Guiding Facilitation in the Canadian Context:

Enhancing Primary Health Care

Multi-jurisdictional Collaboration

Guiding Facilitation in the Canadian Context

Guiding Facilitation in the Canadian Context:

Enhancing Primary Health Care

Multi-jurisdictional Collaboration

"Never doubt that a small group of thoughtful, committed citizens can change the world. Indeed, it is the only thing that ever has."

Margaret Mead *(1901-1978)*

Acknowledgements

This project grew out of the collaborative efforts of five partner provinces – Newfoundland and Labrador (lead province), Ontario, Manitoba, Saskatchewan and British Columbia. Representatives from each of these provinces played a role on the steering committee to guide the development of this document and coordinate the orientation of Canadian health professionals to its content. The steering committee has provided solid direction throughout this project. Special thanks are offered to their respective departments and health authorities that have supported this project:

Department of Health and Community Services, Newfoundland and Labrador

Faculty of Medicine, Memorial University of Newfoundland

Ministry of Health and Long Term Care, Ontario

Department of Family Medicine, University of Ottawa

Department of Health, Manitoba

Parkland Regional Health Authority, Manitoba

Assiniboine Regional Health Authority, Manitoba

Winnipeg Regional Health Authority

Saskatchewan Health

College of Medicine, University of Saskatchewan

Ministry of Health, British Columbia

Vancouver Island Health Authority, British Columbia

This project was further supported by the Federal/Provincial/Territorial Committee. It was this group that broadened the network beyond the partner provinces and supported the delivery of orientation sessions across the country. Many thanks to its members as listed below:

Juanita Barrett (Newfoundland and Labrador)

Paula English (Nova Scotia)

Lise Girard (New Brunswick)

Donna MacAusland (Prince Edward Island)

Valérie Fontaine (Quebec)

Marsha Barnes (Ontario)

Barbara Wasilewski (Manitoba)

Donna Magnusson (Saskatchewan)

Betty Jeffers (Alberta)

Val Tregallis (British Columbia)

Marnie Bell (Northwest Territories)

Wayne Governeau (Nunavut)

Jan Horton (Yukon)

Every effort has been made to ensure that contributors to this guide have been acknowledged and copyright has been respected. Please note that this guide, too, is subject to copyright, and excerpts or quotes must be acknowledged as to their source.

Partner Province Teams

Newfoundland and Labrador:

Juanita Barrett, Heather White, Conleth O'Maonaigh, Noreen Dort

Ontario:

Bill Hogg, Eileen Vilis, Jackie Schultz, Jacques Lemelin, Vena Persaud, Juanita Fawcett

Manitoba:

Rick Sapacz, Cheryl Osborne, Betty Kozak, Colleen Rand

Saskatchewan:

Vivian R. Ramsden, Vivian Krakowski, Eunice Patterson, Gill White, Nandita Chaudhuri

British Columbia:

Val Tregallis, Shannon Turner

Editorial Panel:

Juanita Barrett, Bill Hogg, Vivian R. Ramsden

Managing Editor:

Heather White

Editor:

Wade Kearley

Translation:

Françoise Enguehard

French Editorial Review:

Yves Ducharme

Design:

Vivid Communications Inc.

Chapter Editors:

1 - Primary Health Care: Vivian R. Ramsden, Heather White

2 - The Facilitation Model: Eileen Vilis, Vivian R. Ramsden, Bill Hogg, Heather White

3 - Facilitation as a Vehicle for Change: Vivian R. Ramsden, Eileen Vilis, Heather White

4 - Evidence-based Planning: Vivian R. Ramsden, Heather White

5 - Facilitating Promotion and Prevention: Cheryl Osborne, Betty Kozak, Vivian R. Ramsden, Heather White

6 - Building Community Capacity: Vivian R. Ramsden, Cheryl Osborne, Shannon Turner, Heather White

7 - Chronic Disease Management: Colleen Rand, Eileen Vilis, Noreen Dort, Heather White

8 - Teams: Heather White

9 - Collaboration and Scope of Practice: Juanita Barrett, Noreen Dort, Heather White

10 - Health Information and Communication: Juanita Barrett, Shannon Turner

Over 400 people were given the opportunity to contribute and/or offer feedback through meetings, workshops, interviews and/or online feedback surveys through the duration of the project. Many thanks to our numerous and varied collaborators whose desire to collaborate drove this process. A more detailed listing of our many contributors can be found at the end of this guidebook.

Many thanks to Elaine Fullard and to her colleagues for their contributions to facilitation in health care change. Their work highlights the significant benefits of tending to process and, in so doing, contributes to the understanding of the role of facilitation. This model is further evidence of the value of facilitation in the primary health care setting as generated by studies in the United States[1] and the Netherlands.[2]

Gratitude must be expressed to our colleagues who funded this project: Tools-for-Transition, Health Canada. Their support gave life to this collaboration and to this guidebook.

To request permission to use copyright material from this Guide in print, electronic format or in any other form whatsoever, then please contact:

Heather E. Roberts, Librarian

Division of Policy and Planning

Department of Health and Community Services

Government of Newfoundland and Labrador

Phone: 709-729-2264

Or: 709-729-3657

Email: HRoberts@gov.nl.ca

How to Use This Guidebook

Many health professionals in the field have developed a variety of practical and useful tools for facilitation in the primary health care context. This guidebook provides background information chapter-by-chapter with resource listings that contributors felt were relevant. These tools are listed in the *Facilitation Resources* section at the end of each chapter. These sections are not intended to be an exhaustive national list, but rather a sampling of relevant resources that have proven effective. Although these resources have not undergone peer review, they are supported by anecdotal reports of effectiveness.

The resources list at the end of each chapter is organized into distinct categories to help you determine its relevance to your practice. The icon for each relevant category will appear next to each resource listed throughout the guidebook as an aid to categorization.

🔵	**Organizational Support**	*Indicates that this resource was effective in providing support across an organization's change process.*
P	**Program**	*A program developed to facilitate change.*
🔄	**Process**	*A process used for facilitating change.*
T	**Training**	*A training module.*
🔧	**Tools**	*Specific documents that have been developed to support and promote change.*

Table of Contents

Diagrams and Tables

Introduction

This guide offers information on the strengths and efficacy of facilitation for leaders and facilitators of change in primary health care (PHC). It grew from the collaboration of Canadian health providers, facilitators, managers and researchers who have observed the benefits of facilitation as a vehicle for PHC renewal.

This guide represents the synthesis of what Canadian health providers, facilitators, leaders and researchers have observed from their work in this area. This working document reflects the experience, thoughts and contributions from professionals across Canada on the use and benefits of facilitated change in health care. It offers a collective perspective grounded in theory and practice.

Facilitation is a set of skills and tools that can guide PHC work as attention is focused on health promotion and prevention, complementing the important work of acute and episodic care.

Practitioners who use the skills and tools of facilitation provide guidance through change by focusing attention on the process of change and finding ways to empower others (providers, managers, community members and systems) to move change forward together.

The facilitator, whether a manager, provider or a person hired as a facilitator, eases the way for all stakeholders in this change process, providing an environment where they can be actively engaged and empowered.

The best facilitation models often create environments where people feel involved in the decision-making process. By combining training and/or capacity building, the facilitator assists the stakeholders in navigating the change processes as a team. Values such as respect, neutrality and inclusion allow the facilitator to focus on the needs and goals of the team.

Facilitators also play a role in demystifying evaluation and research. They support evidence-based decision-making, program planning and evaluation. Ideally, facilitators use participatory methods and have a broad base of knowledge and experience as adult educators and leaders of change.

The Oxford Prevention of Heart Attack and Stroke Project[3,4,5,6] introduced many of the key elements of the facilitation approach to preventive primary health care. It was the precursor for what has become known as the UK Facilitation Model.

Primary Health Care is:
- *Essential health care based on practical, scientifically sound and socially acceptable methods and technology.*
- *Universally accessible to individuals and families in the community with their full participation.*
- *The first level of contact with the health system.*
- *Broader than the health system.*

The Declaration of the Alma Ata (WHO and Unicef, 1978)

The growth of evidence supporting the use of facilitation stems from what it can offer teams and practice settings.

The project was based on the belief that primary health care providers are committed to the principles of prevention. This model recognized that, to improve their preventive practice, these providers needed practical assistance to assess and reorient their activities and to deploy staff more effectively.

In order to address this need, the project provided a trained facilitator with experience in primary health care to help the primary care team discuss prevention and set objectives for improvement. The facilitator in the UK model played a role in the recruitment and training of practice nurses for the delivery of preventive measures including the following tasks:

- Identifying individuals at risk;
- Preparing tools and office systems to support preventive practice;
- Organizing inter-professional meetings for the practice team; and
- Setting up an audit system to measure progress.

The facilitator's role was to provide support and resources for changing work patterns. It was not the facilitator's role to serve clients/patients directly. Initial results from audits of practices in the UK project, involving more than 3,000 clients/patients, indicated that the use of a facilitator was the most cost-effective means for changing work patterns in primary health care practices.[3]

This model was adapted and applied by the University of Saskatchewan and subsequently formally implemented in Saskatchewan. The University of Ottawa is exploring similar models that build on the work of Deitrich[1] and Grol.[2]

These Canadian adaptations have set the stage for the introduction of facilitated PHC change. British Columbia and Newfoundland and Labrador are using variations of this facilitation model in their change processes. Manitoba is exploring how facilitated processes can assist in their work.

The decision to use facilitation processes is largely based on the increasing need to ensure efficiency and effectiveness in health reforms that integrate prevention into practice. There is an emerging awareness that facilitation holds the potential to add value to PHC change processes.

There is a growing body of evidence that supports facilitation because it provides a flexible way to build on strengths and meet the needs of individuals, teams and/or communities where they live. The presence of a facilitator offers opportunities, resources and encouragement for the PHC team. The facilitator enables them to make accountable team decisions while negotiating appropriate team-member roles.

Each chapter of this Guide is divided into two sections. The first section of each chapter offers information and guidance on the topic and describes how facilitation can be used. The second section of each chapter provides resources that have been used in making changes.

The Guide begins in Chapter One with a review of the development of PHC and an overview of facilitation. It also looks at PHC's renewal principles and guideposts. Chapter Two explores how the facilitation model can support ongoing changes in primary health care. An examination of the nature of change within a system and its impact on the individuals involved is offered in Chapter Three. This is followed by an overview of the nature and types of evidence in Chapter Four which focuses on understanding the nature of evidence; methods for gathering evidence and translating into practice; and ways to improve planning. Chapter Five highlights the links between the study of disease, prevention and health promotion in PHC settings. It also explores how facilitation can play a role in these settings. Chapter Six examines approaches to engaging communities in and with health care through participatory methods and capacity building. An exploration of the definition and enhancement of chronic disease management is the subject of Chapter Seven. Chapter Eight explores the importance and dynamics of teams as it relates to primary health care. The significant opportunities and challenges of collaborative practice are discussed in Chapter Nine. And finally, in Chapter Ten, the guide describes the role of information management in supporting the many changes occurring today in PHC in Canada.

The facilitation process can create environments in which people feel genuinely valued, respected and involved in the decision-making process.

Chapter 1

By Vivian R. Ramsden,
Heather White

Primary Health Care

A discussion paper of the Commission on the Future of Health Care in Canada (2002)[1] speaks of a "clear consensus" on the need to move toward the integration of an increased focus on primary health care (PHC).

In Canada the terms primary care and primary health care are sometimes used interchangeably. This can be a problem when it comes to providing a clear understanding for change policy and practice. Primary health care (PHC) is not a new concept – its focus extends the traditional delivery of medical services known as primary care. However, research has identified the importance of the non-medical and social determinants of health.[7] These determinants expand traditional delivery of primary care into the realm of PHC – shifting and integrating the focus on individuals to include communities and populations.[8]

This growing understanding highlights the importance of primary health care. It recognizes that "even the most sophisticated and expensive health care systems cannot on their own overcome disparities in health status, and deal with health problems rooted in complex social and environmental circumstances."[9] This chapter reviews the development of PHC and concludes with a discussion intended to clarify PHC's meaning for the purpose of this guide.

Defining Primary Health Care

The Declaration of the Alma Ata (1978)[10,11] defined PHC as essential health care made universally accessible and affordable to individuals and families in the community by means acceptable to them through their full participation. The health care services will be delivered by the most appropriate health care provider and will take into account other health-related sectors such as education, justice and housing. Resulting from the implementation of PHC, sustainable partnerships will be developed with individuals and organizations within their community.

The Alma Ata proposed some guiding principles on which to base continued PHC activities (discussed below). Recognizing that it is difficult to work effectively when working in isolation, it emphasized the critical importance of community participation and inter-sectoral collaboration. In Canada, the Ottawa Charter for Health Promotion (1986)[12] further re-inforced this definition by outlining similar characteristics. Proponents of PHC hold that it is more than

an approach to health service. They believe that PHC calls for major systemic reorientation in the way health care providers think and act on issues that impact health.

With the goal of influencing the health of the population, as well as the individual, PHC is a strategy for organizing health care. It prioritizes each component of health according to its potential to contribute to the health of community members. PHC moves beyond disease and illness care to integrating and incorporating prevention and health promotion. These actions are informed by the community, by a range of professional groups and by input from other sectors.

The Historical Perspective

The idea of PHC began with the 1946 Constitution of the World Health Organization (WHO) that defined health as including both mental and social well being. In Canada the advent of Medicare acknowledged the importance of access to health care services for all Canadians regardless of socio-economic status.

The Lalonde report (1974), *A New Perspective on the Health of Canadians*, developed the idea of non-medical determinants of health. It recognized the importance of prevention and health promotion in health and well being.

The Declaration of Alma Ata (1978), and the report *Achieving Health for All by the Year 2000*, further shaped the emerging concept of primary health care. The authors identified essential PHC indicators and expanded the definition of health. In that definition they included the capacity for individuals and communities to participate productively and fully in self determination.

Health services provided at first point of contact within the health care system are known as primary health care services. These services form the foundation of the health care system.[13]

The Alma Ata's call for joint action by government, by health care practitioners and by communities recognized the growing importance of PHC to health and well being. It provided the first major international push for PHC's development.

The 1986 Ottawa Charter for Health Promotion identified the health determinants as pre-requisites of health. And it identified inter-sectoral and inter-professional action as the means for change. This expanded the Lalonde Report by focusing on the broader social, economic and environmental factors that affect health. The Charter defined health promotion as an integrated and collaborative approach to health care.

A Brief History of Primary Health Care

Year	Event
1946	Constitution of the WHO
1957	Hospital Insurance and Diagnostic Services Act
1964	Royal Commission on Health Services
1966	Medical Care Act
1974	*A New Prespective on the Health of Canadians* (Lalonde Report)
1976	The Canadian Task Force on Preventive Health Care (CTFPHC) established
1977	*Achieving Health for All by the Year 2000*
1978	Declaration of Alma Ata
1984	Canada Health Act
1986	Ottawa Charter for Health Promotion
	Achieving Health for All: A Framework for Health Promotion
1994	*Strategies for Population Health: Investing in the Health of Canadians*
1997	Health Transition Fund
2000	First Ministers agree on vision, principles and action plan for health system renewal
	Primary Health Care Transition Fund
2002	*Building on Values: The Future of Health Care in Canada*
2003	First Ministers' Accord on Health Care
2005	Tools for Transition

Adapted from the History of Primary Health Care presented in the Building a Better Tomorrow training module entitled "Understanding Primary Health Care", 2005. For more information see page 19. Adapted by Viv Ramsden based on the training module... from BBT

In 1994, the population approach was officially endorsed by the federal/provincial/territorial ministers of Health. The previous focus was on providing health care services for each individual's risks and clinical factors. This new approach highlighted the importance of addressing the entire range of factors that determine health. It included the need for strategies to work with populations to achieve health and well being. The Health Transition Fund of the late 1990s was intended to help modernize Medicare. Subsequently Canada's first ministers agreed to support the integration of PHC within the health system. This agreement resulted in the PHC Transition Fund. It was intended to offset the costs of moving toward a sustainable PHC system.

The Romanow report (2002), *Building on Values: The Future of Health Care in Canada*, further solidified the need to fund prevention-related activities by reinforcing the national and regional commitment to primary health care.

The First Ministers' Accord created the Health Reform Fund and the Transition Fund. It targeted PHC and reinforced the commitment to make PHC integral to health system reforms.

Taking a Population Health Perspective

Population health is "an approach that focuses on the inter-related conditions and factors that have an impact on the health of populations across the life stages."[14] A population health focus means engaging in activities that address individual needs through population health strategies by re-aligning our health system to address emerging priorities that ensure the well being of all Canadians.

Central to PHC are the basic principles identified in its many precursors that guide the response to health issues. These principles emphasize the need to:
- Work with people to enable them to prioritize issues for themselves and their community and to select those interventions that they see as most useful; and
- Work with other sectors to address the root causes of ill-health and to find approaches that are sustainable.

Although health reform was not specifically addressed within the population health strategies, they do support one of the key principles of health reform: there is more to health than health care.[15] These guiding principles of population health are useful for planning PHC renewal processes.

In September 2005, the PHC Awareness Strategy was launched. Its authors acknowledged that PHC defies a single, easily understood definition.[16] However they identified four main pillars of PHC that have received general acceptance through an extensive consultation process. The pillars capture the elements described above in four categories.[16]

The following table compares the various historical features that have been integrated into current PHC model.

TABLE 1: Historical Features Integrated into the Primary Health Care Model

Highlights of the consistent themes in the Alma Ata's guiding principles (1978), Ottawa Charter (1986), Determinants of Health (Health Canada, 1998) and the Primary Health Care Awareness pillars (2005).

Awareness Strategy	Alma Ata	Ottawa Charter	Determinants
Healthy Living	Provide preventive, curative and rehabilitative services	Focus on health promotion and illness prevention	Income and social status, Social support networks, Employment/working conditions, Education, Food, Security, Social environments, Health practices and coping skills, Healthy child development, Biology and genetics, Health services, Gender, Physical environments, Culture
Team Approach	Rooted in community needs, Inter-sectoral and community driven, Builds community capacity, Team based	Community, public and individual participation, Team based, Interdisciplinary delivery, Inter-sectoral co-operation	
Access	Sustainable and accessible services	Accessibility	

Consensus is building, at many levels, on the need to increase the focus on prevention and health promotion within health services delivery systems for population health, for PHC and for acute care. The focus on prevention can be increased through a team-based approach that is sustainable and builds the capacity of the community.

Research supports the benefits of team-based delivery on quality of care,[17,18,19] however there is limited evidence to show the effectiveness of team-based delivery in improving effectiveness of care. The issue becomes one of managing, enhancing and measuring effectiveness as the system is reoriented from the traditional focus on illness management to building on strengths of individuals and communities.

Chapter 2

By Eileen Vilis, Vivian R. Ramsden, Bill Hogg, Heather White

The Facilitation Model

The Oxford Prevention of Heart Attack and Stroke Project introduced the facilitation model to health care in the UK. This model demonstrated the benefits of facilitation for improving the identification and follow-up of risk factors for cardiovascular disease and stroke. The role of a facilitator that supported the process of change was found to be particularly beneficial.[3] Much evidence has been gathered through the continued development of the facilitation model in the United States,[1] Netherlands[2] and Canada.[20] This evidence supports the benefits of facilitation for change management.

This chapter explores how the facilitation model can support ongoing change in primary health care. The chapter also looks at the business case for the use of facilitation and encourages discussion to define facilitation. At the end of the chapter are listed tools to assist in supporting change in the PHC setting.

The Canadian Context

Among the successful applications of facilitation in PHC in Canada is the model developed in Saskatchewan.[21,22,19] There, 15 facilitators in 13 regional health authorities are enhancing preventive practice through assessment, screening and education. These facilitators offer support as the team engages in quality assurance strategies (auditing, monitoring and appropriate referral), evaluation and research. The facilitators also create links among the inter-professional team members and the community. Saskatchewan Health and the University of Saskatchewan developed a facilitation training program to support this evolving method of change. And their commitment is such that they now have permanently funded facilitator positions to continue this work in the province.

A team of researchers at the University of Ottawa developed a different approach to facilitation. This model is rooted in the work of Grol[21,22,19] and Dietrich[1]. The team has been collecting data on the use of outreach facilitation as a means of changing

practice behaviour of the existing team members.[23][20] This model assumes that improving preventive performance in PHC is important and necessary. Team members recognize that there is substantial room to improve evidence-based prevention practices in primary health care. Hulscher et. al.[24] have found that adapting facilitator intervention to primary health care, and combining several effective methods, improves prevention. Other randomized, controlled trials have shown that outreach facilitation successfully improves delivery of preventive services.

Ontario's model is based on assigning a trained nurse facilitator (external to the practice or PHC team and referred to as an outreach facilitator) to practice settings. The outreach facilitator's goal is to work with each practice team member to increase delivery of preventive services.

In a discussion paper of the Commission on the Future of Health Care in Canada (2002),[25] the author speaks of a "clear consensus" on the need to integrate an increased focus on PHC into the current health care system. The author notes that despite this consensus, there is an "inability to make changes deemed necessary." Among his recommendations with regard to enhancing the collective ability to make change in Canada's health system is the need to "encourage a rethinking of the managerial role... from comptroller to facilitator."

For managers to make their transition to facilitators of change, it is necessary to support those managers as they develop facilitation skills. Recognizing managers as facilitators offers further support for the use of facilitation in Canada.

There is a growing body of knowledge that supports the use of facilitation as a vehicle for change. And this vehicle is driven by the facilitator, whether she or he is referred to as a facilitator, change agent, manager, health provider or community member.

Multiple interventions tend to be more effective in changing behavior than single ones.

The Business Case for Outreach Facilitation

Improving the delivery of recommended patient services by PHC providers, using evidence-based guidelines, can have an important positive influence on the health of Canadians. There is documented evidence that can guide a group of practicing physicians to organize themselves to deliver preventive medicine effectively. But very few physician groups implement these strategies.

Both prevention screening and chronic disease prevention and management hold a major focus in PHC renewal. The use of outreach facilitation can assist practices to employ plans based on evidence to change behavior in these areas. Successful outreach facilitation fosters collaboration among the PHC team members in the practice setting. This approach, based on best practice guidelines,[20] assists the team in establishing and integrating office systems that improve the delivery of prevention screening and chronic disease prevention and management.

For any given practice, outreach facilitation that focuses on practice performance in the delivery of best practice by the team, will lead to a greater integration of PHC services and to seamless team approaches. This in turn ensures that, as the most appropriate team members provide care, resources are maximized. The Cochrane Effective Practice and Organization of Care Group[26] has compiled evidence that supports the efficacy of outreach facilitation visits combined with additional interventions. The evidence shows this is an effective means of improving professional practice and health outcomes. In addition, 12 randomized controlled trials have shown that outreach facilitation successfully improves delivery of preventive services and prescribing performance.[24]

Evidence shows that a multi-faceted outreach facilitation program, delivered by nurse facilitators, can significantly improve preventive care performance. While not all facilitators are nurse facilitators, this evidence of the use of facilitation further supports facilitation as a valuable process for change.

Improvements in the delivery of preventive services can save health care dollars.[24] Although outreach facilitation is an expensive intervention, all of its costs can be offset by reducing inappropriate screening and increasing appropriate prevention screening. A cost-consequences analysis, taking into account the estimated cost savings to the health system from reducing five inappropriate/not recommended screening tests and increasing seven appropriate/recommended screening tests, was conducted. In a randomized controlled trial, 22 randomly selected intervention primary care practices affecting 90,283 patients were reviewed. Multiple data sources were used to calculate the costs and savings for government.

The total cost of delivering the intervention included facilitators' training and wages, additional recommended screening and investigation of false positives. Savings came from reduced screening that was not recommended and a reduction in unnecessary treatment due to early diagnosis or prevention. The annual net cost savings to the government was (2003 $CDN) $1.87 per patient, $3,687 per physician or $63,911 per facilitator. That was an estimated return of 40 per cent on intervention investment and delivery of recommended preventive care.[27] This evidence of effectiveness is sufficient to support the introduction of outreach facilitation to the larger health care system.

Facilitation as a practice may offer added support as we move through PHC change. The question now becomes, "What is facilitation and how can we integrate this model into PHC renewal?" To further clarify the facilitation model, the next section offers background information on facilitation as a practice.

BETTER CARE

LESS MONEY
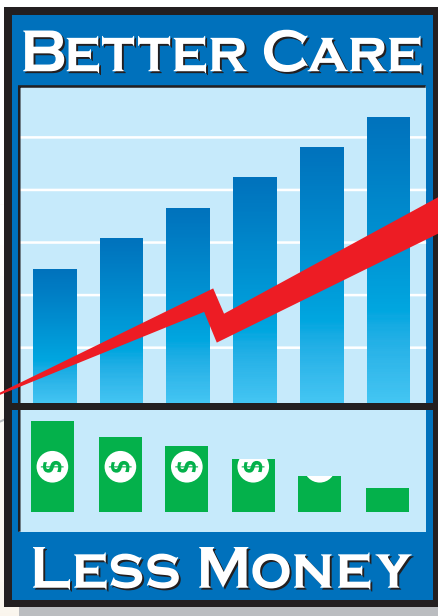
Approaches to Implementation in Partnering Jurisdictions

Newfoundland and Labrador: The province has been using facilitation processes and facilitators to engage in broad provincial consultations, to support the development of relevant proposals for PHC funding, to build team capacity and enhance community engagement and to support the development of managers as facilitators.

Ontario: The University of Ottawa team has assembled a body of knowledge on the benefits of outreach facilitation and on effective strategies for outreach facilitation in the integration of prevention strategies in practice settings.

Manitoba: Manitoba's regional health authorities have been using facilitation methods to engage community participation and build capacity in PHC for several years. Clear examples of successful facilitation exist. Manitoba is committed to developing a provincial strategy to build on existing regional capacity in facilitation.

Saskatchewan: The extensive and impressive work done in Saskatchewan has applied the process of facilitation to build team capacity. Facilitators in the province work closely with several PHC teams to support the shift to team-based delivery-of-care models.

British Columbia: The British Columbia partners developed and integrated the facilitation model into their change process. External facilitators, internal facilitators and change agents lead the chronic disease management and prevention collaborative process and the community capacity-building initiatives.

Facilitation processes are beginning to be recognized as an integral part of PHC change processes. There is now sufficient evidence to begin to apply this model of change. As the knowledge and experience base is enhanced, providers are discovering the many forms that facilitation can take. They are also discovering the many challenges and opportunities posed by these various forms.

Facilitation is a process that can support the people who are moving through change. It can also support the organizational outcomes desired from change. The next two chapters explore the nature of facilitation as a tool for change. Chapter Three delves into facilitation as a process for system change. Chapter Four explores the importance of understanding the nature of evidence and the challenges of monitoring facilitation interventions.

The Nature of Facilitation

The particular form that the role of a facilitator can take may be as varied as the environments in which she or he may work. The International Association of Facilitators defines the role of a facilitator as:

"An individual whose job is to manage a process of information exchange. While an 'expert's' role is to offer advice, particularly about the content of a discussion, the facilitator's role is to help with HOW the discussion is proceeding. In short, the facilitator's responsibility is to address the journey, rather than the destination."[28]

So, regardless of the environment, the facilitator's role is not to determine the process outcomes, but to manage a process of change.... Some facilitators work within a team as internal facilitators or simply as a team member applying facilitation skills in their work (such as a provider or manager with a highly-developed facilitation skill set). Other facilitators are external outreach facilitators providing services as consultants to the team.

Within the context of PHC, there are a number of key tasks in which a facilitator may engage. Many Canadian facilitators (NL, ON, SK and BC) play a role in:

- Identifying opportunities for and supporting the development of PHC teams including collaborating with inter-professional teams to establish priorities and monitor progress; coordinating and facilitating educational endeavours; and supporting team building activity;
- Engaging health professionals, inter-sectoral partners and community in PHC activities through networking, education and participation;
- Planning and supporting organizational change; and
- Encouraging appropriate audit evaluation and research activities as part of an improvement process.

A facilitator emphasizes the change and development process by creating links among organizations and individuals. Facilitators encourage effective communication among team members, with the community and with other inter-sectoral groups. Facilitators empower individuals, teams and organizations to develop quality health services in PHC settings by providing teams with practical help and education before, during and after the change process.

As facilitators assist with the change process they face many challenges:

Organizational Structure
Structural and financial barriers may limit the employment of facilitators or the acquisition of the resources they require to accomplish their tasks.

Go to the people.
Live among them.
Learn from them.
Respect them.
Start with what they know.
Build on what they have.

