

Saskatchewan Institute of Health Leadership

# Leading Collaboration among the Providers of Primary Health Care

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## 1.0 EXECUTIVE SUMMARY

Collaboration among health care professionals is fundamental to the promotion of primary health care and improving the patient experience. Full appreciation and utilization of the skills of provider groups and interprofessional education opportunities will assist in shifting the paradigm of health care delivery from the silos that have evolved in the current medical model. Communication throughout the system must be enhanced by building skills in our human resources and the implementation of technology to support the transfer of information. Teamwork, liaising between professional groups and a willingness to facilitate the patient's care are all essential to meeting the goal of being patient-centred.

*For Patients' Sake Patient First Review*<sup>1</sup>, a survey conducted by Commissioner Tony Dagnone, October 2009, indicates that patients do not feel at the centre of their care. Patient outcomes can be improved with collaborative patient assessment, coordinated plans of care and effective chronic disease management. The *Primary Health Care Patient Experience Survey*<sup>2</sup> reports that patients with access to primary health care teams were relatively satisfied with their experience.

Primary health care is important in order to maintain sustainable, quality services for the population. Community development is fundamental to improving the social determinants of health. Policies and professional accountabilities need to be adjusted to adapt to a collaborative practice environment. Collaboration among health professionals must be promoted, facilitated and expected as part of the development of primary health care and delivery of health services in Saskatchewan. The inclusion of the patient in this collaboration is integral to a satisfactory patient experience and outcome.

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*Patient outcomes can be improved with collaborative patient assessment, coordinated plans of care and effective chronic disease management.*

The inspiration for this project came from the *2010–11 Saskatchewan Ministry of Health's Strategic and Operational Directions for the Health Sector in Saskatchewan*.<sup>3</sup> The history of primary health care at the international, national and provincial level provides a broad overview of this subject. Principles of primary health care are stated. Interviews conducted with health leaders and professionals provided insight into the successes and barriers regarding implementation of primary health care in Saskatchewan. Each interview involved asking the question: “What are the key leadership challenges to implementing primary health care?” Themes of leadership, collaboration, intersectoral partnerships and meeting the needs of the community were identified as contributing to success. The necessity of transitioning from the medical model of health care and measuring progress and outcomes were also discussed.

The *Future of Primary Health Care in Saskatchewan*<sup>4</sup> offers comprehensive coverage of issues regarding implementation of primary health and goal setting. Rather than reiterate information from the above document, this paper focuses on leading and supporting collaboration among health care providers, which in turn will improve the patient experience and place the patient back at the centre of health care. The recommendations are purposely aimed at all members of

levels of the health system. This includes three levels: a) the leaders who develop policy; b) the health organization who develops programs, creates practice environments and sets expectations and standards of performance, and c) team and individual health care providers. The goal of these recommendations is to facilitate bringing collaboration into the culture of health care at all levels.

## 2.0 INTRODUCTION

The Saskatchewan Institute of Health Leadership, 2011, focused this year's projects based on the *2010–11 Saskatchewan Ministry of Health's Strategic and Operational Directions for the Health Sector in Saskatchewan*.<sup>3</sup> The focus of this paper is Leading Collaboration among the Providers of Primary Health Care, which will ultimately improve the patient experience. (See Appendix A for definitions).

Methodology included a literature search for data within the last ten years in regards to leadership, collaborative practice, primary health care and transformative change. Primary health care history was reviewed from a global, national and provincial perspective. The World Health Organization identifies five key principles of primary health care. Saskatchewan's Ministry of Health bases their primary health care plan on a set of defined characteristics.

After consideration of several frameworks in the literature, three were chosen. The first framework is developed by the Canadian Interprofessional Health Collaborative. The *National Interprofessional Competency Framework*<sup>5</sup> addresses Interprofessional Collaboration and Interprofessional Education. It is "a model of interprofessional competencies that is applicable to all health professions"<sup>5</sup>, to develop collaborative practice and incorporate the principles of primary health care.

The second framework is developed by the World Health Organization. The goal of the *Framework for Action on Interprofessional Education and Collaborative Practice*<sup>6</sup> is to provide strategies and ideas that will help health policymakers implement the element of interprofessional education and collaborative practice, as well as health and education systems, which will be the most beneficial in their own jurisdiction. The educational preparation and practice environments, expectations and accountabilities for health care professionals must include and support collaborative practice in order for primary health care to succeed.

The third framework is regarding transformative change. A key to implement effective change is by following a change model framework. John Kotter's stages of transformative change will assist health care providers at all levels to implement the first two frameworks. This will produce a culture change from one of individual providers to a team of collaborative health care providers to ultimately improve the patient's experience.

Interviews conducted with health leaders and professionals provided insight into the successes and barriers regarding implementation of primary health care in Saskatchewan. Each interview involved asking key questions. (See Appendix B for expanded version of interviews). The Saskatchewan Ministry of Health produced a report, with input from various stakeholders, to identify issues and goals for the future of primary health care in Saskatchewan.

Recommendations for leading collaboration among the providers of primary health care complete the focus of this project.

## 3.0 PRIMARY HEALTH CARE

### 3.1 BEGINNING TO PRESENT DAY

Primary health care was first defined by the World Health Organization (WHO, 1978)<sup>7</sup>. It is an approach to health care that is:

- is evidence-based
- uses appropriate technology
- promotes community participation in decision about health services
- is provided at a cost the community can afford
- encourages self-care and empowerment of community members
- is the first level of contact with the healthcare system
- brings health care as close as possible to where people live, work and play

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#### WORLD HEALTH ORGANIZATION

In 1978, primary health care was defined in the *Declaration of Alma-Ata at the International Conference on Primary Health Care, Alma-Ata, USSR*.<sup>7</sup> Delegates to the conference expressed “the need for urgent action by all governments, all health and development workers, and the world community to protect and promote the health of all the people of the world....”<sup>7</sup>

The World Health Organization defined primary health care in 1978 as “essential health care based on practical, scientifically sound and socially acceptable models and technology made universally accessible to individuals and families in the community through their full participation and at the cost that the community can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process.”<sup>7</sup>

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#### CANADA

In 1986 at the First International Conference of Health Promotion in Ottawa the Minister of Health and Welfare, Jake Epp, unveiled a new framework for health promotion as a means of achieving health for all. Primary health care came to the fore again, in late 1990 and early 2000. In 2001, *Caring for Medicare: Sustaining a Quality System*<sup>8</sup>, the Fike Commission released its recommendations on the future of Medicare. In November 2002 the Commission on the Future of Medicare in Canada published its finding in “*Building on Values: The Future of Medicare in Canada*.”<sup>21</sup>

The Western Canadian Interprofessional Health Collaborative was formed in 2008 to “advance research on interprofessional education and collaborative practice to demonstrate the impact of patient quality of care as well as provider and systems outcomes.”<sup>11</sup> This group strengthens

partnerships among the four western provinces of British Columbia, Alberta, Saskatchewan and Manitoba.

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## SASKATCHEWAN

In June 2002 the Saskatchewan Government released *The Saskatchewan Action Plan for Primary Health Care*.<sup>9</sup> This plan, along with *Guidelines for the Development of Regional Health Authority Plans for Primary Health Care Services*<sup>10</sup>, provided the necessary mandate and direction for the province's Regional Health Authorities to begin work.

In the fall of 2010, the Saskatchewan Ministry of Health produced the *Future of Primary Health Care in Saskatchewan*.<sup>4</sup> This report will be discussed in Section 5.2 – Future of Primary Health Care in Saskatchewan.

The Interprofessional Health Collaborative of Saskatchewan provided research funding to three sectors: education, practice and regulatory. Proposal were submitted focusing on Interprofessional Education experiences for health professionals or Collaborative Practice opportunities within health care.<sup>12</sup>

There are various primary health care teams operating in Saskatchewan or currently being implemented. Patrick Livingstone, a facilitator with Health Canada, is currently on month four of an eighteen month contract, in Yorkton, within the Sunrise Regional Health Authority to implement interprofessional collaboration and a learning environment to a primary health care team.

### 3.2 PRINCIPLES OF PRIMARY HEALTH CARE

Principles are the fundamental truths that are shared among a group of people in regards to a particular area of interest. These principles are critical to any framework, as they guide the development in a particular area.

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## WORLD HEALTH ORGANIZATION (WHO)

WHO (1978) identified five key principles of primary health care<sup>22</sup> that were designed to work together to achieve the benefits of primary health care approach. They are:

- *Accessibility*: universal access to health care services
- *Public participation*: active participation by individuals and communities in decisions that affect their health and life
- *Intersectoral collaboration*: partnership with other disciplines, communities and sectors for health
- *Appropriate skills/technology*: appropriate use of knowledge, skills, strategies, technology and resources
- *Health promotion*: focus on health promotion and illness prevention throughout the life experience and focus on the determinants of health



Saskatchewan's plan for primary health care is based on a set of defined characteristics<sup>13</sup>. They include:

- *Accessibility*: access to responsive coordinated primary health care teams and networks province-wide, offering a full range of everyday health services.
- *Public participation*: the development of partnerships between consumers and providers will facilitate community participation in the planning, delivery and evaluation of the primary health care delivery system.
- *Effective health promotion and disease prevention*: focus on health promotion, proactive approach of promoting healthy lifestyles, working towards preventing disease and injury.
- *Proactive and collaborative approach to management of chronic diseases*: interdisciplinary teams will be engaged in all the elements of the prevention and management of chronic diseases.
- *Appropriate technology*: the use of technology to support the delivery of quality health services.
- *Intersectoral cooperation*: collaboration with other community services to address the determinants of health that impact a person's health and dependence on the health care system.
- *Patient/client centred care*: patients/clients participate in decisions regarding their care and their care providers.
- *Community development*: this approach involves consumers and providers working together to enhance the community's overall capacity to address issues and needs affecting the health of the community.
- *Human resources continuum*: uses the most effective and economically efficient health service providers: Ensures training/education of health service providers consistent with the principles of primary health care; Incorporates the appropriate use of and support for self-care, and informal and formal service providers.
- *Integration and coordination of services*: a comprehensive range of coordinated health promotion, prevention, primary curative care, rehabilitative, supportive and palliative services will be provided by integrated, interdisciplinary, multi-service networks of providers.

