

# Interprofessional Collaborative Practice Development Workshop for Maternity Care Providers in British Columbia

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## Proceedings

MAY 26-27, 2017

Sheraton Vancouver Airport Hotel



**The Interprofessional Collaborative Practice Development Workshop was held at the Sheraton Vancouver Airport Hotel in Richmond, BC on May 26 & 27, 2017.**

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**With special thanks to the speakers, guests, and workshop participants for openly sharing their knowledge, insight, and skill as we engage in unlocking the challenges, adapting and spreading our successes, and making the good better for British Columbia's families and communities.**

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## Introduction

The future of primary maternity care in Canada has become a topic of considerable discussion and concern in recent years. The last two decades have seen a dramatic decline in the number of family physicians providing maternity care. Reasons for this decline have included lifestyle issues, perceived competence, liability concerns, and practice sustainability. Lack of access to maternity care has been linked with hospital closures in rural communities and has made it increasingly difficult for women to access needed obstetric care, particularly those living in rural and remote areas of British Columbia.

Nationally and provincially, interprofessional collaboration (IPC) has been widely promoted as an effective and efficient way to improve the quality and sustainability of primary maternity care. It has been shown to increase women's access to care, to improve the care quality, and to promote person-centered care that is responsive to the needs of communities. Effective IPC has been linked to improved patient outcomes, decreased length of stay, fewer cesarean sections, and lower costs. The Multidisciplinary Collaborative Primary Maternity Care Project (MCP<sup>2</sup>) was a joint initiative of all the key Canadian maternity care provider organizations, funded by Health Canada. The goal of this project was to facilitate the implementation of national, multidisciplinary, collaborative strategies to improve the availability and quality of maternity services across Canada. According to the MCP<sup>2</sup> definition, IPC is "a dynamic process of facilitating communication, trust, and pathways that enable health professionals to provide safe, woman-centred care."<sup>1</sup>

In June 2016, the Shared Care Committee co-developed a proposal with communities to address local gaps in maternity services, while facilitating greater spread and sustainability of local improvements. Extensive stakeholder consultation included:

- Four teleconferences to gather input from over 25 participants including GPs, OBs, RMs, and the FNHA
- Several one-on-one conversations with physician leads
- Consultation session with over 25 GPs following the GPSC/Vancouver Division 'Train the Trainer' event
- In-depth consultation with key informants including Perinatal Services BC (PSBC), GPSC Maternity Working Group, and the Rural Coordination Centre of BC (RCCbc)
- Participation on the GPSC Maternity Working Group and collection of feedback
- A comprehensive scan of present and past Shared Care projects
- Discussions with Health Authority representatives

Through the consultation and research process, supporting and enhancing IPC was the number one topic raised by family physicians, obstetricians, midwives, and other allied health care providers. Communities such as Comox and South Vancouver have experienced quality improvements in patient care because of an interprofessional collaborative approach. Enabling maternity care providers to improve IPC through a provincial Interprofessional Collaborative Development Workshop and the creation of a provincial Community of Practice were proposed as initial steps toward supporting the spread of interprofessional collaboration in communities throughout BC.

The aim of the Interprofessional Collaborative Practice Development Workshop was to:

- Profile existing and emerging IPC models of care, approaches, and lessons learned from across BC
- Facilitate dialogue between family physicians, specialty physicians, registered midwives, and allied health professionals to inform the creation of a Community of Practice to further enable and support IPC in BC
- Equip health care providers and administrators with knowledge, tools, and resources to pursue improvements to the delivery and sustainability of primary maternity care in their local communities

This report provides a summary of the proceedings from the *Interprofessional Collaborative Practice Development Workshop for Maternity Care Providers in British Columbia*, held at the Sheraton Vancouver Airport Hotel in Richmond, BC on May 26 and 27, 2017.

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<sup>1</sup> Multidisciplinary Collaborative Primary Maternity Care Project. (2006). Final report: MCP2. Ottawa, ON: Society of Obstetricians and Gynaecologists of Canada. Retrieved from <https://sogc.org/wp-content/uploads/2013/09/repFinHlthCA0606.pdf>

## “Mingle-Mingle”

Participants began the first day with a group activity called “mingle-mingle.” Designed to get everyone out of their seats for introductions and to co-create a list of collaborative practice resources, this activity had participants walk around the room until a bell rang. At the sound of the bell, participants joined in pairs or groups of three for a 5-minute, speed-dating style conversation. During four rounds of “mingle-mingle,” with a different focus question for each round, the following lists were created:

### Essential elements for successful collaboration:

- |   |  |   |
|---|--|---|
| <ul style="list-style-type: none"><li>○ Create an open collaborative community</li><li>○ Physical space – for getting together, working together, making things happen</li><li>○ Willingness to understand and make a connection</li><li>○ Openness for working together and learning</li><li>○ Tolerance</li><li>○ Being non-judgemental and having acceptance for each other’s differences</li><li>○ Commitment to the long game – hold the space for later adopters to come aboard</li></ul> | <ul style="list-style-type: none"><li>○ Recognition and acknowledgment of each other’s skills and assets</li><li>○ Intentional understanding of each other’s scope and role</li><li>○ Understand the extent to which your organization supports your participation</li><li>○ Courage</li><li>○ Open communication</li><li>○ Cultivate a culture of respect and a safe environment to learn</li><li>○ Make time to reflect on what has been said and heard</li><li>○ Celebrate what is going well</li></ul> | <ul style="list-style-type: none"><li>○ Acknowledge the elephant in the room</li><li>○ Persistence</li><li>○ Humour</li><li>○ Alcohol</li><li>○ Coffee</li><li>○ Honesty</li><li>○ Listening with intention to understand</li><li>○ Respectful engagement</li><li>○ Enthusiasm</li><li>○ Asking questions</li><li>○ Be transparent</li><li>○ Learn from other experiences</li><li>○ Self-care</li></ul> |
|---|--|---|

### Potential partners for collaborative work:

- |  |   |
|--|---|
| <ul style="list-style-type: none"><li>○ Shared Care</li><li>○ Divisions of Family Practice</li><li>○ Medical Staff Associations<ul style="list-style-type: none"><li>⇒ Facility engagement activities and funds</li></ul></li><li>○ Physician Support Program</li><li>○ BC College of Family Physicians</li><li>○ Allied Health Providers and Associations</li></ul> | <ul style="list-style-type: none"><li>○ College of Family Physicians of Canada</li><li>○ Perinatal Services BC</li><li>○ Midwives Association of BC</li><li>○ Local Community Groups or Councils</li><li>○ Regional Health Authorities</li><li>○ First Nations Health Authority</li><li>○ National Aboriginal Council of Midwives</li></ul> |
|--|---|