But of the best leaders,
when their task is
accomplished, their work
is done, the people
will remark, "We have
done it ourselves."

Ancient Eastern Saying

Complexity of the Task

The complexity and variability of PHC systems, team formations and individual practices make it difficult to both define a formula for applying a facilitation model and to measure change.

Receptivity of the Practice and/or Team Members

A facilitator's effectiveness is shaped by the professional attitudes, beliefs and knowledge of the providers with whom they work. The effectiveness of facilitation is often influenced by the state of readiness of the individuals in the practice, team or organization to engage in reflective practice or evaluation and implement the changes suggested by the evidence. The level of readiness in turn influences the degree to which individual providers and teams change their behaviours.

Lack of Understanding of the Role

Health professionals have limited exposure to the process of facilitation and, as a result, have a limited understanding of the benefits of facilitation. This limited exposure can translate into professional resistance to the changes being undertaken. This may manifest as rivalry with or anger at the facilitator who is supporting and undertaking change management. Depending on the facilitator's skill set, this can pose a substantial challenge to her or his effectiveness.

Facilitation Capacity

Facilitators have a wide range of skills. This complicates the identification of the specific factors that effect change. The effectiveness of facilitators can also be limited by too few tools/techniques to facilitate in different dynamics, by culture or by population.

Despite these challenges, a growing body of evidence suggests that the facilitators can also act as a catalyst for change at individual, team, organizational and systemic levels by:

- Supporting the development of new collaborative practices;
- Integrating preventive strategies and new models for chronic disease prevention and management;
- Engaging community members; and
- Evaluating the effectiveness of best practices and systems.

The unique vantage point of facilitators often places them in a pivotal role to provide feedback to the PHC team. To integrate a focus on process into the ever-increasing focus on the outcomes of change, it is necessary to build the organizational and professional capacity to support facilitated change.

There is no standard way of approaching this work in PHC settings. But this area is growing quickly and transforming itself as stakeholders gain more comfort, knowledge and evidence to support facilitated intervention. What follows is a synthesis of facilitator characteristics that have been identified as effective in the partner provinces. It is not intended to be an exhaustive list, but to provide insight from collective experience and evidence gathering.
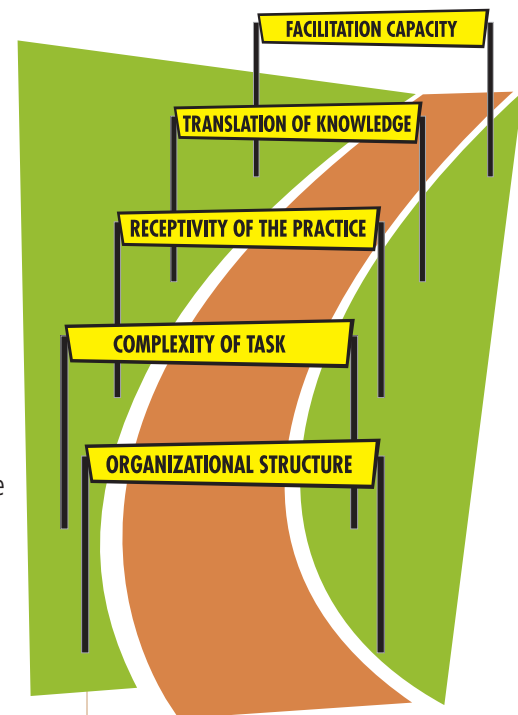
FACILITATION CAPACITY

TRANSLATION OF KNOWLEDGE

RECEPTIVITY OF THE PRACTICE

COMPLEXITY OF TASK

ORGANIZATIONAL STRUCTURE

Ideally, facilitators use participatory methods and have a broad base of knowledge and experience as adult educators and managers of change.

The Primary Health Care Facilitator

Though the skills of a facilitator in PHC may remain constant, the nature of the role may vary. This is necessary because facilitation takes place at many levels and in many settings throughout primary health care. At times providers themselves use facilitation processes. At other times a manager or researcher may develop these skills to assist with change. At other times a professional facilitator will offer dedicated guidance for the change process. Where the facilitator is situated (as an internal member of the organization or team or as an external consultant) can also influence the nature of the facilitator's work.

EXTERNAL

FACILITATION
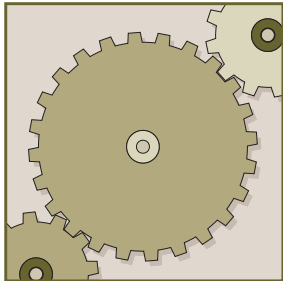
INTERNAL

FACILITATION

External Facilitation

Most of the current evidence that supports facilitation as an effective process stems from the use of external facilitators. When the facilitator is an external practice consultant, the boundaries of facilitation are clear. This tends to ensure that the facilitation role remains focused and neutral. It reduces the likelihood that internal and historical factors within the team or organization will negatively impact the facilitator's ability to act within her or his role.

Internal Facilitators

In-house facilitation practices are common in many organizations, but these practices risk being assimilated into the daily routine. The facilitation role may then be undermined by the daily urgencies of the practice or it may be placed on the back burner and forgotten. Solberg (2000) demonstrated that protecting time for internal facilitators is not necessarily effective.[29] Internal facilitators also have to manage the internal dynamics of the practice setting/team that often pose additional interpersonal dynamics, expectations and organizational pressures that can interfere with their work. They require a more finely tuned sense of the role and a well-developed skill set to navigate the additional level of internal group dynamics that will emerge.

Although the idea of building internal facilitator capacity is not well supported by current literature, this is the common practice in Canadian health care. Therefore, if internal facilitators are preferred, the selection must be made very carefully and with sufficient levels of support and training to ensure effectiveness.

Regardless of the facilitator's background, it is essential that they have the knowledge, skills and personal disposition to facilitate relevant changes. This knowledge may have been accumulated while working in the area or the facilitator may come from a clinical background.

Knowing the difference between doing and facilitating enables the facilitator to let others take over when they are ready and able. The facilitator's focus is to build capacity for individual and organizational self-sustaining facilitation processes. If these are successful

they actually decrease the need for the facilitator's services over time. This understanding informs a facilitator's orientation to empower others to build sustainable change.

Finding the right mix of qualifications, skills and disposition to become an effective facilitator is an important and challenging part of building facilitation capacity. The following table identifies some of the most effective characteristics to look for when identifying people to take on the role of facilitators:

Table 2: Qualities of an Effective Facilitator

Skills and Knowledge	Personal Disposition
Skills Presentation and training Research and planning Analytical and synthesis skills Observation skills Design and customize interventions Interpersonal and collaborative skills Lead group and individual interventions Strong learning skills – quick learner Conflict management and resolution skills Shared leadership **Knowledge** Methods of data collection Relevant guidelines Stages of change – readiness to change at the levels of individual and community Nature of organizational change PHC context and office systems	Neutral, humble, inquisitive Encourages active participation Non-authoritative leadership style Assertive communication approach Able to "champion" the changes as well as solicit and support other champions Focused on building capacity rather than taking responsibility/ownership Comfortable with change and dealing with resistance to change and conflict Willing to share knowledge, skills and information Willing to change approach as is needed Confident and competent

Developing a Facilitative Orientation

Wilson (2003)[30] provides insight into the development of the role of the facilitator. She identified three phases of development. In the 1950s it began with the importance of attaching a person to manage group process – the facilitator. This approach gave way to another concept of the facilitator as a person who chooses, regardless of role, to develop a particular behavioural style that "eases the way people think and take action together."[30] The latest shift in the facilitator role is a combined focus on process and working strategically. This current approach highlights the importance of developing facilitative leaders throughout an organization. As Wilson explains:

> "*working together facilitatively and strategically means that thinking and action are tied to the organization's (individual, team, community, group, collaborative or organization) strategy, mission and vision and the capacity of people to carry it out.*"[30]

The emerging role of the facilitator is one of making process smoother to follow and outcomes easier to achieve. Developing a facilitative orientation that builds on internal resources, links with larger organizational goals and focuses on the process of change is helpful in moving changes forward.

Being facilitative begins with the premise of talking with, rather than at, people. This dialogue empowers all parties to act in an equally facilitative manner. According to Wilson (2003) this shift occurs as a leader moves us from a having-to-know perspective toward one in which we build the capacity of others around us to "be-in-the-know." To do this, facilitative leaders often engage in a common set of activities:[30]

- Asking questions to enrich engagement;
- Sharing relevant knowledge and information;
- Linking minds; and
- Learning and unlearning.

Wilson further defines the tasks that facilitative people engage in by distinguishing between the facilitative and the non-facilitative approaches in the following table:

Table 3: Facilitative and Non-Facilitative Approaches

Non-facilitative approach	Facilitative approach	Facilitative tasks
Giving a report	Dialoguing about a report	Facilitate dialogue
Talking at people	Inviting dialogue	Discern relevant patterns
Controlling the conversation	Sparking new thinking	Spot issues and options
Isolating individual thinking	Linking ideas together	Think comprehensively
Giving instructions	Sparking motivation and passion	Generate passion for the task
Paying attention only to important people	Negotiating roles and tasks	Operate with a stance of possibility
Processing forever	Acknowledging everyone	Reinforce the group's *esprit de corps*
	Moving a group to action	

Adapted from P. Wilson. et al. (2003) "The facilitative way: Leadership that makes a difference."
Shawnee Mission, KS: Team Tech Press.

By enhancing the facilitative orientation at every level in PHC renewal, differences in the individual degree of engagement begin to emerge. Engaged individuals let go of the need to have all the answers when it manifests that the group, team or community has those answers. Individuals engaged in the facilitative orientation are better able to interact with confidence and to focus on process, rather than on the traditional workplace hierarchy. In this way, the group, team or community finds its way beyond an otherwise confusing collection of perspectives and opinions toward a common understanding of the tasks to be completed. They think together before initiating change and then save time by confidently moving from discussion to action. Most importantly, everyone has had the chance to give and receive feedback – increasing engagement.

It is very likely that change will occur in some areas of PHC without the benefit of facilitation. Developing a facilitation orientation will further support the process of this change. A self-assessment of skills, knowledge and limitations is a good place to start. The reader is directed to the work of Bens (2005) for a useful self assessment tool to inform ongoing development in this area.[31] Regardless of your role in PHC renewal, it may be helpful to develop what Wilson refers to as the facilitative screens for clarity.[31] To do this the individual needs to pay attention to the subtle cues offered by the groups in which they work:

Facilitative Screens

Focus

Participation

Implementation

Connections
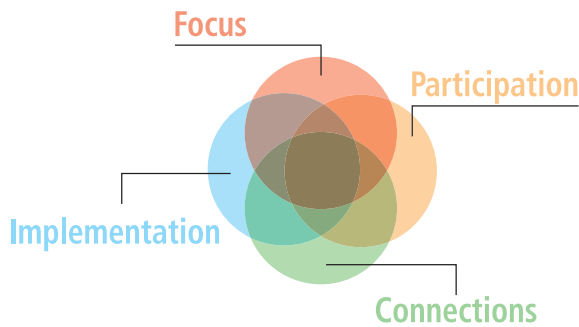
Referenced in footnote #31

Focus

Focus means deciding on the right action for the right issue. It is important to ensure common understanding of purpose and to make effective use of everyone's time and energy.

Participation

The more involved participants are, the more they learn and the more engaged they become. This increases the likelihood that they are solving the right problems. The more their participation is encouraged, the better the group's ability to find necessary solutions and, eventually, to increase the speed with which they reach those solutions.

Connections

It is crucial to encourage connections between ideas. It is also crucial to link perspectives that emerge from discussion. This helps participants overcome any sense of isolation. It increases engagement and it enhances motivation and passion. Successfully channelling the group's passion or emotional engagement makes sustainable outcomes more likely because the group takes responsibility for the change.

Implementation

The integration of evidence into the ongoing change processes gives momentum to the facilitation process. This is accomplished by evaluating the effectiveness of the solutions reached through facilitation. By reviewing facilitation efforts indicators are created that will assist in continuing evaluation and in finding new solutions to new problems.

Managing the Facilitator's Role

Trust in process is fundamental to facilitation. Individually and as a group, participants trust that strong and engaging outcomes will unfold. Regardless of individual roles in PHC – as a leader, provider, educator or facilitator – a facilitative orientation allows process-oriented team members to assist the people with whom they work. This orientation allows them to openly discuss, understand, plan and evaluate the many PHC changes in which they are engaged. Process shifts the focus from outcomes to ways to achieve those outcomes. Process engages everyone and builds on the group's strengths.

Facilitation Resources

Facilitation Skills Training (NL): Two two-day workshops were delivered to the project team (coordinators, facilitators and physician leads) from each of the provincial PHC team areas. The first of these workshops provided training in facilitation skills and collaborative processes. The second two-day workshop offered additional training in facilitation skills with a focus on managing conflict in a changing environment. Contact: *dryan@gov.nl.ca*, Department of Health & Community Services

Facilitating Adult Learning Workshop (NL, on behalf of the BBT Atlantic Initiative): This training module includes both participant and facilitator handbooks and covers the following content areas: characteristics of the adult learner, group dynamics, learning styles, presentation skills, planning instruction and differences between instruction and facilitation. Contact: *merv@gov.ns.ca*, NS Department of Health

Facilitationforum (SK): To support the sharing of information between colleagues, an internet-based group page has been established where facilitators can dialogue about their work. Facilitationforum has been set up through Yahoo! Groups – a free service that offers a convenient way to connect with others who share the same interests and ideas. Contact: *chris.mayhew@saskatoonhealthregion.ca*, Saskatoon Health Region

Facilitator Network (SK): This provincial forum supports the work of provincial team facilitators through quarterly meetings guided by a systems-thinking approach. It offers support with orientation of new facilitators, continuing education, information and resource sharing, regional and provincial updates and updates on facilitation work/initiatives in other areas of the country. For more information, contact Primary Health Services Branch, Saskatchewan Health. Contact: *gary.n@pnrh.ca*, Saskatchewan Health

Understanding Primary Health Care (NL, on behalf of the BBT Atlantic Initiative): This training module includes both participant and facilitator handbooks and covers the following content areas: awareness of the history, evolution, definitions and concepts related to PHC, PHC terminology and links to population health, health promotion and the determinants of health. Contact: *merv@gov.ns.ca*, NS Department of Health

Practice Facilitator Training (ON): This educational package has been developed to train nurses to take on the role of facilitator in practice settings. Contact: *jschultz@uottawa.ca* or *facilitation@scoh.on.ca*, University of Ottawa

Team Facilitator Training (SK): This training has been developed to support the development of team facilitators in Saskatchewan. Contact: w*ww.health.gov.sk.ca/ph_br_phs.html*

Chapter 3

By Vivian R. Ramsden, Eileen Vilis, Heather White

Facilitation as a Vehicle for Change

... one of the immediate needs for Canadian health care organizations is to re-define the managerial role to one of a facilitator.

Primary health care is an approach to health delivery within the larger health care system. Changes in this approach to health delivery that involve gathering evidence, an increased focus on promotion, prevention and team-based practice (with the necessary shifts in roles agreed upon by the team), impact other aspects of the health care system. Therefore an understanding of how systems work and how they change is central to facilitating those changes. Facilitators, providers and leaders who are managing change processes must have an understanding of the larger picture in which they are working.

This chapter examines the nature of change within a system and its impact on the individuals involved. The facilitator's role will be more clearly defined by exploring a model of behaviour change that has proven effective in Ontario's Outreach Facilitation Project. A facilitator is in a unique position to be able to support the team and the organization in translating what they know into what they do.

Change Within a System

Champagne (2002) provides a review of the nature of organizational health care change.[32] He suggests that the lack of sustained changes in the Canadian health care system – as it moves toward vertical integration of care – is a result of decision failures.[32] This refers to the tendency *not* to make the decision to change or *not* to adopt a new practice that emerges out of a change. People do not always do what they know or have evidence to suggest is the right thing to do. In those cases, where the decision to change has been made, another form of failure – referred to as implementation failure – is sometimes found. The change is simply not implemented or its implementation is less than optimal.

As referenced in Chapter One, this document notes that one of the immediate needs for Canadian health care organizations is recognizing that change processes can be enhanced when there are people in the system whose job it is to support the processes that facilitate change. One of the suggested solutions is to re-define the roles of both the manager and

leader to include knowledge and application of facilitation skills.[33] The importance of providing supports for large-scale system change cannot be overstated. It is key to successfully implementing primary health care. The role of facilitation in supporting these changes across the health care system is gaining recognition in Canada.

An important factor in rising above internal systemic inertia is the degree to which decision-making processes are tailored to their setting. This is the ideal role for a facilitated process. It allows for clear decision-making and change processes. These change processes are tailored to fit a particular environment and support the decisions as they are put into operation.

Change management is filled with perspectives and approaches on how best to understand the change process. Champagne[32] identifies three key phases in the change process:
1. Process of making a decision;
2. Implementation of the decision; and
3. Abandonment of identified change (with or without a replacement).

Many problems arise in phases one and two that fall into one of two categories of resistance: either resisting the need to make a decision in the first place or resisting implementation of the decision by withholding sufficient support.

This could be a pivotal role for facilitation processes in supporting changes within systems. The less facilitated the change – the less built-in opportunities for input – the greater the potential for resistance to that change.

Theories on implementation of change explain the circumstances under which the implementation will be successful. Many of the current theories used in health care have been derived from either the field of health promotion – where they were developed to explain life-style changes – or from organizational and management sciences that explain how organizations behave and change. These are influenced by evolving characteristics of health care such as new procedures, technologies, clinical guidelines and care innovations. However knowledge of the relative importance of these characteristics in the clinical setting is still limited.[34]

Miller et al. (2002) offer a theoretical model derived from complexity theory. Data from participant observation field notes collected in 84 US practices were combined with information from the literature on practice organization. This was the basis for the development of a model that views health care practices as complex adaptive systems with a unique shape. The authors felt that this model of practice suggests ways of responding better to the changing and challenging environments of primary health care.[35] They see the health care system as a "complex, dynamic and adaptive system that fluctuates between order and disorder."

Principles of Adult Learning

- Change processes need to be made meaningful for learners as individuals and collectively as members of a team.
- The facilitator must have a basic understanding of learning and educational processes as change typically means learning new things and letting go of old things.
- There are differences in how individuals learn. An understanding of basic learning styles and modalities can assist facilitators in supporting the learning of others.
- Adults come into change processes with much experience, expertise and skill. Facilitators must always seek to respect and integrate this life experience.

Individual Change

Individuals implement system change. Therefore the dynamics of individual change and basic guidelines for adult learning are key to successfully working through organizational change. Facilitators need to be aware of these factors.

There are many models that can provide an understanding of the change process. This Guide explores a model that has been effective in Ontario and Saskatchewan. This approach, which focuses on behavioural change, provides a simple set of rules to illustrate the role of the facilitator.[36, 37, 38, 39]

Trans-theoretical Model (TTM) — Stages of Change

The TTM model of Intentional Behaviour Change was developed to help explain how people change their behaviour when moving through systemic change processes. The main premise is that for people to adopt new behaviour or to stop old/unhealthy behaviour they must use strategies that unfold over time and lead to new behaviour patterns. As people progress toward changing behaviour, their readiness for change increases as the pros for change begins to outweigh the cons. This is the point at which there is a move toward action. If the cons outweigh the pros there is prolonged resistance.[39]
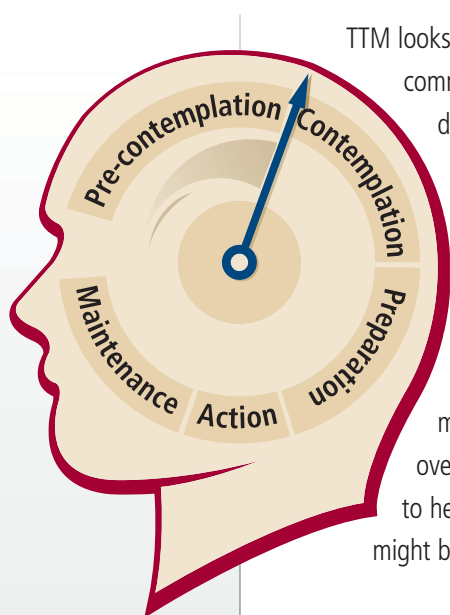
TTM looks at change in stages. It can be widely applied to changes at the individual or community level as well as at the organizational level such as a PHC team. Although described in a linear fashion, the changes are more fluid than linear. People move back and forth through the stages. However, they rarely return to the same point in the process. With each cycle, the desired behaviour becomes more of a reality (e.g. most people stop smoking tobacco 7-10 times before they quit). Changing behaviour is a process, not an outcome.[40]

Pre-contemplation: In the early stages of change, resistance is often made worse by lack of information, by fear of failure or by a sense of being overwhelmed by barriers. Encouragement and information build small successes to help overcome the resistance of, "Why bother?" or, "Why try again?" This attitude might be attributed to a lack of recognition of the need for change.

Contemplation: Individuals become more open to change and information about its benefits. While they have yet to commit, they are curious about possible benefits. People may be ambivalent and at risk for getting stuck rather than moving into the change.

Preparation: This is an active planning stage that is marked by small steps with observable results. Individuals become increasingly ready for change.

Action: This stage requires commitment and energy on the part of individuals, teams, communities and organizations to engage in making the transition to the desired behaviours.

Maintenance: In this stage the challenge comes from supporting new behaviours and working with the barriers that may cause relapse.

Termination: Individuals at this stage have successfully changed their behaviour. The focus shifts from preventing a relapse to maintenance as the individual has developed confidence that the behaviour can be maintained even in high-risk situations.

Facilitated action that embraces these stages of change provides a practical approach that can be applied to the change process for individuals, communities and organizations. This approach also provides a framework for assessing, planning, implementing and evaluating the changes. Facilitation can create a map, informed by many perspectives, to guide leaders as they move through the stages of change.[41]

The timing and movement through the stages needs to be tailored to the organization, team, practice, community or individual. The facilitator as change agent must understand how the team or work environment functions before initiating change processes. Important aspects of the facilitator's work include discussing strengths and areas for improvement and providing support in prioritizing goals and setting specific objectives.
This is accomplished by:
- Identifying strengths and barriers;
- Assessing the pros and cons of changing a specific behaviour; and
- Fostering commitment to agreed changes.

How Facilitation Supports the Stages of Change

Facilitators and/or facilitation processes can play a key role here by enhancing and sharing relevant information and by creating opportunities for input. Below is an exploration of how facilitation could support each of the stages of change.

Pre-contemplation: A facilitator can be particularly helpful in this stage as team/practice members begin to define the process to be followed for the people who will be impacted. A facilitator can offer necessary information, encouragement and help to sort through and prepare for the potential challenges and opportunities.

Contemplation: A key role for the facilitator is to encourage discussion, understanding and planning for the necessary changes and to identify the supports required to move forward. At this stage of change Champagne's[32] observations seem relevant:
- Despite a clear consensus that change is needed, there is no guarantee that change will occur; and
- Without the assistance of an external party, such as a facilitator, there is a high risk of getting stuck in this stage.

Defining and supporting a clear process for the change allows people to become involved and to influence the path. As they articulate a clearer vision of the path, team members

gain comfort with the process and gain trust in the facilitator – whether manager, provider or a dedicated person.

Preparation: In this phase the facilitator creates opportunities for input. There is a positive correlation between the degree to which participants in change are clearly informed of what is to come, and the movement towards change. This progress is encouraged by ongoing input and feedback. Often the facilitator plays a key role in keeping the change process at a pace that includes everyone and ensures ongoing feedback from all participants.

Action: This stage requires commitment and energy for the new behaviour to become a reality. Continued reinforcement and support is necessary for sustainable changes – a key role for a facilitator. Processes that provide ongoing feedback on the changes that have occurred, such as reminder systems and the Plan, Do, Study, Act (PDSA) cycle,[42] can be invaluable tools in this phase of the change. The facilitator is often the guide for the process of sharing feedback, but the data and experiences of the team members provide the direction for the change.

Maintenance: The challenge at this stage is sustaining the new behaviour and acknowledging that re-cycling through the stages of change is normal when striving for a sustainable behaviour. The presence of a facilitator, whose focus is on building capacity along the way, can greatly increase the team's ability to maintain the changes.

Termination: At this stage the facilitator's role becomes less important as the individual/team has sustained the desired behaviour change over time and in the face of challenging circumstances. The facilitator will likely shift their focus to supporting the development of this individual/team capacity by encouraging shared learning and coaching among team members.

Facilitating the Adoption of an Innovation/Change

The rate of adoption of a change is defined as the relative speed with which members of a social system adopt an innovation.[43] The rate of change is also dependent upon individual and organizational characteristics. However, in large part, adoption is related to channels of communication. Individuals and organizations are often categorized according to their ability to make change effectively and efficiently. Rogers (2003) identified these categories as innovators, early adopters, early majority, late majority and laggards. They are defined as follows:

Diffusion of Innovation

- Innovators
- Early Adopters
- Early Majority
- Late Majority
- Laggards

Innovators

These are the pioneers. Their qualities often lead them out of the local systems and into more cosmopolitan, dynamic

systems. They have the ability to understand and apply complex technical knowledge, to cope with a high degree of uncertainty, to accept setbacks and they are prepared to play a gate-keeping role in the flow of new ideas into a system.

Early Adopters

These participants are often a more integrated part of the local systems and are often seen as opinion leaders. The early adopter is often seen by their peers as the individual to check with. They are the embodiment of success. Their early adoption of the innovation decreases the uncertainty for those who follow.

The Early Majority

Those with deliberate willingness to adopt change but who seldom take the lead are included in this group. They provide the connection between early and late adoption.

The Late Majority

This group is the most skeptical. Adoption is often an economic necessity and comes after most of the uncertainty about a new idea has been removed.

Laggards/resistors

People in this category tend to be the traditionalists who maintain the status quo. Frequently within systems, a great deal of energy is spent trying to get the laggards/resistors to change. The time and energy of agents/facilitators may be better spent with the early adopters and early majority. They are the ones that integrate change into the local systems.

One of the main roles of a change agent/facilitator is to make change possible and, in so doing, to build on the strengths of the individuals, teams, communities and organizations. A regular review of successes and areas for improvement will help to ensure that the change process is evolving towards the desired outcome.

Managing the Facilitator's Role

Change is never easy, but it is always present. Most people want to know where they are going, why they are moving in that direction and how they will get to the desired destination. For facilitators this is the information that must be shared by supporting communication processes that answer these basic needs. Understanding the elements of change helps facilitators to:

- Make the desired change possible;
- Build on the strengths of individuals and organizations;
- Build individual and organizational capacity; and
- Reach the desired outcomes.

Seven roles of a change agent/facilitator have been identified by E.M. Rogers (2003). These are:

1. To develop a need for change through the identification of alternative solutions to existing challenges and opportunities;

2. To establish an opportunity for mutual learning through the development of relationships with individuals and organizations built upon trust, credibility, competence and empathy;

3. To analyze existing challenges and opportunities and to identify alternative solutions that would build upon the strengths of the individuals and the organizations;

4. To create an interest for making the desired change while keeping in mind the desired outcomes;

5. To translate a desired change into action through working with opinion leaders (early adopters) and peers;

6. To stabilize adoption and prevent discontinuance by reinforcing the desired behaviour and outcomes; and

7. To help those who have achieved the desired outcomes to develop the skills and tools required by a change agent/facilitator; thus, building capacity within individuals and organizations to further assist with the never-ending change within systems and specifically within primary health care.

Facilitators need to ensure that the tasks they ask of others, as part of the change process, are practical and relevant. Adults share certain expectations of learning experiences. Facilitators must address these expectations using the basic principles of adult learning when working with individuals, teams, communities or organizations.

The application of theory to practice can be challenging when integrated with the promotion of health and well being. The concepts of this model – especially the stages of change – can be used as a framework for planning, developing, implementing and evaluating the change process in the facilitated intervention.

The concept of readiness to change is not only useful for understanding research and change processes, but can also be used practically in the facilitation process to influence behaviour changes and to guide intervention strategies.

Facilitation Resources

Guide to Strategic and Program Planning (ON): This resource will assist interdisciplinary primary health care teams in strategic and program planning. *Visit: http://www.health.gov.on.ca/transformation/fht/guides/fht_strategic.pdf*

Primary Health Care Lens (MB): This easy-to-use tool encourages reflection on the degree to which PHC is integrated into our work. It has been used with communities and staff as a means to evaluate existing programs and design new ones so that they are aligned with the principles of PHC. Contact: *bkozak@arha.ca*, Assiniboine Regional Health Authority.