## 4.0 LITERATURE REVIEW

Frameworks are composed of structural pieces to provide a systemic approach to a specific topic. An extensive literature review was conducted. Three frameworks were chosen to be represented for this project. The first two frameworks provide frameworks for interprofessional collaboration, interprofessional education and competencies. The third framework will be used by providers of primary health care to implement transformative change. The frameworks are:

- National Interprofessional Competency Framework
- Framework for Action on Interprofessional Education and Collaborative Practice
- Transformative Change Framework

### 4.1 NATIONAL INTERPROFESSIONAL COMPETENCY FRAMEWORK

The National Interprofessional Competency framework was developed to inform both Interprofessional Collaboration and Interprofessional Education. It was developed in Canada as a “model of interprofessional competencies that is applicable to all health professions”.<sup>3</sup> This project involves leadership in the implementation of primary health care. History and research have shown that communication and teamwork are fundamental to the development, implementation and practice of primary health care. Interprofessional collaboration is the goal: “a partnership between a team of health providers and a client in a participatory, collaborative and coordinated approach to shared decision-making around health and social issues”.<sup>3</sup> This model is future-focused with the ability to be relevant to the present and was developed to be a living document, continually being improved and adapted to changing health care and community environments.

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*Communication and teamwork are fundamental to the development, implementation and practice of primary health care.*

Competencies integrate skills and knowledge. The competency framework represents an integrated whole that relies on the interaction of each competency to achieve interprofessional collaboration. The capacity of learners or practitioners to demonstrate the integrated set of competencies and transfer their application into different contexts and into each situation is the measure of their ability to practice collaboratively. It is the outcome of the judgments made in each situation based on the ability to integrate knowledge, skills, attitudes, and values that is the measure of competence.

The framework also describes a continuum of learning. The competency statements clearly describe what is expected of a collaborative practitioner/professional and provide direction on the continuum toward positive demonstration of collaborative practice.<sup>3</sup> The expectation is that the integration of skills and knowledge takes time and experience and develops within the educational and practice environments.

The framework consists of six domains. Each domain consists of a competency statement, descriptors of behaviors that demonstrate the competency and the explanation/rationale. The behaviors and rationale that fit each domain are logical and relatively obvious.

There are two domains that are relevant in all situations and also serve to support the others:

- Patient/Client/Family/Community-Centred Care
- Interprofessional Communication

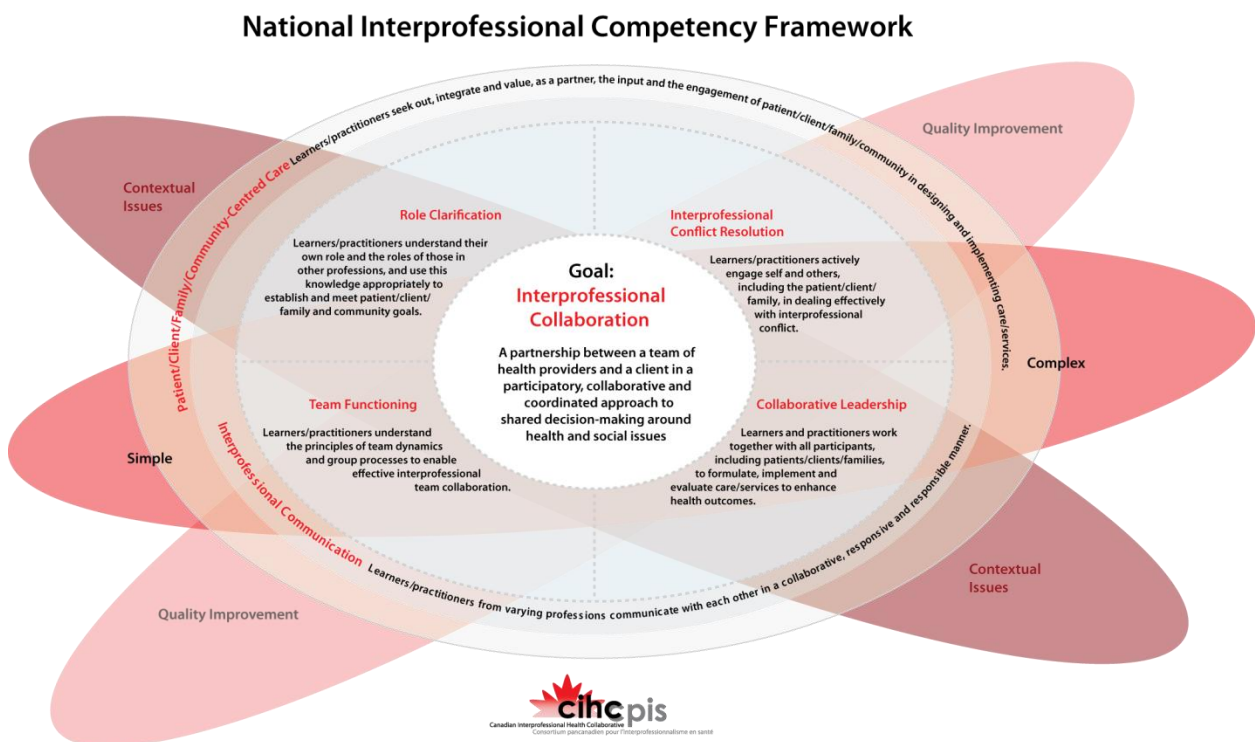
There are four domains within the integrated whole:

- Role Clarification
- Team Functioning
- Interprofessional Conflict Resolution
- Collaborative Leadership

The three background considerations:

- Contextual Issues – the setting or practice area
- Quality Improvement – interprofessional teams can address quality issues in complex systems more effectively
- Simple/Complex – the continuum of needs related to the health care system

Figure 1: National Interprofessional Competency Framework<sup>3</sup>



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## PATIENT/CLIENT/FAMILY/COMMUNITY-CENTRED CARE

Patient/client/family/community-centred care is defined as a partnership between the team of health care providers and the patient where the role of the health care team is to provide access to the knowledge, skills and resources necessary to arrive at a realistic shared plan of care.

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## INTERPROFESSIONAL COMMUNICATION

Interprofessional communication occurs when team members “communicate in a collaborative, responsive and responsible manner”.<sup>3</sup>

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## ROLE CLARIFICATION

Role clarification happens when each practitioner understands their own role, as well as the roles of other health care professionals. They must also have the ability to identify who has the knowledge and skills to best meet the patient’s needs and function in an environment where practitioner resources are used and workload is distributed appropriately. (See Appendix C for Scope of Practice for Health Care Professionals)

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## TEAM FUNCTIONING

Team functioning is all about safe and effective working relationships that include the patient. Teams can be formal or informal; however, good communication is at the heart of effective, coordinated, efficient care and necessary to shared care planning and delivery.

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## COLLABORATIVE LEADERSHIP

Collaborative leadership supports shared decision-making, as well as leadership. It also implies continued individual accountability for one’s own actions, responsibilities and roles as defined by each practitioner’s scope of practice.<sup>3</sup>

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## INTERPROFESSIONAL CONFLICT RESOLUTION

Interprofessional conflict resolution ensures conflict is respectfully and constructively addressed. Disagreement over ‘roles’ and ‘goals’ are to be expected. Proactive steps are required in dealing with conflict as are agreements for the management of specific situations that often trigger conflicts. Skill sets for managing conflict have to be developed in order to function in a collaborative interprofessional environment.

What makes this framework unique is that it “focuses on the ability to integrate knowledge, skills, attitudes, and values in arriving at judgments rather than on demonstrated behaviors to determine competence.”<sup>3</sup> “Competencies do not measure the level of competence. They provide the foundation upon which assessment of ability can be built, but they do not describe the levels

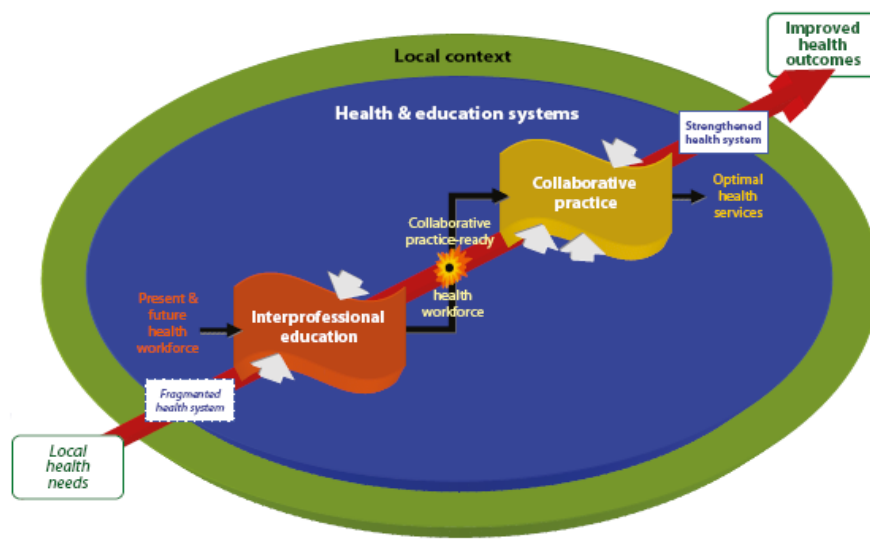
at which individuals are expected to perform”.<sup>3</sup> This may be both its strength and its weakness. Moving into the future this is absolutely the level of competence that a health care professional will require to practice. The point is made in the description of the framework that it is about outcomes as opposed to process. How do we measure progress? Implementing this model into both the education and practice environments of health professionals will require some more concrete tools for measurement and evaluation. Process will be important in the transition from abstract to concrete and understanding whether progress is being made. Making the leap from our current state to that future state may require some focus on behaviors as described by Lesser et al. (2010).<sup>23</sup> Promoting and enforcing changes in practice will require mentoring, professionalism and accountability. It will also require shared goals, policy support and performance measurement. The model is congruent with current Ministry of Health priorities such as Lean and the Patient First review. The patient currently expects interprofessional collaboration in their care and the continued implementation of primary health care requires it.

*Focus on the ability to integrate knowledge, skills, attitudes, and values in arriving at judgments rather than on demonstrated behaviors to determine competence.*

#### 4.2 FRAMEWORK FOR ACTION ON INTERPROFESSIONAL EDUCATION AND COLLABORATIVE PRACTICE

The Framework for Action on Interprofessional Education and Collaborative Practice is the product of the World Health Organization (WHO) Study Group on Interprofessional Education and Collaborative Practice. Considerable support was provided by the Canadian Interprofessional Health Collaborative. The WHO acknowledges that there is sufficient evidence to indicate that effective interprofessional education enables effective collaborative practice.

