CONCLUSIONS

Current consensus in research and practice indicates that optimum outcomes from treatment must address multiple domains in a coordinated manner over a period of time. Treatment involves an integrated approach with the adolescent, family, school and peer group.

It is strongly recommended that continued research for effective treatment programs and interventions for adolescents with conduct disorder or behavior related disorders be coordinated through national and provincial partnerships. Creative partnerships between mental health settings and other resources, wrap-around service delivery models should be strongly encouraged and researched.

This will inform Palliser Health Region as they make long range plans to look at potential change in delivery of services for this patient population.

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BACKGROUND

Organizational Issue

The question for this project is what are the best practices for medication administration on an inpatient acute care unit to minimize medication errors? The focus area is Effective Best practices. Medication errors are of concern for the health care system as they directly relate to patient safety. It is estimated that nearly one in every five medication doses in American hospitals may be administered in error, of which 66% are preventable. Review of present systems is fundamental to determine the congruency with best practices to minimize errors.

Background Information

Palliser Health Region is very committed to providing quality patient care with a focus on patient safety. To help achieve this goal, medication errors are monitored and reviewed. The purpose of this project is to evaluate the present system of medication delivery in Palliser Health Region in relation to best practices. The second component that is looked at is staff efficiency.

METHODS

A literature review was conducted using EBSCO, PubMed, Cochrane and Grey Literature. This yielded 98 articles that were then examined for relevancy to the specific question. It was found that 11 met the inclusion criteria relevant to the specific question. These articles were systemically reviewed.

The literature supports medication storage located at individual patient rooms.

- The evidence shows that this system significantly decreases the incidence of medication errors. Medications were more likely to be given on time, and less likely to be omitted when administered at the patient's bedside. These results were replicated in more than one study.
- The literature also shows increased staff efficiency as compared to using medication carts.
- Other benefits are increased patient and staff satisfaction.

CONCLUSIONS

Using the Alberta Quality of Matrix for Health this project is relevant to the dimensions of quality of safety and efficiency.

Under the areas of Need the focus of this project is primarily on "Getting Better" as it relates to acute care. In the health care system, it is imperative that steps are taken to enhance the safe administration of medications as well as an efficient work environment. These findings support the principles of Service Excellence within Palliser Health Region and the four key focus areas of People, Service, Quality and Efficiency.

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INTERMED: Assessing Patient Complexity in the Inner City

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BACKGROUND

Medical and administrative directors at the Boyle McCauley Health Centre (BMHC), a community-owned primary care resource serving Edmonton's inner city, requested information on tools that could objectively characterize patient complexity. It was thought that such tools could help with allocation of resources and outcome measurement, and to evaluate the assumption of high patient complexity in the current model of care. A preliminary literature search identified the INTERMED tool as the best candidate for further assessment. The INTERMED is a matrix based on a standardized patient interview in which a patient's history, current state and prognosis are scored in four domains (biological, psychological, social and health system) to give an overall assessment of complexity.

The purpose of this literature review was to determine the state of the evidence on the validity and reliability of the INTERMED tool as a measure of patient complexity, and to assess the transferability of this evidence to a primary care context.

METHODS

PubMed, CINAHL, and Web of Science databases were searched using the keyword “INTERMED”. The “related articles” function was used in PubMed for key articles. Selected articles’ references were reviewed, and two key authors were contacted for additional or unpublished information. In addition, the grey literature was accessed through Google and Google Scholar.

CONCLUSIONS

Findings

Sixteen relevant and medium or high-quality research papers were identified. The sum of the evidence seems to indicate that the INTERMED is moderately reliable, but at present, there does not appear to be sufficient relevant evidence to support its use in a primary care setting. Through communication with the researchers however, new adaptations were identified that could be of greater value to the BMHC. One such example is an adapted version of the INTERMED for primary care that is currently being tested by a research team in Minnesota.

Implications

Findings from the review were discussed with BMHC administrators, who felt that the INTERMED adaptations could possibly be used in the following ways:

- To provide a common language for discussing patient complexity.
- To identify highly complex patients who require multidisciplinary team care and increased resources, improving appropriateness of care.
- To improve efficiency of care by identifying which patients need which resources.
- To assess individuals or the clinic population to assist in resource allocation.

Recommendations

1. If interest and resources allow, consider participating in current research on use of an adapted version of the INTERMED in primary care (Minnesota Complexity Assessment Record).
2. If unable to participate in research, consider contacting the research team for information on how this tool is developing in order to assess its utility at the BMHC.
3. When implementing or piloting the tool, prepare a framework for evaluation from the outset in order to assess its utility in the BMHC context.

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Involving Patients and Families in Enhancing Patient Safety

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BACKGROUND

Organizational Question

What interventions can be implemented that will increase the patient and families' role in enhancing a culture of safety within the David Thompson Health Region?

Background Context

The U.S. Report "To Err is Human: Building a Better Health System" by the Institute of Medicine estimated that between 44,000 to 98,000 people die in hospitals each year as a result of an adverse event. The Canadian Adverse Events Study (Baker-Norton) 2004 suggested similar results and had a profound impact on healthcare organizations and the delivery of services in Canada. Patient Safety and medical error have emerged as quality and public policy issues in healthcare. A safety culture is an environment that encourages reporting of errors, ends blame, involves senior leadership and focuses on systems. Accreditation Canada has incorporated patient safety as a focus in accreditation reviews of healthcare organizations. The David Thompson Health Region (DTHR) needed to actively pursue efforts to involve, inform and educate patients/clients across the region about their role in patient safety.

METHODS

The evidence obtained from a literature review outlined the concept of safety management and the need for a systematic approach to continuously improve opportunities for patients and staff to mitigate risk. In order to improve the goal of patient safety, we must create a positive culture of safety. The DTHR was striving to develop characteristics of a positive safety culture. A DTHR Patient Safety Pamphlet was developed and trialed as a mechanism to increase patient's awareness of safety issues and the vital role they can play in receiving safe care, treatment and health services. Reviewing trending data on adverse events, and reviewing other patient safety organization's patient education samples of developed patient safety tips identified the key content of the pamphlet.

CONCLUSIONS

The DTHR Patient Safety Pamphlet was trialed with 51 patients who completed an evaluation on the pamphlet. The positive results from the evaluation were taken to a committee of chairpersons from quality improvement teams. The committee consensus was the pamphlet should be inserted with the patient admission package to increase patient's knowledge regarding patient safety and to facilitate discussion amongst health care providers and patients and families. Just as a roll out plan of the DTHR Patient Safety Pamphlet was being developed, there was a reorganization of Alberta Health Services and a moratorium on printing patient education was evoked. The DTHR Continuing Care Department was in the midst of implementing the Continuing Care Standards and was requiring patient education on fall prevention and safety. The Patient Safety Pamphlet was utilized and the word "patient" was inter-changed for the word "resident" which describes the population that Continuing Care serves and the pamphlet was distributed to their residents and families. Anecdotal evidence gathered to date, suggests that the Patient Safety Pamphlet has been helpful to increase dialogue between healthcare providers and residents and their families.

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Determinants of Effective Collaboration Between Health Care Organizations

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BACKGROUND

Collaboration between health care organizations is essential today in Alberta and in Canada. Sometimes the process of collaboration unfolds more successfully than other times. Alberta Health Services will benefit from knowing the determinants of successful collaboration so that planning can occur to ensure that all possible factors are either in place or deficiencies planned for.

Objectives

To clarify the definition of 'collaboration' and to uncover all known determinants.

Purpose

As collaboration between health care organizations is viewed as valuable and essential, it is important to understand the 'inputs' required for effective collaboration to occur.