Provincial Advisory Council (NL): This council was set up to oversee the process of PHC in the province and to advise the minister, Department of Health and Community Services, on the development and implementation of the Provincial PHC Framework to ensure the work of the Office of PHC is consistent with the principles and objectives outlined in the 2003 Provincial Framework document. The council is chaired by an independent chair appointed by the minister, and meetings are at the call of the chair or bi-annually. The council consists of representatives from across a variety of disciplines and sectors. Contact: *dryan@gov.nl.ca*, Department of Health and Community Services.

Move to PHC (MB): The NOR-MAN RHA has facilitated a PHC change process focused on building capacity, encouraging collaboration, working within a common vision and using communication processes to validate change. By providing a clear, collective and individual understanding of PHC concepts imperative to success, this process changed the way NOR-MAN RHA operates. Contact: *mgray@normanrha.mb.ca*, NOR-MAN Regional Health Authority.

PHC Project Management Teams (NL): All PHC team areas in the province have set up project management teams (PMT) to support and guide the local change process within the provincial framework. Although PMTs have emerged at different points along the change process, these teams facilitate the organizational change process by linking groups, making decisions and changing policy and procedures that would otherwise limit PHC renewal and integration. Contact:*dryan@gov.nl.ca*, Department of Health and Community Services.

Change Management Workshop (MB): It is crucial to recognize that staff members are at different points in the change cycle. As part of their move-to-PHC plan, NOR/MAN RHA, staff collaborated to offer a session to assist staff with the change process. Contact: *mgray@normanrha.mb.ca*, NOR-MAN Regional Health Authority.

One Window Approach (MB): This tool was developed to provide a continuum of service among service providers (within the health care system and with community partners). It is both a tool and a process to assess current programs and create a plan for action to make necessary improvements in: collaborative work, information sharing and referrals, aligning resources, capacity building, assessment, tracking, monitoring and evaluation and communication and connections. Contact: *bkozak@arha.ca*, Assiniboine Regional Health Authority.

Provincial PHC Framework (NL): This consultation process was used in the province to develop a provincial framework document. Through a process of broad and inter-sectoral consultation with provincial stakeholders, a document was generated that reflected the contributions of many perspectives. Contact: *dryan@gov.nl.ca*, Department of Health and Community Services.

Health Quality Council Collaborative (HQCC) (SK) Borrowing from the British Columbia model, the HQCC in Saskatchewan has played a lead role in implementing a collaborative focus on chronic heart disease, diabetes and access. The HQCC takes a learn-by-doing approach, supports the use of best evidence and brings a range of practitioners together to share knowledge and test improvement of ideas. Contact: *www.hcq.sk.ca*

Working Groups (NL): This network of working groups was made up of representatives from each of the team areas, professional groups and professional associations. These working groups were established for each key feature of the provincial PHC framework. They were tasked with supporting planning, implementation and evaluation of all associated activities and to provide opportunities for information sharing and managing challenges. They also supported the development of provincial policies, guidelines and/or standards.
Contact: *dryan@gov.nl.ca*, Department of Health and Community Services.

Chapter 4

By Vivian R. Ramsden,
Heather White

Evidence-based Planning

The integration of quantitative and qualitative approaches allows for the capture of a wider range of measurable changes and their evolution over time.

Sound decisions require sound evidence. Evidence-based planning is essential in health care delivery. Decisions, service delivery and programs need to be grounded in sound data and evidence. This approach moves practitioners toward the ongoing identification and revision of evidence-informed practices as they respond to Canadians' health needs in a PHC setting. Therefore it is essential to understand the nature of evidence – the methods of gathering evidence and the implications for the evidence gathered.

This chapter begins with a discussion of the nature of evidence and moves through a discussion of qualitative and quantitative approaches to gathering necessary data about interventions. This discussion includes an exploration of the challenges for measuring facilitation practices. It also looks at the importance of balancing qualitative and quantitative approaches as a means of capturing the subtlety of complex processes. A final section on the Plan, Do, Study, Act (PDSA) model provides a practical tool for ensuring that the evidence is continually integrated into ongoing activities in primary health care.

Nature of Evidence

Research and evaluation of interventions for health care improvement have historically been based on quantitative indicators/measures of health outcomes. This has also been the basis of most of the research on the efficacy of the facilitation model. However, to capture evidence on the effectiveness and the nuances of facilitated interventions, it is necessary to look beyond traditional quantitative approaches.

Participatory methods, when integrated with action research, invite the participants (whether providers, policy makers, managers or community members) to engage in planning and gathering relevant data to inform ongoing changes. This enhances the degree of engagement between theory/research and practice. It also increases the likelihood that the knowledge generated will be incorporated into ongoing practice.

Action research frequently uses a combination of quantitative and qualitative methodologies. It has been viewed as a form of research in which the researchers work explicitly *with* and *for* individuals rather than *on* them.[44] Rather than studying research *subjects*, the researchers become facilitators in the research process and engage and collaborate with those involved.

The strength of action research is that it focuses on generating solutions to practical problems. Action research empowers individuals, health care practitioners, teams and organizations to collaborate in identifying and finding these solutions. This practical interface in action research is known as praxis[45] – the point where theory meets practice.

The need for sound theoretical and research methods that can be used for and with facilitation is growing. And with this growth, there is an emerging need to choose methodologies that measure change over time – the heart of facilitated interventions. The integration of quantitative and qualitative approaches allows for the capture of a wider range of measurable changes and their evolution.

Qualitative and Quantitative Methods

The central purpose of qualitative inquiry is to understand from the perspective of the individual. Process and meanings of events, rather than the outcomes or products, are often the primary concern. Data is collected from in-depth, open-ended interviews, direct observation and written documents.[46] The data from these interviews, observations and documents are often organized into major themes or categories through a process known as content analysis. However, there are numerous other methods of qualitative analysis.

Qualitative inquiry often results in hypotheses and grounded theories derived from the data gathered.[46] This is contrary to the quantitative methods that begin with and test a hypothesis. Researchers, who often have a strong adherence to one approach over the other, have long debated the merits of quantitative and qualitative evaluation and research methods.

Proponents of quantitative research view quantitative inquiry as objective because the data is systematically gathered and quantified using sound scientific methods. These same proponents may see qualitative inquiry as subjective because the researcher is the instrument of both data collection and data interpretation. However, most credible researchers and theorists in PHC agree that it is highly unlikely, if not impossible, to attain in practice a truly value-free, objective evaluation without taking into account the social nature of the research.

Although the two approaches — qualitative and quantitative research — are often viewed as competitive, they can more appropriately be considered complementary.

In conducting any research or evaluation project, the focus should be on the degree of credibility of the evaluation rather than on the debate. The quality of the evaluation is determined by the training and expertise of the researcher, techniques and methods employed in gathering and analyzing the data, issues of validity and reliability and triangulation of data sources/methods/analysts.[46]

It is surprising that so much time and effort is consumed by both theorists and researchers in highlighting the faults and weaknesses of each approach; each approach serves fundamentally different purposes:
- When researchers are looking for a cause-and-effect relationship between an intervention and an outcome, quantitative approaches would be most appropriate. Findings from this type of study can often be generalized to a larger sub-group or population. This type of inquiry begins with a hypothesis, involves manipulation and control of variables and reduces the data to numeric indices for statistical manipulation.
- When researchers are looking to understand process factors, individual experiences or to monitor the quality of change, qualitative approaches can provide a wealth of relevant data.

Although the two approaches are often viewed as competitive they can more appropriately be considered complementary. For example, a randomized, controlled trial would be the appropriate method to test the effects of a new medical treatment and qualitative methods could help to better understand why some patients choose not to adhere to the prescribed treatment. In evaluation research, using different methods to study the same program is referred to as methods triangulation. By combining both methods, researchers can hope to minimize the intrinsic bias that comes from any single method.[46]

Balancing Research Methods in the Study of Facilitation

Since the key to effective facilitation is flexibility, then meeting the needs of individuals, teams and/or communities conjointly becomes critical to successful outcomes. Facilitation can be defined as the provision of opportunities, resources, encouragement and support for individuals, teams and organizations to succeed in achieving objectives. This is generally achieved by empowering the team to take control and responsibility for the decisions and activities that shape their direction.[47]

As discussed, quantitative and qualitative research methods have different philosophical premises, purposes and sources of knowledge that must be understood, respected and maintained. This is essential if the research and/or evaluation are to be credible and provide sound outcomes.[48] To effectively accumulate evidence that informs the use of facilitation, it is critical that practitioners make sound decisions about the methods to be used. This will enable them to assess the strengths and opportunities for change that will result from integrating facilitation into practice.

To ensure that the data being collected reflects facilitated outcomes, securing and working with reliable data is essential. Therefore, when choosing qualitative research methods rigor must be built in. Rigor demonstrates that the findings and interpretations are credible or demonstrate truth from the perspective of the individual.[48, 49]

Lincoln and Guba (1985) outlined the similarities and differences of rigor between qualitative and quantitative methods. This can be seen in the table below.

Strategies that strengthen the rigor of qualitative research include spending time with the participants, engaging in reflective practice and documenting reflections from the perspective of individuals, teams and organizations.[48] The use of multiple sources of data, or triangulation, is key to building rigor into research methods.

Research practice needs to be visible and accountable; thus, ethics is also an integral part of rigor. Davies and Dodd (2002)[50] indicated that such words as attentiveness, empathy, carefulness, sensitivity, respect, reflection, conscientiousness, engagement, awareness and openness demonstrate attention to the ethical aspects of rigor.

Table 4: Differences of Rigor Between Qualitative and Quantitative Methods

QUALITATIVE	QUANTITATIVE
Credibility	Internal validity
Transferability	External validity
Dependability	Reliability
Conformability	Objectivity

Lincoln and Guba, *Naturalistic inquiry* (Newbury Park, CA: Sage, 1985).

Facilitators need to have a solid understanding of the variety of methods of data collection and their implications. This knowledge can inform interventions or build capacity in the teams and communities to continue engaging in evidence-based planning. The integration of an evidence-based practice into ongoing change and improvement efforts demands that facilitators of this change be well versed in the nuances of methods used for research and evaluation.

Translating Knowledge into Practice

The challenge for maintaining an evidence-based approach to facilitation and health care delivery is in recognizing and bridging the gap between guidelines (what ought to be) and practice (what is). Evidence-based guidelines are not self-implementing. Programs to address physician knowledge alone – such as continuing medical education and dissemination of guidelines – are insufficient to change practice behaviour.[26] To facilitate larger systemic changes in health delivery, it is necessary to influence practice patterns.[20]

Evidence that supports guidelines provides the practitioner with proof that specific screening or treatment is effective. It is these evidence-based guidelines that are used in facilitating primary health care interventions. They impact practice patterns by improving awareness and by guiding the planning for implementation of systematic change.
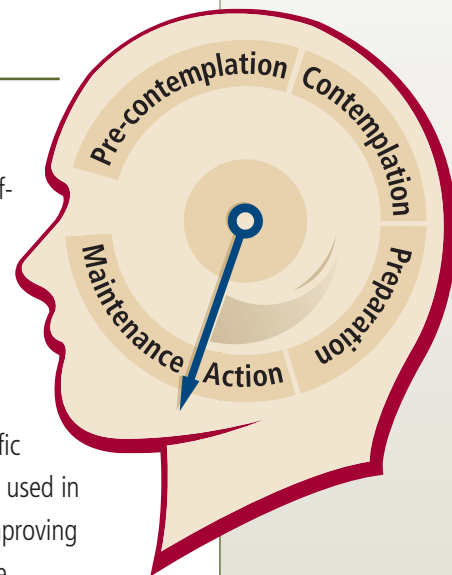
*Evidence-based
guidelines are not
self-implementing.*

Quality improvement efforts close the gaps between research and practice by serving as a bridge between intended changes and practical outcomes. Most often however, the changes proceed on intuition and anecdotal accounts regarding strategies.

Quality improvement efforts proceed largely on presumptions about what practitioners need and on untested assumptions about effective means for addressing and communicating these improvements. This is in direct contrast to the evidence-based paradigm.[51] More recently researchers have begun to focus on identifying barriers to evidence-based care and ways to address them. To do this they are using knowledge translation and implementation research concepts. These tools help researchers to capture the idea that the nature of a given clinical process, and the best way to implement that process, require different research approaches.[51]

Harvey (2005) refers to the term knowledge translation exchange (KTE) as reflecting the process of "different perspectives, knowledge and experience exchanging ideas and information for mutual benefit."[52] Knowledge translation exchange can be defined as:

> *"the exchange, synthesis and ethically sound application
> of knowledge – within a complex system of interactions among
> researchers and users – to accelerate the capture of the benefits
> of research… through improved health, more effective services
> and products, and a strengthened health care system."[53]*

The assumption is that knowledge is socially constructed. The social processes, which occur within and between groups of people, facilitate knowledge creation and use in practice. The facilitator's role becomes one of facilitating this exchange.

The concept of a facilitator as a knowledge broker[52] has also been used to describe a similar role. Harvey's definition of a knowledge broker is a person who focuses on identifying and bringing together people interested in an issue and who can help each other identify evidence-based solutions. This describes the role of a facilitator or a manager/provider serving in a facilitative role. Facilitators help to make the connection between the research and the evidence. They also assist in the translation of that information into the daily practice of providers and PHC teams.

Manske (2005) draws a distinction between data as objective, disconnected facts and knowledge as subjective information that is contextually specific and put into practice. Between these two extremes is the data arranged in a meaningful pattern (i.e. information). The facilitator becomes the knowledge broker. She or he works with the group to put the information in context and to create a learning environment that builds the group's capacity to sustain the changes.

Facilitators translate data into meaningful information for the team. Through facilitated processes, this data becomes practitioner-generated knowledge. This knowledge, as integrated evidence, is more likely to guide practice.[54] Facilitators manage this integration by working collaboratively with the PHC team to create opportunities to share information, allow input and empower team members to make the necessary changes.

The PDSA Cycle[42]

The PDSA (Plan, Do, Study, Act) cycle is a process of implementing rapid, cyclical testing for evidence-based planning.[55] This model is taken from quality improvement science methodology and is currently used within several Canadian contexts. This approach to managing evidence within change processes starts with a hypothesis on how best to manage change or to initiate change in order to make improvements. Once the goal or hypothesis is defined in a measurable way (Plan), data is collected over time (Do), and reviews of that data (Study) determine direction (Act).

The initial step in this process is to know the answers to the following questions:
1. What are we trying to accomplish?
2. How will we know that a change is an improvement?
3. What changes can we make that will result in improvement?

Once the relevant team members have explored the answers to questions, the team determines its measurable goals and plans specific measurable actions to achieve them. At the Planning phase, objectives are defined, predictions made and a plan developed that includes data collection and implementation. In the Do phase, the plan is carried out and a narrative summary of events created.

The Study phase includes a review of the narrative summary; analysis of the measures or targets identified; and an assessment of the available data to determine to what degree objectives of the plan were met. This phase also yields information regarding what worked well and what now needs to change.

The Act phase refers to the need to begin another planning cycle by adopting the measure or recycling with a new plan. If the research confirms the hypothesis then another cycle is planned to test the results on a larger scale or under different conditions. If the hypothesis is proven incorrect, then it's necessary to pose a new or revised hypothesis for testing, to devise a new plan and to run through the PDSA cycle again. Sharing the successes and failures of PDSAs to promote enhanced care is a powerful means for team learning.
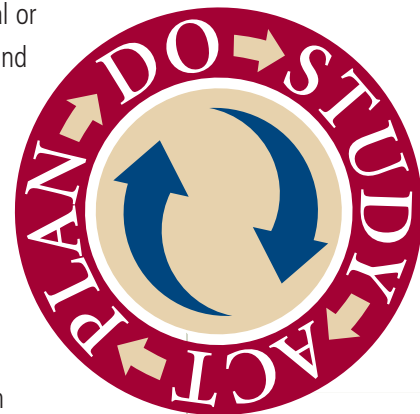
Managing the Facilitator's Role

The challenge of influencing systemic changes becomes one of empowering frontline staff to engage and of finding ways to support knowledge transfer using evidence to promote and change behaviour. The facilitator who understands evidence-based guidelines and research methodologies can tailor the tools that will be used. This allows the practice, team or organization to transition through the change process using their resources as they build their capacity for change.

The PHC facilitator may need to be knowledgeable of relevant evidence-based guidelines. For example, medical practice management provides an in-depth understanding of how PHC practices function, taking into account the roles of the practice/team members, the protocols used and the remuneration that might influence their motivation for change in targeted areas. This background helps the facilitator to understand attitudes of individuals who challenge organizational structures and to appreciate the inertia and pressures of an evolving hierarchy.

Knowledge of evidence-based medicine can assist the facilitator in discussions on best practices with team members. Evidence-based guidelines can then focus on a tailored improvement strategy in target areas — especially if those guidelines are paired with a performance feedback mechanism. The use of facilitators as the catalyst in the change process allows the practices to adjust and adapt to changes and to disseminate strategies that have worked.

Multiple skills are required by the facilitator to assist providers and teams to sort through individual and system changes. Among these skills are knowledge of the theories and models of change for the individual, group, community and organization and the ability to function as a knowledge broker. Knowledge translation can be used to promote discussion and consensus that support practice/team change. However, in order for the knowledge transfer to occur, it must be relevant in the context of the practice setting.

Herein rests the strength and the challenge of facilitated change processes. Sharing and encouraging the sharing of information among colleagues is critical; however, in addition to this, new forms of knowledge/evidence need to be built that correlate with the new forms of work that emerge from this new model of care being incorporated into daily practice.

There is a delicate balance that must be maintained. The basic principles of adult learning must inform the process of building knowledge and capacity among all participants in the change (providers, leaders, community members). If facilitators are to teach, they must be willing to learn what this knowledge is that is being brought forward. Once informed, facilitators can build new forms of understanding and ways of working that integrate, rather than dismiss, the many perspectives that inform the change process.

Facilitation Resources

PDSA Tools (BC, SK, YK and NL): The model for improvement provides a framework for developing, testing and implementing changes to the way things are done that will lead to improvement. The model for improvement consists of two parts of equal importance: the Thinking Part and the Doing Part. The first asks three fundamental questions that are essential for guiding improvement work. The second part is the PDSA cycle that can help implement rapid change. For additional information, visit *www.hqc.sk.ca* or *http://www.hqc.sk.ca*, or *dryan@gov.nl.ca*, Department of Health and Community Services, NL or *Lucienne.Wright@gov.yk.ca*, Health and Social Services, Yukon Government.

Chart Review and Feedback (ON): Chart Review is a snapshot of practice behaviour. It is used as a motivational technique to move through the stages of change and improve preventive health care. The data collected provides feedback to individual practices and compares each practice's result to the overall average. A mini-review provides intermittent feedback. Contact: *facilitation@scohs.on.ca* or *jschultz@uottawa.ca*, University of Ottawa.

Community Accounts (NL): This is the first centralized Internet-based data retrieval and exchange system in Canada. It offers unrestricted access to view and analyze detailed hierarchical data down to community level. This system provides a comprehensive source of key social and economic indicators and creates community awareness of the factors that describe the well being of people and how their community compares to other communities. For information, visit: *www.communityaccounts.ca* or Contact *dryan@gov.nl.ca*, Department of Health and Community Services.

Tailored Reminder Systems (ON): The outreach facilitator and practice staff review the practice operations. Together they develop a reminder system that is tailored to the operation of the practice. Facilitation supports the staff in developing and integrating chosen systemic changes. This process uses the practice resources to initiate and sustain change. Contact: *facilitation@scohs.on.ca* or *jschultz@uottawa.ca*, University of Ottawa.

Team Effectiveness and Scope of Practice Tool (TET-SOP) (NL and SK): The team effectiveness tool (TET) was developed by Saskatchewan to assess key elements of the PHC team including purpose and vision, roles, communication, service delivery, team support and partnerships. It allows teams to periodically assess progress. Contact: *www.health.gov.sk.ca/ps_phs_teamdev.pdf*

This tool was later adapted by NL and expanded to measure provider attitudes in relation to team member roles and functions, standards of practice, co-ordination of services and personal satisfaction in relation to scope of practice in their practice setting. NL's adaptation also integrated the instrument developed by Bronstein[56] to measure scope of practice. Contact: *dryan@gov.nl.ca*, Department of Health and Community Services.

Role of Evaluation in PHC Renewal (NL): The central focus for the reform in Newfoundland and Labrador is a team-based, interdisciplinary approach to service delivery. Eight areas have been funded to implement changes in this area. External consultants have developed an evaluation plan for each site that takes a formative approach to assess whether or not the projects are achieving their objectives using a mixture of qualitative and quantitative collection methods. Contact: *dryan@gov.nl.ca*, Department of Health and Community Services.

Program Planning and Evaluation Skill-building Process (NL): Team area representatives attended a two-day evaluation-skills enhancement workshop, delivered by the provincial evaluation team. Topics included logic models and evaluation methods with a take home resource document. Through ongoing support and training, the PHC areas will build skills to assist in sustaining evaluation efforts after the PHC transition funding has ended. Contact: *dryan@gov.nl.ca*, Department of Health and Community Services.

Client/Patient Satisfaction Tool (NL): The evaluation consultants developed this questionnaire with support from Office of Primary Health Care. The tool was designed to examine the client/patient experience as one means of accessing health and social services in the region. Contact: *dryan@gov.nl.ca*, Department of Health and Community Services.

Quality Scorecard (MB): NOR-MAN Regional Health Authority's (NRHA) quality scorecard is an adaptation of the balanced score card developed by Kaplan and Norton. It is the corporate report card to detail how their health system is doing and provide a vehicle for the board, management and staff to monitor health system performance based on strategic plan priorities. Contact: *scrockett@normanrha.mb.ca*, NOR-MAN Regional Health Authority.

Proposal Development Process (NL): The Office of PHC (OPHC) developed a PHC renewal proposal template process (complete with financial and consultation support from the OPHC) for RHAs submitting requests for PHC transition funding. The template was informed by relevant evidence and included information on: demographics; team area profiles; challenges/solutions; an implementation and financial plan; and a monitoring and evaluation component. Contact: *dryan@gov.nl.ca*, Department of Health and Community Services.

Getting Started in Program Planning & Evaluation (NL, on behalf of BBT Atlantic Initiative): This training module includes both participant and facilitator handbooks and covers the following content areas: steps in program planning; creating a program profile; strategies for achieving program outcomes; creating a program planning model; action planning; steps in program evaluation; and creating a basic evaluation framework. Contact: *merv@gov.ns.ca*, NS Department of Health.

Chapter 5

By Cheryl Osborne, Betty Kozak,
Vivian R. Ramsden, Heather White

Facilitating Promotion and Prevention

The fifth recommendation of the Declaration of Alma-Ata states that primary health care should include at the very least:

- Education about the health concerns in any given community and the methods of identifying, preventing and controlling them; and
- The prevention and control of locally endemic diseases (WHO and Unicef, 1978).

Alma-Ata also stated that the ways of addressing these elements of primary health would vary from community to community (WHO and Unicef, 1978).

To develop, implement and evaluate health promotion and disease prevention programs the health concerns of the community must first be identified. Epidemiology provides the building blocks for addressing the health concerns of the community because its goal is improving the health of populations by identifying the health concerns of the community.[57, 58, 59]

This chapter begins with a brief look at the links between epidemiology and health promotion. This leads into an exploration of the building blocks required in developing, implementing and evaluating health promotion and disease prevention strategies. Also discussed here are the challenges of integrating health promotion and preventive practices into PHC settings.

Epidemiology

Epidemiology refers to the study of the distribution and determinants of health-related conditions or events in specified populations. The term also refers to the application of this study to the control of health problems.[60] Its focus is on identifying the source of illness within the social context, determining the specific behaviours and events that contribute to the presence of particular illnesses
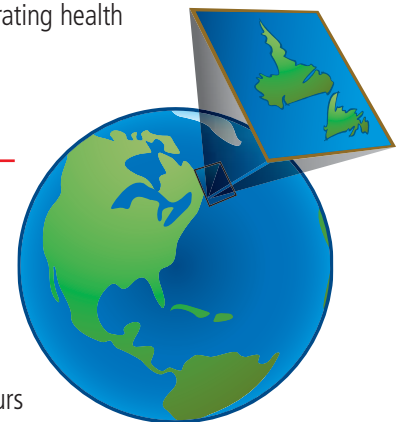
and developing strategies that alter the precipitating factors that lead to such illness.[60] Prevention must begin at the root of the health issue in order to prevent or reduce further occurrences.

Injury, chronic illness, infectious diseases, acute trauma and other health problems significantly impact the population. Therefore, population-based prevention and clinical or individually based strategies are warranted.[61] Public health and PHC settings offer excellent opportunities for incorporating prevention into practice.[62]

The factors leading to health problems are complex and include behavioural, socio-economic, cultural and other influences.[8, 7] Population health and clinical preventive strategies provide frameworks for applying health promotion and disease prevention programs appropriately to these complex factors. However, the determinants of health and the impact of their interactions must also be considered in the process.

Health Promotion

Health promotion fosters positive and productive health behaviours and lifestyles by facilitating the development of supportive environments and the integration of concepts and activities. Health promotion is an inclusive, dynamic process that seeks to empower all people and groups in various social contexts. It does this by increasing the learning capacity of individuals. Health promotion emphasizes adaptive, sustainable activity and tends to focus on five main strategies:

1. Build healthy public policy;
2. Create supportive environments;
3. Strengthen community action;
4. Develop personal skills; and
5. Re-orient health services.

Facilitators of health promotion consider these needs of individuals and communities within the context of their environments. They increase the latter's capacity by examining how the determinants of health directly impact health behaviours.[63] This diagram, taken from a Health Canada website,[64] reflects the role of evidence and collaboration in influencing promotion activity.

Diagram 1: The Role of Evidence and Collaboration in Influencing Promotion Activity

Population Health Key Elements

Stronger Evidence / Knowledge Development

Measure Population Health Status

Base Decisions on Evidence
• health status
• determinants
• interventions

Analyze Determinants of Health

Increase Upstream Investments

Multiple Strategies
Public Involvement
Intersectoral Collaboration

Accountability for Outcomes

GOALS
• Improve health of population
• Decrease health status inequities

Analysis of Health Issue → Priority Setting → Taking Action → Evaluating Results

Population Health Key Elements   Generic Process Steps

Retrieved from *<www.population-health.com>*

The key to successful health promotion is to work with all relevant parties to create a variety of strategies that are based on sound evidence. These can be monitored for effectiveness in reflecting the strategy's efficacy in preventing targeted illness.
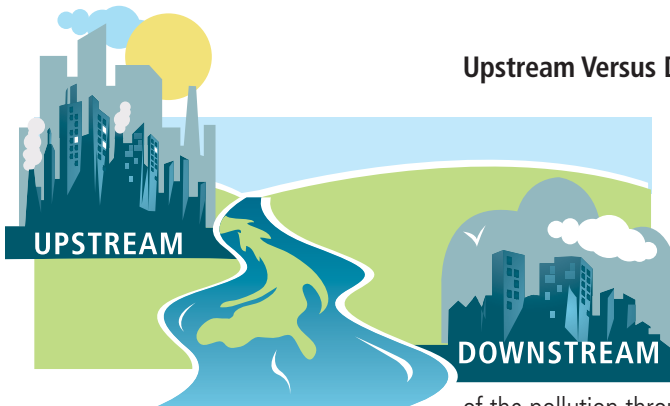
Upstream Versus Downstream

This popular health promotion analogy describes a story of two towns along the same river. The *upstream* town begins to dump toxic materials in the river and as a result the downstream town is affected. The issue becomes one of how the *downstream* town can best respond to the situation.[65]

A *downstream* approach would be to deal with the health effects of the pollution through appropriate treatments (secondary and tertiary prevention). An *upstream* approach would mean working with the upstream community to reduce the pollution; that is, to deal with the problem at its source (primary prevention). Upstream interventions are intended to help people maintain or improve their health before it is compromised and to focus on wider influences on health inequalities as highlighted in the determinants of health.[12]

Prevention within PHC settings tends to focus on upstream strategies. Identifying the sources for the illness becomes equally important to managing the illness once it has been manifested. To do this many of the elements of PHC mentioned in Chapter One form the basis on which prevention strategies are built. Inter-professional teams, inter-sectoral collaboration and community engagement are all important ways of enhancing upstream practice.

The Nature of Prevention

Before proceeding, it is helpful to briefly explain the three levels of prevention.[66]

TABLE 5: The Three Levels of Prevention

Primary Prevention	Secondary Prevention	Tertiary Prevention
Aim to prevent the occurrence of disease. **Activity** aimed at reducing factors leading to health problems and includes: • Immunization • Reducing exposure to risk factors • Facilitating the modification of lifestyles.	**Aim** to identify asymptomatic individuals with early stage disease. **Activity** focus on early identification promises significantly better response to treatment than in those who first present with symptoms.	**Aim** targets individuals who already have the disease.[67] **Activity** • Prevent damage and pain from the disease • Slow down the disease • Prevent other complications • Improve care to affected people and overall health • Help people with disease to do what they used to do.