Figure 2: Health & education systems<sup>6</sup>



The goal of this framework is to provide strategies and ideas that will help health policymakers implement the element of interprofessional education and collaborative practice that will be most beneficial in their own jurisdiction. As each health system is unique, this framework is intended to provide leaders ideas on how to contextualize their existing health system, commit to interprofessional education and collaborative practices and champion the benefits of their regional partners, educators and health workers.

*IECP framework is intended to provide leaders ideas on how to contextualize their existing health systems into something different.*

The need to strengthen health systems based on the principles of primary health care has become one of the most urgent challenges for policy makers, health workers, managers and community members around the world. Governments are looking for innovative, system-transforming solutions that will ensure the appropriate supply, mix and distribution of health staff. This framework is a call for action to move towards embedding interprofessional education and collaborative practice strategies to strengthen health system performance and improve health outcomes.

Interprofessional education occurs when two or more professionals learn about, from and with each other. It is a prerequisite in preparing a “collaborative practice-ready” health workforce that is better prepared to respond to local needs. A collaborative practice ready worker is someone who has education in and is competent to work on an interprofessional team and be an essential member of a collaborative team.

Interprofessional health care teams understand how to optimize the skills of their members, share case management and provide better health-services to patients and community.

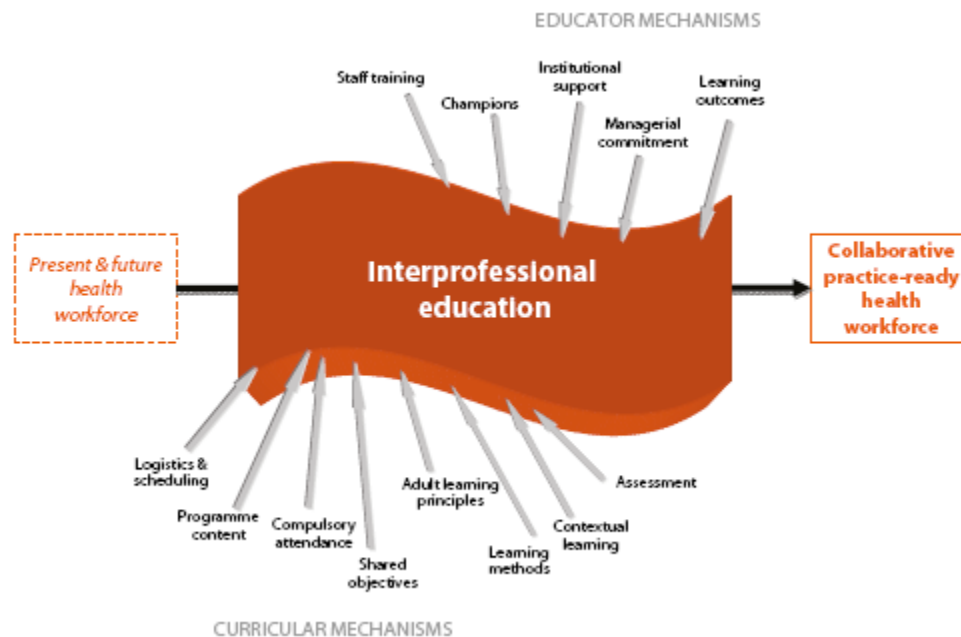
To achieve this outcome, the health and education systems must work together to coordinate health workforce strategies. Once health workforce planning and policy makers work together, interprofessional education and collaborative practice can be fully supported. Achieving this requires a review and assessment of the mechanisms that shape both.

After review of research literature, results of an international environmental scan and interprofessional education practices, country case studies and the expertise of key informants, the WHO Study Group identified a number of key mechanisms. Mechanisms are a natural or established process by which something takes place or is brought about.<sup>18</sup> The mechanisms of the framework were organized into broad themes and grouped into three sections: 1) interprofessional education, 2) collaborative practice, and 3) health and education systems. It is worth noting that there is a great degree of overlap and many of the mechanisms influence throughout the other sections.

## INTERPROFESSIONAL EDUCATION

Interprofessional education occurs when two or more professionals learn about, from and with each other. Two mechanisms shape how interprofessional education is developed and delivered. These are educator mechanisms and curricular mechanisms.

Figure 3: Interprofessional education<sup>6</sup>



### *Educator Mechanisms*

The term educator includes all instructors, trainers, faculty, preceptors, lecturers and facilitators who work within education of any health-care institution, as well as the individuals who support them.<sup>6</sup> Staff are responsible for developing, delivering, funding and managing interprofessional education (For example: staff training, champions, institutional support, managerial commitment, learning outcomes). Sustaining interprofessional education requires:

- Supportive institutional policies
- Managerial commitment
- Good communication among participants
- Enthusiasm for the work being done
- A shared vision and understanding of the benefits
- A champion who is responsible for coordinating education activities and identifying barriers to the progress

### *Curricular Mechanisms*

As health-care and education is provided by many different types of educators in many different settings, there is a challenge in the coordination for interprofessional educators and curriculum developers.

Results of an international environmental scan of 42 countries on interprofessional education practices indicate that it does take place and involves students from a broad range of disciplines. However, courses are usually short and variable in nature. Also evaluation of impact on health outcomes and service delivery are rare.

Research shows interprofessional education is most effective when:

- Attendance is compulsory
- Provides flexible scheduling
- Principles of adult learning are used
- Learning methods reflect the real world practice
- Interaction occurs between students
- Curricula links learning activities, expected outcomes and an assessment of what has been learned

Interprofessional learning domains include:

- Teamwork: being able to be both team leader and team member and knowing the barriers to teamwork.
- Roles and Responsibilities: understanding one's own role, responsibilities and expertise and those of other health workers.
- Communication: expressing one's opinions competently to colleagues and listening to team members.
- Learning and critical reflection: reflecting critically on one's own relationship within a team and transferring interprofessional learning to the work setting.
- Relationship with, and recognizing needs of the patient: working collaboratively in the best interest of the patient and engaging with patients, their families, caregivers and communities as partners in case management.
- Ethical practice: understanding the stereotypical views of other health workers held by self and others, and acknowledging that each health workers views are equally valid and important.

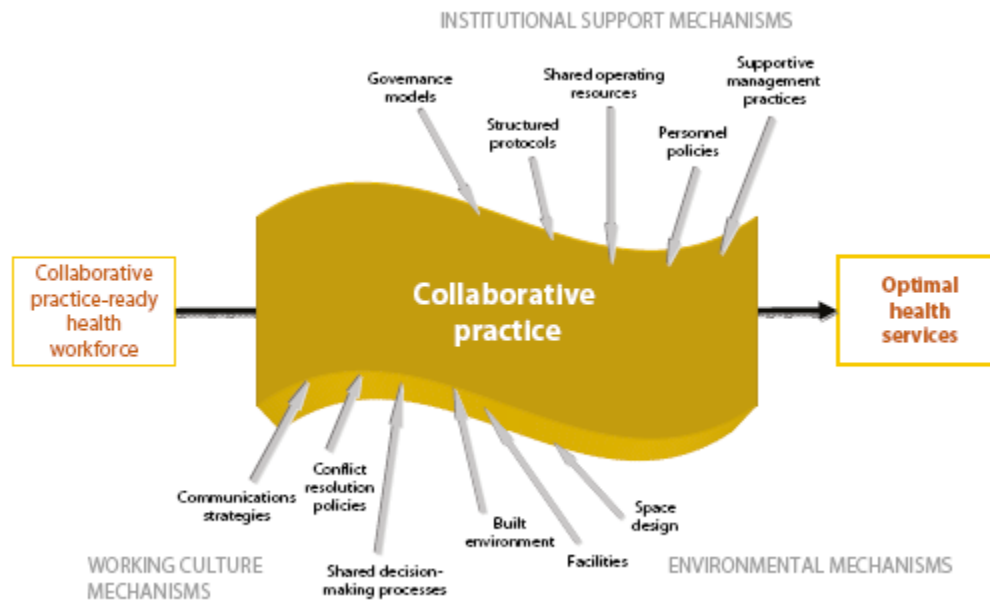
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## COLLABORATIVE PRACTICE

A collaborative practice ready worker is someone who has education in and is competent to work on an interprofessional team and be an essential member of a collaborative team. Interprofessional education is a prerequisite in preparing a collaborative practice-ready health workforce that is better prepared to respond to local needs. There are three mechanisms that shape collaborative practice: institutional support mechanisms; working culture mechanism and environmental mechanisms. These mechanisms focus on how collaborative practice is introduced and executed. It works best when organized around the needs of the population being served and takes into account the way in which local health care is delivered.



Figure 4: Collaborative practice<sup>6</sup>



#### *Institutional Support Mechanisms*

This mechanism can shape the way a team of people work collaboratively. Staff needs the following:

- Clear governance models
- Structured protocols
- Shared operating resources
- Personnel policies need to reflect values of collaborative practice being fair and equitable
- Managerial support

#### *Working Culture Mechanisms*

This mechanism should include:

- Communication strategies which include structured information systems and processes
- Conflict management policies
- Opportunities for shared decision-making and routine team meetings which enables health care workers to decide on patient management plans and goals, as well as balance individual and shared tasks and negotiate shared resources