METHODS

A review of the literature was completed systematically to locate all the known literature containing the key concepts of collaboration, health care organization and determinants. In total, 698 potentially relevant articles were found. Applying specific inclusion and exclusion criteria reduced the total of potentially relevant studies to 25. Furthering filtering eventually reduced the number of studies to 12. The 12 identified studies were critically appraised and after further filtering for quality, five studies with the greatest validity, importance and applicability were identified (three systematic reviews and two qualitative studies). Analysis of these studies yielded 34 determinants of effective collaboration between health care organizations, of which six of the factors were common to at least four of the five studies:

1. Shared and / or adequate resources, including time / human resources and sustainable finances that are sufficient to support the collaborative endeavor (common to all 5 studies).
2. Good communication and an infrastructure for good communication, including information technology (IT).
3. Trust, understanding, respect, and a positive working climate between partners.
4. Skilled, strong leadership.
5. Clear, realistic, concrete, and attainable goals and objectives.
6. Absence of constant reorganization and/or adaptability and ability for the organizations to manage change.

CONCLUSIONS

Implications & Applications

This project contributes to knowledge that has implications at the organizational (interorganizational) or system level and provides information that will help organizations like Alberta Health Services work together with other organizations to improve care for users of health care in Alberta.

When contemplating working with other (one or more) organizations, it is recommended that the organizations:

1. Address the question “Is collaboration the best way of working together?” Collaboration is one way for two or more organizations to work together, however it is not the only way. Other ways of working together (communication, contribution, coordination or cooperation) may yield the intended results with different expectations related to sharing of resources, level of integration and other considerations related to ‘working together’.
2. Engage in open discussion of the known determinants (and the fact that there are known determinants) of collaboration. Being deliberate in considering the many determinants of effective collaboration will help organizations gauge the likelihood of success and resources required to effectively collaborate. Organizations may wish to consider using a tool that measures areas of strength and weakness and reflect on these periodically as the relationship progresses.
3. Create an action plan that capitalizes on determinants that are strengths, and attends to determinants that are areas of weakness.

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Measuring the Quality of Continuing Care Standards

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BACKGROUND

Brief Synopsis

Continuing Care (CC) Standards have been implemented in Alberta Health Services (AHS) -Grande Prairie and area. The CC services are provided by both AHS and contracted partners. In 2003 Statistics Canada projected that the population of seniors living in this area will substantially increase during the period of 2005-2015. This population growth will require AHS to provide ongoing measurable services based on quality. Assessing services based on valid measures will provide valuable program information to AHS employees which, in turn can be used to improve the quality and safety to the residents of continuing care settings within our region.

Question

What valid tools/measures are available to assess quality of care standards in continuing care?

METHODS

The following terms were used to research the question:

group 1- Tool or audit or validated measure or valid instrument or reliable instrument

group 2- Quality of care or standard or program evaluation or program logic model

group 3- Continuing Care or Long Term Care or Nursing Home or Seniors Care

group 4- Canada or International

Additional terms: night care, nursing care, foster care, day home, home for the elderly

The following data bases were searched:

Cochrane, PubMed, EBSCO, Ovid, Medline, PsychInfo, Grey Literature, National Quality Measures Clearinghouse, National Guideline Clearinghouse, Healthcare Papers (Home and Community Care and Law and Governance), Nursing Leadership, Practice Guidelines, IHI, Google Scholar, Google

CONCLUSIONS

Valid Studies

Three studies were found which described pre and post non-controlled validation tests as well as reliability tests of care measures. Findings revealed that MDS assessment tool (presently being utilized within AHS continuing care facilities) indicators that fall into level 1 validation category have highest degree of evidence representing care processes.

For the most part, MDS-based nursing home indicators are reliable such that most of the indicators are replicable and most facilities in the United States are measuring them reliably.

Risk adjustment should be considered to adjust for differences in client populations and maximize the ability to make fair comparisons.

Key Messages

Alberta Health Services has implemented an assessment tool in the Continuing Care facilities which has proven through this literature research to be a valid, reliable tool to measure quality of care being given to residents. This tool should continue to be utilized and resources allocated to ensure accurate initial and ongoing timely assessments are entered into the MDS system.

Alberta Health Services should also encourage and support the contracted partners to adapt this assessment tool as a standard mechanism to measure quality of care.

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Talent Management

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BACKGROUND

Talent Management: “Business processes that systematically close the gap between the talent within an organization and the talent it needs to successfully respond to current and emerging business and human resource challenges.” (Wellins, Smith, Paese, & Erker, 2006).

The majority of EMS staff work in the field, are in their late 20s to 40s (Boomers and Gen Xers) with an average of 10 years of service; resulting in a young and fairly inexperienced workforce. In the next five years 32% of management staff and 10% of unionized field staff will be eligible for retirement. Over and above attrition related to retirements is the loss of staff as a result of the current competitive job market. There is a gap between our current human capital resources and the leadership talent required to meet future business needs. Current EMS talent management initiatives focus primarily on succession planning, identifying and preparing specific employees for “lynch-pin positions”. The state of evidence in relation to strategies that decisively develop capacity job wide was explored and led to the question, “What Talent Management strategies can The City of Calgary Emergency Medical Services use to identify, develop and maximize the potential of its Human Capital?” The objective of this literature review is to add to the organization’s knowledge regarding industry best practice in talent management and prompt discussion amongst decision makers.

METHODS

A literature search was conducted using ABI Inform, EBSCO, and Google Scholar databases. Thirty-two articles were synthesized. Inclusion criteria incorporated peer reviewed articles. These revealed proven processes that identify and develop leaders and managers that were transferable to other organizations and articles that had outcomes or benefits related to enhanced employee engagement, and improved recruitment and retention.

CONCLUSIONS

The literature revealed that most organizations have a talent management system whether by design or default. Talent management strategies focus on five primary areas: attracting, selecting, engaging, developing and retaining employees. Both sustained competitive and financial advantages are achieved when talent plans are tied to the business strategy and driven top-down but owned by front-line managers. Lastly, the use of integrated talent management strategies must be routinely measured and reported and refined.

The results of this literature review may help EMS leverage current talent management initiatives by guiding decisions around attracting, selecting, engaging, developing and retaining the right employees to build internal capacity for the future.

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Towards Early Identification of Children who may have an Autism Spectrum Disorder

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BACKGROUND

Children who may have an autism spectrum disorder (ASD) require specialized services that are of limited supply. A Level II screening tool has the potential to differentiate children who require a coordinated ASD assessment from those who do not and is the first step in optimal resource allocation. The question posed to support the development of strategies to address this issue was: What is the current state of evidence-based knowledge regarding Level II screening tools for autism spectrum disorders?

In the former Chinook Health Region it is estimated that 15 children are born each year with ASD. The demand for the necessary specialized assessment and treatment services continues to increase and those with expertise in ASD have limited time available. It is important both from the point of view of family regarding access and in terms of efficiency and quality of care that the required services must be coordinated across health, social services and education systems. Parents and service providers require a system of navigation to access requisite services in an efficient and coordinated manner. Early identification allows for children to receive appropriate intervention at a critical time in brain development and improves their long term outcomes.

METHODS

A systematic analysis of peer-reviewed literature examined research published between January 2000 and April 2008. Electronic databases were searched, reference lists of selected articles were reviewed and a hand search was conducted at the University of Lethbridge. One-hundred and twelve articles were identified as meeting the inclusion criteria. All articles were reviewed by the writer and 43 were identified as containing information relevant to screening tools for ASD. Ten articles providing information on five tools met the criteria for final review.

CONCLUSIONS

The Modified Checklist for Autism in Toddlers (M-CHAT) and the Screening Tool for Autism in Two-Year-Olds (STAT) have evidence of effectiveness as Level II screening tools for children who have ASD.