Although focused attention at all levels of prevention is crucial to integrating prevention strategies into the PHC renewal processes, this chapter will focus at the level of primary health care. Facilitating changes in awareness regarding the levels of prevention, as well as translating this into practice, often falls into the domain of those who facilitate change.

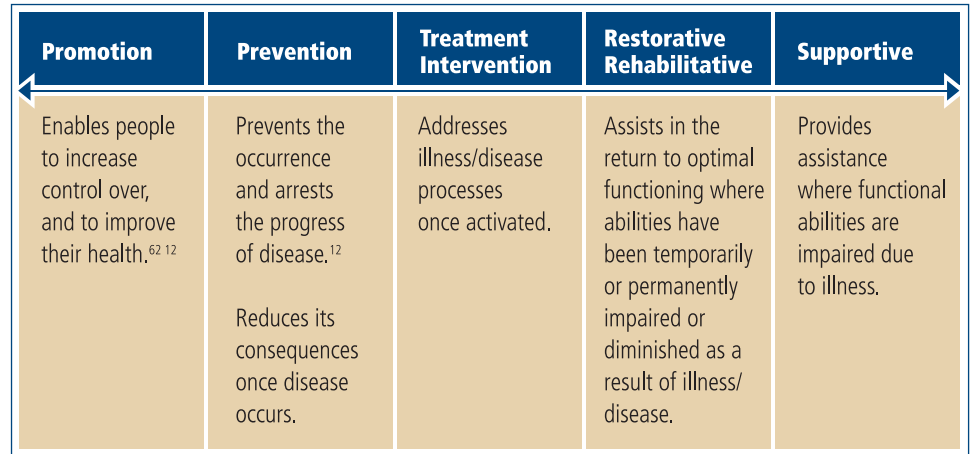Physicians play an extremely important role in integrating prevention into practice within PHC settings. Physicians are perceived by the public as a reliable and credible source of health information. Thus physicians need to take advantage of the teachable moment when clients/patients are concerned about their health.[62]

Continuum of Care

Manitoba's continuum-of-care model organizes the integration of a comprehensive, person-centred approach to health services. The promotion and prevention components of this model illustrate the upstream approach described above. Although there other ways of framing the work, this continuum is useful for highlighting the contributions that different health care teams and professional groups make at various points in the care process. It also highlights that the collective efforts of all aspects of the health system are needed for an integrated approach to health care.

Although the PHC facilitator is likely to focus her or his efforts and attention at the first two levels of care to ensure a sufficient upstream approach, the facilitator needs to understand how each level of care functions and interfaces with the others. This is necessary to effectively support team and organizational changes that bridge the gap between where prevention is today and where it needs to be.

Diagram 2: A Continuum-of-care Model

Promotion	Prevention	Treatment Intervention	Restorative Rehabilitative	Supportive
Enables people to increase control over, and to improve their health.[62][12]	Prevents the occurrence and arrests the progress of disease.[12] Reduces its consequences once disease occurs.	Addresses illness/disease processes once activated.	Assists in the return to optimal functioning where abilities have been temporarily or permanently impaired or diminished as a result of illness/disease.	Provides assistance where functional abilities are impaired due to illness.

Winnipeg Regional Health Authority, 2003

Hancock (2004) highlighted three main challenges for implementing clinical prevention in British Columbia[68] and encourages consideration of these for future planning within primary health care. These are:

1. Finding a local champion;
2. Finding ways to institutionalize the process of prevention; and
3. Acknowledging the importance of external resources such as facilitators.

In order to improve prevention screening there has to be a clear indication for doing so. As a result, facilitators need to understand what interventions can be recommended based on current evidence. The presence of a neutral third party, whose role it is to assist with the *process* of assessment and integration, may provide awareness and necessary additional practice and/or team support.

A solid reference point for the practice/team to establish future performance goals is essential. This reference point can result from engaging in reflective practice or clinical debriefing, which includes considering individual preventive practice performance and making a comparison with a peer group. Such an approach can assist with the integration of evidence-based guidelines. These guidelines reinforce best practices in prevention and they bridge the gaps in practice between what needs to occur to promote prevention and what is actually being done. Hancock (2004) highlights the need for a facilitator to bridge this gap between knowledge and practice.

Managing the Facilitator's Role

Many PHC practices/teams do not use or have efficient office/practice/team systems to enhance the delivery of recommended preventive screening techniques to the populations they serve. Facilitation is a means to operationalize plans for change. It provides support, guidance and structure for the PHC team members to make the changes needed – while they continue to focus on the delivery of necessary care.

Facilitation can and has played a key role in assisting with the integration of prevention strategies into primary health care. It encourages discussion and input from the practice/ team to reach a consensus on defining and targeting improved prevention screening. The result is a systematic organized approach which can ensure the delivery of timely and efficient prevention services. The facilitator may also contact other care agencies on behalf of the practice to expand the practice's knowledge of available community resources and to improve the delivery of care.

Such a process identifies which team member should be involved, where in the process they interact and how consistent reporting/recording will be structured. If this is to be effective, the facilitator needs to be supported by a champion in the practice, on the team or within the organization.

Facilitation Resources

Preventive Health Care (ON): Outreach facilitation has employed up to 53 prevention screening manoeuvres based on Canadian Task Force on Preventive Health Care, regarded as the gold standard for preventive performance. Family practices receive a confidential review outlining their prevention care. Evidence-based prevention data is reviewed and discussed. A consensus-building and planning process leads to the formulation and integration of tailored chart reminder and retrieval systems. See Prevention Flow Sheet Examples and *www.ctfphc.org*

Moving for Health (NL): This program, developed by Eastern Health and Community Services and Heart Health Network, targets the community role to increase adult participation in daily physical activity. Initiated in 1995 by a community volunteer working with older adults, this program as been adopted provincially. Contact: *dryan@gov.nl.ca*, Department of Health and Community Services

Prevention Flow sheet (MB and BC): An electronic flow sheet was developed which contained selected recommended manoeuvres from the Canadian Task Force on Preventive Health Care for patients aged 50-70 years. The flow sheet is part of a physician-based chronic disease collaborative process and was developed for the *MOH* web-based toolkit. Visit: *www.CTFPHC.org*

Health Promotion and Disease Prevention (ON): This resource will assist inter-professional PHC teams in health promotion and disease prevention. Visit: *http://www.health.gov.on.ca/transformation/fht/guides/fht_health_promotion2.pdf*

Snowmobile Awareness Initiative (NL): In the aftermath of a series of snowmobile accidents, one of which was fatal, an outcry from the community resulted in a brainstorming session to develop prevention strategies (education for parents, education for youth, and issues around legislation). Contact: *dryan@gov.nl.ca*, Department of Health and Community Services.

P.A.R.T.Y. (Prevent Alcohol and Risk-related Trauma in Youth) (MB): P.A.R.T.Y. is designed to promote injury prevention through reality education for youth aged 14 - 19 years. It is designed to help them recognize risk and make informed choices about activities and behaviours. The day-long workshop includes a mock car crash, emergency room visit and presentations from survivors, emergency services and therapies. For program information, visit *www.mts/~mbia* or *www.partyprogram.com*

FASD Diagnostic Services (NL): Regional FASD Management Team (including Health, Education and Labrador aboriginal groups) spearheaded a coordinated effort to create an FASD diagnostic service. The Motherisk guide to diagnosing FASD was used in conjunction with guidelines found in the Canadian Medical Association Journal - FASD: Canadian Guidelines for Diagnosis. Plans are in place to ensure that ongoing diagnostic services are available. Contact: *dryan@gov.nl.ca*, Department of Health and Community Services.

Healthy Eating Habits Initiative (MB): A community initiative to raise eating-habit awareness began with a multi-sector group discussing the issue of diabetes, reviewing data, identifying strategies and options and defining next steps. Contact: *mgray@normanrha.mb.ca*, NOR-MAN Regional Health Authority.

Circle of Health (COH) Health Promotion Framework (NL): The Province's COH is based on a health promotion framework developed by PEI in 1996. It served as the foundation of the provincial training workshop offered in October 2005. Three of the BBTI modules "Facilitating Adult Learning", "Understanding PHC" and "Working with Communities" were training perquisites. Contact: *dryan@gov.nl.ca*, Department of Health and Community Services.

Physical Activity Promotion (MB): Parkland Physical Activity Coalition core group developed a mission, vision and goals consistent with the Manitoba Physical Activity Action Plan, and invited regional stakeholders to a workshop to discuss roles. This coalition-building process brought together a diverse group of stakeholders with a

common goal of promoting physical activity. Materials are based on Human Resource Development Canada's model. Contact: *fjeffries@prha.mb.ca*, Parkland Regional Health Authority.

HEAL (Healthy Eating and Active Living) (BC): HEAL is a non-profit society that supports a health promotion network focused on healthy communities and healthy eating/physical activity. Its primary focus is to give a voice to northern citizens so that they can become active and engaged in their own health. Contact: *alice.domes@northernhealth.ca*, Northern Health.

Cervical Screening (NL): To respond to the high rates of cervical cancer in the province, providers embarked on the development of an organized screening program. This work began with provincial data and was launched in Western, Central, Grenfell and Labrador in 2003. Currently there are coordinators and resources are dispersed provincially. Contact: *dryan@gov.nl.ca*, Department of Health and Community Services.

5A's Program of Brief Interventions (BC): An identified need for a common approach to lifestyle change issues for clients with chronic diseases and for brief interventions in acute care, resulted in the development of a tool for self management within chronic disease prevention and management. This tool was presented to managers through a train-the-trainer program. Contact: *alice.domes@northernhealth.ca*, Northern Health.

Injury Prevention (IP) (MB): A regional working group reviewed injury data, identified priority areas and developed a regional framework. Inter-sectoral working groups in priority areas (farm, motor vehicle, falls, suicide and self inflicted harm), coordinate activities using a coalition-building process, based on Human Resource Development Canada's partnership model. Visit: *http://www.gov.mb.ca/healthyliving/injuryreview.html*

Injury Prevention (MB): Since 1993, a manual and yearly community partner's guide is used to plan community events in partnership with the RCMP, Fire Departments, Emergency Medical Services, Recreation Departments and Canadian Red Cross. The theme differs each year and engages different partners in the planning of an event during Safe Kids Week. Visit: *www.safekidscanada.ca*

Women's Health Reproductive Screening (BC): Funding was received to develop a teaching program for RN's to do pips, CBE and bi-annual exams for women in northern BC. Education sessions are delivered via email, conference/phone and consultation with stakeholders and physicians. Contact: *Lynda.anderson@northernhealth.ca*, Northern Health.

Seniors' Health (MB): Programs have been developed in the area of exercise and nutrition as part of a home care quality improvement initiative tailored to meet the specific needs of the seniors' community. Contact: *lnordick@mb.ca*

Immunization (MB): A Regional Immunization Committee developed goals for ensuring safe, quality delivery of vaccines and increasing rates in the region based on regional and community data from Manitoba Health. The Provincial Immunization Coordinator Committee meets bimonthly and shares information between regions in the province. Visit: *www.wrha.mb.ca*

Nicotine Intervention Counselling Centre (NICC) (BC): The mission of NICC is to support a multidisciplinary team of health care providers trained in tobacco addiction counselling and best practices, who incorporate the Centre's program into their role. Contact: *alice.domes@northernhealth.ca*, Northern Health.

Born a Non-smoker Program (NL): The Born a Non-smoker Program, developed in January 2001, provides new babies with a t-shirt that reads *Born a Non-smoker*. In addition the program offers education sessions for parents on the harm of second-hand smoke. This program was team-, community- and evidence-based and has expanded substantially due to positive feedback. Contact: *dryan@gov.nl.ca*, Department of Health and Community Services.

Chapter 6

By Vivian R. Ramsden, Cheryl Osborne, Shannon Turner, Heather White

Building Community Capacity

As discussed in Chapter One, an understanding of the determinants of health is pivotal to PHC renewal. They provide a focus for joint effort and collaboration across jurisdictions. Individuals live in communities where many factors impact on their health. Primary health care should not be delivered in isolation from those factors. As outlined in the Ottawa Charter for Health Promotion (1986), the following elements create the conditions necessary for the prevention of illness: health, peace, income, education, availability of affordable shelter and food, sustainable resources and social justice.

Targeting determinants that are linked to specific community needs (as determined by collecting evidence using needs assessments, asset mapping), begins the process of:
- Identifying the relevant community and inter-sectoral partners; and
- Planning programs that will enhance health and well being.

This population health approach integrates health promotion with traditional epidemiological analysis of population health indices. It focuses on the health of the community rather than on the health of the individual and becomes the blueprint for planning interventions to prevent illness and maintain well-being. This chapter looks closely at capacity building at the community level. It begins with a discussion of the role for and importance of engaging community members and explores three models that can inform such an approach. The different levels of partnerships and the important role of inter-sectoral work to strengthen engagement are also explored as a means of creating meaningful networks that allow improvements in population health.

Engaging Community as a Member of the Primary Health Care Team

The process of engaging the community essentially focuses on inviting community members to become members of the health care team. This means facilitating the process by which they become involved in working to develop strategies and programs for and with the
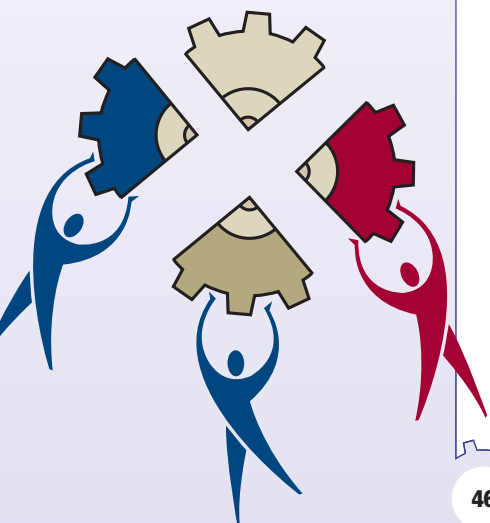
community. Developing community is an approach to facilitating this engagement that has been used in Saskatchewan[69, 70, 71, 72] and is guided by the following premises:

Empowering Services: The goal is to involve the community as an active and contributing member of the team. The facilitator often plays a role in building the necessary connections to sustain this involvement after she or he is gone. Through the use of collaborative strategies and, at times, taking on the role of an advocate for change and collaboration, facilitators create organizational actions that support these changes in the long term.[73]

Connective Processes: The theory of community action for health[74] is based on the principles that the knowledge and skills of the individual are strengths that contribute to enhancing wellness. Developing capacity through participation can best be achieved by building on and strengthening existing knowledge and expertise. Participation must be authentic – not just participating in the ways that have always been done. Rather than making decisions for participants, facilitators need to focus on finding ways to make decisions with participants.

Organizational Actions and Collaborative Strategies: Analysis by local people is an essential part of community action for health. The role of health care practitioners should be to enable people to analyze their situation, reflect on the root causes of their ill health and together design ways to address these causes.[40] Facilitators of change must move outside of their organizations and effectively take action to bring the community into their work. In an effective engagement process the community sets the agenda for change based on a shared community vision. The facilitator is the resource that supports the community as the individuals identify their priorities, capacities and issues while continuing to develop collaborative partnerships.

Advocacy that Challenges: At times facilitators need to challenge existing structures and processes that impede true community engagement. In order to support meaningful engagement of the community, it is important to work with community members and encourage attempts to actively involve the community partners.

Enhancing the Process of Working with Community

There are challenges to working with the community that must be addressed. The role of the community is clearly delineated in the Declaration of Alma Ata.[10, 11] It indicates that people have the right and duty to participate in the process of changing primary health care. The declaration also states as a principle that they are equal partners in the process through which they jointly assume responsibility for their health and well being.

These principles are often challenged in practice by systems. Thus, the values that guide the work with the community must be mutually negotiated and agreed to, written down and re-visited frequently to ensure that they continue to meet the needs of health care team members.[75]

Citizen participation in PHC is espoused in principle; however, it is challenged by systems in practice.
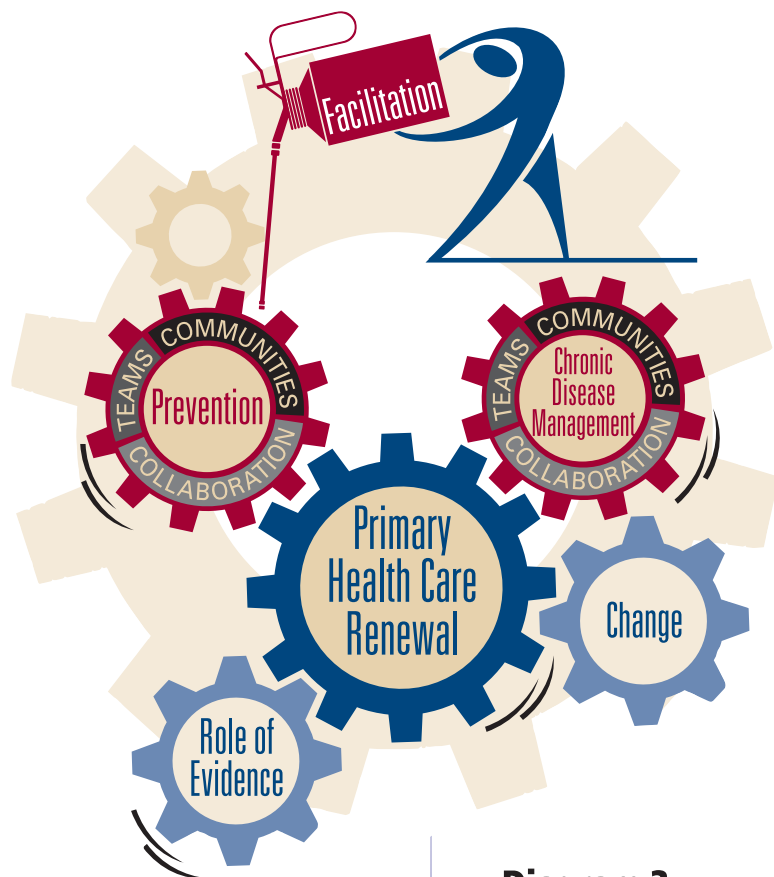
The content of PHC at the community level should address the main issues facing the community that have been mutually agreed upon. But, the content must also recognize the need for addressing those issues in ways that are deemed appropriate by the community.[10, 11]

The Declaration of Alma Ata requires and promotes maximum community and individual self-reliance and participation in the planning, organization, operation and control of primary health care. This process must make full use of local, national and other available resources. And to this end, PHC must develop the ability of communities to participate through appropriate education.[10, 11]

There are a variety of models that can and could enhance this process. Identified below are three models that address the various aspects of community engagement:

1. Arnstein Ladder (Arnstein, 1969);[76]
2. Public Participation Spectrum (International Association for Public Participation, 2005);[77] and
3. Community Empowerment (Rissel, 1994).[78]

Diagram 3:
Arnstein Ladder

8	Citizen Control
7	Delegated Power
6	Partnership
5	Placation
4	Consultation
3	Informing
2	Therapy
1	Manipulation

Degrees of citizen power

Degrees of tokenism

Nonparticipation

Referenced in footnote #76

Often within the health care system, consultation is used to demonstrate participation; however, the information gleaned may or may not be heard or applied in practice. The Arnstein Ladder[76] (Diagram 3) can help to sort through the reality of participation and engagement as PHC change commences and is sustained in the work with community partners.

The Public Participation Spectrum (International Association for Public Participation, 2005)[77] on page 49 displays the levels of participation on a continuum. At one end is informing while at the other end of the continuum is empowerment. The model further illustrates the tools or techniques for public participation that are associated with each of the levels.

This model not only illustrates a continuum of participation or impact but also allows for an understanding of what the community experiences or understands from that engagement. The implied promise associated with each level of engagement speaks to the level and degree of decision-making power available to the public.

Before deciding on a level of participation or even the techniques to be used, the message and/or implied promise to the public must be determined. Once the message is clear, it is

easier to understand and appreciate the desirable level of participation and thus easier to choose appropriate tools and techniques that correspond with that level of engagement.

Increasing the level of public participation is important but it is more important that the techniques and promises are aligned. This creates the process of participation and engagement that is authentic and meaningful.

Diagram 4: The Public Participation Spectrum

IAP2 Public Participation Spectrum

Developed by the International Association for Public Participation

INCREASING LEVEL OF PUBLIC IMPACT

INFORM	CONSULT	INVOLVE	COLLABORATE	EMPOWER
Public Participation Goal:	Public Participation Goal:	Public Participation Goal:	Public Participation Goal:	Public Participation Goal:
To provide the public with balanced and objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions.	To obtain public feedback on analysis, alternatives and/or decisions.	To work directly with the public throughout the process to ensure that public concerns and aspirations are consistently understood and considered.	To partner with the public in each aspect of the decision including the development of alternatives and the identification of the preferred solution.	To place final decision-making in the hands of the public.
Promise to the Public:	Promise to the Public:	Promise to the Public:	Promise to the Public:	Promise to the Public:
We will keep you informed.	We will keep you informed, listen to and acknowledge concerns and aspirations, and provide feedback on how public input influenced the decision.	We will work with you to ensure that your concerns and aspirations are directly reflected in the alternatives developed and provide feedback on how public input influenced the decision.	We will look to you for direct advice and innovation in formulating solutions and incorporate your advice and recommendations into the decisions to the maximum extent possible.	We will implement what you decide.
Example Techniques to Consider:	Example Techniques to Consider:	Example Techniques to Consider:	Example Techniques to Consider:	Example Techniques to Consider:
• Fact sheets • Web sites • Open houses	• Public comment • Focus groups • Surveys • Public meetings	• Workshops • Deliberate polling	• Citizen advisory committees • Consensus-building • Participatory decision-making	• Citizen juries • Ballots • Delegated decisions

Empowerment can be a complex idea. Rissel (1994) views it as a process by which people, organizations and communities gain mastery over their lives.[78] The World Health Organization (2002)[79] has stated that individuals and their families are the most undervalued assets in the health care system. Their potential to affect change and generate outcomes is undeniable. It is expertise at that level that enables society to observe and engage in transforming the health care system in a way that enhances the health and well being of individuals, and maximizes the potential of health care practitioners.[40]

Diagram 5: Community Empowerment Model[78]

Community Empowerment

Psychological Empowerment

Empowerment Deficit

1	2	3	4	5
Personal development	Mutual support groups	Issue identification, campaigns, community organization	Participation in organization's / coalition advocacy	Collective political + social action

Degrees of success in gaining control over resources

Health

Sense of community
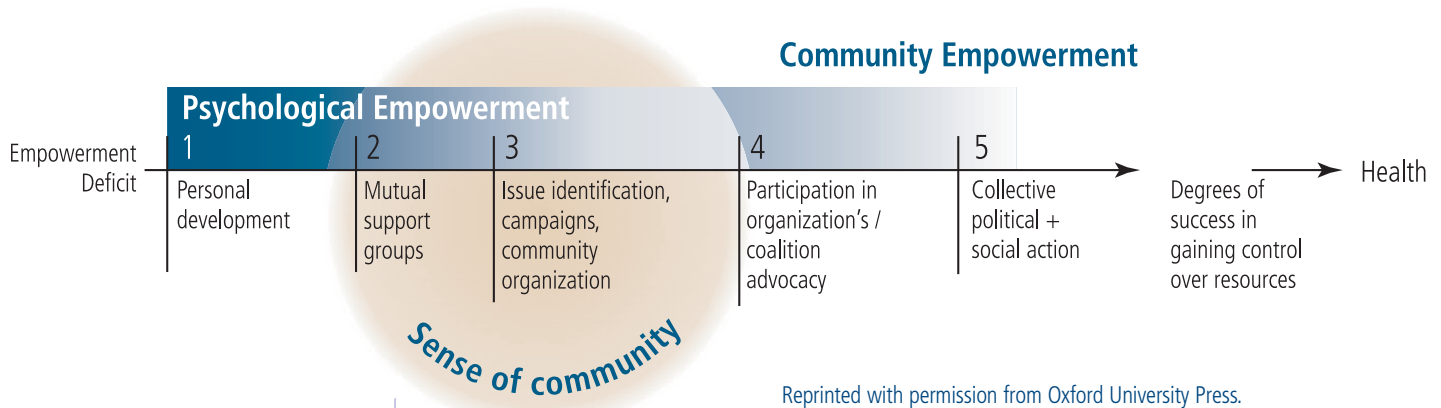
We can only build capacity in a community by involving the people who live in the community. Facilitation in PHC develops programs that address the issues mutually agreed upon using ways and means deemed appropriate by the community. Then, no matter which model, method or strategy is used, capacity is enhanced and sustainability is built by working with the community.

Applied Facilitation

Regardless of the method, the facilitator's role is to use process and tools of community engagement in her or his everyday activities to work with the community rather than on or for the community.[80] The focus is on building capacity with the community; thereby helping them to help themselves as it relates to health and well being.[40]

A central notion of this facilitated change is the belief that individuals can change their world and that this change is most effective when it begins with the people affected. (This is often true, however, individuals who are oppressed, for whatever reason, lack the self-confidence, opportunities and encouragement they need to build on their strengths.[81, 82]) The degree to which facilitators of change partner with communities, and in turn with individuals, to tap into their strengths in the change process, is the degree to which they have facilitated the community's empowerment and the empowerment of the individuals who comprise that community.[73]

This process begins with a vision that is informed by the community and rooted in its particular needs, resources and culture. Ongoing support creates a process of change that is owned and shaped by the community, but implemented through facilitated interventions such as educational opportunities, support and coordination.

The primary goal is to build sustainability by learning with community members how to fish in their lake – rather than giving them the fish. Truly effective facilitators slip into the background long before they depart the scene. With a successfully facilitated process, the work continues in the hands of the community after the facilitator has left. This is the nature of empowerment, facilitation and shared leadership.

Example of Success – **The Green Bay Development Project, Newfoundland and Labrador**
In the summer of 1997, Health and Community Services – Central (HCS-C) initiated a two-phase project to maximize available resources and to improve service delivery by working more closely with the community. Funding for this project was re-directed from the operational budget of HCS-C and staff changes provided an opportunity to re-distribute resources. Three public health nursing districts were collapsed into two, due to declining population/need, enabling the funds from the third position to be diverted to this project. Phase one supported the funding of a research coordinator. Phase two funded a health promotion coordinator to act as a catalyst for community mobilization.

Green Bay's population (8,895 by 2001 census data) is dispersed among 21 communities that share a large geographic area. Staff and community groups in the region exhibited the *community readiness* necessary for engaging communities. The following facilitated steps empowered the community to engage as a member of the health delivery team.

Self-reflection: What are your personal values and beliefs about community empowerment? Do you believe that people want choice and are willing and able to exercise it on their own behalf? Or do you believe that you know the answers?

Organizational Assessment: Will your organization support you doing things that are not traditionally within the description of a PHC provider?

Community Assessment: Develop some baseline data including the history of the communities that are now coming together to solve problems. What are some current initiatives or activities in the community?

Lessons Learned from the Green Bay Project:

- **Create community awareness.** Use multiple approaches in order to reach all sectors of the community. *The least successful method was public meetings.* Effective approaches were: word of mouth, participation in community events, and invitations to people to participate.
- **Provide a variety of opportunities for participation**. Don't just include official or regular leaders. Time of day, location of meetings and childcare are all things to consider. (9 a.m. – 5 p.m. Monday to Friday meetings limit participation). Keep critics informed and invited to participate.
- **The importance of language.** Make sure to use language that is relevant to the people you are working with. Avoid jargon.
- **Take the time to build relationships and trust.** This is a time commitment but is often the foundation needed to proceed. Pay attention to the process as well as the outcomes.
- **Don't assume need** – **clarify and validate.** To learn what is needed, listen!
- **Start small.** Find issues of interest to the community that already have some resources.
- **Communicate success.** Success boosts morale while creating a sense of movement and commitment.
- **Partnerships are vital.** Communicate clear expectations for team membership and clarify level of commitment. Respectfully provide opportunities for members to have input and share ideas. In other words, meaningful involvement – not tokenism.
- **Don't re-invent the wheel.** If something is already being done, look for ways to support and enhance it rather than competing with it.
- **Maintain momentum.** Celebrate milestones and achievements. Provide updates to the larger community. Encourage new people and organizations to become involved. Create opportunities for members to recommit, to take a break or to take on a new role with the process. It is an ongoing process; ongoing support is essential.
- **Remember: one size does not fit all.**

The Green Bay initiative (see text box) is one of many that have used these principles to enhance community involvement. By facilitating a process of engagement, Green Bay staff and community members have made real the language of PHC community participation and enhanced their service to residents in the Green Bay area.