### Opportunities for enhancing interprofessional collaboration:

- |  |   |
|--|---|
| <ul style="list-style-type: none"><li>○ At department meetings (ie: for goal-setting)</li><li>○ Create IP engagement opportunities (ie: lunches)</li></ul> | <ul style="list-style-type: none"><li>○ Co-creating hospital and agency policies</li><li>○ Teaching learners outside of our own disciplines</li></ul> |
|--|---|

### Relevant education and CME resources:

- |   |   |
|---|---|
| <ul style="list-style-type: none"><li>○ Robert Gas leadership course at Hollyhock</li><li>○ Physician Leadership Courses</li><li>○ UBC CPD</li><li>○ MORE-OB</li><li>○ Clinical Practice Guidelines</li><li>○ “But I Don’t Do Maternity Care” Workshops from the Vancouver Division of Family Practice</li><li>○ Cultural Safety and Humility Training – FNHA</li></ul> | <ul style="list-style-type: none"><li>○ Facilitation training with Magda Dominik and Geordie Atkin at <a href="#">Atkin Leadership Group</a></li><li>○ Sauder Business course</li><li>○ SFU Leadership Program</li><li>○ SFU Management Development Program</li><li>○ CIHC – Canadian Interprofessional Health Collaborative</li><li>○ <a href="#">Brazelton Touchpoints Centre</a></li></ul> |
|---|---|



### Online resources:

- [Community Tool Box](#)
- [Institute for Healthcare Improvement](#)
- Maternity Care Discussion Group online forum
- [Optimal Birth BC](#)

- [Thunderbird Partnership Foundation](#)
- [International Association of Public Participation \(IAP2\)](#)
- [Perinatal Services BC](#)

### Other resources to enhance or support collaboration:

- Patients Medical Home paper from CFPC
- Patients at the Centre – White Paper
- Brené Brown – author; topics of trust and vulnerability in relationships

- EMRs – OSCAR
- FNHA documents and online resources
- Talk with Elders in your community
- John P. Kotter's books on leading change

### Desired resources:

- Funding for someone interested in an interprofessional collaborative to travel to community of interest to witness and/or mentor
- Scheduling models for collaborative practices
- Project management
- IPC from other areas of healthcare and other industries
  - ⇒ Develop best practices
- Decision aids and decision tools
- Facilitator tools (for workshops, patient groups, engagement activities)

- Collaborative practice agreement examples
- Learning Hub – more IPC offerings
- Patient-reported experience and outcomes measures
- Collective Impact Evaluation Framework
- History on why we need to include cultural humility in the provision of care
- Needs Assessment Surveys:
  - Patients
  - Care providers
- Ideas for engaging community partners



## The Journey So Far

What has happened on national and provincial stages to create the opportunity and conditions for the conversations and explorations in this workshop?

### A Collaborative Approach

- Multidisciplinary Collaborative Primary Maternity Care Project (MCP<sup>2</sup>) – 2006
- A National Birthing Initiative for Canada – SOGC – 2008
- Primary Health Care Charter: A Collaborative Approach – BC MoH – 2008
- A National Interprofessional Competency Framework – CIHC – 2010
- Toward a Primary Care Strategy for Canada – CFHI – 2012
- Interprofessional Collaborative Practice in Primary Health Care – WHO – 2013
- Primary Maternity Care: Moving Forward Together – BC MoH – 2014
- Getting the Most out of Primary Health Care Teams – Recommendations for Action – Conference Board of Canada – 2014

**What makes this so hard to do?**

### Mandate to Push Forward



- MoH: Patient-Centred Care Framework
- MoH: Primary Maternity Care Plan
- MoH: Primary and Community Care
- Patient Medical Home
- CFPC/SOGC/SRPC: Rural Road Map
- Rural Networks White Paper

### Benefits of Collaboration

#### For Families

- Quality of care
- Improved access

#### For Providers

- Satisfaction
- Lifestyle
- Enhanced learning

#### For Communities

- Sustainability
- Recruitment of maternity care providers



### Important Considerations

Perceived:

- Fragmentation
- Loss of autonomy
- Loss of professional identity
- Loss of stability
- Disconnection between provider and community needs



### Partnering Across BC to improve Maternity Care

- ♦ Comox
- ♦ South Okanagan Similkameen
- ♦ Kootenay Boundary
- ♦ East Kootenay
- ♦ Nanaimo
- ♦ Abbotsford
- ♦ Central Okanagan
- ♦ South Island



Focusing on interprofessional collaboration as a means to enhance access, continuity, and coordination of maternity care.



### Scope

- ♦ Creating or clarifying local maternity pathways
- ♦ Strengthening team-based care
- ♦ Co-developing local models of care
- ♦ Clarifying roles and standardizing care
- ♦ Improving communication and referral
- ♦ Improving patient self-management



## Explorations of Collaborative Innovation

Set up as 12-minute rapid-fire rotations, these mini knowledge-sharing sessions gave participants the opportunity to have small group conversations with providers working in five innovative maternity care collaborations across BC. The objectives for this session were to help participants:

- ⇒ Acquire an understanding of how different communities have used interprofessional collaboration or a collaborative model to meet their community needs.
- ⇒ Identify common determinants of effective collaborative practices within their communities and learn how they can leverage them to support patient-centred care.
- ⇒ Anticipate potential barriers to effective collaboration and learn how to access tools and mechanisms to address them and to facilitate effective patient-centred care.