It is critical that the health care system utilize evidence-based knowledge to design assessment, diagnostic and treatment activities in order to efficiently, effectively and appropriately allocate limited specialized services for children with ASD. Recommendations based on this systematic review

include the development of a regional pathway which will identify core activities in the provision of an evidence-informed, family centred approach to care for children with ASD. Foundational elements for the implementation of this pathway include:

- Allocation of time to key individuals of a multidisciplinary team for assessment, diagnosis and treatment.
- Implementation of a pilot project using one of the two identified tools as a Level II screen.
- Identification and provision of training to support the development of skills and knowledge required for effective service provision.

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Factors in Formal Mentoring Programs in Healthcare

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BACKGROUND

In recent years there has been an increased focus on mentoring programs in healthcare settings. Formal mentoring programs continue to grow despite limited empirical research regarding how programs should be designed for maximum effectiveness. The goal of this review is to identify the factors that contribute to success in formal mentoring programs in healthcare organizations.

METHODS

A systematic literature review was conducted from June 2007 to December 2007. Terms used were "mentoring program" and "effectiveness", "implementation", "implementation factors", "evaluation", "peer mentoring", "formal mentoring", and "workplace mentoring". In total over 320 abstracts were reviewed. Further criteria for studies were to include peer-reviewed articles, which were actual research studies or meta-analysis of current research in relation to workplace formal mentoring programs. Studies on student preceptor programs were excluded. This reduced the number of studies to be reviewed to 34. Criteria included sample populations from business, industry, education, and health sectors. Studies included both quantitative and qualitative studies. It was recognized that the majority of the studies would be associational and not causal in reviewing factors and outcomes. Additionally, specific studies on program characteristics and program effectiveness were lacking and therefore a more overall review on factors studied in formal programs was required. The factors that contributed to successful mentoring focused on a variety of issues but were based mainly on self-report surveys by protégés and mentors; these findings did not focus on organizational outcomes.

CONCLUSIONS

It is recommended that health organizations explore formal mentoring programs to address the transition of new employees into the workplace.

Specific recommendations based on this literature review are as follows:

1. Organizational support - There must be a clear indication of support of the mentoring program from senior management to the front-line.
2. Purpose - The overall purpose of the program needs to be clarified so organizational objectives and expectations are understood and realistic at all levels.
3. Focus - The organization needs to consider how the mentoring program fits into the overall development, education, and training of staff. There needs to be differentiation between orientation, training, and mentoring.
4. Selection of mentors - Mentors need to be targeted for participation based on motivation and commitment to learning.
5. Participation - Involvement should be voluntary, especially for mentors.
6. Training - The training program needs to be available to both mentors and protégés (mentees) with ongoing opportunities for training and networking.
7. Facilitation/monitoring - There needs to be ongoing facilitation of the mentoring relationships by designated staff. Specific policies and procedures need to be in place for the mentoring process.
8. Meetings - There needs to be a clear allowance and expectation for staff to meet on a frequent basis.
9. Mentoring – staff/managers - The mentoring program should be available to all staff, not only healthcare professionals.
10. Informal mentoring – It is beneficial to encourage informal mentoring to develop, especially if timelines for formal mentoring program involvement have ended.
11. Evaluation – Consideration should be given to parallel evaluation of mentored and non-mentored staff.

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Finding Value in the Evaluation of Public Health Syndromic Surveillance Systems From a Policy Perspective

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BACKGROUND

This project aimed to identify and assess published approaches to evaluation of surveillance systems. Investment and interest in surveillance systems has increased after the events of 9/11 in 2001, SARS in 2003, proclamation of the World Health Organization International Health Regulations in 2005, concerns about Avian Influenza, and more recently in 2009 the evolving potential pandemic due to a Swine origin Influenza H1N1 strain.

Investments have not only been made in traditional public health surveillance systems but also novel approaches such as syndromic surveillance systems. It is important to have timely, relevant evaluations of these systems to assess their usefulness at both the operational level in terms of technical accuracy and feasibility as well as at the organizational level in terms of cost effectiveness, risk management, and adherence to standards and best practices.

METHODS

Literature Identification and Selection

PubMed search terms were developed and searches in PubMed conducted. Google was used to search grey literature. Wikis dealing with surveillance were subscribed to and explored. Text books on surveillance were consulted. Citations of key articles were perused to further ensure saturation of the published literature.

Comparison of Evaluation Frameworks

Three frameworks were selected for a more detailed comparison. They were selected because of having been cited most frequently (CDC), of global significance (WHO), and specific to the Canadian context (PHAC). Thematic elements of the three frameworks were tabulated and compared and contrasted.

CONCLUSIONS

Findings

1. There is increasing use of specific frameworks to guide evaluation of surveillance systems.
2. The framework developed by the US Centers for Disease Control (CDC) is the most commonly cited framework in recent published literature.
3. Public Health Agency of Canada (PHAC) has developed its own framework for evaluation. The Auditor General of Canada has recommended that this framework be used to guide evaluation of PHAC surveillance systems.
4. The three frameworks relevant for the Canadian context (CDC, PHAC, WHO) are showing increasing convergence in systematically evaluating not just technical attributes of the system but also system attributes such as acceptability, usefulness, simplicity, portability, stability and cost.

Relevance and Recommendations

1. Adoption of a standardized evaluation framework would encourage comprehensiveness and comparability.
2. The stage at which evaluations are done should guide evaluation purpose and design. Initial exploratory evaluations are essential to identify needs, resources, capacity and sustainability. Intermediate process and formative evaluations could highlight issues with system operationalization. Summative and ongoing evaluations evaluate impact and outcomes as well as monitoring ongoing system usefulness and relevance.

Key Points for Policy Makers

From a policy perspective, standard frameworks are available to conduct comprehensive, context specific yet comparable evaluations of public health surveillance systems.

Aspects of an evaluation of a surveillance system that are important at a policy level include factors that evaluate whether the system:

1. Meets or exceeds best practice / standard
2. Is cost effective
3. Manages risk
4. Enhances organizations integration and efficiency
5. Is flexible- adapts to changing needs and environments

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What Impact Does Physician Pay-For-Performance Program have on Quality of Care in Office-Based Chronic Disease Care?

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BACKGROUND

Context

- Increasing prevalence of chronic diseases poses challenges to the application / adherence of clinical practice guidelines or quality standards.
- Traditional approaches to optimizing care, including continuing education and certification, do not appear to guarantee minimum standards.
- Few financial incentives exist to modify the status quo and reward providers with high performance and/or great improvement in quality of care.
- Pay-for-performance (P4P) is a new form of reimbursement on the basis of providing financial incentives to physicians for attaining certain quality benchmarks established by the payers.

Purpose

To assess the association between explicit financial incentives and quality of care.

METHODS

A systematic review of peer-reviewed, English language literature published from January 2000 to March 2008.

CONCLUSIONS

Results

- Six Cohort studies identified: 2 UK & 4 US.
- Financial incentives have a positive effect in improving achievement/adherence to quality standards or clinical practice guidelines.
- Process-based quality measures are used more often.

Key Message

Several key issues need to be considered in determining optimal design and implementation for P4P programs, including:

- The source and size of financial incentives
- The receiver of financial incentives
- The selection of quality measures and performance targets that determine incentive eligibility
- The approach of performance data collection

Implication

The result of this local project leads to in-depth understandings of the effect of P4P on quality of care, particularly in the domain of chronic disease care, which may be beneficial for the potential consideration of a similar program in Alberta's primary care settings.