Inter-sectoral collaboration is an expansion of the concept and definition of the team to include the many players that have a role to play in PHC prevention.

Linkage with Inter-sectoral Groups

The determinants of change include areas outside the traditional health system such as justice and education. Therefore facilitators must recruit partners from other sectors to strengthen their work. The World Health Organization defines inter-sectoral collaboration as:

"A recognized relationship between part or parts of the health sector with part or parts of another sector which has been formed to take action on an issue to achieve health outcomes … in a way that is more effective, efficient or sustainable than could be achieved by the health sector acting alone."[12]

Inter-sectoral collaboration expands the PHC facilitation model. Based on the WHO's definition of inter-sectoral collaboration, the PHC team can be broadened to include the many new players who can influence PHC prevention.[79] Facilitators of inter-sectoral collaboration must consider how the elements discussed in working with teams can be adapted and integrated into the work engaged in with those outside the immediate provider group. Facilitators also need to understand the forms of partnership that can exist and the necessary supports required for sustaining them over time. To build capacity as a facilitator, it is necessary to develop and pass on the skills, knowledge, roles and supports that will continue to sustain the changes made within the community.

Building Partnerships

Partnerships, including inter-sectoral groups, can take many forms within the community. Communication and involvement of members varies with each form. This has important implications for facilitators tasked with building capacity. Four levels of partnership have been identified that can help to sort through the nature of each partnership and the elements necessary to sustain it.[83]

Table 6: Four Levels of Partnership – Necessary Elements

	Characteristics	Facilitator's Role
Communication	Most basic level Information and resource sharing Lowest level of commitment	Create lines of communication Coordinate activities Seek to increase level of collaboration Support relationship and team building
Coordination	More commitment and activity Focus on reducing duplication and/or providing service One or more agencies coordinating activity	Actively involved in the process of discussion Organizing and facilitating meetings across groups Encouraging clarity of purpose, roles planning through group consensus
Co-operation	Activity across agencies or sectors Established communication lines Increased integration of partners Autonomy of bodies retained with individual identities and functions	Focused on relationship building Engage in some "doing" such as leading meetings and education Focus is on supporting other members to become the do-ers
Collaboration	Greatest commitment to a common goal Recognition that all partners are essential Greatest sharing of resources and information Strong, well-defined relationships	Provide support where needed Support emerging leaders Get out of the way

Referenced in footnote #83

Once the nature/level of the partnership is established, the next step is to sort through the various characteristics needed to support the partnership's work over time. The following characteristics can help to clarify the nature of the partnership.

Table 7: Four Levels of Partnership – Sustaining the Relationship

Characteristic	Low	High
Commitment	A verbal agreement as needed	A Memorandum of Understanding is created to define the partnership
Formality	No established procedure for planning communication and work sharing	Terms of reference document to clarify roles, expectations and means of dispute resolution
Personal Contact	Limited interaction of partners and minimal efforts to encourage it	Regular meetings, ongoing interactions and communication
Autonomy	Partners operate in relative isolation. Limited attention paid to soliciting feedback and coordinating activities to meet the collective goal	Partners regularly consult to plan activities, solicit input and organize their respective schedules to accommodate the goals/activities of the partnership

Referenced in footnote #83

These four dimensions further clarify the need for additional strategies to structure the relationships between the relevant parties. Depending on which dimension the partnership finds itself in and the relative importance of that dimension to the long term goals that have been established, the facilitator will work with others to build the necessary structures to support the preferred partnership.

Managing the Facilitator's Role

Facilitation promotes empowerment. It engages the community in the change process by recognizing the elements necessary to build capacity. Facilitators must be able to assess people's readiness to learn and then tailor their responses accordingly. They must understand the processes by which strong teams and partnerships form and grow. To effectively assist individuals and communities, facilitators must understand the community context and the needs of the individuals and groups who live there. This understanding assists with facilitating the growth of community involvement and also ensures that the development is occurring in the right direction by addressing real community needs. The facilitative role is one that seeks to improve the ability to think and act by creating opportunities for everyone involved in the process to experience an increased level of awareness and personal growth.[84]

Facilitation has a place in working with communities that seek to build capacity. Whether in the form of a facilitator role or building skills in providers to fulfill this role, facilitation has a place in working with communities. The particular form the facilitation process takes depends on the community, the provider skill set and the disposition and resources available to support local empowerment.

The key is fulfilling the need by building the internal capacity to sustain the momentum of change. In choosing a facilitator(s), the community must recognize the importance of long term sustainability – through building capacity. Otherwise they are simply creating a need for sustained support that limits building of capacity in others and actually decreases sustainability over the longterm.

The balance the facilitator maintains between doing and guiding is subtle. Initially some doing (in the form of leading meetings) will be needed to initiate the process. This allows for the observation and role modeling often necessary to support skill development. Educational sessions and joint planning sessions are common. However, the facilitator must not stay too long in the role of do-er. Her or his focus ought to be on coaching and on supporting leaders in the group as they take on relevant roles that will build the necessary capacity to move forward with or without the facilitator.

Facilitation Resources

Making Public Policy Healthy (NL): Developed by Newfoundland and Labrador Heart Health, "Making Public Policy Healthy" discusses how to influence public leaders, through community action, to adopt healthy public policy. Whether from the top down (governments) or the bottom up (community/citizens), facilitators are instrumental in enabling communities to initiate the development of public policies. Contact: *dryan@gov.nl.ca*, Department of Health and Community Services.

Community Collaborative Process (BC): Northern Health (NH) community collaborative focuses on empowering the local multi-disciplinary team to make practice changes in medical care and the broader PHC system. The aim is to address the gap in care and achieve quality care improvement targets, with improved health outcomes. Contact: *Debbie.lewis@northernhealth.ca*, Northern Health.

Engaging Community as a Member of the Team (NL): In the summer of 1997 the Green Bay Community Development Project was implemented to identify opportunities for improving community strategies. The focus was on building relationships, tending to the process and outcomes and clarifying community needs by building on currently effective programming. Contact: *dryan@gov.nl.ca*, Department of Health and Community Services.

Building Community Capacity (BC): The Mackenzie area hired a facilitator to work with providers and community to enhance local delivery of diabetes education through a diverse group of players and community resources rather than through a central diabetes centre. Contact: *Debbie.lewis@northernhealth.ca*, Northern Health.

Building Caring Communities - A Community Workbook (SK): This process enables the community to identify one or more of the determinants of health as a priority and then plan activities that will strengthen the community by building on one or more of the determinants. A key aspect of this process is encouraging community participation with special attention paid to teaching community leadership and training individuals to facilitate all aspects of a community project. For information, visit: *www.health.gov.sk.ca/mc_dp_bcc_com_wkbk.pdf*

Hearts@Work (BC): This toolkit to screen people at risk for heart disease is an evidence-based community capacity-building initiative that is supported through a train-the-trainer process. At present, this program operates in over 250 BC communities. Contact: *jresin@healthyheart.bc.ca*, Healthy Heart Society.

Building Community Relationships (NL on behalf of the BBT Atlantic Initiative): This training module includes both participant and facilitator handbooks with content covering these areas: identifying new community supports and resources, referral practices, nature and levels of partnerships, exploring new partners and strategies for initiating them, critical factors for a successful partnership and assessing partnership effectiveness. Contact: *merv@gov.ns.ca*, NS Department of Health.

Community^PLUS (SK): School^PLUS and primary health care share similar goals, principles and challenges. A partnership was formed in one region resulting in the merging of the two provincial initiatives to form 'Community^PLUS'. The overall goal of Community^PLUS is to achieve healthier communities and to support children, youth and their families in pursuit of learning and well being. For more information contact the Five Hills Health Region or visit: *SchoolPLUS@sasked.gov.sk.ca* and *www.health.gov.sk.ca/ps_phs_services_over.html*

Guide to Community Funding Partnerships and Program/Service Integration (ON): This resource will assist interdisciplinary PHC teams with possible local-level funding sources as well as potential community partners and services that may assist family health teams in providing comprehensive care to their patients. Visit: *http://www.health.gov.on.ca/transformation/fht/guides/fht_community_funding2.pdf*

Community Advisory Committee or CAC (NL): As part of the PHC change process in NL, each of the eight provincial project sites have set up a CAC to promote and facilitate community involvement in health care. CAC members represent partnerships with a variety of communities, groups or agencies and play a role in identifying needs, appropriate approaches and resources required or available. Contact: *dryan@gov.nl.ca*, Department of Health and Community Services.

Healthy Eating Habits Initiative (MB): This community initiative was focused on raising awareness of the impact of eating habits on health. The coordinator developed and delivered programs based on community input. Contact: *mgray@normanrha.mb.ca*, NOR-MAN Regional Health Authority.

Circle of Health: Health Promotion Framework (NL): Prince Edward Island Health and Community Services Agency developed this framework in 1996. It is used to help the health providers at project sites to establish a common understanding of health promotion and provide them with a tool to guide strategic health promotion planning. Contact: *dryan@gov.nl.ca*, Department of Health and Community Services.

Facilitation Skills Training (MB): Regional health promotion coordinators have developed staff training in facilitated discussion for use in planning with community groups. Trained staff, with enhanced skill in facilitating discussion, help to identify community issues and the solutions to promote health in community development and program planning. Contact: *cosborne@prha.mb.ca*, Parkland Regional Health Authority.

Community Capacity Building Tool (NL): This tool was adapted from a Health Canada instrument by the Office of Primary Health Care and Wellness Division. The tool is designed to assist PHC projects in building capacity in relation to health promotion work. Contact: *dryan@gov.nl.ca*, Department of Health and Community Services.

Chapter 7

By Colleen Rand, Eileen Vilis,
Noreen Dort, Heather White

Chronic Disease Management

As with the other areas discussed in this guide, chronic disease management (CDM) is another area where facilitative processes can have a positive impact. Facilitation can ensure the use of evidence, fluid team building and broad collaboration. As facilitation begins to define and communicate different expectations for the delivery of CDM, providers and clients/patients alike are being asked to change their behaviour.

Facilitation in this area of practice will support a new approach to the prevention and management of chronic disease – based on relevant clinical practice guidelines. The new associated processes and tools will focus on primary and secondary prevention. They will also provide a focus on the enhancement of client/patient self-management and on collaborative inter-professional provider practice.

This chapter initially offers the reader some thoughts on defining CDM and on making the shift needed to enhance the focus on prevention in this area of practice. The reader is lead through a discussion of the care gap and the importance of changing clinical practice patterns. The elements of a chronic care model, currently used in British Columbia, will help the reader in a discussion of the role of the facilitator in CDM.

In addition, Chapter Seven explores this emerging area of care and the opportunities and challenges that exist as the approach to health care is reshaped. This chapter illustrates how the facilitator works to identify a path that moves all those involved through a reoriented model of care. Facilitators do this by working with teams of providers, inter-sectoral groups and organizational environments that may not yet be aligned with this new approach.

Defining Chronic Disease Management

Chronic disease management is a clinical management process of care. It spans the continuum of care from primary prevention to ongoing long-term maintenance for individuals

with chronic health conditions or disease. This approach identifies individuals with chronic diseases, assesses their health status, develops a program of care and collects data to evaluate the effectiveness of this process. The focus is on proactive interventions including treatment and education. This enables the individual with a chronic disease to maintain optimal functioning with the most cost-effective and outcome-effective health care expenditure.

Although this Guide uses the language of chronic disease management (CDM), there is no clear consensus on the best language to describe this shift in focus. For some the use of the word "chronic" is problematic. For others, the use of the word "management" is best replaced with "prevention." No solution is offered to this ongoing dialogue around language usage to articulate this work. While acknowledging the debate, this Guide embraces the language of CDM for the purposes of discussion.

The focus of the CDM approach is to encourage disease prevention and the maintenance of good health. The promotion of accurate diagnosis and treatment planning across the continuum will:

- Maximize the clinical effectiveness of interventions;
- Eliminate ineffective or unnecessary care and interventions; and
- Reduce the duplication of effort and activity.

The idea and practice of continually improving the outcomes of the service delivery process is a guiding force of this approach. The intention is to use only cost-effective diagnostic tests and requirements while increasing the efficiency of health care delivery in accordance with appropriate standards of quality. As with other PHC activities, the emphasis is on evidence-based planning.

Making the Shift

It has been suggested that chronic disease is the main financial driver of our current health system, contributing to the growing concerns around sustainability.[14] In trying to cope with a chronic disease in a health system not set up to cope with it, the challenge is how best to re-align this system of care and service delivery. A way must be found if there is to be a shift in our paradigm of service delivery. Rauscher (2003) identified four main interventions to support this shift:

1. Focus on the health of the population through the development of programs and services which address the broader determinants of health;
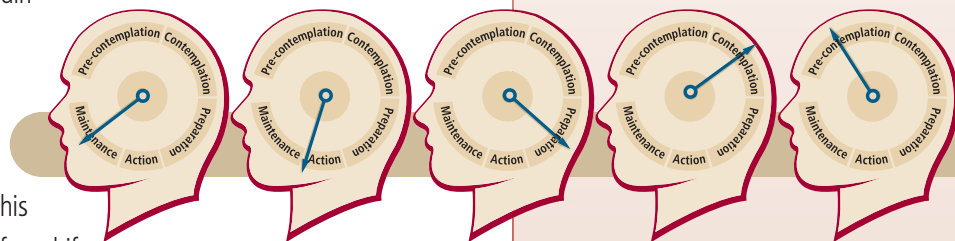
2. Emphasize prevention by addressing the known risk factors that contribute to the development of the disease;
3. Enhance efforts to manage the disease effectively to limit its progression; and
4. Respond to acute events as they occur and intervene accordingly.

He continued to explain that our Canadian system has been focused on the last two methods of intervention and warns that:

"…as we move past the acute medical events, we need to make sure that we don't settle for 'managing diseases' or even addressing the risk factors of the diseases without addressing the broader determinants of health: this is the real paradigm shift in health and chronic disease management."[14]

Table 8: Chronic Illness and Current Health Care Delivery

Chronic Illness is:	Health Care Delivery is:
Multidimensional	Single dimensional
Inter-dependent	Segmented
Ongoing	Episodic
Disabling	Disease-oriented
Personal	Institutional

Referenced in footnote #14

In keeping with this, Table 8 contrasts the characteristics of chronic illness with that of the current health delivery system.[15] This comparison highlights the need for system wide re-design to effectively prevent, treat and support people with chronic disease.

This new paradigm of service delivery requires educational support for providers and persons living with chronic diseases, but it can also benefit from the added supports that facilitation can offer in making such a large systemic shift.

The Service Delivery Gap

There is no shortage of models/ways that attempt to manage the complexities of people with long-term illness. These people often experience co-morbidities that increase the complexity of care. To meet the challenge of providing the complex care needed by individuals (and their families) living with chronic illness, there has to be a fundamental change in how the approach to chronic care is integrated into the PHC system.

Multiple guidelines exist for a range of chronic conditions. This can be confusing for teams. An additional challenge to systemic change in CDM is the remuneration structure. It does not include payment for the time necessary to explore individual patient issues, goals and motivations that may affect medical treatment or the coordination of both internal and external allied health resources.

Managing chronic illness care in an organized systemic fashion may prove to be a difficult transition for a health system that has been based on an acute care model. Evidence exists to support a system change. And that evidence clearly indicates how best to implement chronic disease support into primary health care. Yet, the system change has not yet been implemented. It is here that facilitation – may provide a process to move through and integrate such a system change.

Approaches to Implementation

There are increasing examples of successful shifting into this new paradigm of CDM care – many of which have benefited from facilitated processes. British Columbia was the Canadian forerunner in making this shift with their CDM collaborative process – a process that is marked by a team-based approach to early intervention and prevention. The CDM collaborative is rooted in the PDSA improvement cycle and supported by many levels of facilitated processes and educational offerings. Following in a similar fashion, Newfoundland and Labrador and Saskatchewan have developed their own CDM collaborative process. NL's approach is based on the use of facilitative supports. The University of Ottawa has included CDM (CICM – Chronic Illness Care Management) in their outreach facilitation research and Manitoba has embarked on activities to support this paradigm shift.

Changing Clinical Practice Patterns

To sustain changes in CDM, clinical practice patterns that entrench the current approach must be replaced with reinforced patterns that move the system into the new CDM paradigm. University of Ottawa's focus has been on changing clinical practice patterns through a structured yet tailored systemic approach to coordinate patient care using the CICM care plan as a tool. The five components within this care plan are:

1. Medication review;
2. Education/self-care;
3. Community integration/social support;
4. Psychological assessment/social assessment; and
5. Prevention screening.

An initial visit with the client/patient sets the stage for both client/patient and practitioner commitment to explore the care choices. They look for ways to reconcile the client's/patient's goals with the medical reality over the period of planned visits. The client/patient is encouraged to take an active role in planning her or his care. This approach provides an opportunity to integrate, review and track involvement of other health or community resources involved in client/patient care. In the University of Ottawa's model, this shift in approach is supported by a facilitator who guides the team in making necessary shifts in practice.

British Columbia's Expanded Chronic Care Model

The following expanded Canadian Chronic Care Model (adapted from Wagner et al.[85]) identifies the essential elements in a system that is striving for enhanced chronic care management as including: the community; the health system; self-management support; delivery system design; decision support; and clinical information systems. This framework can be adapted for a variety of chronic illnesses, health care settings and target

populations where the goal is better health outcomes, healthier clients/patients, more satisfied providers and more cost-effective expenditure of health care resources.

The following adaptation of Wagner's model[86] is provided by British Columbia. In it, the role of the community is emphasized and health promotion and disease prevention are integrated.

Diagram 6: Population Health Outcomes/Functional and Clinical Outcomes B.C.'s Expanded Chronic Care Model[87]
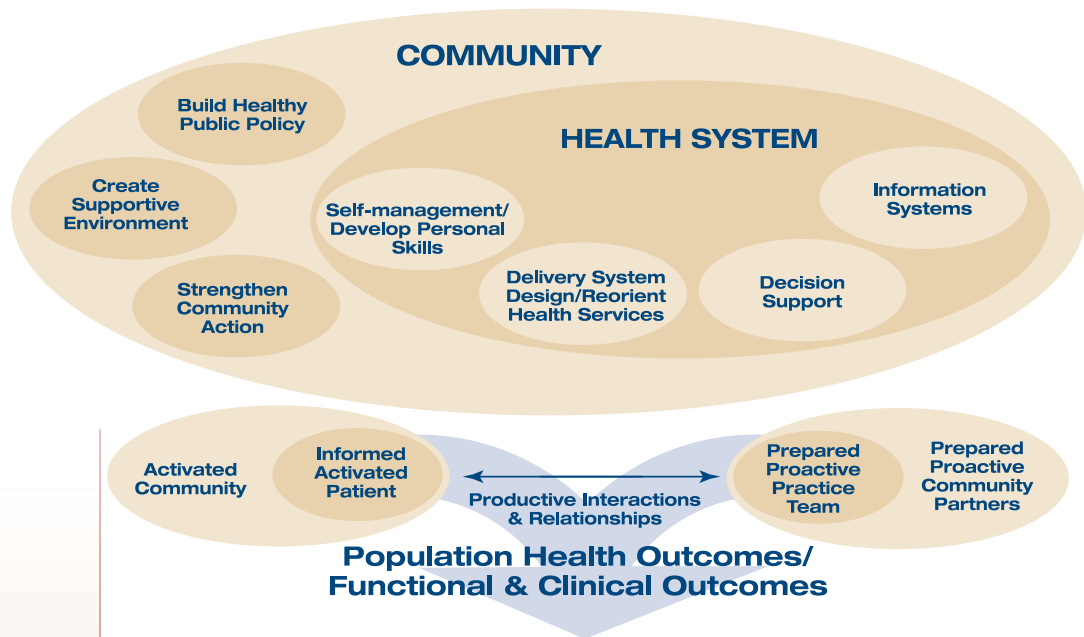
Created by: Victoria Barr, Sylvia Robinson, Brenda Marin-Link, Lisa Usdark III, Anita Dotts & Darlene Revenadale (2002) Adapted from Glasgow, R., Orleans, C., Wagner, E., Curry, S., Solberg, L. (2001). Does the Chronic Care Model also serve as a template for improving prevention? *The Milbank Quarterly, 79(4),* and World Health Organization, Health and Welfare Canada and Canadian Public Health Association. (1986). Ottawa Charter of Health Promotion.

Last Revised: July 21, 2005

Key Elements of this Model

The following section lists the various components of this model and incorporates the role of the facilitator in supporting the paradigm shift.

Health Care System Organization: This concept refers to the leadership commitment required to successfully implement chronic disease management at a systemic level. This is achieved via:
- Support of the CDM strategy at all levels including senior leaders and decision makers;
- Improvement strategies aimed at system change or design;
- Open and systematic handling of errors and quality problems to improve care;
- Agreements that facilitate care coordination within and across organizations; and
- Incentives provided based on quality of care.

Community Resources: The mobilization of community resources to support or expand healthcare for chronically ill clients/patients is an important element in this work. The key focus here is to encourage:

- Client/patient participation in community programs (exercise, seniors and self-help groups);
- Partnerships with community organizations to support and develop interventions to bridge the gaps in needed services; and
- Advocating for policies to improve client/patient care.

Self-management: The client's/patient's role is crucial to maintaining health and involves:

- The client/patient having a central role in managing her or his health;
- Self-management support strategies that include assessment, goal-setting, action-planning, problem-solving and follow-up; and
- Establishing contact with community resources that provide support.

Delivery System Design: Examining health care service delivery helps practitioners to:

- Define roles and distribute tasks among team members;
- Use planned interactions to support evidence-based care;
- Provide clinical case management services for clients/patients with complex health issues;
- Ensure regular follow-up by the care team; and
- Give culturally sensitive care that clients/patients understand.

Decision Support: The provision of decision support promotes clinical care that is consistent with scientific evidence and supportive of the client's/patient's understanding of her or his disease or condition. This includes:

- Incorporating evidence-based practices into daily clinical practice;
- Sharing evidence-based information with clients/patients to encourage their participation;
- Using proven provider education methods; and
- Integrating value-added specialist expertise and primary care into the care of the client/patient.

Clinical Information Systems: The purpose of effectively and efficiently designing health care information systems is to ensure that both client/patient and population data is accurate and comprehensive. This permits:

- Timely reminders for providers and clients/patients of upcoming appointments or concerns;
- Identifies relevant sub-populations targeted to receive more involved care;
- Facilitates individual client/patient care planning;
- Shares information with clients/patients and providers to coordinate care; and
- Monitors the performance of the health care team and system.

Managing the Facilitator's Role

The issue of facilitation in this area of practice will be clearly defining the facilitator's role and ensuring that the role is supported with adequate time and resources to facilitate changes at the various points in the health organization.

The facilitator's role is to create opportunities for participation of the many stakeholders in this change process. To support the system reorientation toward a team-based model of care, the facilitator can encourage providers to make necessary shifts that allow them to provide enhanced care to clients/patients. In order to shift providers toward facilitating self-management by clients/patients, facilitators will need to ensure sufficient levels of educational support by encouraging responsibility rather than engaging in the do-onto-others approach.

Forward momentum is sustained with activities that are based on evidence. This is crucial in supporting a meaningful re-alignment. It is also crucial that facilitators in CDM understand evidence and the methods for gathering relevant evidence to inform ongoing changes.

The re-alignment called for by the expanded CDM model is both exciting and challenging. As with all change processes, having a dedicated resource in the form of a facilitator whose role it is to support this change will be beneficial. It is however, important to note the relative newness of this shift in thinking. While facilitation for change has proven effective in various areas and is beginning to build supporting evidence, it does not yet sit on a solid base of evidence. It is important to continually gather information on facilitated change and activity in order to build the evidence that grounds this work.

Facilitation Resources

Chronic Illness Care Management (CICM) (ON): The CICM approach is a comprehensive, planned evaluation of patient care requirements designed to organize challenging patient care delivery for those with multiple chronic illnesses. It is a shared care approach between the PHC physician and patient using a tailored care plan with five major components (medication review, self-management, community integration, psychological assessment and prevention). Contact: *facilitation@scohs.on.ca* or *jschultz@uottawa.ca*, University of Ottawa.

Regional Diabetes Program Framework (MB): This document defines the provincial expectations for a regional diabetes program. The purpose is to increase awareness and understanding of the systems integration necessary to implement a public health approach to diabetes and to assist in the development of RHA specific plans to meet the needs of the health regions. Contact: *KrAnderson@gov.mb.ca*, Manitoba Health.

Risk Factor and Complication Assessment Train-the-Trainer Program (MB): This program provides information about knowledge and skills to assess for the risk

of developing type 2 diabetes, the presence of type 2 diabetes, the risk of developing long-term complications and the presence of long-term complications. *KrAnderson@gov.mb.ca*, Manitoba Health.

Provincial Diabetes Collaborative (NL): Using the 2003 Canadian Diabetes Association Clinical Practice Guidelines for the Prevention and Management of Diabetes in Canada as a foundation, the NL Diabetes Collaborative structured systemic processes to achieve its goal to enhance team-based preventive CDM health delivery. A range of processes and tools were implemented in the expanded chronic disease model. The breakthrough series improvement model for organizational change was adapted for the province. Contact: *dryan@gov.nl.ca*, Department of Health and Community Services.

Children's Therapy Initiative (MB): The Children's Therapy Initiative (CTI) was proposed by Healthy Child Manitoba to provide coordinated, regionally-based therapy services that help children reach their full potential. To bridge the gaps in referral and assessment processes, a universal referral tool was developed based on a no-wrong-door system entry point. Contact: *espencer@normanrha.mb.ca*, NOR-MAN Regional Health Authority.

Getting a Grip on Arthritis (SK): This multi-disciplinary community-based approach to managing arthritis aims to increase the capacity of PHC providers, communities and people with arthritis to manage the symptoms and impact of arthritis. The approach also aims to enhance prevention, early detection, comprehensive local care and more appropriate and timely access to specialty care and self-management strategies. Visit: *www.arthritis.ca*

Guide to Chronic Management (ON): This resource will assist inter-professional PHC teams to plan chronic disease management and prevention programs for their clients/patients. Visit:
http://www.health.gov.on.ca/transformation/fht/guides/fht_chronic_disease.pdf

CDM Collaborative (BC): The CDM Collaborative steering committee met several times to develop a collaborative charter. As targets for improvement were identified, these were added to the charter. a change package was developed for PDSA cycles. Collaborative teams participated in three learning sessions and a closing conference. Sessional funding to support general practitioner participation in learning sessions helped to get their buy-in to the process. Between collaborative learning sessions, teams were supported via conference calls and email listserves. For more information:
http://www.heartbc.ca/pro/collaboratives/collaboratives.htm
http://www.healthservices.gov.bc.ca/cdm/practitioners/structured_collaboratives.pdf

Chapter 8

By Heather White

Teams

A principle of PHC reform is the desirability and importance of inter-professional and inter-sectoral teams. This growing consensus has created an expectation that enhancing PHC team practice will build sustainable local capacity as a means of effective health care delivery. Despite the strength of that consensus, this is an area where public policy is ahead of the research. In many situations inter-professional teamwork will enhance the quality of care.

Although there is little evidence in the medical or health literature to support the enhanced effectiveness of teamwork, the business and policy literature provides insight.[18,88, 19] Katzenback and Smith (1994) indicated that when performance requires multiple skills, judgements and experiences, then teams outperform individuals acting either alone or in large organizational groups. So an evaluation of the effectiveness of team-based health services delivery over time is warranted.

Across Canada team work in PHC has grown out of necessity, particularly in rural locations. Many PHC renewal processes have focused attention on exploring what a team approach looks like and on finding ways to sustain and develop PHC teams. Teamwork can be divided into two categories — team outcomes and team process. While the facilitator may be involved with identifying and supporting team outcomes (the work of the team), this chapter focuses on how facilitators enable the PHC team-based process to develop.

This chapter provides a template for identifying effective teams. It begins with a look at the variations in team formations and explores the basic elements of PHC teams. This is followed by a discussion of the stages that teams move through. The final section explores the facilitator's role in transforming conflict and provides information on relevant facilitation resources.