### TABLE ONE – South Community Birth Program, Vancouver

The practice:

- Multidisciplinary – NP, RN, RM, GP, Doula
- Set up in South Vancouver to meet community needs – patients were not accessing care; community driven, aligning with patient wants, ‘what’s best for women is best for community’
- Commitment to the model of care; providers bend to the model, practice serves community, person-centered, success measured as a group – not as individual providers, everyone must ‘stretch’
- Provider equity, no hierarchy, no labels = “care providers,” all come together with ideas, contribute equally
- Early seed funding through federal Primary Health Care Transition Fund program
- 69 clients in 2004; 535 clients in 2015 (65% primip, 77% vaginal birth, 16% c/section in labour)
- Clinic appointments to ~20wks then most clients choose Connecting Pregnancy group care
- “Meet the Team” nights for clients to come and meet all providers
- Clients are not concerned about not knowing who attends birth – team’s shared philosophy, cohesive approach

Compensation:

- Paid for call shift, clinic block, CP group class – flat fee for each, same for RMs or GPs
- Pooled resources, funding, billings
- Bill RM code for prenatal, postpartum care
- Birth billed by attending GP or MW

On-call:

- Days = 10 hr shift and nights = 14 hr shift; with 2<sup>nd</sup> on call rotating every 24hrs as back-up

Homebirths:

- GP not trained to do homebirths
- Had caseload of 50 births in June -> 3 Homebirths
- In Vancouver; transfer primips to midwifery practice group if wanting homebirth

Connecting Pregnancy:

- Empower clients and families, shared learning
- Groups run every night, begin at 20wks, 2hrs long, co-facilitated by one provider (RM/GP) and RN or Doula
- 10-12 women and partners per group, with due dates in the same ½ month, stays together through course
- Clients do own self-care; BP, urine dip, weight, etc.

Doulas:

- Funded through BC Women’s grant, attached to reduced length of stay postpartum, L&D doula only
- Clients who can afford – donate to foundation’s doula program
- Tap into FNHA doula funding when available
- If shortfall – cover from MSP billing

Quality Assurance:

- Wider range of risk satisfaction
- Active quality assurance
  - Chart leads, regular chart review
  - Leads have charts checked by 36wks
  - Monthly team meetings – discuss complicated care
  - Need to be humble – “what does everyone think?”
- OSCAR EMR – paperless, contemporaneous, accessible across sites and from home



## TABLE TWO – Apple Tree Maternity, Nelson

The practice:

- 2 ½ years as an interdisciplinary collaborative practice
  - 4 RMs + 2GPs + locum (4 full-time, 2 part-time)
  - Shared care – team of 3 for continuity
  - 24 hr call shifts
  - About 180 births/yr; hospital does ~300/yr
  - GPs do home births; supported by RMs, RMs attend also - until GPs can bill for home birth
  - 20% c/section rate; 20% plan homebirth and 80% successful
- More like midwifery model → longer prenatal visits, greater support in active labour, home visits
- Other physicians and midwives in community generally supportive, OBs super supportive
- Practice meetings held once/wk; 'Meet the team' nights for clients

Reason to come together:

- Sustainability & call coverage (originally worked w/community outreach)
- Programs:
  - By combining 'families' in group care settings -
    - Lactation consultant & RN time reduced
    - Breastfeeding group 2x week and perinatal mood support group
    - Connecting pregnancy group care or one-on-one appointments
  - Do encourage patients to see their GPs if needed during pregnancy
  - Tele-maternity services in winter months for clients in more remote communities

Challenges:

- Hospital nurses → resistant → fear their loss of autonomy; roles and responsibilities: RNs w/ RMs vs RNs w/ GPs
- Establishing the practice – lots of meetings, community outreach, etc.
- Overcoming assumptions by others (i.e. prenatal courses, who else, etc.) – did outreach to other GPs in community when starting through face-to-face and stakeholder meetings, focus groups

Physical Space:

- Health co-op in community
- Large waiting room, doubles for group meetings at night; two exam rooms; space at back for lactation support

Funding and other programs:

- Combine billing for whole team, funding for homebirth equipment through provincial program
- GPs can bill consultants/reference for funding (i.e. if GP refers for mood)
- GPs can bill group visit for connecting pregnancy
- Other programming (breastfeeding group, mood support group) funded out of clinic dollars

## TABLE THREE – Smithers

What's happening:

- Interest in collaborative approach to maternity since 2013 provincial workshop
- Originally was GP, RM, RN, and prenatal educator; now GP and RN
- Providers maintain independent practice, trying to sustain Connecting Pregnancy in community for patients
- Some seed funding from NHA for RN and small community grant

Challenges:

- Small community, ~220 births/yr; only have 6-8 patients per CP Group → scale, sustainability
- 8 maternity providers in community, territorial 'my patient' (though this is improving), perceived loss of control
- 3 physicians with surgical skills for C/S
- Life changes, provider sustainability, moving
- Provider billing: CP groups mostly 'volunteer' work unless GP can bill 'group medical visit' if 3+ patients attending, assessment in CP could not replace appointment with GP or RM

Connecting Pregnancy:

- Monday evenings, bi-monthly; 6-8 patients and support people per group with due dates as close as possible
- Adapted curriculum from South Community Birth Program
- Facilitated by RN; GP does BPs and belly checks

Strengths and successes:

- Patients are more satisfied regardless of mode of birth (ie: if they have a c/section) and decreased c/section rate
- Provision of quality, person-centered prenatal education, enables self-assessment and responsibility
- Patients feel better prepared, increased self-care, responsibility, and understanding of choices, shared passion
- Core committed group in community keeping Centering Pregnancy program alive

#### TABLE FOUR – Comox

What's happening:

- Reality and need for change:
  - Increased costs (not sustainable), loss of services (no home visits by PHNs), access challenges
  - Fragmented care, not collaborative, team-based care reduced
  - Changing provider demographics; many coming from outside the province
  - Cultural shifts; community mood and needs; immediate access?
  - Increasing c/section rates - what can we do to bring it to more acceptable?
  - More complex patients and increasing system complexity
  - Disconnection between providers and community needs; "meets our needs" and "not necessarily community needs" -> "don't know what we don't know"

Community of providers:

- Original desire to establish collaborative maternity care practice; then realized first needed to cultivate collaboration and communication across provider groups in community -> no one on the same page, working well together in hospital but not so much in community, conflicts around care and philosophy
- Enhancing Interprofessional Collaboration in the Comox Valley – process supported by Shared Care and PSBC
  - 2 groups of RMs, 2 groups of GPs, 2 OBs interested (of 19 maternity providers in Comox Valley)
  - Only 4 full-time providers, 8 work part-time
  - 600 births/yr in community
  - OBs want standardization, GPs want stability and not to lose providers/practice, RMs 'right to be there'
- Provider and community needs assessments
- Round table conversations and World Café evening; get to know everyone, shared experiences, shared desire to 'work better,' review needs assessments, decide on next steps
- Phase 1 focus = creation of maternity pathways; Phase 2 focus = perinatal mental health
- #1 take away = "The process is the project" – IPC enhanced through engagement and working together
- Outcome is positive, less splitting in the community, continue moving forward