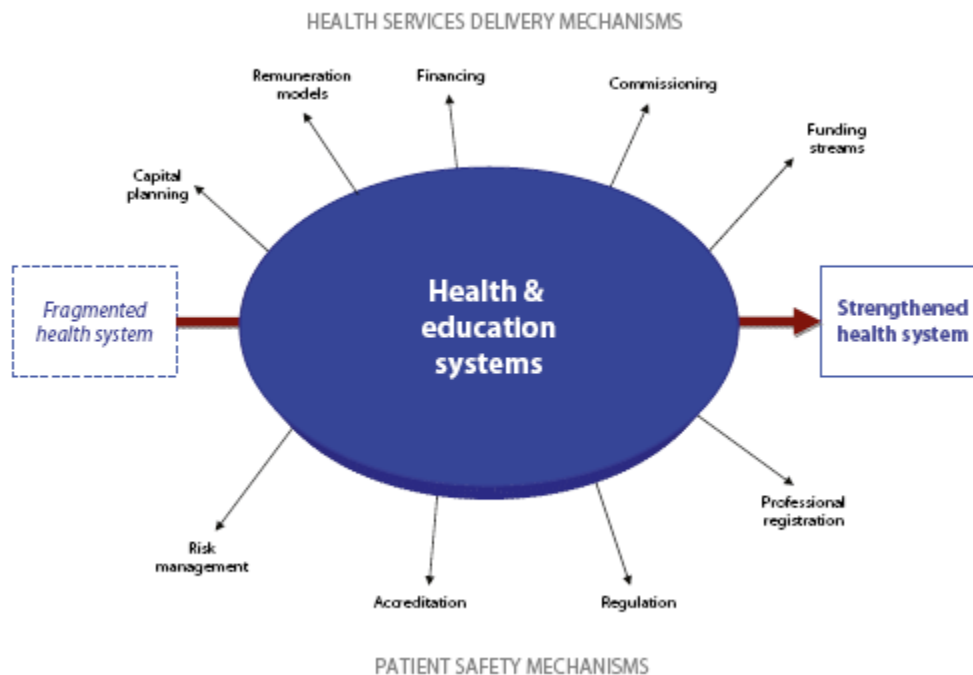
#### *Environmental Mechanisms*

The physical working environment has a big impact on the success of collaborative practice. Input and recommendations from community, patients and members of health care teams are important. Physical space should not reflect a hierarchy of position. Shared spaces better facilitate collaborative practice. Environmental mechanisms include:

- Built environment
- Facilities
- Space design

Two mechanisms discuss how health and education services are delivered and patients are protected. These are: health services delivery mechanisms and patient safety mechanisms.

Figure 5: Health and Education Systems<sup>6</sup>



### *Health Services Delivery Mechanisms*

A coordinated effort between health and education will ensure the future workforce is appropriately qualified. In developing collaborative practice, health workers and health educators must discuss how to make the transition from education to the work environment.

Key principles that can guide the movement towards interprofessional education and collaborative practice include context relevance, policy integration, multi-level system change and collaborative leadership.

Legislative changes can influence how health workers are educated, accredited, regulated and remunerated and has a significant impact on the development, implementation and sustainability of interprofessional education and collaborative practice.

Aspects of the health services delivery mechanism include:

- Capital planning
- Remuneration models
- Financing

- Commissioning
- Funding streams

### *Patient Safety Mechanisms*

Governance mechanisms that establish system-wide standards and support patient safety can be used to embed interprofessional education and collaborative practice within the entire healthcare system. These include:

- Risk management
- Accreditation
- Regulation
- Professional registration

Interprofessional education and collaborative practice can be difficult concepts to explain, understand and implement. Many health care workers believe they are practicing collaboratively, when in reality they may only be working within a group where each individual has agreed to use their own skills to achieve a common goal. Collaboration is more than an agreement and communication; it is about creation and synergy. This framework focuses on the importance of introducing interprofessional education and collaborative practice as strategies that can transform the health system.

No two health systems are alike, for that reason the framework suggests beginning by assessing what is readily and currently available and building on what you have. The framework provides suggestions and ideas that will build on what is currently working and open dialogue and discussion around initiatives that can be implemented in the future. By implementation of some of the framework strategies, it is hoped that the healthcare system would move from a fragmented state to one where systems are strengthened and health outcomes are improved.

## 4.3 TRANSFORMATIVE CHANGE

One of the keys to leading collaboration is to follow a model in order to produce transformational change. The National Interprofessional Competency Framework and the Framework for Action on Interprofessional Education and Collaborative Practice will be more effectively implemented by using a change model framework for implementation. There are several change models available which involve various numbers of steps or stages. Effectiveness of a model is deciding on one model and thoroughly following all the steps.

John Kotter is a retired professor from the Harvard Business School and regarded as an authority on change. Kotter maintains that people need to realize change is a process, not an event. Kotter's model involves eight stages, as illustrated in the following table<sup>14,15</sup>. Included in the table are stages, actions and pitfalls. It is important when implementing change to understand where the pitfalls may occur in each of the stages. This gives the change champion a broad perspective of all aspects of the project, as well as helps the change champion narrow the gap if a project is not rolling out as planned.

Stage	Actions	Pitfalls
1. Establish a sense of urgency	<ul style="list-style-type: none"> <li>• Perform market analyses</li> <li>• Determine problems, potential crises and untapped opportunities</li> <li>• Use techniques to focus people's attention on the importance of change to meet these challenges</li> <li>• Convince at least 75% of managers that the status quo is more dangerous than the unknown</li> </ul>	<ul style="list-style-type: none"> <li>• Underestimating the difficulty of driving people from their comfort zones</li> <li>• Becoming paralyzed by risks</li> </ul>
2. Form a powerful guiding coalition to guide the change	<ul style="list-style-type: none"> <li>• Create team structures to help drive the change</li> <li>• Assemble the group with shared commitment to help lead the change effort</li> <li>• Ensure teams have sufficient power to achieve the desired change</li> </ul>	<ul style="list-style-type: none"> <li>• No prior experience in teamwork at the top</li> <li>• Relegating team leadership to an HR quality, or strategic-planning executive rather than a senior line manager</li> </ul>
3. Develop a vision	<ul style="list-style-type: none"> <li>• Develop a vision that provides a focus for the change</li> <li>• Develop strategies for realizing that vision</li> </ul>	<ul style="list-style-type: none"> <li>• Presenting a vision that's too complicated or vague to be communicated in five minutes</li> </ul>
4. Communicate the vision	<ul style="list-style-type: none"> <li>• Use multiple channels to constantly communicate the vision and strategies for achieving it</li> <li>• Teach new behaviors by the example of the guiding coalition</li> </ul>	<ul style="list-style-type: none"> <li>• Under communicating the vision</li> <li>• Behaving in ways antithetical to the vision</li> </ul>
5. Empower staff to act on the vision	<ul style="list-style-type: none"> <li>• Remove organizational policies and structures that inhibit achievement of the vision</li> <li>• Remove or alter systems or structures undermining the vision</li> <li>• Encourage risk taking and nontraditional ideas, activities and actions</li> </ul>	<ul style="list-style-type: none"> <li>• Failing to remove powerful individuals who resist the change effort</li> </ul>
6. Ensure there are short-term wins by planning and creating	<ul style="list-style-type: none"> <li>• Wins help support need for change</li> <li>• Rewarding 'wins' helps to provide motivation</li> <li>• Define and engineer visible performance improvements</li> <li>• Recognize and reward employees contributing to those improvements</li> </ul>	<ul style="list-style-type: none"> <li>• Leaving short-term successes up to change</li> <li>• Failing to score successes early enough (12 – 24 months into the change effort)</li> </ul>
7. Consolidate improvements and produce more change	<ul style="list-style-type: none"> <li>• Continue to remove organizational policies and processes that inhibit change</li> <li>• Reward those who engage positively with the change</li> <li>• Establish new, related change projects</li> <li>• Use increased credibility from early wins to change systems, structures and policies undermining the vision</li> <li>• Hire, promote and develop employees who can implement the vision</li> </ul>	<ul style="list-style-type: none"> <li>• Declaring victory too soon – with the first performance improvement</li> <li>• Allowing resisters to convince 'troops' that the war has been won</li> </ul>
8. Embed the change in the culture	<ul style="list-style-type: none"> <li>• Link change to organizational performance and leadership</li> <li>• Articulate connections between new behaviors and corporate success</li> </ul>	<ul style="list-style-type: none"> <li>• Not creating new social norms and shared values consistent with changes</li> </ul>

	<ul style="list-style-type: none"> <li>• Create leadership development and succession plans consistent with the new approach</li> </ul>	<ul style="list-style-type: none"> <li>• Promoting people into leadership positions who don't personify the new approach</li> </ul>
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The history of primary health care has been described above; internationally in 1978, nationally in 1986 and provincially in 2002, as well as current. At this point it is important to note that primary health care is at varying stages of implementation throughout the nations, provinces and local regions. In the areas where there has not been as much success with primary health care, acknowledging that one framework was not chosen to implement the change in practice is reasonable. According to the dates above, Saskatchewan is in the infancy stages of implementing primary health care.

In order to move forward with primary health care at any level, the organization needs to advance through all the stages, without eliminating any stages. When a world, a nation, a province and a community change the healthcare system to operate within a primary health care model, this transformative change will change the way health professionals interact, both with each other and with the patient.

## 5.0 THE SASKATCHEWAN EXPERIENCE

Saskatchewan continues to pursue a future that includes developing rural and urban primary health care services. Steps have been taken to address barriers in the delivery of primary health care, however challenges still exist.

### 5.1 CURRENT STATE OF PRIMARY HEALTH CARE

The current climate of primary health care was explored by interviewing people throughout the province of Saskatchewan who are currently involved or were previously involved in primary health care or areas that used the basic principles of primary health care. Each person interviewed was asked the key question, “What are the key leadership challenges to implementing primary health care?” Other questions asked were “What is working well?” and “Why or why not?”

The following is a summary of the statements that each interviewee determined as the key leadership challenge. (See Appendix B for complete interview summaries).

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#### CLARK, VELDA

Former Director, Palliative Care, Regina Qu’Appelle Health Region (RQHR)

- Velda felt that it was imperative to have upper management support as the basis for the team. She felt that in developing the right team, it was important to get the right people in the right spots, including strong leaders. At the heart of it all is the patient and if you listen to their needs then the decisions the team makes will be the right ones.

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#### HOLMES, PEGGI

Primary Health Care Facilitator & Chronic Disease Manager, Cypress Health Region (CHR)

- Peggi has been a team facilitator since the initial development of primary health care sites in the Cypress Health Region. The first leadership challenges she had was community education and defining what primary health care really is, team building for the primary health care team and finding the right leader in each location.

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#### JORGENSON, DEREK

Pharmacist, Westwinds Primary Health Care

- Derek has been involved at the grassroots level with the integration of pharmacists into primary health care teams in Saskatchewan. He feels that the two main challenges of providing primary care team services in Saskatchewan are the systems focus on a medical model instead of all determinants of health and the absence of immediate ‘measurables’

of this model. He feels that collaboration will always suffer under this business model and that leadership is missing at a very high level.