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Making Exercise Sticky: A Systematic Review of Long-Term Exercise Maintenance Following a Chronic Disease Exercise Program

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BACKGROUND

Up to 60% of people participating in chronic disease exercise programs (CDEPs) stop exercising within six months of finishing their program. The purpose of this review was to search for effective, evidence-based practices that support long-term exercise maintenance following participation in a chronic disease exercise program.

METHODS

The author conducted a systematic review of exercise maintenance following cardiac rehabilitation as an example of a well researched, exercise-based CDEP. Identified articles were assessed for validity, importance and applicability to local context. The results were synthesized and compared to similar research with diabetic, COPD and sedentary adult populations. Effective strategies that were common to all populations were identified and shared with key stakeholders to inform the design of CDEPs in the former Aspen Health Region.

CONCLUSIONS

Results

Six randomized controlled trials met the specified inclusion criteria and were assessed for quality. Following the assessment, synthesis, and comparison of these studies to the aforementioned populations, the authors, along with the key stakeholders, identified four strategies from the literature that had evidence to effectively improve exercise maintenance rates following participation in CDEPs. The four strategies were:

- Promotion of self-efficacy.
- Encouragement of self-directed goal setting.
- Re-assessment of outcomes at various intervals following participation.
- Exercise consultation with a health professional in the year following participation.

Implications

For provincially supported CDEPs to be effective, it is imperative that participants continue to exercise following completion of the program. Incorporation of these four strategies into existing CDEPs requires minimal additional resource investments and will ensure that CDEPs are being delivered in an effective, evidence-informed manner.

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PROVINCIAL PROJECTS

Provincial projects are conducted by teams of SEARCH Classic participants, across jurisdictions, and involve primary research on priority topics to address an issue of relevance to the broader health system.

Keys to Successful Collaboration: An Exploration of a Successful Collaboration Between a First Nations Community, a Regional Health Authority and Health Canada

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BACKGROUND

In Canada, First Nations Communities receive health services through a complex mix of community, provincial and federal government involvement. Working collaboratively with First Nations Communities in the design of their health services is essential to ensure that these services are accepted and are consistent with their cultural values and health concepts. Although we know that collaboration is a key element in successfully implementing health-related interventions in First Nations Communities, surprisingly there is little research available about the process of collaborating with these communities, in particular, the process of collaborating to deliver health services.

The Purpose of the Research was to Explore

What factors helped to facilitate a successful collaborative process to occur between the Athabasca Tribal Council, the Northern Lights Health Region and Health Canada in their recently signed memorandum of intent?

METHODS

A qualitative, case study based on the tribal participatory research model was used to explore in detail the specific factors that helped contribute to a successful collaborative process between the Athabasca Tribal Council, the Northern Lights Health Region and Health Canada. We used semi-structured interviews to understand what factors helped make the process successful, to identify any

challenges that existed, and to discuss mitigation strategies for those challenges. We analyzed the data using thematic content analysis and triangulated the interview results with written documents and the available literature. Following this we used participant checking to validate the results.

CONCLUSIONS

Data is currently being analyzed. Results will be shared upon completion of the analysis and validated by participant checking.

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Lessons Learned from the C.O.A.T. Integration Project

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BACKGROUND

More children die or are negatively affected from a Traumatic Brain Injury (T.B.I.) than any other cause of death or disability. A measure of the severity of T.B.I. is post traumatic amnesia (P.T.A.). The Children's Orientation and Amnesia Test (C.O.A.T.) was developed in 1990 to objectively assess the degree of P.T.A. in children who sustained a head injury. The C.O.A.T. was designed to be given by a homogenous group of health providers at a consistent time of day. To that end, it was hypothesized that incorporating the C.O.A.T. into the daily nursing routine of children with brain injury would meet these suggestions for implementation.

Question

On the trauma unit, where children are admitted with traumatic brain injuries or non-neurological traumatic injuries, what is needed for successfully integrating the routine use of the C.O.A.T. by the nursing staff?

METHODS

An embedded team of collaborative healthcare professionals from the Alberta Children's Hospital Brain Injury team was assembled to refine the C.O.A.T. form into a format acceptable for use at this site. Meetings with the Nurse educators from the trauma unit were conducted to discuss and plan for the educational needs of the nurse participants in the project. The project was implemented for three months during which time nurses conducted the C.O.A.T. with appropriate patients. One of the nurse educators conducted spot inter-rater reliability assessments to ensure consistent application of the test. All suggestions from the embedded team and the nurse participants were complied and the both the form and implementation process were modified accordingly.

CONCLUSIONS

In interviews with the Nurse Educators and Nurses, it was identified that contributory factors to the success of the project included the simplicity of the C.O.A.T., a shared feeling of inclusion in the project from its inception, how easily and quickly the staff nurses were able to achieve proficiency in the use of the C.O.A.T., and the consensus that the results elicited on the forms were a valid representation of the child's degree of amnesia which contributed to the belief in the value of the information that the C.O.A.T. form provided about the patients' cognitive status. It is the perception of the writer that the nursing staff's resiliency to change and the willingness of the nursing staff educators and nursing staff to participate were additional contributing factors to the success of the integration of the C.O.A.T. assessment into daily nursing practice on the unit.

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Leveraging Technology to Support Collaboration

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BACKGROUND

The new provincial Alberta Health Services workforce is geographically disbursed and time is also a factor as health care providers who need to collaborate are either not available at peak times, or work shift work. Social software can be an important tool to develop communities of practice in health. This research was undertaken to explore the opportunities and impediments to the use of social software in the health care setting.

METHODS

Study design

This was an exploratory descriptive study that utilized World Cafés to gather information. The World Café format is an open approach that supports divergent thinking, as opposed to focus groups where the facilitator can quickly suppress divergence and move to convergence. The informal groups are leaderless and all participants are allowed and encouraged to participate. Health care providers were recruited from urban tertiary care, rural mental health, and provincial community health and were asked to discuss the following three questions:

- How do you currently collaborate with each other at work and for what purpose?
- What do you know about social software and how do you use social software in your personal life?
- What are the opportunities/ impediments of using social software at work?

Results

Six major themes emerged.

Relationships

Relationships were identified as fundamental to collaboration, and collaboration as the heart of the work of healthcare providers. Social software was seen as an opportunity for geographically or time dispersed collaboration and also as a barrier to building and maintaining relationships between individuals.

Knowledge

Knowledge acquisition emerged as the primary purpose to collaborate. Social software provides a vehicle to access expertise and yet the knowledge required in the continuously evolving world of technology was seen as intimidating and challenging.

Risk and Safety

There was a perceived risk to privacy, security of patient information, inappropriate use of social software in the workplace and safety issues related to incomplete or questionable credibility of information found on social software sites.

Culture and Technology

Etiquette, social norms, and the language of computer mediated conversations, work life balance, and the erosion of language and relationships were identified as barriers.

Organizational Value

Opportunities for organizational benefit emerged as a theme focusing on utility of social software in program development and as a saving of resources used in time and travel.

System Attributes

A theme related to the 'system needs or attributes' was highlighted that included: ability to obtain or access technology, time saved or time wasted using technology and the need for resources to support, maintain, and educate users.

CONCLUSIONS

Knowledge and experience of social software was limited across the multiple domains of practice, and beliefs and perspectives were similar regardless of profession or domain of practice. Two notable differences emerged. The first was that the community medicine residents, who used social software more often in their practice, as a group did not utilize social software in their personal lives. This may be reflective of their student status as several commented that they had no time to indulge in social software use at home. The second difference was the front line tertiary care staff perceived

social software as support for themselves either through social networking with peers at work or through sharing of information, whereas the other two groups identified ways that social software could support patient/client care or program development.