Connecting Pregnancy:

- Piloting "shared group care" using Connecting Pregnancy model; providers are 50% RM and 50% GP
- Running community group care sessions, every two weeks, co-facilitated by one GP and one RM
- Paid through GP for group medical visit, some MSP billing
- Patients enter group care stream ~24wks GA, groups every two weeks, and go back to providers in between groups when weekly appointments are needed

#### TABLE FIVE – Vancouver

What's happening:

- How to expand maternity care and primary care in Vancouver?
  - 20 OBs, 70 GPs, 60-70 RMs
  - Strengthen primary maternity care
  - Vancouver Division of Family Practice continuing collaborative initiative to attach patients to GP following their birth (with any provider)
  - "But I Don't Do Maternity Care" and collaborative "Train the Trainer" workshops from the Vancouver Division of Family Practice

Next steps:

- How to collaborate with midwives?
- Shared educational resources and opportunities with midwives
- Cross-reflection with midwives
- Grant proposal: create a template website which is centrally located, for communities to use and modify prn
- Who is doing what and how to partner with them?
- Survey GPs who refer to OBs and find out why

## Seeding the Ideas of Shift

In this session, designed to create a space for dialogue, for co-sensing what may be encountered personally and philosophically, and for bridging across difference, participants explored possibilities for approaching interprofessional collaboration. At tables of 8-10 people, participants responded to questions about the system level 'big picture,' community level collaborations, and about personal and professional beliefs.

### 1. What excites you most about interprofessional collaboration?

- Accessing GPs and OBs in a team
- Having other options for delivering maternity care, such as group care
- IPC has the potential to improve work/life balance
- There is a common understanding between providers
- Decreased anxiety for patients (perceived conflicts between providers are reduced/improved)
- Learning about the perspectives and approaches of other providers
- Relationship building leads to better care
- Meeting gaps of care within a community of care
- Enhancing IPC can help bring birth back to a community
- Opportunity to see how things can be done differently and opportunity for change
- Sustainability and sharing each other's gift of knowledge

### 2. What concerns you most about IPC?

- People think IPC needs to be all or nothing (it doesn't always have to be – create innovative, local solutions)
- Liability – with IPC, would one provider or group be held liable for the acts and/or omissions of another?  
⇒ See the [Joint Statement on Liability Protection for Midwives and Physicians](#) on the CMPA website
- Difference of education between midwives and MDs
- Two separate Colleges for dealing with complaints
- Ensuring everyone is providing the same level of care
- For GPs and RMs – need certain volumes for sustainability

### 3. What opportunities exist within your community to begin to build an IPC?

- Needed time and patience to mature into IPC re: creating trusting relationships with team, and shared roles and responsibilities -> Lots of unpaid time is spent on this (average first 2 years of commitment) - but it pays off!
- Need to address fear of being watched by others, of being open, vulnerable, and having humility
- Increasing openness to other ways of doing things, of new philosophies and models, and understanding that multiple ways of doing could be correct

### 4. What is one thing you would need to change in yourself to work in an interprofessional team?

- Need to step back and have conversations; as clinicians we're often stuck on 'hamster wheel'
- Leave ego at the door, create a horizontal structure vs hierarchy – need this for appropriate space for IPC
- Work on myth- and profession- based fears, territorial, scope, training, levels of fear
- Build a model of care around patient and community needs (can be threatening to provider wants/desires)
- Shifting from 'continuity of carer' to 'continuity of care' perspective

### 5. What is the patient's role in an interprofessional team?

- Important stakeholder; after all, care is about them, to meet their needs
- How do we meaningfully engage patients and include them in practice design?
- Patients will best identify what their needs are and how they can be met
- Begin to seed change from provider-driven to patient-centered system

### 6. What do you see as a barrier(s) to IPC – and what would be one thing to overcome the barrier(s)?

#### Barriers:

- Time – providers don't have time for cultivating relationships and IPC, can't do it solely out of altruism, paid only for clinical care time via MSP
- Perceived loss of referral base, patients, sustainability if volume reduced
- Different models of care between providers, different training, perceptions about working in another model
- Different funding models do not enable or support IPC, team-based care, or Connecting Pregnancy group care