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MAGNUSSON, DONNA AND SCHUSTER, FAY

Executive Director/ Director, Primary Health Services Branch, Saskatchewan Health

- Fay and Donna were able to give a wonderful overview of both previous and current challenges at the Ministry level to the development of primary health care in Saskatchewan. Electronic medical records are a common thread when looking at the future of primary health care. They feel that the leaders need to take a community development approach and understand: who makes up primary health care teams and what is their scope of practice, community engagement and collaborative practice, and chronic disease management. Teams that have really looked at the needs of the community first and formed intersectoral partnerships have succeeded.

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ISHAK BECKMAN, BRENDA

Director of Inpatient and Regional Diagnostic Services (Former Director of Primary Health Care, MCRRHA).

- Brenda feels that one of the key challenges is creating an understanding of what primary health care really is and what a primary health care team looks like. She also feels that there is a need to increase supports for determinants of health within communities. The teams that worked well put the patient at the center and met their needs as a team. Respect and understanding among team members and problems solving skills is key.

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WHITE, DR. GIL

Former Director for Ministry of Health

- Dr. White feels that the key leadership challenges to implementing primary health care are community involvement and needs assessment, understanding the role of collaborative practice and the role of the physician within this framework. Healthcare professionals need to answer the question ‘what are you trying to achieve with primary health care?’ He feels that electronic medical records are a key component to improving collaboration in the primary health care model.

## 5.2 FUTURE OF PRIMARY HEALTH CARE IN SASKATCHEWAN

In 2010, the Saskatchewan Ministry of Health invited key stakeholders to a workshop. The goal of the workshop was to identify practical ideas to transform Primary Health Care. A report entitled *Future of Primary Health Care in Saskatchewan*<sup>4</sup> was produced with six key areas of focus. Within these six focus areas, the issues or barriers were identified. Leaders then proposed

goals or recommendations in each of these priority areas. The barriers in each area are highlighted, as well as the top three goals for each and where they fit into the overall priorities.<sup>4</sup>

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## FOCUS ON COMMUNITY PARTICIPATION

### *Issues/ Barriers:*

- The conversation about community needs has to start with a focus on healthy communities and what creates health.
- We need to provide education with the right information to the communities, health care professionals, patients and the public so we can get informed participation.
- The barriers of the past are getting in the way of change.
- Getting the right people in the community involved and engaged in looking at opportunities – enough people to initiate change and mobilize communities.
- Communities taking ownership of recruitment and retention, physicians understanding and driving for primary health care solutions.
- Competition between communities and disincentives to collaboration.

### *Goals:*

- Priority 1: To ensure that practice in rural Saskatchewan is desirable. This will help ensure an improved quality of life for all health care professionals working in communities while improving the provision of primary health care in these communities.
- Priority 4: Communities and citizens understand and take ownership for primary health care – competencies, roles and contributions of a variety of providers.
- Priority 18: Communities become more efficient by sharing services and working together, rather than competing for resources. Within five years, we have electronic health records across the province.

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## INTERPROFESSIONAL COLLABORATION

### *Issues/ Barriers:*

- We lack the appropriate electronic information system and infrastructure to support interprofessional collaboration.
- Current incentives/compensation models are not flexible enough to encourage participation in interprofessional teams.
- There is a lack of mutual respect/trust/recognition among professions. Scope of practice is essential to addressing this.
- There is a need for pre and ongoing education in collaborative practice for all professions.
- The system is not designed to support integration of services within a primary health care framework.



- We are forgetting to place the patient at the center. We have to remember this assumption – that interprofessional collaboration is anchored in a patient-first assumption.
- There is a lack of clarity on who owns/leads the patient.

*Goals:*

- Priority 8: Within ten years, we will have successfully engaged all health care professionals and their representative organizations to empower them to deliver care to the full scope for their individual practice.
- Priority 9: Within five years, all primary health care team members have appropriate access to an integrated and effective electronic health record.
- Priority 13: Within two years, all central primary health care teams offer practicums in their teams for students and current practitioners.

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## LEADERSHIP AND ACCOUNTABILITY

*Issues/ Barriers:*

- People need to understand the working scope definition for primary health care and the alternative operating models it implies.
- Physician leadership is critical to the transformation of the primary health care system at both the system and team levels.
- We have an engagement issue between community leadership and the primary health care sector as they are currently working against each other in some cases.
- Our ability to measure outcomes is critical to the success of primary health care teams.
- We have not aligned the financial resources and incentives to achieve the outcomes we want.

*Goals:*

- Priority 2: By 2012, we must define some core indicators for health outcomes that measure optimized access to primary health care. We must accelerate the implementation of electronic health record and related data capture and reporting systems.
- Priority 14: By 2020, X% of the Saskatchewan population will demonstrate exceptional health as described by the pre-defined and measured outcomes while being able to say “I receive the care I want and need exactly how and when I want and need it.”
- Priority 15: By 2012, there must be a statement by the government and Ministry of Health that they are serious about advancing primary health care in the province – makes commitments to action regarding the long term goals.

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## THE PATIENT EXPERIENCE

### *Issues/ Barriers:*

- We need to articulate what we mean by ‘superior patient experience’, which encompasses a variety of factors, including access/wait times, patient responsiveness, diverse workforce, and effectiveness.
- Chronic disease management must be the focus for transforming primary health care.
- We need to build interdependent relationships among health care providers.
- Physicians’ relationship with the health care system needs to be examined.
- No ongoing measurement of patient experience.

### *Goals:*

- Priority 3: Everyone in Saskatchewan has an identifiable primary health care team that they can access within twenty-four hours.
- Priority 10: Health promotion/population health: ‘healthy living in core curriculum in all schools; all current chronic disease management programs to include self-management strategy and increase number and scope of chronic disease management programs.
- Priority 16: Health promotion/population health where individuals are empowered to take responsibility to maintain good health and prevent disease and includes education and support/prevention/self-management.

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## SUSTAINABLE AND STABLE DELIVERY

### *Issues/ Barriers:*

- We need a flexible model to meet community needs.
- We need to figure out funding - how many bricks and people we can afford.
- The service delivery model should drive payment.
- We need electronic health records throughout the province.
- We need to identify population health needs based on desired outcomes and goals.
- We need a broader vision of the team.

### *Goals:*

- Priority 5: ‘We’ engage communities, including politicians at all levels to: define a set of core services and set expectations for a basic level of service, set priorities based on needs and informed by costs and define measures and outcomes.
- Priority 6: Saskatchewan is fully self-sufficient in the production of health care workers.
- Priority 11. Remuneration fosters collaboration and facilitates the provision of a team of health care providers.
- Priority 17. We have outcomes and measures that: cross boundaries and initiate collaboration; include long-term outcomes; are attainable; and have the capacity and capability to monitor and report against.

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## UNDERSERVED POPULATIONS

### *Issues/ Barriers:*

- The concern is the need to ensure that services are delivered to the populations with the greatest need, as opposed to the loudest voice.
- Innovation and flexibility are required in primary health care delivery to underserved populations.
- There is a gap between regional health authorities and community level – consultation and inclusion must be early, meaningful and collaborative.
- Ensuring equal access to health for everyone.
- Optimization of health care professionals – do we have the right people with the right skills to run the ‘business of health’.
- Education of health care professionals.

### *Goals:*

- Priority 7: Legislative, regulatory and licensing bodies are updated to reflect the current environment and optimize the scope of practice for health care professionals.
- Priority 12: Involve communities and underserved populations from the ground up and build empowerment for them to partner.

## 6.0 RECOMMENDATIONS TO LEAD COLLABORATION

Recommendations in this project are approached within three levels: Ministry of Health; Primary Health Care Organization and Primary Health Care Providers.

As a conclusion to this project, the following is a series of recommendations regarding how to lead collaboration among health care providers. Recommendations identified in the Future of Primary Health Care in Saskatchewan<sup>4</sup> report are supported by this project and will not be reiterated. These recommendations address three major levels within the health system – Ministry of Health, a primary health care organization and the individual health care provider.

### 6.1 MINISTRY OF HEALTH

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#### RECOMMENDATION:

Challenge all ministries within the Government of Saskatchewan to collaborate and communicate to address the determinants of health.

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#### RECOMMENDATION:

Ensure representation of primary health care organizations and providers throughout all processes in the development of programs/strategies/future direction.

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#### RECOMMENDATION:

Develop a communication strategy to distribute primary health care information from the Ministry of Health through primary health care organizations to the healthcare providers.

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#### RECOMMENDATION:

Create frameworks and health policies regarding interprofessional collaboration for all health care providers.

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#### RECOMMENDATION:

Empower the primary health care providers to have input in the future development of the health care system.

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#### RECOMMENDATION:

Collaborate with the professional and licensing bodies of all health care professionals to promote interdisciplinary educational and networking opportunities.

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RECOMMENDATION:

Create frameworks and health policies to support interprofessional education regarding primary health care.

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RECOMMENDATION:

Ensure the commitment of educational leaders to one common vision for interprofessional education.

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RECOMMENDATION:

Ensure the commitment of educational leaders to implement the principles of primary health care within health care programs.

## 6.2 PRIMARY HEALTH CARE ORGANIZATION

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RECOMMENDATION:

Engage communities to define core services and expectations for a basic level of service. Priorities will be set based on needs and available resources with defined measures and outcomes.

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RECOMMENDATION:

Facilitate community participation in public education regarding primary health care.

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RECOMMENDATION:

Conduct evaluation processes with the community and the clients to support strategic planning to meet the needs of all stakeholders.

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RECOMMENDATION:

Develop a code of conduct policy for each primary health care organization.

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RECOMMENDATION:

Select leaders that share the vision of collaboration will champion the cause.

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RECOMMENDATION:

Create practice environments that utilize policies, resources, education and infrastructure to support collaborative models of primary health care

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RECOMMENDATION:

Develop human resource policies, which include expectations, evaluation and performance, to recognize, support and reward collaborative models of primary health care.

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RECOMMENDATION:

Implement professional development programs to build skills in effective communication and collaboration, conflict resolution, as well as quality management for all primary health care providers.

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RECOMMENDATION:

Facilitate interdisciplinary preceptorship opportunities for student health care providers to increase understanding and appreciation of the role of all members of the interdisciplinary team.

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RECOMMENDATION:

Advocate the prompt implementation of a provincial electronic integrated health record within the next two years. Commit as a primary health care organization to implement the provincial health record.

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### 6.3 PRIMARY HEALTH CARE PROVIDER

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RECOMMENDATION

Challenge self and other team members to keep the patient at the centre of their practice.