Healthcare workers seem to be more conservative than the general public in using social software personally and professionally, which suggests that it's individuals rather than the organization that may be limiting opportunities to bring software to the workplace. Impediments to social software usage seem to be both intrinsic to healthcare workers' inherent attitudes as well as extrinsic to the culture of the healthcare environment.

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Patient and Family Centered Care in Primary Care Networks

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BACKGROUND

In 2003, Alberta Health and Wellness established the Primary Care Initiative (PCI) to improve access to family physicians and other frontline health care providers in Alberta through the use of Primary Care Networks (PCNs). The investigators identified a gap both within the peer reviewed literature, and within the primary health care indicators and evaluation framework related to evaluating the practitioners' perspective of patient and family centred care (PFCC) in a primary care network setting.

The provision of PFCC has been shown in the literature to improve patient and staff satisfaction with care, increase safety and improve overall quality of the care interaction. The Institute of Family Centered Care recommends that organizations begin to address/ensure they are patient and family centred by assessing the extent that principles of family centred care are being implemented in the organization. Once a baseline is determined, priorities can be established and a work plan developed. Subsequent assessment can then be used to monitor progress and to realign the goals and objectives.

Objectives

Two primary objectives guided this knowledge generating project:

1. To gain an understanding of the perceptions of patient and family centred care in Primary Care Networks in the former Chinook Health and Capital Health Regions.
2. To provide Primary Care Networks with a mechanism for evaluating PFCC and the identification of areas, which can benefit from improvement.

Three Research Questions Were Explored

1. What is the perceived status of the provision of patient and family centred care by frontline service providers in primary care network clinics in Chinook and Capital Health regions?
2. What are the perceived opportunities for change/improvement in the provision of patient and family centred care by frontline service providers in primary care network clinics in Chinook and Capital Health regions?
3. Would this survey be a helpful tool for use by Alberta PCNs to evaluate and monitor their progress in providing PFCC, and for identifying priorities for improvement?

METHODS

Two surveys were identified that have been used in the evaluation of PFCC and were adapted with permission from the authors. Key informants knowledgeable about PFCC and PCNs were consulted regarding the adaptation. Ethical approval was granted by the University of Alberta Health Research Ethics Board (stream B – Expedited Review) and administrative approval was also provided by AHS-Chinook and AHS-Capital Health.

Participants from the sites who agreed to participate were provided the adapted survey during a site meeting time. For data management and analysis, quantitative data from the collected surveys was entered into an Access Database (2003) then imported into SPSS (16.0) and qualitative data was entered into Excel (2003). Analysis of the open-ended questions data, which were related to the utility of the survey itself, resulted in the identification of common themes.

CONCLUSIONS

Results

Common themes identified and analyzed from quantitative and qualitative survey questions showed a consistent pattern of the highest ratings in Current Status involving the core concepts of respect and dignity, information sharing and participation. In the areas that were most frequently identified to be doing less than “OK” on the Current Status, the core concept of collaboration was most often noted. The survey shows promise as being an effective tool for PCNs to obtain baseline and ongoing measurement of the practitioner’s perceptions of the Current Status and identifying priorities for change / improvement.

Conclusions

Overall, the intent of the research study was to meet the primary objectives: To gain an understanding of the perceptions of patient and family centred care in Primary Care Networks in AHS-Chinook and AHS-Capital Health and to provide Primary Care Networks with a mechanism for evaluating PFCC and the identification of areas which can benefit from improvement. The research study provides readers with insight as to how PCN staff perceived the Current Status of PFCC and

priorities for change / improvement at their site. The study also provides an overview of how the adapted survey can be used as a mechanism for continued quality improvement.

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Patients' Experience of a Collaborative Health Care Team

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BACKGROUND

Despite the recent focus on collaborative interprofessional practice in health care as a means of optimizing scope of practice and patient care, what remains poorly understood is the patient's perspective of team based collaboration. For example, what practices allow the patient to fulfill their role as a team member? What events lead professionals and the patient to the embedded value within collaborative health care that the patient is a member of their health care team? From the patients' perspective, what are the barriers to collaboration with a team? How can they be overcome? The identification of this gap in knowledge led to the development of our overarching research question: What is the patient's experience of a collaborative interprofessional team? The intention of our study is both to inform practice at the unit level and to contribute to knowledge around the patient's experience.

METHODS

An exploratory, descriptive study design will be used to examine patient experience and from this examination to derive consensually validated knowledge. Using our internal networks we identified a Rehabilitation Unit (Unit 35) at the Red Deer Regional Hospital that was both highly regarded for its collaborative work and appropriate for the purposes of responding to our question. Open-ended interview will be conducted with a purposive sample of patients who have been recently discharged from the unit. The interview data will be analyzed using Constant Comparative Analysis. Complete transcripts of each of the interviews will be individually reviewed and coded, and codes will be further categorized and clustered by the investigators.

CONCLUSIONS

Our group has learned many lessons and become much more knowledgeable about developing an ethical research protocol for understanding a patient's perspective of their experience of interdisciplinary care and about navigating a research study in the midst of organization transition. First, largely due to the system re-organization and key positions turnover, it became very challenging to obtain a support letter from the host organization, and to have potential interview participants selected. Second, the development of the information letter and consent form, and the framing of an interview guideline/protocol were intriguing but time-consuming. Last but not least, because of our strong team spirit, good team collaboration, and fair workload sharing, we have been able to keep the momentum and the commitment to complete our project in the midst of a challenging context. We received ethics approval on May 14th, 2009, and are now arranging for interviews with patients. With this study we expect to contribute to the body of knowledge on both interdisciplinary care and patient experience of health services. The Red Deer Regional Hospital's Rehabilitation Unit is also interested in using the results of this work to inform how they work collaboratively with their patients.

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Team Effectiveness in Primary Care Networks in Alberta

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BACKGROUND

Primary care networks (PCNs) are interdisciplinary, region wide programs designed to improve patient care, team collaboration and appropriate resource allocation and one of governments' approaches to deliver quality health care with finite resources.

The primary objective was to explore the level of perceived team effectiveness in PCNs in three Health Regions in Alberta. A secondary exploratory objective was to identify strategies, including team composition, that relate to team effectiveness in PCNs. A literature review identified six factors associated with PCN team effectiveness: purpose, goals, leadership, and communication within the group, cohesion, and respect (between team members).

METHODS

PCNs in three rural regions agreed to participate in the study. All team members were invited to participate in the survey. The descriptive, cross sectional, exploratory semi-structured questionnaire study design was modified with permission. The Team Effectiveness Tool (TET) was originally designed and used by Saskatchewan Health. The TET has 35 questions covering six dimensions for team effectiveness. Open ended questions were added to explore overall team effectiveness as well as associations between perceived team effectiveness and effectiveness of particular strategies. SPSS was used for quantitative analysis and open-ended questions analyzed using thematic analysis.

CONCLUSIONS

Results

Of the 171 participants 121 (70%) returned completed questionnaires with responses coming from all three regions and 14 of the 25 teams. Ten of the 14 teams had a response rate of over 70%. Of these 10, seven teams' mean TET was >3.0 out of 4.0 indicating no significant concerns. None of these teams scored >3.5 out of 4.0, indicating the perception of an effective team according to the TET scoring guide. Three of the 10 teams fell below 3.0 indicating perception of a team that would benefit from improvement. The mean TET score for all respondents was 3.04 compared to 2.91 for the qualitative question rating of perceived overall team effectiveness. Correlation between the TET survey questions and the one overall qualitative question of team effectiveness was moderate to strong ($r=.337$ to $.690$). Respondents identified five themes for strategies to improve team effectiveness: meetings/communication, identification of innovative service delivery, team development, role clarification, and definition of purpose and goals. The most frequent reference was in regard to frequent, regular team meetings to address information sharing, issues and concerns, and, secondly, strategies for innovative service delivery. This was referenced consistently across the three prominent professional groupings, physicians, registered nurses, and licensed practical nurses. Responses to open ended questions identified three of the six factors identified in the literature as associated with team effectiveness.