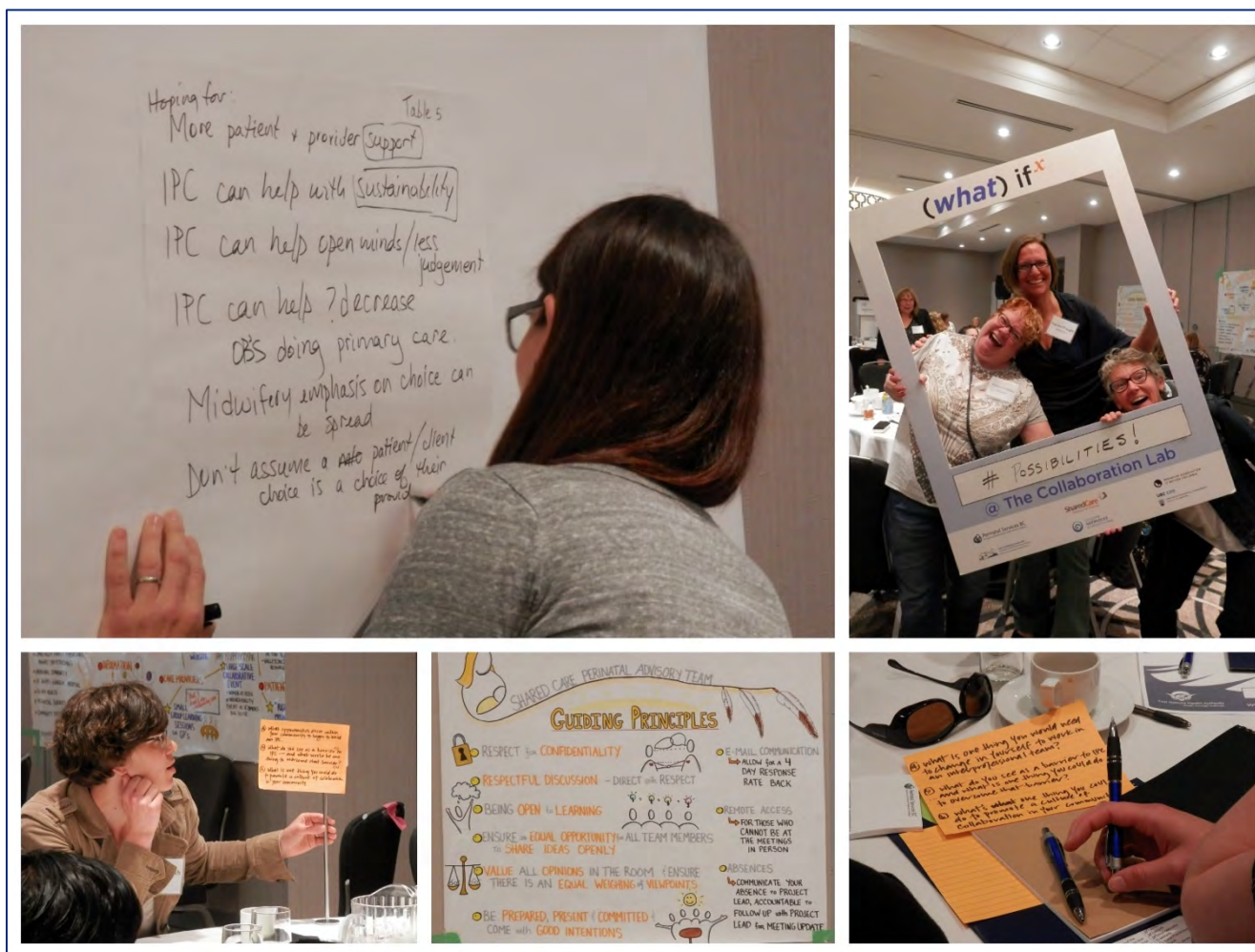
- Midwifery requirement to provide choice of birth place to all clients in any model
- Interpersonal conflicts – especially around patient’s declining recommended care or not following guidelines
- How to find ‘right’ balance of providers for a community
- Providing culturally competent care
- People have different ideas of what collaboration looks like – need dialogue! (and enabled time for it)

#### Overcoming barriers:

- Time - need compensation as an enabler; billing structure needs to value the time it takes to develop IPC
- Increased interprofessional opportunities – rounds, more IP discussion, CME events and conferences, email/newsletter, shared policies and guideline development, celebrating with each other
- Money via Medical Staff Associations and other sources – choosing to be inclusive with funding for IPC
- Accepting that change is difficult and it’s hard to have energy for change; there’s “no way through but through”
- Need to “see” the culture, to recognize and name it – before it can be changed
- Recognize and value each other’s strengths and build on those; requires shift from ‘problem-based’ fixing
- Solutions from the “top” never work – enable local co-sensing, co-creating environments, supported from “top”
- Toolkits are useful – but teams need to be working together first to make use of the tools

#### 7. What is one thing you could do to promote a culture of collaboration in your community?

- Communicate; pick up the phone and talk with one another; have intention re: improving IPC and teamwork
- Have a universal electronic health record (EHR)
- Engage with curiosity, not judgement; open-mindedness
- To begin with collaboration – focus on the patients and the community as the unified cause





## Co-creating New Ways of Working Together

Introducing a patient-centric design approach to problem solving can lead to innovation. After an overview of 'design-thinking,' participants worked in groups to begin to articulate and design models for interprofessional collaboration.

### Design-Thinking Framework



### Design-thinking Framework

- Step one: conduct research to develop an understanding of your users
  - Consider a patient you have supported recently in her maternity journey
  - Individually take 5 minutes to design her ideal service
    - Who is your patient?
    - How does your patient think?
    - What does she and her family want?
    - What encourages / discourages her?
    - Where does she experience frustration?
    - What would be her ideal journey?

### Design-thinking Framework

- Step two: Define use the data gathered to glean insights ~ organize all your observations and create a common user profile to begin to highlight opportunities for innovation

### Design-thinking Framework



**Goals:**

**Attitudes:**

AGE: 31  
Location: Grand Forks BC (rural)  
Job Title: Mom of all trades  
Family:  
one older child and father; grandmother and family live nearby

**Behaviours:**

### Design-thinking Framework

- Step Three: Ideate ~ brainstorm a range of crazy, creative ideas that address the users needs
  - You have total freedom ~ nothing is too farfetched and quantity wins a prize!
  - Using the flipchart at your table
    - Think of 50 ideas as a group in the next 5 minutes for the service model for Hilary (Method 50)
- Step Four: Prototype ~ build a representation of your idea
  - Create a "pitch" summary of your model to share with the room ~ and give it a name ~ include:
    - Must haves
    - Should haves
    - Nice to have

### Design-thinking Framework

- WHY?? The advantages:
  - ❖ It is a user-centric process that starts with user data, creates designs that address real and not imaginary user needs, and then tests those designs with real users
  - ❖ It leverages collective expertise and establishes a shared language and buy-in amongst your team
  - ❖ It encourages innovation by exploring multiple avenues for the same problem

"A wonderful interface solving the wrong problem will fail" ~Jakob Nielsen

## Building Relationships and Meeting Community Needs: Looking Deeper into the Adverse Childhood Experiences Model (ACEs)

Trauma-informed practice and attention to ACEs require inherent and purposeful upstream, downstream, and cross-sector collaborations through the care continuum, and within and across communities. In this session, participants began:

- ⇒ To identify, as a group, the possible benefits associated with including ACEs in history-taking and trauma-informed practice
- ⇒ To assess readiness for prototyping ACEs screening and discussion in their maternity practice
- ⇒ To identify, as a group, what (if any) systemic requirements need to be addressed to support the integration of ACEs history-taking in their practice

### ACEs: A Lifespan Approach



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Understanding a person's adverse childhood experience takes nothing away from understanding her resilience.

It puts into perspective how spectacularly resilient she may be, the strengths she is building on for the next phase of her life, and opens the space to talk about the life she wants for her self and her family.