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RECOMMENDATION

Advance patient care by sharing information, practice tools, ideas, successes, challenges and failures with other primary health care providers.

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RECOMMENDATION

Champion interprofessional collaboration by committing to 100% personal and professional accountability.

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RECOMMENDATION

Practice efficient and effective communication.

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RECOMMENDATION

Commit to advancing personal communication skills by attending workshops, conferences, self-development and team activities.

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RECOMMENDATION

Acknowledge personal contributions as being an integral and valuable part of the primary health care team.

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RECOMMENDATION

Commit to enhancing positive behaviors by demonstrating respect, developing trusting relationships, encouraging others and engaging in crucial conversations.

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RECOMMENDATION

Incorporate code of conduct into daily practice and orientate new primary health care team members regarding the code.

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RECOMMENDATION

Ensure all team members understand their own scope of practice, as well as other members of the team within the primary health care organization.

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RECOMMENDATION

Commit to personal leadership development throughout career.

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RECOMMENDATION

Identify and address gaps in personal knowledge and competencies.

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RECOMMENDATION

Commit to attend interprofessional and collaborative education opportunities throughout personal career.

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RECOMMENDATION

Participate in a professional mentorship program within designated health care field, as either mentor or mentee, or both.

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RECOMMENDATION

Understand and apply the principles of team dynamics to enable effective team collaboration.

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RECOMMENDATION

Commit to creative problem solving and innovation.

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RECOMMENDATION

Build positive working relationships by being open-minded, present, visible, flexible, adaptable and participatory.

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RECOMMENDATION

Participate in and promote community development.



## 7.0 CONCLUSION

The advancement of primary health care requires leadership and support at government, employer and individual levels to succeed. All health care providers and their professional organizations must be engaged in promoting collaboration in both education and practice. Community development and needs assessment necessitate collaboration and consultation with the community. The principles of primary health care emphasize the participation of the patient/community and being proactive in the provision of health services.

A knowledge base of frameworks provides this project with the necessary tools to advance primary health care. The National Interprofessional Competency Framework and the Interprofessional Education and Collaborative Practice frameworks address a variety of concepts for primary health care. John Kotter's change model was chosen as a staging tool when implementing changes, in order to gain success.

Personal interviews were conducted with health leaders and professionals to provide insight into the successes and barriers regarding implementation of primary health care in Saskatchewan. A key document produced for the Saskatchewan Ministry of Health, September 2010, completed the status of primary health care in Saskatchewan, as issues and goals were identified.

As a conclusion to this project, there is a series of recommendations regarding how to lead collaboration among health care providers. These recommendations address three major levels within the health system – Ministry of Health, a primary health care organization and the individual health care provider.

Communication and teamwork are integral to the implementation and practice of primary health care. Patient-centred care cannot be accomplished by groups of health care providers acting concurrently. Coordination of care requires that roles be defined, accountabilities accepted and that each member of the team is working toward the common goal of meeting the patient's needs. The synergy created by true collaboration will be much greater than the sum of each professional group's individual contribution.

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## 10.0 APPENDICES

### 10.1 APPENDIX A - DEFINITIONS

Collaborative practice	occurs when multiple health care providers from different professional backgrounds provide comprehensive services by working with patients, their families, caregivers and communities to deliver the highest quality of care across settings. <sup>6</sup>
Health Care Provider	refers to all people engaged in actions whose primary intent is to enhance health. <sup>6</sup>
Interdisciplinary	implies a deeper degree of collaboration among team members, with an integration of the knowledge and expertise of several disciplines to develop solutions to complex problems in a flexible and open-minded way. <sup>16</sup>
Interprofessional Collaboration	the process of developing and maintaining effective interprofessional working relationships with learners, between practitioners, patients/clients/families and communities to enable optimal health outcomes <sup>5</sup>
Interprofessional education	occasions when two or more professions learn with, from and about each other to improve collaboration and the quality of care <sup>17</sup>
Interprofessional competencies	a complex integration of knowledge, skills, attitudes, values, and judgments that allow a health provider to apply these components into all collaborative situations. <sup>5</sup>
Intersectoral	implies a relationship with other community services outside health care to address the determinants of health <sup>18</sup>
Multidisciplinary	refers to situations where several participants representing several disciplines work on the same project on a limited and transient basis. <sup>16</sup>
Patient/family centred care	a partnership between a team of health providers and a patient where the patient retains control over his/her care and is provided access to the knowledge and skills of team members to arrive at a realistic team shared plan of care and access to the resources to achieve the plan <sup>19</sup>
Primary Health Care	Primary health care extends beyond the traditional health care system to include services that encompass the determinants of health such as income, housing, education and environment. Primary health care considers the health care needs of the community as well as the individual. Communities and individuals are active partners in making decisions that will affect their health and health care. <sup>10</sup>
Primary Care	Refers to the first contact people have with the healthcare system to seek out primary care services for diagnosis, treatment and follow-up for a specific health problem, or to access routine screening such as an annual check-up. Primary care is a core component of primary health care, although it is usually more narrowly focused on individual illness treatment and rehabilitation. <sup>10</sup>



## 10.2 APPENDIX B – PERSONAL INTERVIEWS

These are the complete documentation of interviews held with various stakeholders in the province of Saskatchewan. Each interview involved asking the key question – “What are the key leadership challenges to implementing primary health care?”

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### INTERVIEW WITH VELDA CLARK

Former Director of Palliative Care. One of the first Primary Health care initiatives

- Moving to developing a program that works for families and patients versus the system.
- Key issue was jealousy from other groups, upper management allowing them autonomy and believing that a team could do this, and developing the ‘right’ team.
- Putting the right people in leadership positions was an issue.
- The right leader needs to work with the team to develop a strategy for the team. A strategy is a plan that has all of the components figured out: funding, senior management support, vision, the right staff available, etc.
- Also need to invest in leadership development so that the ‘right fit’ can be found for the ‘right people’. The team will be successful if this is done.
- A key leadership skill is ‘listening’. This means not solving the problems of the team. If you pay attention to staff and they pay attention to patients, then the patient will be in the centre of all decisions that are made.

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### INTERVIEW WITH PEGGI HOLMES

PHC Facilitator & Chronic Disease Manager, Cypress Health Region. Peggi’s role and responsibilities include: Team Facilitator for Maple Creek and Leader, Chronic Disease Coordinator for Cypress Health Region and Manager of Educators – Six educators in 3 Health Centers

What are the key leadership challenges to implementing Primary Health care?

- Initially the challenge was to educate the public on what Primary Healthcare is and demonstrate what it can do for them.
  - The challenge was to get members at interdisciplinary team meetings and developing an agenda that gives members the opportunity to share among themselves. Basic team building and building trust so that they can share.
  - Physician shortages – impacted implementation of primary health care and chronic disease management.
  - Primary health care looks different in different locations. Chronic Disease Management is what they do. A leader has not emerged in certain sites.
  - Primary health care is based on four pillars – she reviews them at each meeting.
- 1) Are we improving access? 2) Information sharing 3) working in teams 4) healthy living – programs they have in common for patients.
- The Ministry of Health has been very supportive in this development and provides a team effectiveness (evaluation) tool. Based on the feedback from team members, she often

has a speaker do a presentation to generate discussion and provide accurate information on job scope, programs being offered, etc. The bottom line is improving customer satisfaction.

- As a team leader, she attends an annual two-day program for facilitators and has ongoing support as well. Her role is not to act as the 'answer giver' in meetings, but to focus on the pillars of primary health care and how each team member contributes to these. She is there to help get the process going.
- She also helps people to communicate with each other and holds Chronic Disease Management committee meetings four times per year. They focus on who is doing what in each primary health care team and who can they partner with.

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## INTERVIEW WITH DEREK JORGENSON

### Pharmacist with West Winds Primary Health Care

Derek had two strong thoughts related to the challenges of providing primary care team services in Saskatchewan:

- The primary health care system suffers because it focuses on a medical model instead of all determinants of health. For example, providing and promoting activity and healthy diets in a high diabetes community. Prevention of disease and promotion of healthy lifestyles is key.
- The problem with this type of model is measurables. They may not be seen for 15- 20 years down the road. This not very palatable in the political world. Government wants to promote the positive measurables and this will not be apparent in their term.
- Collaboration will always suffer as long as a "business model" is used. Physicians, pharmacists and many more health care providers are paid a fee for service. Therefore there is no incentive to have the regular meetings (collaboration) that seem to be a hallmark of a successful primary health care team.
- The rural setting has even more challenges. Health care providers cannot be spread anymore thin than they already are. Even with additional funding to provide services, health care providers do not have enough hours in a day to provide services to everyone who needs them.
- Leadership is missing at a very high level. There needs to be a champion of "collaboration". Primary Health Care teams need a leader to be accountable to. Right now it is in very few directors', management or government's portfolio, and the buck is getting passed.
- For example, integrating pharmacists into primary health care teams:
  - Derek Jorgenson educated the primary health services branch on the skills and abilities of pharmacists. He used Westwinds as an example of how much value pharmacists can add to a team. The Ministry gave funding for 1 year as a pilot project.
  - Then Derek in essence lobbied the 73 health care teams (Primary Health Directors and managers of the region) across Saskatchewan about adding a pharmacist to their teams. They thought it was a great idea. Provisions were made for 23 teams and pharmacists were paid to provide services by the Ministry of Health.

- Even though the teams were really excited to have the pharmacists, nobody knew what to do next. Nobody championed the integration. Their role was not defined before or during the last pilot year on most teams. That being said, the outcomes of the work that pharmacists were able to provide were very positive, even though they were only able to spend half the allocated time providing services to patients within the team. Generally these pharmacists were/are full time employed in a small town community pharmacy in addition to providing primary care team services.
- There are several potential reasons why this did not happen: a) there was no champion to help guide the integration of pharmacist; b) the funding was temporary. Management may not have been able to justify the resources needed to develop and define these new roles since there was no guarantee they would be back and c) the pharmacists themselves may not have know how to approach the team to define their role on their own. It takes a VERY assertive and confident person champion their own role with established team members they may not know in a new position. There were a couple pharmacists who were very successful integrating into the team. They booked a weekly meeting over one month for the entire team to attend to help define their scope of practice and role on the team. This worked extremely well. But again- not everyone has the assertiveness to head this up.

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#### INTERVIEW WITH DONNA MAGNUSSON AND FAY SCHUSTER

Executive Director/ Director, Primary Health Services Branch, Saskatchewan Health

What are the key leadership challenges to implementing Primary Health care?