Conclusion

This was a small study but results suggest that Alberta PCNs may benefit by continuing to focus on team effectiveness using all five types of strategies, although regular meetings, innovative service delivery and team development are suggested as most beneficial.

This study suggests that the modified TET will be useful to Alberta Tripartite Committee and PCN teams to monitor and improve team effectiveness. More study is required to confirm the modified TET's utility for both rural and urban PCNs and to specify strategies associated with PCN team effectiveness.

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The Voice Behind the Glass: Perceptions of Facilitators Using High Fidelity Simulation for Clinical Training

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BACKGROUND

SEARCH VI sponsor organizations identified the need for more information about simulation as a method for teaching skills and maintaining clinical competency. Three SEARCH participants explored the state of evidence and arrived at the question: "What are the experiences and perceptions of facilitators using high fidelity simulation to teach or reinforce clinical skills of healthcare professionals?"

The literature briefly recognizes the role of facilitators, however, there is paucity in the research in relation to their preparation, role, or experiences using high fidelity simulation to teach or reinforce skills. The voice of the trainer/facilitator is noticeably absent in the literature.

Our objectives are to add to the general body of knowledge regarding the facilitator's experience using High Fidelity Simulation and position investigators to better focus future research, as well as raise awareness and prompt discussion amongst decision makers in our respective organizations.

METHODS

The research approach chosen can be described as qualitative, informed by phenomenology. Semi-structured, in-depth interviews using both facilitative and non-facilitative responses were used. Participants in the study consisted of nine volunteers from Calgary Emergency Medical Services. Criterion sampling was used to obtain a range of information and perspectives (Crabtree and Miller, 1999). The interviews were digitally recorded and transcribed into word documents for data management. The transcribed interviews were analyzed using elements of Tesch's method of descriptive analysis (Creswell, 2006:192).

CONCLUSIONS

Three main themes were identified from the interviews:

1. **The use of simulation as a method for training** was at the forefront with specific emphasis placed on the development and use of scenarios, the training of facilitators and debriefing as the cornerstone of the process.
2. **The context within which training takes place** was reiterated with emphasis on the importance of organizational support, distinct cultures of platoons, and the turmoil experienced as a result of transitioning EMS to Alberta Health Services.
3. **Traits of EMS simulation facilitators** included a strong drive to make a difference and to be recognized and respected as clinical experts among peers and other healthcare professionals.

The results of this research may help guide decisions for the evolution of mobile high fidelity simulation training in the province, but more importantly, it poses many questions which are opportunities for further research.

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Useful Elements of Discharge Planning: Consumer Perceptions

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BACKGROUND

The professional literature is clear that effective discharge planning contributes to the continuity of care of individuals suffering from mental illness (Adair et al., 2005) and is associated with reduced suicide and hospital readmissions rates and improvements in social functioning and quality of life (Boyer, 1997). Despite this, clients and their families often report a lack of support as they transition back to the community after discharge from hospital. In Alberta, as elsewhere, this contributes to high readmission rate, medication non-adherence, and poor use of community resources (Durbin, Goering & Streiner, 2004; Eija & Marja-Leena, 2005; Rose, Gerson & Cabo, 2007). To our knowledge, no one has explored what constitutes effective discharge planning from the perspective of clients receiving mental health/psychiatric care and their families.

Purpose

To identify what elements of discharge planning foster continuity of care from the perspective of individuals recently discharged from an acute psychiatric unit and their families.

METHODS

This exploratory, descriptive study employed a 12-item telephone questionnaire developed by the investigators with 39 adults recently discharged from one of several Alberta Health Services Mental Health/Psychiatric Units. The interview tool consisted of 12 questions, each relating to a particular component of the discharge process. Interviews took place from November 2008-April 2009. The study was reviewed and approved by SEARCH Canada Faculty, by the Community Research Ethics Board of Alberta (CREBA) and approved by Alberta Health Services.

CONCLUSIONS

Results

Findings of the current study support the published literature, which indicates that the elements of discharge planning that foster continuity of care are perceived as helpful by mental health clients. These elements include being assigned a Case Manager; speaking regularly with their Case Manager before and after discharge; being given information about medication, what to do in a crisis/emergency and community services; meeting with a care team to discuss upcoming discharge; having the opportunity to participate in counseling, and having family and friends to participate in their care. The authors note that these services are not being consistently delivered to all mental health clients in Alberta.

Implications

These findings suggest that a standardized approach to helping clients prepare for discharge will enhance continuity of mental health care. Such an approach must include the components identified as helpful by research, healthcare professionals, and most importantly, mental health clients.

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CUSTOM PROJECTS

Projects completed by SEARCH Custom participants are identified in response to local priorities; staff work with health organizations to strengthen local capacity for using research to inform practice and programs. These projects are collaborative, and focused on community-based learning, knowledge generation and network initiatives designed to enhance capacity for evidence-informed decision making.

A Pilot Study to Evaluate a New Early Screening Instrument for Speech and Language Delays

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BACKGROUND

Speech and language delays, which range in prevalence from 1-15%, are a common developmental problem facing many children. The early identification of speech and language delays and referral of children to appropriate intervention programs are the primary goals of screening, as children's early cognitive and language development has bearing on later development and readiness for learning and social competence. The Speech and Language Pathology Early Screening Instrument (SLPESI) was therefore developed to identify possible speech and language delays in 18-21 month old children. The purpose of the present study was to pilot the SLPESI and assess its ability to identify speech and language delays in children of this age group.

METHODS

A total of 252 children, aged 18-21 months who were receiving immunizations at community health centres, participated in the SLPESI which took less than five minutes to administer. Parents were approached following the immunization of their children and were asked to consider participating. Parents who answered no to one or more questions on the SLPESI were advised to take their child for a follow-up assessment with a Speech-Language Pathologist.

CONCLUSIONS

Results

Of the 252 children screened, 56 (22%) were recommended for assessment by a Speech and Language Pathologist (SLP) based on the results of the questionnaire. Of those recommended, 34 came in for assessment and 31 (91%) were assessed and diagnosed with speech and language delays ranging from mild to severe. Twenty-two families (39.2) declined to participate in the follow-up assessment. In order to examine the reliability and validity of the SLPESI, 19 children who passed the initial screening procedure were brought in for a follow-up assessment; 18 had age appropriate speech and language skills and one had a mild to moderate speech and language delay.

Implications

The SLPESI proved to be a valid, quick and easy to use screening instrument that accurately predicted speech and language delays in children 18-21 months of age.

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Community Needs Assessment – Eckville

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BACKGROUND

In 2005 our committee recognized a need to consult with the community. We wanted the community to identify strengths and weakness within existing programs and services. It is important to ensure

that resources and initiatives are focused on areas that are identified by the community. We wanted to be proactive and have a sense of direction.

Jennifer Harty assisted in connecting the committee with Scott Oddie and SEARCH Canada.

METHODS

Scott Oddie and his research assistant provided guidance and support as we developed a Community Needs Assessment Survey that we felt would meet our objectives.

The survey was sent out to our community in January of 2006. We mailed out 1090 surveys which included postage-prepaid self-addressed return envelopes. We had an approximate 25% return rate. The results of the survey were shared with the community in June 2006.

CONCLUSIONS

Existing services and programs in some areas were not being well utilized. It proposed a need for education programs in the areas of drugs and alcohol. Programs were also needed in the area of bullying awareness and prevention.