ACE Interface  
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### ACE Categories Considered in Study

#### Abuse

1. Child physical abuse
2. Child sexual abuse
3. Child emotional abuse

#### Neglect

4. Physical Neglect
5. Emotional Neglect

#### Indicators of Family Dysfunction

6. Mentally ill, depressed or suicidal person in the home
7. Drug addicted or alcoholic family member
8. Parental discord – indicated by divorce, separation
9. Witnessing domestic violence against the mother
10. Incarceration of any family member

ACE Interface

### ACE Study Major Findings

ACE Categories (ACEs) are Interrelated

ACEs are Common

Accumulation Matters

Dose-Response: Disease, Disability, Social, Productivity

Scores= Good Proxy Measure Childhood Toxic Stress Dose

ACEs are the Most Powerful Known Determinant of Health

ACE Interface

## ACE Study: Why it is Relevant

Adverse childhood experiences are the most basic cause of health risk behaviors, morbidity, disability, mortality, and healthcare costs.

**More than six adverse experiences is correlated with:**

- The development of serious health, behavioral, psychiatric, and potentially life-threatening illnesses.
- A life span shorter by an average of 20 years (60.0 years versus 79.1 years)

[www.cdc.gov/NCCDPHP/ACE](http://www.cdc.gov/NCCDPHP/ACE)

## Impact of Prolonged Trauma

❖ **Being in a state of fear for prolonged periods of time may present as:**

- Impulsive
- Hyper vigilant
- Hyperactive
- Withdrawn
- Depressed
- Anxious
- Regressive behavior
- Sleep difficulties
- Acquire new developmental tasks at a slower rate

• **Often meet criteria for:** ADHD, Anxiety Disorder NOS, Major Depressive Disorder, Conduct Disorder/Oppositional Defiant Disorder, Attachment Disorders

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## Where it all starts?

- ❖ Maternal post-partum behavior is the mechanism upon which the cross generation transmission attachment bond is built.
- ❖ Oxytocin is a bio-feedback loop: more touch and attunement causes oxytocin release and vice versa.
- ❖ Maternal Behavior shapes infants oxytocin system=the ability to connect
- ❖ Maternal Behavior shapes the cortisol system=the ability to handle stress

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## Why Early Intervention...

- ❖ Babies are face experts, with-in minutes of birth, they seek a response from the mouth as a neurological preparation for language, and the eyes for a gaze that signals connection.
- ❖ Feeding is one of the first human caregiving interactions that begin a process of synaptic connections about the safety and protection that exists in the caregiving relationship.

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## Framing the ACE History In Care Settings

**Adopt Protocol: Educate, Ask, Listen, Affirm, Remember**

*"We now know that childhood experience has a big impact on health throughout our lives. Understanding your history of adversity while you were growing up will help us to work together to improve your health and the health of your family."*

**ACE InterTag**  
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**Every single human encounter is an opportunity to create a template of positive human interaction.**



## Topic-based Exploration

A series of sessions designed to seed awareness and assist participants' continuation of them in their local communities.

### Billing and Innovative Resourcing

This facilitated discussion began with a brief overview from panelists and continued through a series of questions. Due to the quick and robust discussion, few notes were captured. It quickly became evident that a fulsome resource on 'Billing and Innovative Resourcing' would be a beneficial and supportive addition to the development of IPC in BC – this 'ask' was carried forward for the Community of Practice.

#### Questions for consideration:

- ⇒ How did you approach the issue of billing and remuneration?
- ⇒ Are there ways that you tackled [X] that would be helpful for others to know?
- ⇒ How did you get around [Y]?
- ⇒ Now that you've gone this far on your collaborative practice journey – what are you thinking about funding that we should be bringing to other tables to address the questions of support and remuneration more comprehensively?
- ⇒ What resources would support your collaborative efforts in the future?
- ⇒ ***When we think about the way we work together – is remuneration and support just about money exchange or, are there other ways we navigate questions of compensation and worth?***

#### Resource requests:

- GP/RM/OB MSP billing and available practice resource summary sheets
- Physician billing "cheat" sheet – including available incentives, special fee codes (ie: group medical visit)
- Collaborative practice – examples of possible billing/payment structures and scenarios
- List of possible sources of funding – ie: grants, gov't agencies, project funds, etc.
- How do shared care groups manage the 2% MABC levy? (Midwives Association of BC levy on RM fees)

### Community Building and Getting Started – The Shared Care Comox Project

- A family physician in Comox who attended the 2013 IPC Workshop was inspired to connect with colleagues to develop a collaborative approach to delivering perinatal care in the Comox Valley
- Gather interest -> at Divisions meeting, engaged RMs and OBs
- Gauge: What's our tension? -> evolution, manpower, OBs stopped doing primary care
- Early establishment of a Multidisciplinary Advisory Team with RMs, GPs, OBs, Mat/Child Health Coordinator, Public Health Coordinator, Aboriginal Liaison Nurse, and the ED of Perinatal Services BC to develop the project together
- With assistance from a project manager, a proposal was developed and submitted to Shared Care -> *goal* to establish strategies for ongoing collaboration to enhance quality of perinatal services and care in community
- Survey -> providers, patients -> what our community wants (what do the women need and want) -> ideas -> multigroup gatherings, World Café, etc.
- Next steps: How do we move this forward?

\*We didn't take this on as a change project

\*We discovered things that were going on in the community that we didn't know about!

### Connecting Pregnancy – Delivering Perinatal Care in a Group Setting

No notes were captured for this small group session.