Previous challenges:

- Introduction of the Nurse Practitioner – changes in scope of practice
- Physician reimbursement model – change from fee for service

Health Canada provided ‘transition funding’ for primary health care. In Saskatchewan, this was used to fund team facilitators and Directors of primary health care. If they were strong – this worked well.

A redesign in primary health care is going on right now – refer to SYNTEGRITY Report

Challenges:

- physician leadership and accountability
- community engagement and collaborative practice
- Chronic Disease management

\*Electronic Medical Records runs throughout all of this.

Challenges of the Ministry:

- Struggled with the ‘flavor of the day’. Saskatchewan political leaders are now embracing this model. There is an understanding by leaders that primary health care is key if we want sustainability. A commitment from the government to primary health care is key.
- Another challenge is ‘communities’.
  - Communities are struggling against each other. Need to first build capacity within the community leaders to help facilitate this change. This is a community

- development approach – have to have their buy-in and enable them to create the right environment. Teams that have really looked at the needs of the community first and formed intersectoral partnerships have succeeded. Physician champions have been key – if they show leadership, then it happens.
- Communities may not be open to the concept of getting an understanding of what they as patients need and who can provide that to them. Need to create leadership in the patient themselves to utilize the resources in the community properly (pharmacists, physio, nutritionists, etc.).
  - They need to focus on quality and the patient first piece.

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## INTERVIEW WITH BRENDA MISHAK BECKMAN

Former Director of Primary Health Care for MCRRHA

What are the key leadership challenges to implementing Primary Health care?

- One of the key challenges was/is a clear understanding of what primary health care really is. It appeared early on that people around the various tables, including high level leadership tables, called direct patient care services, which are primary care services, primary health care services. Primary care only one of the pillars of primary health care.
- The focus on the role of nurse practitioner was another stumbling block for primary health care teams. It was as if you didn't have a nurse practitioner, then you were not a primary health care team. This philosophy is fundamentally flawed.
- The set up of primary health care teams, needing 7 physicians (that number may be off) to one nurse practitioner was and is backwards. The system was not created to successfully integrate nurse practitioners into the primary health care model. The number of nurse practitioners remains small.
- Brenda feels that there is a need to increase supports for determinants of health. There is a reason why they are called determinants of health - they determine health status. This seems obvious, but yet the system makers are oblivious. While we do need the brightest and the best to care for the ill, many of the disease processes we face are related to:
  - Lack of access to nutritional foods.
  - Crowded housing
  - Alcohol and drug misuse
  - Lack of education in local communities. Even at primary levels, the math and sciences are not there for the students.

If we focused on these issues, like a quality education and housing and jobs, then we would see the client needs being met.

- Adult education programs in the local communities need to be developed and grown.
- Starting HealthLine in Saskatchewan was helpful, but really couldn't we get a shorter number...like 511, something people could actually remember.
- Brenda feels that we are moving in the right direction but using the analogy of a ship, they are moving a ship the size of the titanic. It is going to take a long time.

What worked well?

- The team was resourceful and wanted to meet the needs of the client (community as client sometimes).

- The integration of health promotion and teaching for many professionals was important.
- Inter-professional practices and collaborative care models were adopted and followed. Traditional turf protection wasn't an issue, because as a team, if there was a gap, the most suitable member of the team closed that gap.

Why or why not?

- Respect and understanding of the importance each member of the team was key. A leader with practical and educational background will help facilitate the primary health care growth and development. Problem solving skills by the team were vital.

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## INTERVIEW WITH DR. GIL WHITE

Ministry of Health (former) Dr. White is a family physician who worked on PHC development from 2002 to 2005 at the SK Ministry of Health

What are the key leadership challenges to implementing Primary Health care?

- Community involvement
- The role of collaborative practice
- The role of the physician in primary health care

\*The 'Syntegrity Report' provides an overview of the future focus of primary health care in Sask.

There was a demand for primary health care. People were thinking about chronic disease management models and how to provide care with the physician shortage. Access to care drove this model.

Problem – the politics of this. Providing access to care without upsetting the rural population.

There are different types of teams – a physician is not necessarily involved. The challenge is to answer the question 'what are you trying to achieve with PHC?'

- Chronic disease management for example, you can go with a smaller team. This is a good primary health care focus.
- Larger teams are hard to do without doctors – there has to be some degree of interaction with them.
- Funding is now a bit more flexible to account for this.
- The difficulty is also the 'measurables'. How do you tell if you are providing benefit?

Challenges:

- Getting information from each community. Can they identify what is important to them? Assessment of community needs using the 'Community Development Model'. Once identified – how can you get each individual to work towards it?
- What is primary health care trying to accomplish? Chronic disease management, access, emergency care?
- How do we measure outcomes?

\*He feels that Electronic Medical Records is a key part of improving collaboration in the PHC model.

## 10.3 APPENDIX C – SCOPE OF PRACTICE

Health care professionals operate under their own roles and responsibilities. One of the challenges of interdisciplinary work is ensuring clear definitions. This will enhance the positive elements of the collaborative interdisciplinary model and reduce the possibility of ambiguity and misunderstanding regarding protocols, procedures, responsibility and authority. The following information is intended to provide an outline of possible roles and responsibilities for each practitioner based on their regulated scopes of practice. Ultimately, it is the responsibility of the group of health providers who will work as a team to define their roles and responsibilities for themselves within the team context.

### **Addictions Counselor:**

- works through hospitals, schools, and employee assistance programs (EAPs) to provide biopsychosocial counseling to people of all ages who have substance use and/or gambling problems;
- intakes and assesses clients and develops a treatment plan;
- counsels individuals, couples and families;
- facilitates counseling groups, for example, relapse prevention, guided self-change, anger management, stress management;
- assesses and adjusts treatment plans on an ongoing basis;
- works closely with various regulated health professionals;
- develops discharge plans.

### **Audiologist:**

- assesses, diagnoses and makes recommendations for treating children and adults with hearing loss, balance and related disorders;
- supports early detection of hearing loss in infants and children;
- selects and fits hearing aids;
- assists training in speech-reading and listening skills;
- designs and implements rehabilitation strategies for clients with hearing impairments;
- provides hearing rehabilitation and educational programs targeted at preventing hearing loss;
- collaborates with other professionals such as physicians, psychologists, social workers, nurses, teachers, speech language pathologists, occupational therapists, physical therapists, and counselors;
- supports industry by providing hearing conservation programs to prevent hearing loss due to noise exposure;
- facilitates educational and social adjustment of the hearing impaired person; and
- suggests communication strategies for the individual/family/community support networks.

### **Chiropractor:**

- assesses conditions related to the spine, nervous system and joints and provide a diagnosis;

- requests/utilizes x-rays as authorized;
- works to prevent and treat, primarily by adjustment, dysfunctions of the spine, nervous system and joints;
- uses joint manipulation and mobilization and a wide variety of soft tissue techniques, electrotherapies such as ultrasound, electrical stimulation, laser, etc.;
- develops effective self-management plans for their patients; supervises therapeutic exercise programs;
- refers to and work with other health care professionals when appropriate;
- partners in injury prevention and health promotion strategies; and
- assesses workplace or home environments to advise patients on treatment and to provide ergonomic activity.

### **Continuing Care Assistant:**

- program was formerly known as Home Care/Special Care Aide;
- a major area of study is gerontology;
- use dementia management strategies;
- provide personal care;
- apply the philosophy of long-term care in home care, special care and community settings;
- promote independence in safe environment;
- attend to individual psychosocial needs and;
- with people from all cultures and at different levels of physical and cognitive impairment.

### **Dentist:**

- diagnoses, treats, and manages the services to meet the oral health needs of patients;
- may practice in specialty areas such as orthodontics, pediatrics or oral surgery etc. which require additional education.

### **Dental Therapist:**

- conducts primary oral dental treatment and preventive dental services;
- works with dentists to provide community-based preventive health programs;
- assesses patients, provides oral diagnosis, dental radiology and restorative procedures;
- involved in oral surgery, periodontal techniques, local anesthesia;
- educates patients regarding oral health; and
- maintains dental equipment.

### **Denturist:**

- specializes in any non-surgical oral procedures in order to make a removable dental prosthesis These may include dentures, dentures over implant, mouth guards and anti-snoring devices;
- takes medical and dental histories, does oral examinations;
- takes impressions of ridges and/or natural teeth;
- constructs dentures and fits patient with final product;
- repairs or relines existing dental prosthesis;

- consults with other medical and dental health care providers; and hires auxiliary staff.

**Dietitian:**

- develops nutritional plans based on comprehensive needs assessments;
- provides nutritional counseling;
- provides weight management counseling;
- supports with education/advocacy;
- promotes behaviour change related to food choices, eating behaviour and preparation methods to optimize health;
- promotes patient independence and autonomy in decision-making for patient to achieve health;
- conducts patient workshops and seminars; and
- identifies community capacities and facilitates community skill-building, health advocacy, and social action.

**Exercise Therapist:**

- monitors patients' blood pressure, heart rates, flexibility, strength and other physical attributes;
- creates customized rehabilitative exercise programs for various orthopaedic/medical conditions.
- Supervises patients as they complete the exercises;
- Perform functional evaluations and return-to-work planning and monitoring,
- provide fitness testing and exercise prescription for healthy populations.
- exercise science knowledge development, transfer and application

**Interpreter:**

- assists healthcare professionals in communicating with the patients in their native language; and
- makes the patient comfortable in the medical setting as well as allowing the patient to communicate with the healthcare team.

**Licensed Practical Nurse:**

- independently cares for patients whose care needs are well defined and the health condition is well controlled;
- observes, assesses, documents and reports symptoms, reactions, and progress in patients;
- assists physicians during surgeries, treatments, and examinations;
- assists in convalescence and rehabilitation;
- develops and manages nursing care plans, instructs patients and their families in proper care, and help individuals and groups take steps to improve or maintain their health;
- collaborates with other members of the healthcare team and with the patient and the family to plan, implement, co-ordinate and evaluate patient care;
- administers medications and treatments as prescribed by a physician or according to established policies, protocols and regulations;
- operates and monitors medical apparatus or equipment;



- develops and implements discharge planning process on admission of patients.