Varieties of Team Formation

The context in which a PHC team operates (including geography, culture, population and urban or rural setting) often influences the team's makeup and defines the necessary supports for the team to function at its optimal capacity. Some teams are composed of a doctor and a nurse or nurse practitioner. Other teams are more broadly composed of the full range of providers and community members. In many rural sites where providers are separated by distance, teams need to develop a virtual existence. These virtual teams require the technological support to communicate and work effectively. The availability of supports/infrastructure such as email, cell phones, teleconferencing and video conferencing become crucial to ongoing team development. Face-to-face meetings for such groups are less frequent but of a longer duration than meetings for teams in a more compact local setting. Regardless of the original form, team memberships evolve due to changes in role, people and organizations. Teams must respond to the ongoing change. Often, teams will distinguish a core group (Saskatchewan) or a core team plus extended network (Newfoundland and Labrador) that reflects the involvement of team members based on their role and availability. However, teams also need to allow for the natural ebb and flow of turnover. This flow poses challenges for group cohesion, but team members should resist forfeiting the team approach for a focus on outcomes. The strength of the team process influences sustainability.
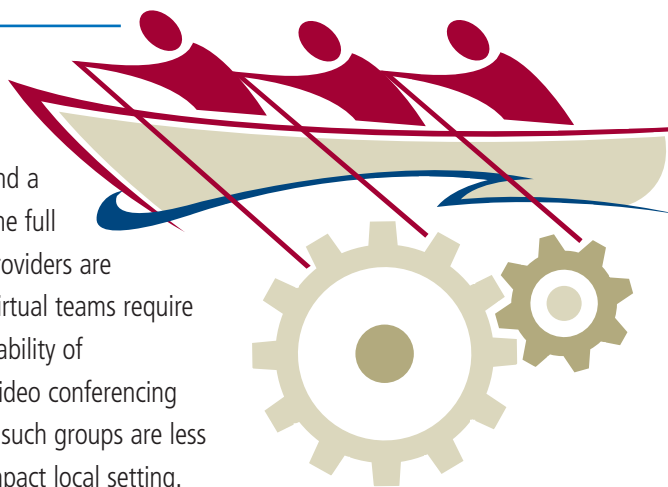
Basic Elements of Teams

In exploring the dynamics of team-based care, it is helpful to start with the World Health Organization's (1985) definition of a team:

"A group of persons who share a common health goal and common objectives determined by community needs, to which the achievement of each member of the team contributes, in a coordinated manner, in accordance to his/her competence, and skills and respecting the functions of others."[12]

PHC teams share common goals, informed by community strengths and opportunities for change. These shared goals are realized when providers from many backgrounds offer their expertise in this emerging inter-professional practice.

The PHC team collaborates as members coordinate service delivery, with the client/patient in mind. They focus their knowledge and skill on each person to ensure that she or he has the best opportunity for enhancing health and well being. Collaboration with inter-sectoral team partners further operationalizes the concept of population health.

Regardless of where we find our team, we need to tend to team *process* and outcomes. The PEW Health Professions Commission (1995)[89] has identified five main building

blocks for health care teams that can help focus on team process. The following table has been adapted from the PEW Commission's work:

Table 9: Building Blocks for Health Care Teams

Element	Tasks	Facilitator's Role
Goals	Set team focus with all team members based on evidence/community needs; Refine goals over time.	Leads goal setting discussions; Differentiates tasks from team process goals; Important in early stages and transitions; Discuss team values and expectations.
Tasks and Roles	Focus on team tasks to define team needs and overlapping skills/ roles; Clarify responsibility/accountability; Ensure fair distribution of work.	Assist with clarification of task/roles; Ensure sufficient time spent on expectations; Manage impasses and conflicts as they arise; Re-define tasks when needed to move forward.
Shared Leadership and Decision Making	Allow opportunity to participate; Encourage sharing of responsibilities; Allow leadership to shift with issue; Define decision making process and limits; Decision by consensus when possible.	Encourage balanced decisions; Include all team members in process; Coach members to take on leadership roles; Recognize how power inequities may limit necessary team conversations.
Communication	Discuss communication needs; Identify barriers to communication; Design a documentation process; Develop team charter/terms of reference.	Ensure productive meetings as needed; Assess and re-define communication process; Address communication barriers; Build team interpersonal relationships.
Conflict Resolution	Define a clear resolution process; Build resolution capacity; Encourage resolution; Create a safe space for raising issues.	Assist with conflict resolution; Facilitate necessary skill building; Coach members to share concerns; Encourage respectful exchanges.

Referenced in footnote #89

Stages of Team Development

Several authors identify the necessity of understanding the stages of team evolution.[89, 90] Although there may be some differences in the stages identified and the order in which they appear, there is a consensus on the concept of team stages. We will explore the dynamics of these stages as defined in Drinka and Clarke's Health Care Teamwork (2000)[90] – Forming, Norming, Confronting (other models refer to this stage as Storming), Performing and Leaving.

Forming

- Moving from individual to group member;
- Learning about each other's role, skills, backgrounds;
- Relationships tend to be guarded and formal;
- Members tend to follow pre-formed, stereotypical notions about other professionals; and
- A period of questioning is needed to establish collaborative teams.

A key task in this stage is establishing clear goals through a participatory process that encourages involvement of all members. Learning about the scope of practice of the various providers is an important part of the development process at this stage as well as when new members enter the team. Developing relationships based on mutual respect and shared goals is crucial to the successful passage from the forming phase.

Norming

- Members need to establish usual patterns of interaction;
- Individuals reconcile professional loyalties and team responsibilities;
- Members need to accept the rules and structures of the team;
- Members need to establish and honour day-to-day functioning as a team; and
- As members get to know each other, friendliness and team cohesion grows.
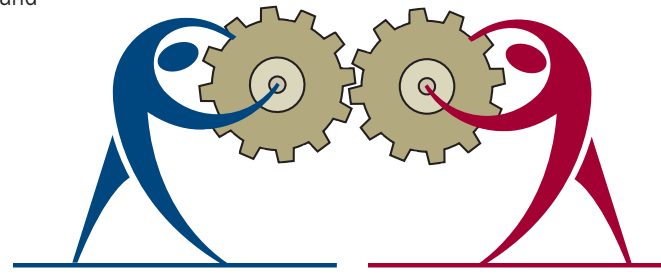
This is the stage when tasks and roles of team members are established. Once the different expertise that each member brings to the table has been identified, it is possible to determine who will do what. Setting up clear and effective mechanisms for communication is particularly helpful at this stage. It allows a means by which the team can maintain contact.

The nature of the leadership at this stage impacts team dynamics. True team leaders share process and decision making as appropriate. Leaders should ensure that all team members develop their capacity to influence decision making.

Confronting

- Members begin to perceive problems with their roles and tasks;
- As conflicts about team functioning arises, personality differences may become more apparent; and
- Issues arise with regard to workload, team leadership, hierarchical patterns and formulation of team goals.

Once a team has formed, it begins slowly to unravel as established team processes and expectations are questioned. It is normal to have members pose questions regarding the effectiveness of the team and the team's goals/outcomes. In fact, it is healthy and expected and, when facilitated, can strengthen team dynamics. Negotiation as well as conflict resolution skills and processes become essential for navigating the storm of internal change. Clear methods of identifying opportunities for change with team members can help to create a process for re-evaluating goals, tasks and roles as needed and to continue to support team development.
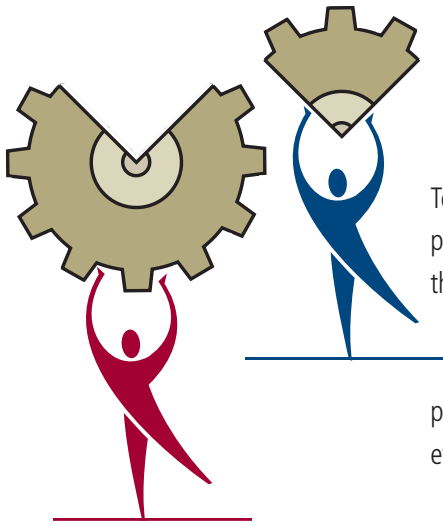
Performing

- Teams begin to function smoothly;
- Members have a clear sense of goals and roles;
- Members have a positive sense of group identity; and
- Members establish good working relationships.

Team facilitators who are able to manage conflict will find this skill useful throughout the process. At this stage, conflict is embraced as a valuable impetus for improvement. Although the initial storm has passed, unexpected challenges continue to arise. Responsive teams make necessary and appropriate team adjustments as needed. That is why it is important to continue to foster effective mechanisms for dialogue and for conflict resolution. The process of goal and role re-evaluation is dynamic. It is informed by ongoing research and evaluation of team functioning and outcomes.

Leaving

- Membership changes require ongoing assessment of roles and responsibilities; and
- Team reflection to identify strengths and opportunities for change.

The leaving stage is not included in some models of team development but it is a reality of all teams. The turnover in membership shifts the team's skill set, workload, knowledge base and leadership. Such changes often trigger a return to earlier stages. Facilitators and team members who understand these stages can anticipate and manage the challenges as the team evolves.

Transforming Conflict

Given the mix of skills and professional backgrounds, as well as the complexity of inter-sectoral collaboration, disagreement is inevitable. This conflict is necessary and desirable. The key to manage it well is to have clear processes for working through or negotiating both team and individual conflict. The goal is to prevent a conflict from becoming a destructive force in the workplace.

A team facilitator responds to emerging conflicts with several goals in mind:

- Prevent unnecessary conflict and facilitate necessary discussions;
- Resolve emerging conflicts constructively;
- Facilitate development of conflict resolution skills; and
- Guide the team along a constructive resolution path.
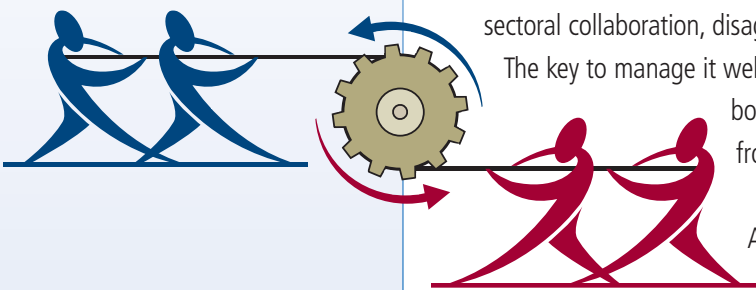
These principles guide the facilitator's work. As does the knowledge offered by the PEW Commission[89] that highlights conflict challenges, unique to Health settings, that may be encountered as being:

- An idealized sense of togetherness that inhibits necessary, open dialogue;
- A professional obedience to authority that limits member engagement and re-inforces hierarchical relationships;
- Banding together as a profession when faced with a disagreement that interferes with team cohesion;
- Personality differences that negatively impact team process or outcomes;
- Mis-understanding of the roles, skills, responsibilities and accountabilities of other team members; and
- The absence of clear, negotiated boundaries between team members and roles.

It is important to be aware of the potential affect that these challenges can have on teams. This is a normal part of teams in transition to a horizontal structure from a vertical organization grounded in a traditional hierarchy. And the process is greatly enhanced by a neutral third party. A facilitator, particularly an external facilitator, with well-developed conflict resolution skills is better able to address these issues. She or he can assist the team with creating habits that support team-based care. Skilled facilitators can encourage the integration of alternative approaches to care and team communication that sustain these new behaviours. A facilitator can also help to root out old, unproductive habits that can otherwise remain hidden. Unchecked, such old habits could create destructive team conflict.

Navigating Team Work

Facilitating team process often means reframing challenges as opportunities for change. This sets a proactive path for team development. The following discussion summarizes the opportunities for change experienced by Newfoundland and Labrador's Teams Working Group,[91] PEW Commission[89] and by the PHC teams in Saskatchewan (2004)[19] during the development process.

Organizational: Opportunities for change at this level stem from policies, bureaucratic processes, reporting structures and fee arrangements. To take full advantage of these opportunities requires the collaboration of leaders and providers.

Typical Challenges/Opportunities for Change:
- Separate lines of reporting and control;
- Differing compensation mechanisms limiting provider engagement;
- Scheduling and priority setting;
- Time required for teams to meet;
- Leadership for supporting the team process;
- Lack of recognition of the benefit of facilitation in team development.

Facilitator's Role:
- Navigate the group/team through this process;
- Balance needs of team and organization;
- Seek remedy for issues that impede team development at the organizational level;
- Remain fluid depending on needs of team (i.e. consultant, planner, negotiator, advocate, educator, data collector, reporter).

Team: Opportunities for change at this level are marked by the normal dynamics of people coming together to organize and collaborate. Facilitating team process involves building on the strengths of the group and identifying the opportunities for change and development.

Typical Challenges/Opportunities for Change:
- Ensuring that meetings are productive;
- Managing perceived inequities in status of team members;
- Fostering commitment to team process;
- Developing leadership in establishing and sharing the team process;
- Ensuring clarity and effectiveness of dialogue;
- Conflict resolution as needed.

Facilitator's Role:
- Become a potential advocate for the team and its members;
- Ensure that the focus is on team process;
- Create opportunities to plan for challenges;
- Enhance team cohesion and team effectiveness.

The team needs to discuss how they will work through conflict as part of the team's values charter. A team charter (sometimes termed a team mandate or terms of reference) is a working document that defines the team and the scope of its work. It is a framework that may include the team's vision, mission (purpose), objectives, values, membership, history, key responsibilities, parameters, measures of success, communication and decision making processes.[92, 93]

Facilitation allows for the creation of a safe space for dialogue. A charter, as part of that process, defines what team members expect from each other. It delineates a clear process for resolving conflicts. This helps to define avenues for resolution. Using these avenues when conflicts arise is the key to turning challenges into opportunities for positive change. Charting a constructive path for team conflict includes the separation of team conflict from individual differences that need to be resolved privately. Both types of conflict require guidance and support for resolution, though the type of intervention required may differ.

Facilitating team process often means reframing challenges as opportunities for change. This sets a proactive path for team development.

Individual: The opportunities for change at this level are created by the diversity of the group. The larger the group, the greater the probability that individual perspectives will result in disagreements among team members.

Typical Challenges/Opportunities for Change:
- Fostering co-operation among members;
- Encouraging open and transparent communication;
- Working through member conflicts;
- Transforming individual conflicts into constructive moments.

The Facilitator's Role:
- Encouraging conflict coaching and skill development;
- Normalizing these opportunities for change;
- Clarifying conflict resolution expectations/procedures.

Team members assume responsibility for their personal concerns. They should raise them when appropriate with the person with whom they have the concern – or let it go. Determining which response is most appropriate is often a delicate matter. Most conflicts are resolved through respectful conversation that allows both perspectives to be heard. Sometimes a neutral third party can help resolve the matter.

Educational: These educational opportunities for change arise in the educational supports needed to sustain team growth.

Typical Challenges/Opportunities for Change:
- Allocating of resources to offer training and supports that foster team and organizational growth;
- Providing training for clinical skills that supports shifts in scopes of practice;
- Fostering the development of facilitation skills.

Facilitator's Role:
- Focusing on building capacity formally and informally;
- Acting as trainer, advocate, coach or mentor as needed;
- Helping to identify areas needing clinical skill development.

Regardless of the particular need, facilitators frequently act as educators in their continuous focus on building capacity with others.

Managing the Facilitator's Role

Schwarz (2005) suggests that the facilitative process requires entering the system and helping the group become more effective without becoming negatively influenced by the inertia of the system.[94] In a team-based approach to service, the change and the nature of teamwork are likely to create conflict – perhaps even trigger long-dormant conflicts. Varying degrees of resistance and conflict are inevitable in the process of change. But these moments hold positive potential – they can even be a transformative force.

This is an important task of facilitation – to encourage inclusive engagement in an environment that has historically evolved with symbolic and practical power differences. The default response to this conflict is reverting to power-based approaches for resolution. This will not resolve interpersonal matters. Teams move through fairly predictable stages, each stage marked by its own expected conflicts and challenges that can be transformed into opportunities for team development.

The key to this transformation is the creation of a safe space for dialogue. This means establishing clarity around expectations for dealing with conflict and for offering support before and after difficult conversations. To fully embrace these opportunities, the team must create ways to limit the negative impact if they are emerging from a hierarchical organization of people and professions. The team must find ways of enhancing their positive contributions to team development – supported by facilitation – and thereby transform conflict into opportunity.

Facilitation Resources

Team Formation (MB): The NOR-MAN RHA engaged in a facilitated process for forming their PHC teams based on staff engagement and community need. Contact: *mgray@normanrha.ca*, NOR-MAN Regional Health Authority.

Guide to Collaborative Team Practice (ON): This resource will assist interdisciplinary PHC teams in collaborative team practice. Visit: *http://www.health.gov.on.ca/transformation/fht/guides/fht_collab_team.pdf*

Developing Team Relationships within PHC (MB): NOR-MAN RHA used a facilitated process to support the development of team relationships through the development of a matrix for clarifying role relationships. Contact: *mgray@normanrha.ca*, NOR-MAN Regional Health Authority.

Engaging PCN Teams in Change (AB): A workshop in June 2006, supported by Alberta Health and Wellness, for leaders from health regions and Primary Care Networks, with significant participation from primary care physicians, gave a boost to team development. On-going support to PCN teams offered by Toward Optimized Practice. Contact: *doug.stich@topalbertadoctors.org* Toward Optimized Practice.

Learning Circles (NL): The Council for Licensed Practical Nurses collaborated with the Association of Registered Nurses of NL on a facilitated Learning Circles initiative to support changes in attitudes; professional roles and boundaries; group learning; and information sharing. Contact: *dryan@gov.nl.ca*, Department of Health and Community Services.

Team Charters (SK): A team charter (team mandate or terms of reference) is a working document that defines the team and its scope of work. The charter is a useful foundation document that supports a team discussion on purpose, roles and elements of team functioning. Contact: *chris.mayhew@saskatoonhealthregion.ca*, Saskatoon Health Region.

Team Building Workshop (NL on behalf of the BBT Atlantic Initiative): This training module includes both participant and facilitator handbooks and covers the following content: nature and phases of teams, role clarification, process of change, managing meetings and consensus building. Contact: *merv@gov.ns.ca*, NS Department of Health.

Team Development in Primary Care Networks (AB): Supported by Alberta Health and Wellness, Capital Health and Calgary Health Region hosted a project to develop a manual which supports interdisciplinary teamwork in Primary Care Networks across Alberta. It includes learning activities and resources on system context, using evidence, building teams, collaboration and scope of practice and sustaining team facilitators. Contact: *Kelly.Holmes@gov.ab.ca,* Alberta Health and Wellness.

Team Handbook (NL): This handbook, developed through a facilitated input process, supports inter-professional teamwork in the Health and Community Services, St. John's Region. Contact: *dryan@gov.nl.ca*, Department of Health and Community Services.

Conflict Resolution Workshop (NL and NB, on behalf of the BBT Atlantic Initiative): This training module includes both participant and facilitator handbooks and covers the following content: nature and dynamics of conflict; constructive versus destructive conflict; the conflict cycle; positions versus interests; and communication techniques. Contact: *merv@gov.ns.ca*, NS Department of Health.

Chapter 9

By Juanita Barrett, Noreen Dort, Heather White

Collaboration and Scope of Practice

Fostering a collaborative PHC culture requires an understanding of the delicate balance between the needs of:

- Individuals and community;
- The community and the providers;
- The individual team member and the PHC team as a whole; and
- Different professionals and groups.

The provincial mandate and local organizational culture are key contributors in creating a collaborative culture for the delivery of primary health care. One aspect of facilitating change in this area is a solid understanding of the role of professional associations and regulatory bodies and their likely response to facilitated change.

Facilitators must have insight into the competing perspectives that can shape the attitudes regarding the roles of, and within, health care teams. And they must create opportunities for the team to reflect on those attitudes. As part of the discussion of shared and individual responsibility and accountability with groups of providers, professional differences need to be explored and reconciled to some degree before there can be a shared vision of care.

This chapter first looks at the nature of collaboration and its definitions. The subsequent section explores the basic elements needed to engage in collaborative PHC practice. A discussion of the nature and role of inter-professional education highlights the importance of finding opportunities for the team to learn together and to enhance their understanding of each other's role. At the end of the chapter are listed resources to facilitate changes in this area.

Nature of Collaboration

A fundamental part of a team-based inter-professional approach to PHC is the clear understanding of the scope of practice (SOP) including roles, functions, responsibilities and accountability. The following definitions[95] of collaboration are useful for beginning the discussion:

Collaborative practice is:

- *An integrated approach to delivering services. Health providers function as colleagues and are grounded by common care goals, supported by shared decision making, and nourished by a climate of mutual respect, trust and support. Effective communication and clear definitions of roles and responsibilities are integral to success; and*

- *An inter-professional process for communication and decision making that enables the separate and shared knowledge and skills of primary health care providers to synergistically influence the service provided to a population or to an individual.*

Common to both definitions is the importance of respecting each other's roles and responsibilities. There is also a shared commitment to ensure that the right provider delivers the right service at the right time.

Aside from the system and provider benefits in a collaborative approach to health service delivery, there are also many benefits for the individuals and communities. Some of these are supported by evidence and others are supported by consensus:

Evidence supported[96]

- The provision of a broad range of health care and health promotion services;[96] and
- Improved quality of health care delivery.

Consensus supported[25, 97]

- Improved service coordination that enhances timely access to needed care:
- Reduced duplication of services and visits plus an increased integration of care; and
- Improved communication among providers with consistent health-related messages.

The Commission on the Future of Health Care in Canada (Romanow, 2002) indicated that implementing strategies such as teams and networks of health care practitioners would help
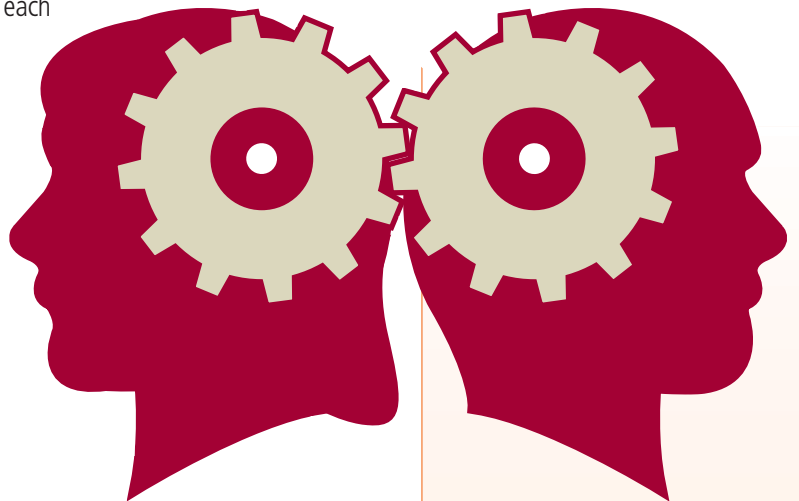
to build the PHC agenda. This in turn will transform Canada's health care system which needs to integrate values that have been mutually negotiated and agreed on (Romanow, 2002).

Basic Elements of Collaborative Practice

As with other models of care, collaboration has several elements that ensure success. The work of the Enhanced Interdisciplinary Collaborative Practice initiative (EICP)[98] is guided by a definition of inter-professional collaboration that has the following attributes:

- Development of a common purpose or care outcome;
- Acceptance and recognition of complementary skills and expertise among different providers; and
- Effective coordination and communication among relevant providers.

Collaboration is a framework for strengthening inter-professional communication and increasing the effective delivery of health care.

Newfoundland and Labrador facilitated a scope of practice (SOP) process in 2005-06 as part of the provincial PHC renewal plan. These facilitated SOP discussions encouraged exploration of ways to support the health needs of the community by enhancing SOP where relevant and appropriate. The following elements are taken from the enhancing SOP process defined by the provincial Scope of Practice Working Group.[95] These elements of collaborative practice guide a provincial network of NL facilitators and teams:

Client/Patient Centred: PHC teams work in collaborative partnerships with clients/patients and communities to promote and support choice and partnership in care decision making.

Coordination: Collaboration requires a structured process that allows providers to move into this model of care while simultaneously providing the flexibility needed to adapt to the needs of their local team, community and the clients/patients served. This requires defined collective goals and respect for each member's contribution.

Communication: Open and transparent communication is encouraged. Each member of the team is expected to share a respectful willingness to voice their own ideas and concerns and to listen to ideas and concerns from team members. Individual feedback to the team is as important as periodic team discussions on how to improve communication processes to ensure timely, focused and relevant dialogue.

Co-operation: Collaborative practice is grounded in shared decision-making and shared accountability that embraces a structured process, a client/patient focus, and a conflict resolution mechanism. The shared accountability must respect professional autonomy. It must also enable the appropriate provider to deliver appropriate service at the appropriate time.
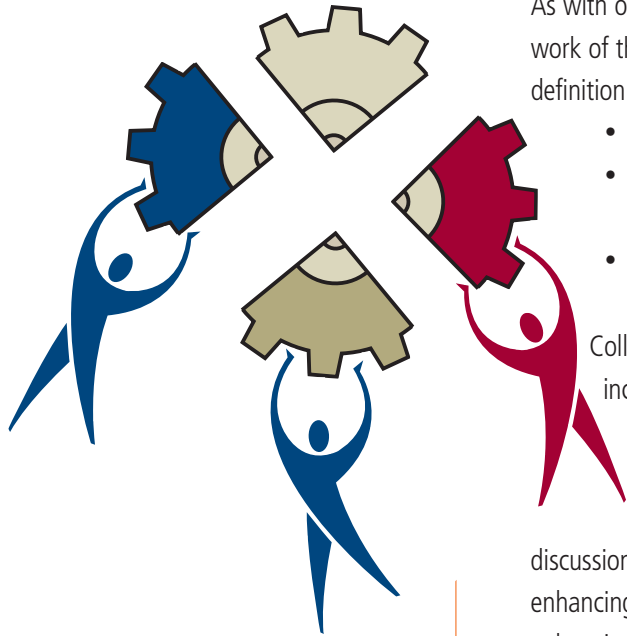
The key attributes of a collaborative process include: a practice that recognizes all team members as important contributors; shared and individual responsibility and accountability for processes and outcomes of health planning; and a sense of mutual trust and respect.

Commitment: A shared understanding of the need to work inter-professionally supports collaboration. The presence of organizational support to foster collaboration is as important as ongoing evaluation of both processes and outcomes of inter-professional practice.

The degree to which these factors are actualized in PHC teams reflects the quality of the collaboration. This was the guiding vision of the SOP process in NL. The time and effort involved with building a team is determined by the size and nature of each team. Through the support of a central facilitator and a team of local facilitators, NL is moving through the identification of roles and responsibilities as a team-building process for collaborative care. The need to transform conflict related to professional boundaries into opportunities for change was a core focus of the facilitator.

Professional Enculturation

To create a culture of collaboration, the inherent challenges in historical and current forms of health care delivery must be understood. Several authors identify the need to understand the barriers that professional cultures can pose to collaborative practice.[99] The literature points to a few key factors that must be considered to foster collaborative capacity – history, professional cognitive maps, systems of training and education; and necessary team supports. This section focuses on a discussion of the first two factors.

The evolution of the hierarchical health care culture involves professional groups offering increasingly specialized services. In this environment professions have created boundary-work to differentiate one profession from another[100] and to promote one professional ideology over another. Professional culture becomes the framework through which individual providers interpret inter-professional interactions, and by which they set relevant boundaries that shape team relationships.

In attempts to build collaborative practice by enhancing SOP, the notion of professional cognitive maps[101] highlighted in recent literature[99] greatly helps to explain the team dynamics.

Hall (2004) suggests that these cognitive maps grow out of the education and social experiences of students in each health profession and act as the building blocks of professional cultures. The maps influence inter-professional relationships by creating a stereotype blueprint for interactions. Petrie (1976) explains that two providers of different professions can look at the same situation and see different things.[101] In SOP work, the disparity between professional maps sparks challenge and opportunities for change.

Inter-professional team members must learn to deconstruct their own profession's map and re-integrate it into a collaborative cognitive map. The culture of collaboration is created at that point.

Role of Inter-professional Education

Hall and Weaver (2001) suggest that increasing professional specialization has reduced the opportunities for providers in different disciplines to interact. Gilbert (2004) highlighted increasing specialization as an impediment to inter-professional work.[102] Steinert (2004) refers to Freidson's (1986) suggestion when she says, "the process of professionalization is characterized by domination, autonomy and control rather than collegiality and trust."[103]

That is the challenge, or the opportunity, for change – to create formal and informal opportunities for providers to learn together. This is re-inforced by Steinart (2004) who says facilitators need to "develop a context in which learning becomes a vital part of working together."[103]

If learning in the inter-professional context is the process of making a new or revised interpretation of an experience that guides subsequent understanding, appreciation and action,[104] then the training modules developed through the Building a Better Tomorrow initiative may be tools that a facilitator could use to support necessary inter-professional learning.[105]

Though many involved in PHC believe in the importance of breaking down inter-professional silos through inter-professional education,[106] this perspective is supported by a minimal amount of evidence – though this area of research is under rapid development. Therefore it is important that PHC providers continue to gather evidence that will inform opinions about the efficacy of inter-professional learning. It is also important to note that this is only one of many factors that enhance collaboration.