Crime, crime prevention and lack of recreation for youth and children were identified as significant community issues that strongly needed to be addressed.

Implications

Community stakeholders needed to reallocate resources to meet the needs of the community. Results of the assessment should be used to apply for funding or sponsorship to improve existing services and programs and/or to create new programs to address community needs.

Directing efforts and resources in the areas identified should improve the overall health and well being of the community.

What Have we Learned

- The needs assessment has been a catalyst for community engagement and change.
- We have a collaborative partnership that is working on community improvement.
- The assessment has given the committee credibility within the community and with various municipal leaders.
- We have a much improved Community Communication Network that is always evolving.
- We have increased intergenerational activities and initiatives.
- We have improved programs and services that are being accessed and new services and programs. A Town of Eckville Directory has been developed that lists all local programs and services, all services provided by Alberta Health Services in Eckville and the Central Alberta Services that have a mandate to provide support and services to the community of Eckville.
- We used our needs assessment to become an Active Creative Engaged (ACE) Community with Alberta Parks and Recreation for two years. The potential for our ACE initiative is exciting – it is keeping us focused on the future.

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SEARCH Canada Custom E-Literacy Limited Evidence Synthesis Project – Generalist Public Health Nursing and Specialist Public Health Nursing Teams; An Exploration of the Evidence

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BACKGROUND

More than a decade ago, public health nursing in Grande Prairie was reorganized from generalist, geographic assignments to specialist, target population focused teams, with the intent to evaluate both the process and the clinical result. For a number of reasons, that evaluation has never occurred. The aim of this project was to find a body of existing literature describing practice-based evidence to inform the evaluation of generalists versus specialist teams and to determine whether there is an existing consensus for best practice in public health nursing.

METHODS

A number of sources were searched with varying combinations of the following terms: community health, community health nurse (nursing), public health, public health nurse (nursing), generalist, specialist, organizational development. Due in large part to the breadth and varying definitions of public health nursing and the historical scarcity of quantitative research in the public health field, no one combination proved to be entirely satisfactory, resulting in a significant amount of “hand” filtering. Sources included PubMed, CINAHL Plus, Cochrane Library, WHO, and CIHI.

CONCLUSIONS

While there is recognition for the value of specialists in specific settings of public health nursing, the recurring theme is that in order to practice good, holistic public health nursing encompassing the broad concepts of health promotion, disease prevention, and community interaction, nurses must practice in a generalist role. This is consistent across the UK, Australia, US, and Canada, even though public health is practiced differently in each of those countries.

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Associations between TV/Computer/Videogame Viewing and Speech/Language Skills & Associations Between Soother Use and Speech/Language Skills

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BACKGROUND

The purpose of the "Associations between TV/Computer/Videogame Viewing and Speech/Language Skills & Associations Between Soother Use and Speech/Language Skills" project was to study the impact of television/computer/videogame viewing and soother use on speech/language development. Research questions included: a) Is there an association between the amount of TV/computers/videogames viewed by preschool children and their speech and/or language skills; and b) Is there an association between the amount of soother use by preschool children and their speech and/or language skills?

METHODS

All three-year-old children in the city were invited to have a three-year-old screening appointment with their parents upon their 3rd birthday. The first 185 three-year-olds whose parent(s) consented to participating in the research survey for their 3 year-old-child became part of the study. Children who did not pass the speech/language portion of the screening were referred to the health region department SLPs (Speech-Language Pathologists) for assessment.

CONCLUSIONS

Results

1. Television/computer viewing hours impacted language development. Average expressive language score for children (n=8) who had a television in their bedroom was 75 (moderate delay). Average expressive language scores for the children (n=45) who did not have a TV/computer in their bedroom was 89 (average score).
2. Few parents provided a television/computer in their child's bedroom (8 participants) as compared to 177 children who did not have a television or computer in their bedroom. Average receptive (understanding) language score for the 8 children who had a television/computer in their bedroom was 80 (moderate delay). Average receptive language score for the 45 children tested for language ability who did not have a TV/computer in their bedroom was 92 (average score).
3. As a child's weekly average of TV/computer/videogame hours surpassed a cumulative of 15 hours for the 7 age categories between birth and 3 years of age, expressive and receptive language scores were negatively impacted. The average expressive language score was 88 (average) before the critical juncture of 15 cumulative hours (0 to 14 hours) and the average expressive language score after this critical juncture of 15+ hours was 66 (severe delay).

The average receptive language score was 92 (average) before the critical juncture of 15 cumulative hours and the average receptive language score after this critical juncture was 72 (moderate delay).

4. Once a child's total number of television hours across the age span past 15 hours (i.e., adding the average number of hours per day at age 6 months, 1 year, 1.5 years, 2 years, 2.5 years and 3 years of age), the subjects had moderate to severe speech sound delays.
5. The number of hours a child used a soother did not appear to impact their speech sound or language assessment scores. Findings were inconclusive due to sample size.

Conclusions

Television/computer/videogame viewing had a negative impact on speech and language development. A cumulative impact of TV/computer/videogame hours was associated with a delay in speech and language development.

On average, three year old children who had a television or computer in their bedrooms had moderate language delays compared to children who did not have TVs or computers in their bedrooms (average language skills).

There was no statistical impact of soothers on speech or language development, likely due to our small sample size for this tested group of children. Findings were inconclusive and further research would be useful.

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Yellow Ribbon Program Evaluation – Regional Suicide Prevention Council from Palliser Health Region

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BACKGROUND

In the former Palliser Health Region, suicide is the 2nd leading cause of death (ACICR 2005)" and attempted suicide/self-inflicted injuries are the 3rd leading cause of injury hospitalizations." (ACICR 2005) This region covers 26,000 square kilometers.

Youth in communities throughout the Palliser Health Region are at risk to attempt or die by suicide. Service providers, teachers, parents and students themselves are concerned about youth suicide and have expressed interest in becoming part of a community approach to the problem.

In September of 2006 the Regional Suicide Prevention Council (RSPC) implemented the Yellow Ribbon Suicide Prevention Program for Youth (YRP). The Yellow Ribbon focuses on teaching our youth that “It’s Ok to Ask 4 Help”®. This early intervention, community-based program is an all-out effort for further education, action and advocacy toward the prevention of suicide in youth. In our region the YRP was implemented in two phases over a three-year period. During both phases of the Yellow Ribbon project, pre and post testing was administered to help ascertain the programs effectiveness.

METHODS

This project was a collaborative effort that encompassed five school districts throughout our region. RSPC members from various communities in our region worked on fundraising to bring the YRP into our area. Other members worked on promotion, connecting with school personnel and administrators to set up dates and times, connecting with the facilitator of the YRP, ordering of materials and arranging flights and rooms for the facilitator.

Pre and post attitudinal tests were developed in consultation with SEARCH Canada. They also provided dissemination of results for the pre and post tests from phase one of the Yellow Ribbon Project. The pre and post tests in phase one measured help seeking behaviour. In addition to the attitude section from phase one, phase two included a question which asked students to identify the issues they were dealing with. For the second phase of the project Dr. Karl Mueller, PhD Statistician provided independent evaluation, in consultation with SEARCH Canada.

CONCLUSIONS

Key Messages

1. Yellow Ribbon saves lives.
2. Yellow Ribbon helped increase help seeking behaviour.
3. Number 1 issue for students is grades
4. Students in grades 6 - 9 are more receptive to the Yellow Ribbon Program than their high school counter parts.