[Perinatal Services BC provides some Connecting Pregnancy resources on the agency's website.](#)



## Cultural Safety and Humility in Health Care

### What?

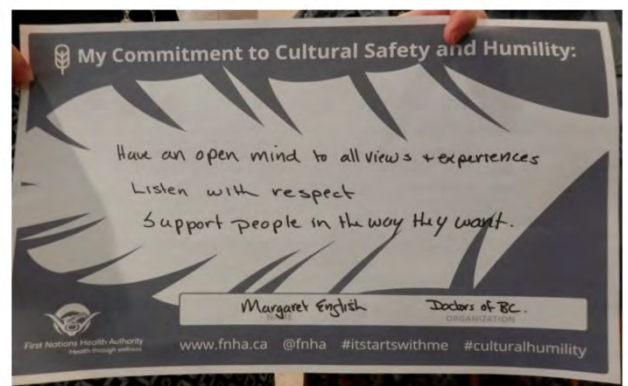
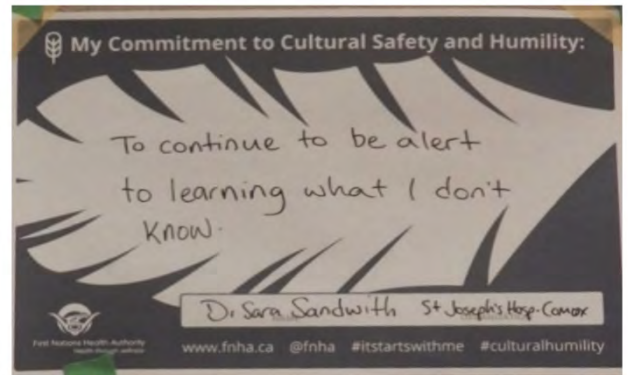
- Cultural safety is an outcome, based on respectful engagement that recognizes and strives to address power imbalances inherent in the healthcare system. It results in an environment free of racism and discrimination, where people feel safe when receiving health care.
- Cultural humility is a process of self-reflection, to understand personal and systemic biases, and to develop and maintain respectful processes and relationships based on mutual trust. Cultural humility involves humbly acknowledging oneself as a learner when it comes to understanding another's experience.

### So What?

- It is important to acknowledge that cultural humility involves a life-long learning process and continual self-reflection. Cultural safety training may facilitate this but, is only the beginning of the journey.
- Practicing with cultural humility is one step towards creating a culturally safe environment for First Nations and Aboriginal people who access services in a health care setting.
- We can only know if a service is culturally safe if our client tells us it was safe for them. Hence, we need to listen without judgement.
- As providers, we need to be aware that some people have experienced trauma and could be triggered by any seemingly disrespectful behavior.
- As a provider, it is useful to understand the cultural protocols, ceremonies, and ancestral laws of the nation used to guide relationships in a good way.
- As providers, we mustn't lose perspective on the wider health system, and how it has been shaped by systemic racism in a way that adversely affects First Nations and Aboriginal people. Hence, our day to day actions as providers either re-inforce or challenge that system and result in a better quality of care.

### Now What?

- Signing the pledge for cultural safety and humility is a powerful step to reflect on your role as a change agent in bringing about better care for First Nations and Aboriginal people in BC.
- Taking active steps to learn a few phrases of the local indigenous language of the territory you are on is a great way to connect with the nation's worldview and gain an entry point to understand more about the culture.
- Moving forward, it's important to spend establishing relationships with the clients and their families, to gain trust and to see the whole person.



More information and resources are available at:

- FNHA's Policy Statement on Cultural Safety and Humility: <http://www.fnha.ca/Documents/FNHA-Policy-Statement-Cultural-Safety-and-Humility.pdf>
- FNHA Cultural Safety and Humility: Key Drivers and Ideas for Change: <http://www.fnha.ca/Documents/FNHA-Cultural-Safety-and-Humility-Key-Drivers-and-Ideas-for-Change.pdf>
- Declaration of Commitment on Cultural Safety and Humility in Health Services from BC Health Authority CEOs: <http://www.fnha.ca/Documents/Declaration-of-Commitment-on-Cultural-Safety-and-Humility-in-Health-Services.pdf>

## Creating a Provincial Community of Practice for Interprofessional Collaboration

Leading into the workshop wrap-up, this session was designed to harness the ideas, passion, and energy of the whole group to seed the beginning of a provincial community of practice that will anchor existing knowledge and resources, and actively support the spread of interprofessional collaboration.

### What is a CoP?

#### Why Create a CoP for interprofessional collaboration in BC?

- ⇒ A Community of Practice will enable providers to share lessons, models of care, ideas, and dialogue about best practices. The creation of a an IPC “community hub” will encourage and enable engagement, reduce duplication, generate ideas, enhance collective impact for local and system change, and act as a secure learning space for providers seeking to improve interprofessional collaboration and implement team-based collaborative practices in their communities.

#### Desired Outcomes:

- Improved patient care
- Enhanced collaboration; locally and intra-provincially
- Enable spread through an effective sharing and learning platform for providers and communities
- Increased engagement, community building, capacity building, collective advocacy
- Lessen the burden on individual providers and existing ‘collaborative champions’
- Move from Local to System change; create a provincial mandate to support IPC
- Less duplication of effort; go to the ‘hive’

#### Guiding Principles:

- Be community driven, with community/shared ownership and co-leadership
- Be iterative and evolutionary
- Have a way to ensure no one person or group dominates the agenda or process
- Be open, respectful, curious and non-judgemental, transparent, accessible, supportive, enabling, courageous
- Be appropriately resourced; cannot be accomplished from providers’ side-desks
- Integrate wider community involvement: pentagram partners; patients, learners, policy makers, providers; expand engagement across disciplines
- Embrace joy of thinking outside common boxes and collaborative exploration

#### Shaping the Community of Practice:

- A secure forum for conversations and questions that is inclusive and respectful:
  - For posting questions (a question board)
  - For addressing misconceptions and barriers
  - For collective advocacy and organizing around shared issues
  - For beginners: a portal for problem solving
  - For mentoring and access to experienced providers and administrators
  - For connecting providers with similar interests and goals, pooling resources, not having to ‘reinvent the wheel’
  - For decreasing provider isolation
  - For fostering interprofessional relationships through:
    - Interprofessional gatherings – CME, workshops, working groups (virtual and in-person)
    - Inter-divisional and inter-regional communication, updates, and information sharing
    - Asynchronous electronic communication, regular teleconferences and/or webinars
    - Professional networking
- Practical Resources including:
  - Curated IPC toolkit:
    - How to get community ‘buy-in’
    - How to create a ‘space’
    - A journey map
    - Steps to starting out; FAQ
    - Have specifics for rural and/or lower volume practice

- Create smaller interest groups around specific issues:
  - Connecting Pregnancy – providing group perinatal care
  - Breastfeeding support and resources
  - Mental health, perinatal mood, and substance use
  - Adolescent and youth pregnancy
- Demographic map including:
  - Who is doing what, where?
  - Community profiles, collaborative practice profiles
  - Identification of local connecting points to enable increased in-person connection across distance; “local events”