Enhancing Collaboration

Transformation may occur at different levels: at the individual group or community level;[107, 108] at the organizational level; or at the level of society.[104] The current health care culture has a long history and deep roots, so change will not be easy. It may be helpful to see the process of change as a learning process from which many new ideas can emerge.[84] Through this collaborative practice, an inter-professional culture will take root. It will empower individuals to discover the validity of their own ideas and experiences and to look at them in a new way. Out of this process the team members will learn new ways of viewing each other and of framing their work.[109] It is important to recognize some of the challenges that come with this shift – after all, they will bring the opportunities for change.

That is the challenge, or the opportunity, for change – to create formal and informal opportunities for providers to learn together.

Scope of Practice (SOP)

Many challenges and opportunities for change have been found as Newfoundland and Labrador's providers move through this process.[95] Their work has highlighted three key areas needing attention before seeking to create shifts in professional scopes of practice. These are:

> *Authority:* Changes in scope must remain within the parameters set out by the relevant legislation and regulatory bodies. Providers working to an enhanced scope must accept the responsibility and accountability that comes with changes in competence level.

> *Practice Setting:* SOP changes must be aligned with the organizational policies that govern the practice site. Relevant changes must be determined through and guided by an analysis of the strengths/needs of the community and address the strengths/needs of each client/patient.

> *Education:* Appropriate levels of basic and continuing educational supports must be available in both formal and informal contexts to support the desired SOP shifts.

The process of making shifts in scope is as collaborative as the vision of team-based practice that guides it. It is important to work with key stakeholders to create a shared plan for moving forward with SOP work – a key place for a facilitated intervention.

Remuneration Models

An emerging barrier to facilitating collaborative practice is the absence of appropriate remuneration models. The ability to find the right remuneration model to encourage a fee-for-service provider to participate in PHC initiatives is a key challenge to advancing team-based delivery.[110] There is a range of fee-for-service providers including physicians, pharmacists and physiotherapists. Funding models are needed to encourage the members of these groups to collaborate. Facilitators must be aware of the strengths and limitations of various funding models in the delivery of PHC. Although facilitators may have little direct influence over the development of these funding models, they may facilitate the discussions and processes needed to develop relevant models.

One such process, which occurred in NL, began with a working group responsible for overseeing changes in this area specific to physicians. A series of facilitated discussions led to the creation of a discussion document.[111] This in turn lead to the development of contracts for physicians. Once this process is finalized, it will be repeated for other provider groups needing alternative funding models.

Managing the Facilitator's Role

A facilitator of collaborative change must know how to build a collaborative practice. It includes the encouragement of open dialogue, of shared visioning and of collective planning, all based on evidence gathered about which team members do what and when. With this knowledge a facilitator can work with groups of professionals and PHC teams to reshape work relationships in line with the emerging model of collaborative care. It is crucial that all stakeholders, including members of the community, are represented from the outset at the planning table.

By transforming individual and team conflicts into opportunities for change, facilitators enhance team-based inter-professional delivery of services. Using facilitated processes to build collaborative practice, facilitators support providers. When these providers are working to their full scope of practice they are encouraged to engage in dialogue. This engagement is necessary to build a shared understanding and a collective consensus on the changes that are relevant to a particular team/practice setting.

Facilitation Resources

Enhancing Scope of Practice (NL): The NL Office of PHC is using a facilitated collaborative process to enhance scope of practice in each of the eight provincial PHC sites. Contact: *dryan@gov.nl.ca*, Department of Health and Community Services.

Expanded Medical Office Assistant Role (BC): As part of the diabetes collaborative, the role of medical office assistants was enhanced to include data recording, planning of office visits and related details of the visit (blood pressures, height and weight, foot exams and self management). Contact: *Debbie.lewis@northernhealth.ca*, Northern Health.

Enhanced Scope of Practice for Paramedics (NL): Through a facilitated process of engagement, necessary changes occurred to support the enhanced scope of practice changes for local paramedics. For information, visit: *www.programsinparamedicine.com*. Or Contact: *dryan@gov.nl.ca*, Department of Health and Community Services.

Expanding Registered Nurses' Scope of Practice (MB): This role expansion grew out of a collaborative practice model that initiated the Well Women program through facilitated consultations and staff engagement. Contact: *mgray@normanrha.mb.ca*, NOR-MAN Regional Health.

Interdisciplinary Team Roles and Responsibilities (ON): This resource provides basic information to sponsors of inter-professional PHC teams to aid in the design and coordination of an inter-disciplinary primary health care team. Visit: *http://www.health.gov.on.ca/transformation/fht/guides/fht_inter_team.pdf*

Shared Scope of Practice LPN/RN (NL): The licensed practical nurse's (LPN) role was expanded to include the administration of medication. An exploration of SOP for RNs and LPNs using learning circles resulted in a document written by the Association of Registered Nurses of Newfoundland and Labrador and CLPN (1999) highlighting emerging issues. Contact: *dryan@gov.nl.ca*, Department of Health and Community Services.

Guide to Collaborative Team Practice (ON): This resource will assist inter-professional PHC teams in collaborative team practice. Visit: *http://www.health.gov.on.ca/transformation/fht/guides/fht_collab_team.pdf*

NP Scope of Practice (NL): As part of the process of integrating nurse practitioners (NP) into the PHC model, a consultation process resulted in a report highlighting changes to NP regulations. Contact: *dryan@gov.nl.ca*, Department of Health and Community Services.

Chapter 10

By Juanita Barrett,
Shannon Turner

Health Information and Communication

PHC was designed to include, in addition to the health sector, all related sectors and aspects of national and community development in agriculture, animal husbandry, food industry, education, housing, public works and communications. It demands the coordinated efforts of all those sectors.[10, 11] This is one of the reasons why information has been identified as a pillar of PHC. The intent is that, as PHC teams work together there will be a greater need and enhanced opportunities to communicate with each other and to share health information.

Shared patient records between PHC team members and across related services will support better and more efficient care, faster communication of test results, reduced duplication of tests and a better understanding by providers of the comprehensive needs of the client/patient and community.

Initially teams may have to rely on more traditional methods of communicating and sharing health information. A well-integrated information system can occur in both manual and electronic environments. In most cases, PHC providers work with both.

Investments in technologies, such as telehealth/telemedicine, can provide better access to diagnoses and treatment within a client's/patient's community, especially where access to providers is difficult. Toll-free telecare services can support 24-hours-a-day access to health advice/information. It can also help individuals decide whether they should present their symptom or complaint to a PHC provider or a hospital emergency department.

This chapter begins with a look at the current context and explores opportunities related to electronic health records, chronic disease management and telehealth. A discussion of the challenges inherent in facilitating changes in this area is followed by the identification of resources that have been developed to assist with making the most of the opportunities for change.

As PHC teams work together there will be a greater need and enhanced opportunities to communicate with each other and to share health information.

The Current Context

PHC renewal can occur in the absence of well-integrated information systems. They are useful, but not absolutely necessary, for change to occur. However, implementation of information management systems is occurring to varying degrees in many jurisdictions. These enhanced management capabilities create opportunities to improve communication among team members and provide support for clinical and educational activities. This is especially true in geographically challenging areas.

Although the presence of well-developed, integrated information systems can assist with PHC changes, planning, implementing and evaluating these systems is difficult and includes such considerations as:

- Lack of understanding of how they can help;
- Lack of understanding of how to access information on these systems and their use;
- Seeing them as an add-on to an already heavy workload;
- Dealing with the fear of potential job loss and/or job change with technology implementation;
- The cost of implementing and operating;
- The fear of using technology;
- Privacy and confidentiality issues.

Leaders supporting PHC change processes must be aware of information management initiatives in their jurisdiction. They should understand the implications for the evolving context within which providers must work. The role of facilitation in helping providers to identify and manage the technology challenges must be clearly defined. Clarity is also essential on where to access the expertise to support and direct technology implementation and usage.

The Opportunities

Enhanced Sharing of Electronic Information

An integral component of PHC change is setting up electronic means by which providers can communicate and share relevant information and documentation to assist with client/patient service and care. One of the methods currently used to share health information is the electronic health record (EHR), which may or may not include the physician record known as the electronic medical record (EMR). These EMRs are electronic records set up for or by physicians for communication among physicians and to collect (and sometimes collate) client/patient information. Such records are typically set up to support case management which allows various providers to access electronic client/patient files and information specific to their role in the client's/patient's service or care.

An integral component of PHC change is setting up electronic means by which providers can communicate and share relevant information and documentation to assist with client/patient service and care.

Ideally, both types of records should be able to interface. This allows necessary linkage and integration of services, delivery and communication across an inter-professional team. Many EHR systems and EMR systems were set up prior to the introduction of PHC teams. As a result, they focus primarily on the information needed by specific providers. This often limits the effectiveness of these systems as new PHC members enter the team, each with their own charting and information needs and styles. As a result, many EHRs and EMRs need to be adapted as the nature of the team's needs change.

There are a number of electronic health and medical record vendors in Canada. The penetration of the technology varies widely across the country. Most jurisdictions are at varying levels of EHR and EMR implementation processes in institutional, community and physician settings. For example, in British Columbia in 2006 only 15 per cent of PHC providers report having implemented electronic medical records. This profile will no doubt change dramatically as provincial support for establishing information technology and information standards in PHC advances.

Chronic Disease Registries

Many jurisdictions use registries to implement guideline-based care in family practice. Clinicians establish a registry of clients/patients based on a clinical practice guideline such as diabetes or clinical prevention. The registry contains the cohort of practice clients/patients experiencing a particular health issue or requirement for clinical prevention. The registry tracks the number of client/patient contacts, the screening or tests completed, dates, results and institutes reporting on parameters of interest such as an HbA1c value.

Physicians and their teams can track the consistency of their practice, client/patient progress and institute recall. When a collaborative of PHC providers employs a registry in common they can set performance targets for their quality improvements and track their efforts in the aggregate. This database is a powerful instrument for quality improvement. When a facilitator, or a team of facilitators, further supports this, then dramatic and rapid progress can be achieved.

The ongoing feedback provided by such an electronic resource is an exceptional tool for motivating change and, when shared with a community of providers, becomes a common frame of reference and evidence-based change management tool.

When a collaborative of PHC providers employs a registry in common they can set performance targets for their quality improvements and track their efforts in the aggregate.

Telehealth

Telehealth, an area of growth in information management, can be defined as:

> *"The use of communication and information technologies to deliver health services, expertise and information over distance, geographic, time, social and cultural barriers."*[112]

> *"The use of communications and information technology to deliver health care services over large and small distances, including remote and rural areas."*[113]

Telehealth is supported by a range of technologies that foster information sharing,[114] including broadband technology strategies and other multiple applications for telehealth. These applications include videoconferencing (room-based, mobile, desktop, home); store and forward software; peripheral devices (e.g. electronic stethoscope); home care technology; and point of care (e.g. palm tablets, Blackberry).

These new technologies can help to foster sharing of health information, such as the use of video facilitation to practice/team sites as is occurring in Ontario, Newfoundland and Labrador and Saskatchewan. It reduces the number of face-to-face visits and maintains ongoing contact between the practice team and referral services. This cost-effective format promotes discussion on system changes within the practice. A number of jurisdictions also use video-conferencing for professional and inter-professional development.

ICPC2

International Classification of Primary Care (ICPC2) is a coding system that can be linked to present ICD9/10 classification systems. The latter systems allow family practice physicians to record, organize and retrieve the process of care in PHC settings. It has been designed to classify and document three important elements in PHC:

1. The reason for the client/patient encounter;
2. The diagnosis or problem; and
3. The process of care.

There have been recent discussions with a variety of stakeholders at the jurisdictional and national levels regarding ICPC2 and its potential for application and evaluation in PHC teams. Other PHC providers have showed considerable interest in the use of this system. It can provide additional information to PHC providers and governments about population health status and client/patient management. This can be of use in assessing service delivery, planning for service delivery and supporting remuneration/funding models.[115]

The Challenges

As jurisdictions have developed effective health information systems, they have encountered a number of challenges. The lack of standards for the different technologies in health care settings poses significant obstacles. As provinces move to build integrated networks they need to ensure those systems can interface with existing systems.

Increased complexity drives up the cost of building systems to support change. System change and planning in this area need to factor in these additional costs to support successful implementation. These costs include:

- Length of time associated with such initiatives;
- Funds required to develop and sustain the work; and
- Educational support needed for providers to learn the new systems.

Some potential challenges that have been identified in telehealth include:

- Sustainability, regional involvement, equitable services to regions
  (e.g. technical support);
- Evaluation;
- Payment for fee-for-service practitioners;
- Agreed-upon governance model;
- Integration of telehealth into health care delivery;
- Privacy and confidentiality; and
- Integration with other systems.

The privacy and confidentiality of client/patient information has traditionally been a challenge for the health care system. The need for facilitated discussions, decision-making and formalized processes and tools to ensure that privacy and confidentiality are maintained is essential in an electronically enhanced health information-sharing environment. The rapid evolution of technology and software adds another layer of complexity to the task of developing and integrating meaningful, useful systems that support the work of health care providers.

The transition time and support required to move from paper files to electronic files poses significant challenges for providers already striving to keep up with other major changes. Varying degrees of acceptance by those who need to use electronic systems further complicates the process. In addition, the complexity of systems-level change is great. Some providers have concerns with issues surrounding confidentiality of information as health information is shared more broadly.

As provinces move to build integrated networks they need to ensure those systems can interface with existing systems.

Managing the Facilitator's Role

Changes requiring technical knowledge and expertise are considered outside the scope of a PHC leader or facilitator. However, these changes are part of the setting in which providers work. So there is a role for facilitation in building the case for opportunities for change in electronic information management. Often the role would be one of facilitating the change processes required for implementation of information management initiatives. The implementation processes include: the identification and development of action plans to manage the challenges; planning discussions; implementation; and evaluation of the required changes. The facilitator would also advocate for the well being of the providers who are seeking their place in a changing system.

Project leaders/managers may use some of the tools discussed below as they work through the change management to implement technology with providers in the process of sustainable change in primary health care.

Facilitation Resources

Enhanced Sharing of Electronic Information Toolkit (NL): A pilot PHC team area was identified to proactively enhance electronic health information sharing among the various providers and systems across the continuum of service/care. A toolkit was subsequently developed to assist others in the province in making these changes. Contact: *dryan@gov.nl.ca,* Department of Health and Community Services.

Needs Assessment Tools for EHR at the PHC Level (NL): To support planning for enhanced sharing of electronic health information among PHC providers, a series of tools and processes were utilized, including a variety of needs assessment tools. Contact: *dryan@gov.nl.ca*, Department of Health and Community Services.

Evaluation of Enhanced Sharing of Electronic Information (NL): A pilot PHC team area was identified to proactively enhance electronic health information sharing among the various providers and systems across the continuum of service/care. A formal evaluation process was developed to determine the outcome of this enhancement for providers and clients. Contact: d*ryan@gov.nl.ca*, Department of Health and Community Services.

Diabetes Collaborative Tool development (NL): The aim of this project was the development of a tool kit to support PHC sites in implementation of the provincial Chronic Disease Collaborative program, starting with diabetes. Tools adopted included ones to support electronic clinical data entry and reporting to support service and care to individuals with diabetes. Contact: *dryan@gov.nl.ca*, Department of Health and Community Services.

MB Telehealth (MB): The MB Telehealth program is a centralized provincial telehealth program. The program supports the deployment of new telehealth applications – ranging from new program users to new locations and equipment. The process is effectively applied in tertiary settings for PHC/primary care related applications. The program follows a specific project-based approach that is modified to fit the nature of the application and deployment.
Contact: *lloewen@mbtelehealth.ca*, Winnipeg Regional Health Authority.

Immunization Management System (SIMS) (SK): The Saskatchewan Immunization Management System, known as SIMS, is a computerized immunization database. It is a confidential, population-based, computerized information system that collects immunization data, primarily for children, within each health region. SIMS is a key tool to increase and sustain high immunization coverage by providing complete and accurate information on which to base immunization decisions, prevent under-immunization or duplicate immunizations and manage outbreaks of communicable diseases. Contact: *rtuchscherer@health.gov.sk.ca*, Saskatchewan Health or visit: *http://www.health.gov.sk.ca/ph_hisc_proj_sims.html*

NL Provincial Telehealth Implementation Plan (NL): A provincial telehealth strategy was completed, through a process of collaboration and stakeholder engagement, during the winter of 2005, with funding from Canada Health Infoway. Five strategic directions: 1) Self-care/telecare; 2) Chronic disease prevention and management; 3) Access to specialists and specialty services at the primary, secondary and tertiary levels; 4) Home care; and 5) Point-of-care learning for health care professionals. Contact: *dryan@gov.nl.ca*, Department of Health and Community Services.

Newfoundland and Labrador Centre for Health Information (NLCHI) (NL): Work to date in NL includes a unique patient identifier; diagnostic imaging-patient archiving system (DI-PACS); the pharmacy network; and an RFP for pilot testing an electronic health record is in progress. Contact: *dryan@gov.nl.ca*, Department of Health and Community Services.

Comprehensive Community Information System (CCIS) (SK): CCIS is an innovative vehicle for sharing resources, information, tools and knowledge, for sparking curiosity, identifying key wellness issues and determining priorities. It also promotes evidence-based research, programming, policy development and evaluation. CCIS is also a community-based tool that fosters empowerment through the sharing of information and through a collaborative, holistic and humanistic approach to the ongoing process of community wellness. For more information, visit *http://ccis.cronustech.com*

Chronic Disease Management Toolkit (CDM) (BC): The provincial development of quality improvement collaboratives emphasises the clinical value of electronic data entry and reporting. It also places emphasis on the patient disease registers, by provider, to support chronic care. These require an electronic support system. A range of tools has been developed for this work. For additional information visit: *www.e-ms.ca*; *www.healthservices.gov.bc.ca/cdm*

ICPC2 (NL): The International Classification of Primary Care (ICPC2), as developed by the World Organization of National Colleges, Academies and Academic Associations of General Practitioners/Family Physicians (WONCA), has been designed to classify and document three important elements in PHC: the reason for the client/patient encounter, the diagnosis or problem and the process of care. A literature review and benefits case has been completed in co-operation with multi-jurisdictional partners. For more information, visit: *www.aafp.org/online/en/home/aboutus/specialty/international/wonca.html* or contact: *dryan@nl.gov.ca*, Department of Health and Community Services.

Privacy and Confidentiality (NL): There are a number of processes and tools available nationally and provincially to ensure that privacy and confidentiality issues are addressed and managed with increased and/or new ways of sharing health information. This includes working groups and privacy impact analysis tools adapted for PHC use in NL. Contact: *dryan@gov.nl.ca*, Department of Health and Community Services.

FINAL THOUGHTS

Facilitation can be a powerful process. It offers unrivalled support for individuals, teams, communities and organizations involved in the changes occurring in and envisioned for the health care system.

When the role is supported with resources, time and attention, then the inevitable conflicts will be transformed into opportunities for change. It can ease the burden of providers as they respond to immediate requests for client/patient care in an environment that is shifting beneath their feet. In this context, facilitation can ensure that the process of change gets as much attention as the outcomes.

Among health care providers and leaders there is consensus that the priority for health care is serving the individual and the community who seek support for their health and well being. This is a necessary and important focus. However, care for the provider must not be overlooked.

In the midst of massive change to a system that has been relatively consistent for a long time, facilitators ought to remind those with whom they work to tend to themselves. The resilience and dedication of health providers and administrators is the driving force behind many of the ongoing changes within PHC and the health care system.

The 2001 provincial health consultations in NL identified an emerging consensus on the need for system change – though opinions differed on the nature, direction and timeframe of that change.[116] In the larger Canadian context, many in the health care sector recognize this need for large-scale change across the country.[25] PHC practitioners have become adept at managing change at many levels in the system. This has many implications for the outcomes of their work and the provision of health services in Canada.

Leaders and facilitators of change must appreciate the depth of change, the implications for frontline providers and the supports that they will need to manage the opportunities for change that arise from the inevitable conflicts. Too many changes, too fast, at too many levels, with limited support, can negatively impact health providers and their team, many of whose members are already moving as fast as they can.

When facilitating change, attention must be paid to the health of the work environment. A high demand, low control, workplace undermines individual and workplace wellness.[117] The health care workplace is a high demand environment. Adding systemic change to health providers' reality serves to highlight the value of facilitation processes that empower and engage providers and solicit their input and feedback.

The resilience and dedication of health providers and administrators is the driving force behind many of the ongoing changes within PHC and the health care system.

There are many benefits to encouraging participation in planning for ongoing change. However, in the absence of an explicit process or role that focuses on engaging providers, communities, teams and inter-sectoral groups, the likelihood is that the burden will fall to the already overburdened frontline health providers who are working at the interface between a changing system and the current needs of the client/patient and community. Facilitation is not a panacea, but it is a skill set/tool that can assist people (providers, managers, community members, clients/patients) who interact in a system that is constantly evolving.

Contributors

Newfoundland & Labrador

Heather Alaverdy, Canadian Diabetes Association, Newfoundland & Labrador Region

Diane Aylward, Primary Health Care, Labrador-Grenfell Regional Integrated Health Authority

Juanita Barrett, OPHC, Department of Health and Community Services

Andrea Battcock, OPHC, Department of Health and Community Services

Trina Burden, Western Regional Integrated Health Authority

Rob Bryenton, Western Regional Integrated Health Authority

Linda Carter, Community & Wellness Branch, Department of Health and Community Services

Ann Colbourne, MUN, Eastern Health, Department of Health and Community Services

Pegi Earle, Association of Registered Nurses of Newfoundland & Labrador

Judy Davis, Primary Health Care, Eastern Regional Integrated Health Authority

Diana Deacon, Centre for Collaborative Health Professional Education, MUN

Noreen Dort, OPHC, Department of Health and Community Services

Derek Fleming, OPHC, Department of Health and Community Services

Lori Harnett, Western Regional Integrated Health Authority

Claudine Kean Dobbin, Labrador-Grenfell Regional Integrated Health Authority

Diane Kieley, OPHC, Department of Health and Community Services

Eva Laing, Primary Health Care, Department of Health and Community Services

Lilly LeDrew, Central Regional Integrated Health Authority

Betty Lundrigan, Association of Registered Nurses of Newfoundland & Labrador

Elaine Lyall, Labrador-Grenfell Regional Integrated Health Authority

Sherry Kennedy, Eastern Regional Integrated Health Authority

Kim Osmond, Central Regional Integrated Health Authority

Colleen Rixon, Labrador-Grenfell Regional Integrated Health Authority

Heather Rumsey, OPHC, Department of Health and Community Services

Heather White, Department of Health and Community Services & Memorial University

Nova Scotia

Merv Ungurain, Department of Health

Ontario

William Hogg, Department of Family Medicine, University of Ottawa

Ingrid LeClaire, Primary Care Project, University of Ottawa

Jacques Lemelin, Department of Family Medicine, University of Ottawa

Nancy Molson, Primary Care Project, University of Ottawa

Jackie Shultz, Department of Family Medicine, University of Ottawa

Eileen Vilis, Department of Family Medicine, University of Ottawa

Manitoba

Kristin Anderson, Manitoba Health

Susan Crockett, NOR-MAN Regional Health Authority

Flo Frank, Common Ground Resource Group

Margot Gray, NOR-MAN Regional Health Authority

Fiona Jeffries, Parkland Regional Health Authority

Darby Johnson

Betty Kozak, Assiniboine Regional Health Authority

Liz Loewen, Winnipeg Regional Health Authority

Lesa Nordick

Cheryl Osborne, Parkland Regional Health Authority

Colleen Rand, Winnipeg Regional Health Authority

Rick Sapacz, Primary Health Care Branch, Manitoba Health & Community Services

Saskatchewan

Nandita Chaudhuri, PHSB, Saskatchewan Health

Kathleen Filipowich, Five Hills Health Region

Lydia Franc, Community & Primary Health Development, Prince Albert Parkland Health Region

Tammy Hankel, Heartland Health Region

Megan Jones, Saskatchewan Health

Vivian Krakowski, Primary Health Care Branch, Saskatchewan Health

Chris Mayhew, Primary Health, Saskatoon Health Region

Gary Nolin, Primary Health Care, Prairie North Health Region

Eunice Patterson, Primary Health Care Branch, Saskatchewan Health

Vivian R. Ramsden, Department of Academic Family Medicine, University of Saskatchewan

Gill White, Department of Academic Family Medicine, University of Saskatchewan

Alberta

Kelly Holmes, Alberta Health and Wellness

Doug Stich, Toward Optimized Practice

Crispin Kontz, Primary Care Division, Capital Health

JoAnn Beckie, Primary Care Division, Capital Health

British Columbia

Lynda Anderson, Northern Health

Alice Domes, Northern Health

Trevor Hancock, Ministry of Health

Joanne Houghton, Northern Health

Judy Huska, Northern Health

Deborah Lewis, Northern Health

Angela Micco, Primary Health Care, Ministry of Health

Howard Platt, Primary Health Care, Ministry of Health

Joyce Resin, Healthy Heart Society

Valerie Tregallis, Primary Care & Chronic Disease Management, Ministry of Health

Shannon Turner, Health Promotion & Clinical Prevention, Vancouver Island Health Authority

Georges Fettes, Ministry of Health

Chris Rauscher, Ministry of Health

Yukon

Lucienne Wright, Health and Social Services, Yukon Government

GLOSSARY OF TERMS

Accountability - The ownership of conferred responsibilities combined with an obligation to report to a higher authority on the discharge of these responsibilities and on the results obtained. (*Achieving Excellence*, Treasury Board, Government of Newfoundland and Labrador [St. John's: 2000]).

Best Practices - Approaches that have been shown to produce superior results, selected by a systematic process, and judged as "exemplary," "good," or "successfully demonstrated." They are then adapted to fit a particular organization. (*Achieving Improved Measurement*, Canadian Council on Health Services Accreditation [Ottawa: 2002], glossary).

Capacity Building - Involves enhancing the ability of individuals and groups to mobilize and develop resources, skills and commitments needed to accomplish shared goals. (*Mental Health Promotion Tool Kit: A practical resource for community initiatives*, Canadian Mental Health Association, 1999).

Client/Patient - When an individual enters the health care system, he/she is referred to as a patient or client, depending on the health care provider (e.g., physicians typically serve patients, while social workers serve clients). In community health, families, groups or the community itself can be the client.

Community Capacity - Refers to the ability of community members to use the assets of its residents, associations and institutions to improve quality of life. Each community's collection of assets will be unique for it will reflect the specific characteristics of its population, its political structures and geography. (*Mental Health Promotion Tool Kit: A practical resource for community initiatives*, Canadian Mental Health Association, 1999).

Community Development - A process involving a partnership with community members or groups to build the community's strengths, self-sufficiency, well-being and problem solving. This process enables the community to make decisions, plan, design and implement strategies to achieve better health. (B. Haen & R. Labonte, 1990).

Continuity - The provision of unbroken services that are coordinated within and across programs and organizations, as well as during the transition between levels of services, across the continuum, over time. (*Achieving Improved Measurement*, Canadian Council on Health Services Accreditation [Ottawa: 2002], glossary).

Continuum of Care - A full range of flexible, effectively linked services, from institutional care to home-based/community-based care. (*21st Century: A new vision for health care*, McGill University Health Centre [Montreal: 1997]).

Continuum of Services - An integrated and seamless system of settings, services, service providers and service levels to meet the needs of clients or defined populations. Elements of the continuum are: self-care, prevention and promotion, short-term care and service, continuing care and services, rehabilitation, and support. (*Achieving Improved Measurement*, Canadian Council on Health Services Accreditation [Ottawa: 2002] glossary).

Determinants of Health - Factors that together contribute to the state of health and well being of a population or individuals. These are factors such as: income and social status, social support network, education, health services, employment and working conditions, physical environment, biology and genetic endowment, personal health practices and coping skills, and child health and development. (Federal, Provincial, and Territorial Advisory Committee on Population Health, 1994).

Evidence-based Decision Making - The explicit, conscientious and judicious consideration of the best available evidence in the provision of health care. (*Policy Statement on Evidence-based Decision-making and Nursing Practice,* Canadian Nurses Association, 1998).