Follow-up Stage

This project is now in the sustainability stage. Presentations are given to new staff and students who have not heard the message of Yellow Ribbon as well as students who were part of the initial Yellow Ribbon Project. It was found that reinforcing the message is important to keep students, staff and community members apprised of the YRP the message that “It’s Ok to Ask 4 Help”®

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Alberta Community of Practice Collaborative

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BACKGROUND

Many professionals find that sharing stories of work experiences helps them to continuously improve practice. Such groups, although often unbeknownst to participants, are communities of practice (CoPs). CoPs are defined as groups of people who share a concern or a passion for something they do and, interacting regularly, collectively learn how to do it better.

CoPs have been introduced in major institutions as a strategy to enhance performance. Over the past year, significant interest in CoPs in Alberta has been demonstrated by enthusiastic participation at CoP related workshops and conference sessions.

Feedback from these events indicates a need for a provincial initiative: first, to assess need and then to make the case for focused resources to build capacity to promote CoP development and professional interactivity as a strategy to enhance practice.

METHODS

In the spring of 2008, a group of individuals spanning practice, academia and various networks¹ came together to explore a mutual interest in cultivating and supporting CoPs in the health, adult education and not for profit sectors in Alberta. A working group was formed with leadership from the Health Workforce Research Network of Alberta (HWRNA) and SEARCH Canada. Its purpose has been to build a community of professionals experienced in facilitating inter-professional groups to collective learning and discover innovative solutions to practice issues in the health, adult education and not for profit sectors in Alberta. The working group has undertaken the following activities over a period of 8 months:

In October 2008, 40 invited practitioners experienced in convening and engaging groups in health and education met for a day to review what was known about CoPs and how their capacity to build communities at work could be enhanced. They indicated their interest in joining a CoP of professionals who facilitated teams at work and wanted to enhance their expertise as team facilitators. Summit participants agreed that there was a need to increase capacity in Alberta institutions to use CoPs to enhance job satisfaction as well as continuously improve the quality and safety of the workplace in healthcare and education.

In January 2009, the Summit participants and a further 10 practitioners with an interest in CoPs completed a survey which provided information on the knowledge and current activities in CoPs. The results confirmed earlier information collected on participants and identified volunteers to actively start work in developing strategies in three main areas of CoP facilitators' practices.

CONCLUSIONS

As a living project, we have a plan of action rather than a conclusion.

The next phase of the project is developing three core strategic areas:

¹ Networks involved: SEARCH Network, Health Workforce Research Network of Alberta (HWRNA), Alberta Respiratory Health Network, Calgary adult education network.

- CoP Facilitator Resource Centre: provide information sources and enabling tools to help facilitators start and maintain workplace CoPs. Work has begun on a repository of articles, texts and video clips on the topic.
- CoP Facilitator Mentoring: provide support and mentoring to professionals in health and education starting CoPs at their workplace. Two Healthcare organizations contacted the Working Group in May with requests for mentoring.
- Measuring (assessing) Progress in CoPs: provide facilitators with valid, reliable evaluation tools. The group has tested a survey tool to determine the needs of potential clients for their service. A number of CoPs in health care have requested help in measuring progress and outcomes.

Guiding Principles

- Align with various movements in the Alberta health system: quality, safety, interdisciplinary practice, education, and collaboration
- Start small and focus on building a “core” group of people committed to CoP philosophy
- Design interactive opportunities to encourage ownership of this initiative within the community
- Ongoing evaluation and needs assessments will be conducted in a participatory fashion with the community

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Feeding Practices in the NICU

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BACKGROUND

This SEARCH Custom limited evidence synthesis project sought to address the controversial topic of feeding in the NICU. It was a quest to find a developmentally appropriate family centred evidenced based practice guideline for feeding in the NICU.

METHODS

EBSCO databases CINAHL Plus with Full text, MEDLINE, and PsycInfo were searched. Search terms included the following key words: *feeding and NICU, feeding and development and NICU, breastfeeding and NICU, developmental care and NICU, family centered care and NICU* The same key words were searched in PubMed. Two experts in the field, Dr. Heidelise Als and Dr. Kerstin Hedberg Nyqvist were contacted and they suggested 10 articles. Searches in National Guideline Clearing House and Practice Guidelines yielded no results. The American Academy of Pediatrics and the Canadian Pediatric Society and the World Health Organization websites yielded three position statements.

The titles and abstracts were reviewed. Articles were selected for review if they met the following criteria: they were: English; full text; published after 1998; discussed or investigated NICU feeding practices; and/or breastfeeding support and education; and/or included the perspective of the mother. Thirty articles were read and 10 were excluded because they did not answer the research question. Twenty articles were included for review.

CONCLUSIONS

Although a practice guideline was not found, the literature did provide implications for nursing practice. There is little doubt that breastfeeding is preferred and there must be a comprehensive program of education and support that addresses all the complexities involved in feeding the preterm infant. The literature confirmed the need for a philosophy of care, which is transmitted to mothers. The fact the neonates are capable of feeding at a much earlier gestational age than is commonly thought must be considered when developing feeding guidelines. It is more complex than just a practice guideline. Neonatal nurses and administrators are encouraged to seek out and listen to the voices of mothers. Mothers indicate the need for privacy to sit and hold their infant; that early extensive physical contact is needed; that breastfeeding advice must be given to all mothers; and that mothers not nurses should feed infants. Lactation support of mothers must promote mother child bonding and individualized care. Further research is warranted to gain understanding of local practice and experiences of families and health care professionals.

This research combined with further evidence from the literature is required to develop a locally applicable program to support breastfeeding in the preterm infant. Components of this program would need to address unit design, equipment, feeding guidelines and schedules, staff attitudes and knowledge, policies and procedures, education and support for parents and educational programs for neonatal nurses and other staff.

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From Courtship to Collaboration: The Development of the Integrated Planning & Evaluation Framework Course

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BACKGROUND

The 'Integrated Planning and Evaluation Framework' (IPEF) promotes a consistent approach to work processes. It aims to ensure that work is evidence-informed and integrates evaluation into the early stages of planning. This seven stage process was designed by the Healthy Living Department of the former Calgary Health Region (now Alberta Health Services) as a model for understanding:

- The close relationship between evidence, planning and evaluation
- How the bigger strategic picture impacts day-to-day operations
- How to practically connect all of these in designing and delivering services

Currently, Alberta Health Services is partnering with SEARCH Canada to develop an on-line and face-to-face course that provides the learning and skill development required to understand and implement the IPEF through a blended learning approach. The course will be available to health professionals working in Alberta.

METHODS

Currently, Alberta Health Services and SEARCH Canada are undertaking an iterative process to develop the content and format of the course, as well as plans for course piloting, evaluation and delivery. The Centre for Health Evidence will provide the online platform for curriculum delivery. The partners are collaborating to develop tools and provide learning opportunities to build the knowledge and skills of potential users and doers of planning and evaluation in the health field.

CONCLUSIONS

With regards to conclusions from the collaboration experience between SEARCH Canada and Alberta Health Services in the development of IPEC, the following were key learnings:

- Collaboration should not be entered into lightly. True collaboration requires significant time and flexible resources.
- Clear definition of roles is needed that takes into account the diversity among the collaborators, particularly for lead roles in content expertise and project management.
- Attention to the building of strong, close relationships is required. Such relationships, fun and humor are key to overcoming challenges related to change, turnover, and scarce resources.
- Seek out expertise that is missing from the team (e.g., instructional design).
- Constant attention to building strong groups processes to clarify roles, facilitate communication and deal with conflict.

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For over a decade, SEARCH Canada has been supporting the public health care system by providing learning opportunities, project facilitation, network support and information services to health professionals and researchers in Alberta and elsewhere in Canada. SEARCH creates strong networks that connect evidence to the immediate issues facing decision-makers. The result is a direct increase in the ability of health professionals and health organizations to apply high quality evidence to practice and management decisions.

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