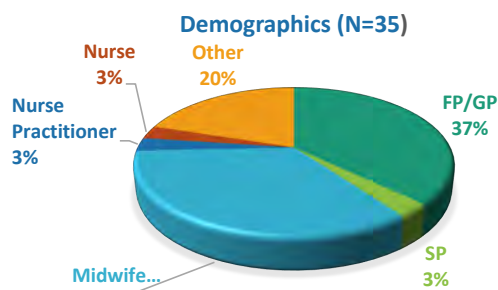
#### Modality:

- Interactive web or electronic forum; use of online modalities to increase access
- Host virtual meetings and educational opportunities; increase face-to-face interactions through webinars
- ‘Do-Purpose-Value’ – enable connectivity and sharing across distance
- Must be reliable, renewable, up-to-date, multi-platform accessible (PC, MAC, smartphone, tablet), moderated



# Workshop Evaluation Report

## INTERPROFESSIONAL COLLABORATIVE PRACTICE DEVELOPMENT WORKSHOP – EVALUATION REPORT\*



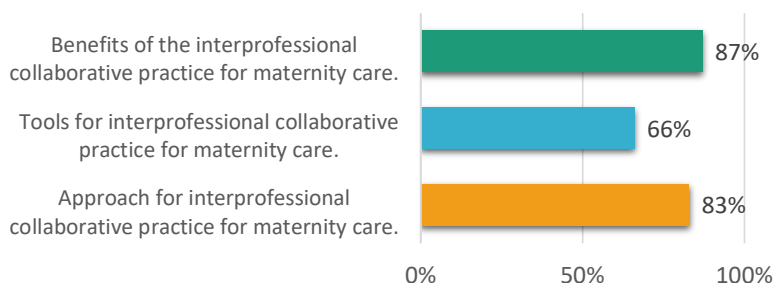
### Workshop Quality

**100%** thought the workshop was well-organized and the speakers and format were effective.  
**97%** reported presentations offered balanced views and the stated learning objectives were met.  
**94%** reported the workshop free of any perceived bias, whether industry or other, in any of the content.  
**100%** reported that overall, the workshop was a good use of my time.

### Workshop Impact

On average, respondents reported a **65% increase** in their level of understanding of interprofessional collaborative practice for primary maternity care.  
**97%** of respondents reported having a greater understanding of the subject matter as a result of the workshop.  
**97%** of respondents indicated they are more likely to participate in efforts to increase interprofessional collaboration in their community.  
**88%** of respondents indicated they are more likely to lead efforts to increase interprofessional collaboration in their community.

#### Percent of respondents that strongly agreed or agreed that the workshop met the following objectives:



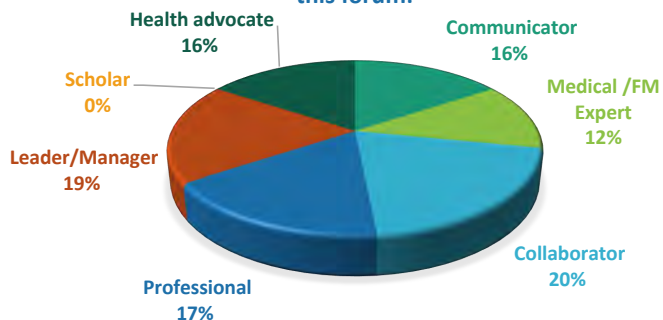
#### The most effective part of the workshop:

- Knowledge sharing, learning from others
- Networking
- Balance, collaborative approach
- Small group discussions

#### The least effective part of the workshop:

- Didactic presentations
- Some of the instructions for group work were not clear
- Too theoretical, not concrete

#### Canmeds/Canmeds-fm roles you felt were addressed during this forum:



#### Key pearls learned:

- Must be patient-centred, community-driven
- Different models for collaboration
- Need for all providers to buy-in
- Start small and focused

#### Future event topics:

- Billing/Payment models
- "How to" build a collaborative practice
- Working with First Nations
- Solutions for low-volume sites

\* From the Interprofessional Collaborative Practice Development Workshop held at the Sheraton Vancouver Airport Hotel in Richmond, BC on May 26 & 27, 2017.



# Interprofessional Collaborative Practice Development Workshop for Maternity Care Providers

May 26-27, 2017

## AGENDA DAY 1

- 7:30-8:15 **Registration and Breakfast**
- 8:15-8:30 **Opening**
- 8:30-8:45 **Welcome and Overview**
- 8:45-9:15 **Introductions**
- 9:15-9:45 **The Journey So Far**  
Exploring what has been happening on the provincial stage that is creating the environment to create collaborative models of care.
- 9:45-10:00 **Break**
- 10:00-11:30 **Explorations of Collaborative Innovation**  
Knowledge sharing sessions. Learning from communities along the collaborative journey:
- South
  - Surrey
  - Nelson
  - Smithers
  - Comox
  - Vancouver
- 11:30-12:00 **Seeding the Ideas of Shift**  
Exploring different ways to approach collaboration.
- 12:00-1:00 **Lunch and Networking**
- 1:00-2:45 **Co-Creating New Ways of Working Together**  
Small group work to begin to articulate and design improved models of care using a patient centred method.
- 2:45-3:00 **Break**
- 3:00-4:30 **Tools for Building Relationships and Meeting Community Needs**  
Introduction to the Adverse Childhood Experiences (ACEs) approach and trauma-informed practice.
- 4:30-5:00 **Setting the Stage for Tomorrow**
- 5:15-6:30 **Reception**  
Sponsored by the Midwives Association of BC and the College of Midwives of BC.



# Interprofessional Collaborative Practice Development Workshop for Maternity Care Providers

May 26-27, 2017

## AGENDA DAY 2

- 7:30-8:00 **Breakfast**
- 8:00-8:30 **Debrief of Previous Day**
- 8:30-10:00 **Topic-Based Exploration** (45 min)
- Billing and Innovative Resourcing Panel
- Smaller Group Sessions** (Choose one; 45min)
- IPC Relationship and Community building
  - Cultural Safety and Humility in Care
  - Group Maternity and Connecting Pregnancy
- 10:00-10:15 **Break**
- 10:15-12:00 **Creating a Provincial IPC Community of Practice – ‘The Collaboration Lab’**
- 12:00-12:30 **Reflections and Closing Remarks**
- 12:30-1:30 **Lunch available for take away or stay, eat, and network more before you depart**