Facilitation - The facilitator's role includes providing leadership, advice and assistance. The flexibility of the role allows the facilitator to adapt to the constantly changing demands of the members of the primary health care team which includes individuals who reside in the communities being served, organizations and the environment in which primary health care is delivered. The essence of the role and the skills that support the role enable the facilitators to provide practical assistance and support to PHC team members and to the communities that they serve.

Health Promotion - Process of actively supporting and enabling people to increase control over and improve their health (World Health Organization, 1998).
- Process of enabling people to increase control over, and to improve, their health. To reach a state of complete physical, mental and social well being, an individual or group must be able to identify and to realize aspirations, to satisfy needs, and to change or cope with the environment. Health is, therefore, seen as a resource for everyday life, not the objective of living. Health is a positive concept emphasizing social and personal resources as well as physical capacities. Therefore, health promotion is not just the responsibility of the health sector, but goes beyond healthy life-styles to well being. (*First International Conference on Health Promotion*, Ottawa Charter for Health Promotion, 1986).

- Concerned with maximizing the involvement of individuals and communities in improving and protecting quality of life and well being. Health promotion aims to address equity in health, the risks to health, sustainable environments conducive to health and the empowerment of individuals and communities by contributing to healthy policy, advocating for health, enabling skills development and education. (*Mental Health Promotion Tool Kit: A practical resource for community initiatives*, Canadian Mental Health Association, 1999).

Inter-professional Primary Health Care Model - An approach to primary health care delivery which emphasizes universally accessible continuous, comprehensive, coordinated primary health care provision for a defined population through the shared responsibility and accountability of physicians and all other primary health care providers. (Interdisciplinary Primary Care Models: Final Report, Working Group on Interdisciplinary Primary Care Models, Advisory Committee of Interpersonal Practitioners [n.d.]). *NOTE: This guidebook substitutes the synonym inter-professional for interdisciplinary.*

Inter-sectoral Collaboration - A recognized relationship between part or parts of different sectors of society which have been formed to take action on an issue to achieve health outcomes in a way which is more effective, efficient or sustainable than might be achieved by the health sector acting alone. (*Health Promotion*, World Health Organization, 1998, glossary).

Leadership - Leadership is a process of giving meaningful direction to collective effort. It is the influencing of the activities of an organized group toward goal achievement. (Jacobs and Jacques, 1990. Rauch and Behling, 1984).

Management - The act, art or manner of controlling or conducting affairs and the skilful use of means to accomplish a defined purpose. (*Achieving Excellence*, Treasury Board, Government of Newfoundland and Labrador [St. John's: 2000]).

Performance Measurement - A systematic process that enables an organization to track, manage and report progress toward its strategic goals and objectives. Performance measurement focuses on the desired quantitative and qualitative outcomes required for an organization to achieve its mission and goals and is a means of determining an organization's planned versus achieved results. (*Achieving Excellence*, Treasury Board, Government of Newfoundland and Labrador [St. John's: 2000]).

Population Health Approach - A way of looking at health and services and an approach to managing them, that focuses on the needs of a given group as a whole, and the factors that contribute and determine health status. A population health approach facilitates the integration of services across the continuum. (*Achieving Improved Measurement*, Canadian Council on Health Services Accreditation [Ottawa: 2002], glossary).

Primary Care - The first level of contact with the medical care system provided primarily by general practitioners (including office visits, emergency room visits and house calls). Primary care operates inside the larger context of primary health care. (*Report of the Primary Care Advisory Committee: The Family Physician's Role in a Continuum of Care Framework for Newfoundland and Labrador*, [St. John's: 2001]).

Primary Health Care - The first level of contact with people taking action to improve health in a community. Primary health care is essential heath care made accessible at a cost that the country and community can afford, with methods that are practical, scientifically sound and socially acceptable. (*Health Promotion*, World Health Organization, 1998, glossary).

Primary Health Care Team - A group of persons who share a common health goal and common objectives determined by community needs, to which achievement by each member of the team contributes, in a co-ordinated manner, in accordance with his/her competence and skills and respecting the functions of others. (World Health Organization, 1985).

Public Health - Public health is a social and political concept aimed at improving health, prolonging life and improving the quality of life among whole populations through health promotion, disease prevention and other forms of health intervention. (*Health Promotion*, World Health Organization, 1998).

Scope of Practice - The scope of practice for an occupation refers to the range of activities that a qualified practitioner of an occupation may undertake. It establishes the boundaries of an occupation, especially in relation to other occupations where similar activities may be performed. The scope of practice for an occupation may be established through governing legislation or through internal regulations adopted by a regulatory body. (*Glossary of Terms*, HRDC, 2002).

Self-Care - The decisions and actions taken by someone who is facing a health challenge/concern in order to cope with it and improve his or her health. (*Enhancing Health Services in Remote and Rural Communities of British Columbia*, 1999).

Secondary Care - Consists of first level specialized care requiring more sophisticated and complicated diagnostic procedures and treatment than provided at the primary care level, normally delivered in hospitals. (*Health Services Review: Report of the Committee*, New Brunswick Health and Community Services, 1998).

Telehealth - Efforts of health telecommunication, information technology and health education to improve the efficiency and quality of healthcare. (Health Canada, 2001, glossary).

Tertiary Care - Sub-specialty care requiring a high level of intensive hospital-based care. (*Health Services Review: Report of the Committee*, New Brunswick Health and Community Services, 1998).

Endnotes

[1] 1. AJ Dietrich, GT O'Connor, A Keller, PA Carney, D Levy, FS Whaley. Cancer: improving early detection and prevention. A community practice randomised trial. *BMJ*. 1992 Mar 14;304(6828):687-691.

[2] 2. M Wensing & R Grol. Single and combined strategies for implementing changes in primary care: A literature review. *Int J Qual Health Care*. 1994 Jun;6(2):115-132.

[3] 3. G Fowler, E Fullard, M Gray. Facilitating prevention in primary care. *BMJ*. 1992 May 2;304(6835):1177.

[4] E Fullard, G Fowler, M Gray. Promoting prevention in primary care: controlled trial of low technology, low cost approach. *Br Med J (Clin Res Ed)*. 1987 Apr 25;294(6579):1080-1082.

[5] E Fullard et al. *Guidelines for Family Health Services Authorities and Health Authorities on the appointment of primary care facilitators*. Oxford, UK: The National Facilitation Development Project. 1991.

[6] National Facilitator Development Project. *Primary care facilitator's handbook*. Oxford, UK: National Facilitator Development Project. 1993.

[7] D Raphael, ed. Social determinants of health: Canadian perspectives. Toronto, ON: Canadian Scholars' Press Inc. 2004.

[8] World Health Organization. *Social determinants of health: The solid facts, 2nd ed.* (R Wilkinson, M Marmot, eds.). Copenhagen, DK: WHO EURO Non-serial Publication, 2003.

[9] S Lewis. *Moving forward with primary health care*. Winnipeg, MN: Conference Synthesis Paper, 2004.

[10] World Health Organization & Unicef. *Alma-Ata 1978: Primary health care*. Geneva, Switzerland: Author. 1978.

[11] NA Vanselow, MS Donaldson, KD Yordy. From the Institute of Medicine. JAMA. 1995 Jan 18;273(3):192

[12] World Health Organization. *Ottawa Charter for health promotion.* Ottawa, ON: Author. Retrieved on February 1, 2004 from *www.who.int/hpr/archive/docs/ottawa.html*. 1986.

[13] Health Canada. *Canada's Health Care System: What Happens First (Primary Health Care Services)*. Retrieved on November 20, 2006 from *http://www.hc-sc.gc.ca/hcs-sss/pubs/care-soins/2005-hcs-sss/del-pres_e.html#1*.

[14] C Rauscher. *Chronic disease management through quality improvement: A discussion paper.* Vancouver, BC: Western Healthcare Improvement Network. Retrieved on November 21, 2006 from *http://www.whin.org/publications.asp.* p. 4.

[15] Federal, Provincial and Territorial Advisory Committee on Population Health. *Strategies for population health: Investing in the health of Canadians.* Retrieved on July 29, 2006 from *http://www.phac-aspc.gc.ca/ph-sp/phdd/pdf/e_strateg.pdf.* 1994.

[16] National Primary Health Care Awareness Strategy. *Fact sheet: Primary health care.* Retrieved on November 21, 2006 from *http://www.phc-ssp.ca/pdf_files/NPHCAS-FactSheet_EN.pdf.*

[17] R Curry, J Hollis. An evolutionary approach to team working in primary care. *Br J Community Nurs.* 2002 Oct;7(10):520-527.

[18] JR Katzenbach, DK Smith. *The wisdom of teams: Creating the high performance organization.* New York, NY: HarperBusiness. 1994.

[19] Saskatchewan Health. *Team development and implementation in Saskatchewan's primary health care sector.* Retrieved on July 24, 2006 from *www.health.gov.sk.ca/ps_phs_teamdev.pdf.* 2004.

[20] J Lemelin, W Hogg, N Baskerville. Evidence to action: A tailored multifaceted approach to changing family physician practice patterns and improving preventive care. CMAJ. 2001 Mar 20;164(6):757-763.

[21] VR Ramsden, V Campbell, B Boechler, J Blau, Y Berscheid. Strategies to stroke prevention: Nurse facilitation. *Concern.* 1994 Dec;23(6):22-23.

[22] BA Reeder, VR Ramsden, A Shuaib, R Webb, SG Smith, GN White, R Knaus, 1994 (June). The Saskatchewan Clinical Stroke Prevention Project: Design. *Health Reports.* 1994;6(1):166-170.

[23] NB Baskerville, W Hogg, J Lemelin. Process evaluation of a tailored multifaceted approach to changing family physician practice patterns improving preventive care. *J Fam Pract.* 2001 Mar;50(3):W242-9.

[24] ME Hulscher, M Wensing, T van Der Weijden, R Grol. Interventions to implement prevention in primary care. *Cochrane Database Syst Rev.* 2001;(1):CD000362.

[25] RJ Romanow. *Building on values: The future of health care in Canada - Final Report.* Saskatoon, SK: Commission on the Future of Health Care in Canada. 2002.

[26] LA Bero, R Grilli, JM Grimshaw, E Harvey, AD Oxman, MA Thomson. Closing the gap between research and practice: An overview of systematic reviews of interventions to promote the implementation of research findings. The Cochrane Effective Practice and Organization of Care Review Group. *BMJ.* 1998 Aug 15;317(7156):465-468.

[27] W Hogg, N Baskerville, J Lemelin. Cost savings associated with improving appropriate and reducing inappropriate preventive care: Cost-consequences analysis. *BMC Health Serv Res.* 2005 Mar 9;5(1):20.

[28] R Bacal. *The role of the facilitator: Understanding what facilitators really do!* Retrieved on November 21, 2006 from *http://www.iaf-world.org/i4a/pages/Index.cfm?pageid=3291.*

[29] LI Solberg, TE Kottke, ML Brekke, S Magnan, G Davidson, CA Calomeni, SA Conn, GM Amundson, AF Nelson. Failure of a continuous quality improvement intervention to increase the delivery of preventive services. A randomized trial. *Eff Clin Pract.* 2000 May-Jun;3(3):105-115.

[30] P Wilson. *The facilitative way: Leadership that makes a difference.* Shawnee Mission, KS: Team Tech Press. 2003.

[31] I Bens. *Advanced facilitation strategies: Tools and techniques to master difficult situations.* San Francisco, CA: Jossey-Bass. 2005.

[32] F Champagne. *The ability to manage change in healthcare organizations.* Discussion Paper No. 39 submitted to the Commission on the Future of Health Care in Canada. Montreal, QC: University of Montreal. 2002.

[33] J Manion. *From management to leadership: Interpersonal skills for success in health care.* San Francisco, CA: Jossey-Bass. 1998.

[34] R Grol, M Wensing, M Eccles. *Improving patient care: The implementation of change in clinical practice.* New York, NY: Elsevier Butterworth Heinemann. 2005. p. 16.

[35] WR Miller, S Rollnick. *Motiviational interviewing: Preparing people to change* (2nd Ed.). New York, NY: The Guilford Press. 2002.

[36] JO Prochaska, JC Norcross, CC DiClemente. *Changing for good: The revolutionary program that explains the six stages of change and teaches you how to free yourself from bad habits.* New York, NY: W Morrow. 1994.

[37] JO Prochaska, WF Velicer. *A primer on stages of change.* Lawrence, Kan: American Journal of Health Promotion in conjunction with National Wellness Association. 1997.

[38] JO Prochaska, CC DiClemente. *The transtheoretical approach: Crossing traditional boundaries of therapy.* Malabar, FL: Krieger Pub. 1984.

[39] JO Prochaska, JC Norcross. Stages of change. *Psychotherapy.* 2001;38(4):443-448.

[40] VR Ramsden. *Enhancing wellness model: Participatory development of an individualized wellness/health promotion program based on the integration of story-telling and the health history.* Doctoral Dissertation, University of Saskatchewan. 2004.

[41] University of Rhode Island. *Cancer Prevention Research Centre: Measures.* Retrieved on November 25, 2006 from *www.uri.edu/research/cprc/measures.htm.*

[42] Saferpak. *The Shewhart Cycle - The Deming Wheel - Plan-Do-Check-Act.* Retrieved on November 25, 2006 from *http://www.saferpak.com/pdsa.htm.*

[43] EM Rogers. *Diffusion of innovations, 5th ed.* New York, NY: The Free Press. 2003.

[44] J Meyer. Using qualitative methods in health-related action research. In, *Qualitative Research in Health Care, 2nd ed.* (C Pope & N Mays, eds.). London, UK: BMJ Books, 2000.

[45] EDucate! A quarterly on education and development. Glossary: Praxis. Retrieved on November 25, 2006 from *http://www.sef.org.pk/educatewebsite/educate2fol/glosiconedu2.asp.*

[46] MQ Patton. *Qualitative evaluation & research methods, 2nd* ed. Newbury Park, CA: Sage Publications Inc.

[47] T Bentley. *Facilitation: Providing opportunities for learning.* London, UK: McGraw Hill. 1994.

[48] M Leininger. Evaluation criteria and critique of qualitative research studies. In, *Critical Issues in Qualitative Research Methods* (JM Morse, ed.). Thousand Oakes, CA: Sage Publications Inc. 1994.

[49] YS Lincoln, EG Guba. Naturalistic inquiry. Newbury Park, CA: Sage Publications Inc. 1985.

[50] D Davies, J Dodd. Qualitative research and the question of rigor. *Qual. Health Res.* 2002;12(2):465-468.

[51] K Shojania, J Grimshaw. Evidence-based quality improvement: the state of the science. *Health Aff (Millwood).* 2005 Jan-Feb;24(1):138-50.

[52] D Harvey, M McDonald, B Riley. *Canadian Cancer Society Manitoba Division (CCS) Knowledge Exchange Network (KEN).* 96th Annual Conference of the Canadian Public Health Association: Mapping the Future of Public Health: People, Places and Policies. Ottawa, ON: September 18-21, 2005. Abstract.

[53] D Davis, M Evans, A Jadad, L Perrier, D Rath, D Ryan, G Sibbald, S Straus, S Rappolt, M Wowk, M Zwarenstein. The case for knowledge translation: Shortening the journey from evidence to effect. *BMJ* 2003 July 5;327:33-35.

[54] S Manske, C Lovato, S Leatherdale, D Murnaghan, MA Jolin. *The school health action, planning and evaluation system (SHAPES).* 96th Annual Conference of the Canadian Public Health Association: Mapping the Future of Public Health: People, Places and Policies. Ottawa, ON: September 18-21, 2005. Abstract.

[55] Health Quality Council Saskatchewan. *The model for improvement - PDSA cycles.* Retrieved on November 25, 2006 from *http://www.hqc.sk.ca.*

[56] L R Bronstein. A model for interdisciplinary collaboration. *Soc Work.* 2003 Jul;48(3):297-306.

[57] World Health Organization. *Basic Epidemiology* (R Beaglehole, R Bonita, T Kjellström, eds.). Geneva, Switzerland: World Health Organization. 1993.

[58] G Egger, R Spark, R Donovan. *Health promotion strategies and methods.* New South Wales, Australia: McGraw Hill. 2005.

[59] P Puska, J Tuomilehto, A Nissinen, E Vartiainen. *The North Karelia project: 20 year results and experiences.* Helsinki, Finland: Helsinki University Printing. 1995.

[60] JM Last. *A dictionary of epidemiology, 4th ed.* New York NY: Oxford University Press, Inc. 2001.

[61] G Rose. *The strategy of preventive medicin*e. Oxford, UK: Oxford University Press. 1992.

[62] S Stenchenko. Preventive guidelines: Their role in clinical prevention and health promotion. In, *The Canadian Guide to Clinical Preventive Health Care,* Canadian Task Force on the Periodic Health Examination, eds. Ottawa, ON: Health Canada. 1994.

[63] Public Health Agency of Canada. *Implementing the population health approach.* Retrieved on November 25, 2006 from *http://www.phac-aspc.gc.ca/ph-sp/phdd/implement/implementation.html#heatlh_pro.*

[64] Public Health Agency of Canada. *Population health approach.* Retrieved on November 25, 2006 from *http://www.phac-aspc.gc.ca/ph-sp/phdd/.*

[65] JM Caccamo. Sharing the vision: healthy, achieving students what can schools do? *J Sch Health.* 2000 May;70(5):216-218.

[66] Canadian Task Force on Preventive Health Care. *Key Definitions*. Retrieved on November 26, 2006 from *http://www.ctfphc.org/*.

[67] National Centre for Chronic Disease Prevention and Health Promotion. Module 13: Levels of Disease Prevention. Retrieved on November 26, 2006 from *http://www.cdc.gov/excite/skincancer/mod13.htm*.

[68] T Hancock. *Challenges in implementing clinical prevention*. Victoria, BC: Population Health and Wellness, Ministry of Health Services, British Columbia. 2004.

[69] Health Canada. *First Nations and Inuit Tobacco Control Strategy: Building best practices with community* (VR Ramsden, B Beatty, eds.). Ottawa, ON: Health Canada. 2002.

[70] VR Ramsden, AJ Cave. Participatory Methods to Facilitate Research. *Can Fam Physician*. 2002;48:548-549, 553-554.

[71] VR Ramsden, Transition to an Integrated Primary Health Services Model Research Team (GN White, PR Butt, E Korchinski, H Albert, E Baptiste, G Braun, E Calder, J Crowe, MP Dressler, P Ferguson, A Fineday, D Fineday, D Fisher, L Francis, C Gamble, S Hunt, M Jackson, K Hay, GJ Laliberte, M Michaels, D Morales, C Popadynec, S Wolfe and the Department of Family Medicine), AJ Cave, 2003 (February). Learning with the Community - Evolution to Transformative Action Research. *Can Fam Physician*. 2003 Feb;49:195-197, 200-202.

[72] Peter Ballantyne Cree Nation Health Inc in collaboration with VR Ramsden, PR Butt, MP Dressler, S Woods, B Beatty, D Ballantyne, R Budd, M Cook, K Custer, S Custer, S Custer, S Custer, T Dumais, D Dusterbeck, M Linklater, L Michel, V McCallum, C Merasty, D Sinclair, A Weber-Beeds and D Fisher. *Working with Northern Aboriginal Communities through Transformative Action Research: The Peter Ballantyne Cree Nation Health Inc and the Department of Family Medicine, University of Saskatchewan's Experience on the Health Transfer Evaluation Project*. CASTS Conference, Saskatoon, SK: September 18-20, 2003. Abstract.

[73] M Bopp, J Bopp. Recreating the world: *A practical guide to building sustainable communities*. Calgary, AB: Four Worlds Press. 2001.

[74] World Health Organization. *Community involvement in health development: A review of the concept and practice* (H. M. Kahssay & P. Oakley, Eds.). Geneva, Switzerland: World Health Organization.

[75] AC Macaulay, LE Commanda, WL Freeman, N Gibson, ML McCabe, CM Robbins, PL Twohig. Participatory research maximises community and lay involvement. North American Primary Care Research Group. *BMJ*. 1999 Sep 18;319(7212):774-778.

[76] J Vanderwal. Arnstein's Ladder of Participation (adapted). Retrieved on November 26, 2006 from *http://www.interchange.ubc.ca/plan/thesis/vanderwal/chap3.htm#fig31*.

[77] International Association for Public Participation (IAP2). IAP2 Public Participation Spectrum. Retrieved on November 26, 2006 from *http://www.iap2.org/associations/4748/files/spectrum-web.gif*.

[78] C Rissel. Empowerment: The holy grail of health promotion. *Health Promot Int*. 1994;9:39-47.

[79] World Health Organization. *Innovative care for chronic conditions: Building blocks for action*. Geneva, Switzerland: World Health Organization. 2002.

[80] C Moustakas. *Being-In, Being-For, Being-With*. Northvale, NJ: Jason Aronson Inc. 1995.

[81] R Chambers. *Rural development: Putting the last first*. Edinburgh Gate, England: Addison Wesley Longman Ltd. 1983.

[82] International Institute for Environment and Development. *Participatory Learning and Action (50) - Critical reflections, future directions* (R Chambers, N Keaton, H Ashley, eds.). London, UK: International Institute for Environment and Development.

[83] Building a Better Tomorrow Initiative (BBTI): An Atlantic Provincial Primary Health Care Initiative. Building community relationships: Four levels of partnership. Retrieved on November 26, 2006 from *http://www.gov.ns.ca/health/primaryhealthcare/bbt_module/bbt_Building_Community_Relationships.pdf*.

[84] J Mezirow & Associates. *Learning as transformation: Critical perspectives on a theory in progress*. San Francisco, CA: Jossey-Bass Publishers. 2000.

[85] Improving Chronic Illness Care (ICIC). *The Chronic Care Model*. Retrieved on November 26, 2006 from *http://www.improvingchroniccare.org/change/model/components.html*.

[86] EH Wagner, BT Austin, C Davis, M Hindmarsh, J Schaefer, A Bonomi. Improving chronic illness care: translating evidence into action. *Health Aff (Millwood)*. 2001 Nov-Dec;20(6):64-78.

[87] Government of British Columbia. Expanded Chronic Care Model. Retrieved on November 26, 2006 from *http://www.health.gov.bc.ca/cdm/cdminbc/chronic_care_model.html*.

[88] Saskatchewan Health. *Guidelines for the development of a Regional Health Authority plan for primary health care services*. Regina, SK: Primary Health Services, Saskatchewan Health. 2003. Retrieved on November 26, 2006 from *http://www.health.gov.sk.ca/ph_phs_publications/phs_pub_guidelines_%20for_dev.pdf*.

[89] Pew Health Professionals Commission. *Interdisciplinary collaborative teams in primary care: A model curriculum and resource guide*. Pew Health Professions Commission and the California Primary Care Consortium. January, 1995. Retrieved on November 26, 2006 from *http://futurehealth.ucsf.edu/compubs.html*.

[90] TJK Drinka, PG Clark. *Health care teamwork: Interdisciplinary practice and teaching*. Westport, CT: Auburn House Pub Co. 2000.

[91] Government of Newfoundland and Labrador. *Newfoundland and Labrador teams working group*. St. John's, NL: Government of Newfoundland and Labrador, Department of Health and Community Services. 2006

[92] P Baguley. *Teach Yourself Teams and Team-Working*. London, UK: Hodder and Stoughton. 2003.

[93] Saskatchewan Health. *Developing high performance teams for the Saskatchewan primary health care project: Train the trainer workbook*. Regina, SK: Developed for Saskatchewan Health by Centre for Strategic Management & Med-Emerg International Inc. 2003.

[94] R Schwarz, A Davidson, P Carlson, S McKinney. *The skilled facilitator fieldbook: Tips, tools and tested methods for consultants, facilitators, managers, trainers and coaches*. San Francisco, CA: Jossey-Bass. 2005.

[95] Government of Newfoundland and Labrador. *Scope of practice working group*. St. John's, NL: Government of Newfoundland and Labrador, Department of Health and Community Services. 2004.

[96] L Thomas, N Cullum, E McColl, N Rousseau, J Soutter, N Steen. Guidelines in professions allied to medicine. *The Cochrane Database of Systematic Reviews*. 1999, Issue 1. Art. No.: CD000349. DOI: 10.1002/14651858.CD000349. Retrieved on November 26, 2006 from *http://www.mrw.interscience.wiley.com/cochrane/clsysrev/articles/CD000349/frame.html*.

[97] Saskatchewan Health. *Saskatchewan Action Plan for Primary Health Care*. Regina, SK: Saskatchewan Health. 2002. Retrieved on November 26, 2006 from *http://www.health.gov.sk.ca/ph_phs_publications/phs_action_plan_for_primary_health_care.pdf*.

[98] Canadian Nurses Association & Canadian Medical Association. *Working together: A joint CNA/CMA collaborative practice project - HIV/AIDS Example [Background paper]*. Ottawa, ON: Canadian Medical Association & Canadian Nurses Association. 1996. Retrieved on November 26, 2006 from *http://www.cma.ca/index.cfm/ci_id/19733/la_id/1.htm#ref36*.

[99] P Hall. Interprofessional Teamwork: Professional Cultures as Barriers. *Journal of Interprofessional Care*. May 2005 May;19(Suppl. 1):188-196.

[100] TF Gieryn. Boundary-work and the demarcation of science from non-science: Strains and interests in professional ideologies of scientists. *American Sociological Review*. 1983;6(48):781-795.

[101] HG Petrie. Do You See What I See? The Epistemology of Interdisciplinary Inquiry. *Journal of Aesthetic Education*. 1976 Jan;10(1):29-43.

[102] J Gilbert. Interdisciplinary Learning and Higher Education Structural Barriers. *Journal of Interprofessional Care*. 2005 May;19(Suppl. 1):87-106.

[103] Y Steinert. Learning together to teach together: Interdisciplinary Learning and Faculty Development. *Journal of Interprofessional Care*. May 2005 May;19(Suppl. 1):60-75.

[104] J Mezirow & Associates. *Fostering critical reflection in adulthood: A guide to transformative and emancipatory learning*. San Francisco, CA: Jossey-Bass Publishers. 1990.

[105] Atlantic Primary Health Care Initiative. Building a Better Tomorrow. Retrieved on November 26, 2006 from *http://www.gov.ns.ca/health/primaryhealthcare/building.htm*.

[106] RW Swanson, VR Ramsden. Advanced Cardiac Life Support: A Survey of Interprofessional Attitudes. *Heart and Lung: The Journal of Critical Care*. 1988 May;17(3):254-255.

[107] P Freire. *Pedagogy of the oppressed*. New York, NY: The Seabury Press. 1972.

[108] J Marshall, D Chigarire, H Francisco, A Gonçalves, L Nhantumbo. *Training for Empowerment*. Toronto, ON: International Council for Adult Education. 1990.

[109] S Burns, C Bulman. *Reflective practice in nursing: The growth of the professional practitioner, 2nd ed*. Malden, MA: Blackwell Science. 2000.

[110] R Wilson, J Dorland (eds.). Implementing primary care reform: Barriers and facilitators. Montreal, QC: McGill-Queen's University Press. 2004.

[111] Government of Newfoundland and Labrador. *Physician payment model*. St. John's, NL: Government of Newfoundland and Labrador, Department of Health and Community Services. August 2006.

[112] A Battcock. *Telehealth presentation*. Health Telematics Unit, University of Calgary. Calgary, AB: The Health Telematics Unit, University of Calgary. *http://www.fp.ucalgary.ca/telehealth/What_Is_Telehealth.htm*

[113] A Battcock. *Canada Health Infoway*. St. John's, NL: Telehealth presentation *http://www.infoway-inforoute.ca/en/WhatWeDo/TeleHealth.aspx*

[114] A Battcock. *Telehealth presentation*. St. John's, NL: Telehealth presentation.

[115] WONCA. *International classification for primary care - ICPC2*. Retrieved on November 26, 2006 from *http://www.globalfamilydoctor.com/wicc/sensi.html*.

[116] Government of Newfoundland and Labrador. *Healthier together: A strategic health plan for Newfoundland and Labrador*. St. John's, NL: Government of Newfoundland and Labrador, Department of Health and Community Services. 2002. Retrieved on November 26, 2006 from *http://www.health.gov.nl.ca/health/strategichealthplan/pdf/HealthyTogetherdocument.pdf*.

[117] Health Canada. *Best Advice on Stress Risk Management in the Workplace - Part 1*. Retrieved on November 26, 2006 from *http://www.hc-sc.gc.ca/ewh-semt/alt_formats/hecs-sesc/pdf/pubs/occup-travail/work-travail/stress-part-1/stress-part-1_e.pdf*