**Mental Health Worker – Community:**

- facilitate linkages with appropriate services, supports, and resources;
- provides crisis intervention and intensive/short-term support;
- evaluates achievement of patient goals;
- financial management: budgeting, banking;
- nutrition: menu planning, grocery shopping, food preparation;
- leads personal effectiveness: problem-solving, decision making, communication and interpersonal skills, goalsetting, time structuring and management;
- supports community integration such as use of transit, social/recreational, peer support;
- supports clinical plan including medication, appointments, healthy choices and lifestyle;
- supports maximum involvement in volunteer, community service or paid employment;
- encourages hygiene grooming, self-care skills, clothing maintenance;
- household management: such as laundry and house cleaning; and
- housing support: finding adequate housing, liaison/support to landlord, utilities.

**Midwife:**

- provides pre-natal education and ongoing clinical care for women throughout pregnancy;
- supervises the birth process, conducts spontaneous normal vaginal births in both home and hospital;
- administers, during delivery, a substance, by injection or inhalation, where regulated;
- assesses/monitors new babies;
- performs amniotomies and episiotomies, lacerations not involving the anus, anal sphincter, rectum, urethra and periurethral area;
- orders tests if necessary, takes blood samples from newborns by skin pricking or from women from veins or by skin pricking;
- counsels mothers and their families on infant care and continues to monitor the mother's and infant's health for a six-week period after birth; and
- inserts urinary catheters into women when needed.

**Nurse Practitioner (NP):**

- completes holistic assessments, including a health history and physical examination;
- formulates and communicates medical diagnoses;
- monitors the ongoing therapy of patients with chronic stable illness by providing effective pharmacological, complementary or counseling interventions;
- performs minor surgical procedures;
- uses family assessment tools to evaluate family strengths and needs;
- determines the need for, and orders from, an approved list of screening and diagnostic laboratory tests and interprets the results;
- prescribes medications from an approved list using the best available evidence and considering patient's preferences for care;
- provides services to patients in all developmental stages, families and communities; and
- refers patients to appropriate healthcare specialists when needed.

**Occupational Therapist:**

- provides treatment plans designed to help the individual perform daily tasks and to develop the skills to live independent and productive lives;
- develops and implements health promotion programs with individuals, community groups and employers;
- may specialize with specific populations such as children or adults, or persons with distinct problems such as dementia, traumatic brain injury and chronic pain;
- provides special interventions such as return-to-work programs;
- addresses not only the physical effects of disability, injury or disease but also the psychosocial, community and environmental factors that influence function; and
- prescribes specialized adaptive equipment and teach proper usage.

**Ophthalmologist:**

- diagnoses and treats disorders of the eye;
- diagnoses systemic disease when manifest in eye signs or symptoms;
- treats all aspects of visual function in health and disease, including refraction, orthoptics, binocular vision and strabismus;
- provides medical and surgical treatment of disease involving the visual system and awareness of ocular manifestations of systemic disease.

**Optometrist:**

- diagnoses, manages and treats conditions of the human eye and visual system;
- prescribes and fits visual aids (glasses, contact lenses, etc.) in order to correct vision problems;
- prescribes treatment (excluding surgery) in order to conserve ocular disorders;
- educates and counsels patients on contact lens use and care, visual hygiene, lighting arrangements, working distances and safety factors; and
- refers patients to ophthalmologists or other physicians and surgeons for further treatment of ocular diseases or conditions.

**Orthotist:**

- design, fabricate and fit orthoses (braces or splints)
- examines and measures patients in order to assess the orthotic needs of the patient;
- designs orthoses using computers and sketches;
- fabricates or supervises the fabrication of the orthotic appliances;
- fits and adjusts the devices for patients;
- instructs patients in the proper use and care of the devices; and
- repairs and maintains orthoses.

**Pharmacist:**

- dispenses and (where regulated) prescribes medications;
- provides and counsels on non-prescription drugs and health care devices;

- provides drug information to patients in order to optimize drug therapy;
- reviews the patient profile to gather patient information including bloodwork, past medical history, chronic and acute illnesses, drug allergies, etc.;
- identifies drug-related problems and recommends appropriate therapeutic options to physicians/nurse practitioners or other health care professionals as needed;
- monitors patient compliance with drug therapy; and
- compounds or oversees the compounding of medication.

### **Physician:**

- performs complete health assessments including a full medical history, presenting complaint, past illnesses, social history, family history, and physical examination;
- diagnoses and treats acute medical conditions ranging from minor ambulatory care visits to severe life threatening illness presenting to emergency rooms;
- treats chronic medical problems, patients with complex co-morbidities;
- screens patients at risk for hereditary conditions and potentially preventable disorders;
- provides primary reproductive care, primary mental health care, palliative care;
- screens for and treats sexually transmitted diseases (STDs);
- provides immunizations and advises for disease prevention;
- assists patients in self-management of their disease; and
- maintains and keeps safe the medical record of each patient.

### **Podiatrist/Chiropodist:**

- assesses the foot in order to provide the treatment and prevention of diseases, disorders or dysfunctions of the foot by therapeutic, orthotic or palliative means;
- treats patients with the use of braces, casts, shields, orthotic devices, physical therapy or surgery; chiropodists and podiatrists are both allowed to perform surgery by cutting into subcutaneous tissues of the foot. Podiatrists may also perform surgery by cutting into bony tissues of the forefoot if the required training has been completed;
- exams and reviews lab tests, diagnostic tests and consulting medical and surgical notes;
- prescribes and injects into feet, substances approved in the regulations;
- evaluates overall foot and ankle function relating to activities of daily living; and
- assesses the impact of an injury or disease (arthritis/diabetes/sprains) on foot function.
- Podiatrists may also communicate a diagnosis identifying a disease or disorder of the foot as the cause of a person's symptoms.

### **Physiotherapist:**

- assesses a patient's physical abilities and needs;
- develops a treatment plan according to the patient's individualized needs;
- implements programs including therapeutic exercise, manipulations, massage, education, and the use of electro-therapeutic and other mechanical equipment and hydrotherapy;
- provides physical rehabilitation and pain relief to people including those with osteoarthritis, repetitive strain injury, whiplash, sports injuries, or spinal cord injuries;
- may focus their practice in specialty clinical areas such as senior's health, women's health, oncology, rheumatology, orthopedics, children's health, or sports injuries; and

- provides consultation on injury prevention and health promotion.

**Prosthetist:**

- design, fabricate, and fit artificial limbs (prosthesis) examines and measures patients in order to assess the prosthetic needs of the patient;
- designs prostheses using computers and sketches;
- fabricates or supervises the fabrication of the prosthetic appliances;
- fits and adjusts the devices for patients;
- instructs patients in the proper use and care of the devices; and
- repairs and maintains prostheses.

**Psychologist:**

- assesses and diagnoses the functioning of individuals, groups, families and organizations related to mental health;
- provides a treatment plan for behavioural and mental disorders in order to maintain and enhance physical, intellectual, emotional, social and interpersonal functioning;
- assists in treatment of addictions and substance abuse; pain management; stress, anger and other aspects of lifestyle management;
- helps people make healthy changes in their coping styles and emotional and behavioural patterns;
- manages psychological problems associated with physical conditions and disease (e.g., diabetes, heart disease, stroke), as well as, in terminal and chronic illnesses such as cancer, brain injury, and degenerative brain diseases;
- treats problems involving cognitive dysfunction such as learning, memory, problem solving, intellectual ability and performance; and
- assesses psychological factors related to work such as motivation, leadership, productivity, and healthy workplaces.

**Public Health Inspector:**

- inspects restaurants, food processing facilities, liquor outlets, water systems and sewage disposal systems
- ensures compliance with government regulations regarding sanitation, pollution control, and food safety;
- conducts environmental surveys and inspections;
- carries out and interprets various tests;
- monitors the natural environment to identify sources of air/water pollution and ensures control of rodents, insects and communicable diseases; and

**Public Health Nurse/Community Health Nurse:**

- A Public Health/Community health nurse has a baccalaureate degree in nursing and is a member of the SRNA.
- Combines knowledge from the public Health science, primary health care (including the determinates of health), nursing science and the social sciences.
- Focus on promotion. Protection and preserving the health of the population

- Links the health and illness experiences of individual, families and communities to population health promotion practices
- Practices in increasingly diverse settings, such as community health centers, school, street clinics, youth centre, and nursing outposts, and with diverse partners, to meet the health of specific populations.
- Reduces the risk of infectious diseases outbreaks; this includes early identification, investigation, contact tracing, immunizations, preventative measures and activities that promote safe behaviors.

**Registered Massage Therapist:**

- assesses the soft tissue and joints of the body;
- performs myofascial release, craniosacral therapy, sports massage, infant massage, pregnancy massage, deep tissue massage physically stretching the muscles, encouraging circulation, inhibiting muscle spasm, and sedating or stimulating the nerves by reflex to ease pain or promote function as necessary;
- must complete a minimum of 2,200 hours and successfully complete the Board Examinations.

**Registered Nurse:**

- autonomously meets the nursing care needs of patients whose needs are not well defined/established or are changing;
- observes, assesses, documents and reports symptoms, reactions, and progress in patients;
- assists physicians during surgeries, treatments, and examinations;
- assists in convalescence and rehabilitation;
- develops and manages nursing care plans, instructs patients and their families in proper care, and helps individuals and groups take steps to improve or maintain their health;
- collaborates with other members of the healthcare team and with the patient and the family to plan, implement, co-ordinate and evaluate patient care;
- administers medications and treatments as prescribed by a physician or according to established policies, protocols and regulations;
- may supervise licensed practical nurses and other nursing staff;
- operates and monitors medical apparatus or equipment;
- develops and implements discharge planning process on admission of patients.

**Registered Psychiatric Nurse:**

- uses critical thinking and clinical judgment to apply holistic psychiatric nursing to patients of all ages and in different settings
- conducts standard tests, rating scales for mental health assessment, concepts of relapse, recovery and co-morbidity;
- helps clients with mental illness, psychiatric disorders and developmental and/or cognitive difficulties to function at their maximum potential; and
- provides safe administration of psychotropic agents.

**Respiratory Therapist:**

- assists physicians in the diagnosis, treatment and care of patients with respiratory and cardiopulmonary disorders;
- performs diagnostic tests eg. arterial blood gases to measure lung and heart functions;
- operates and monitors respiratory equipment to administer treatments such as oxygen and inhaled medications;
- provides patient and family education;
- performs interventions such as line or tube insertions to support breathing;
- performs cardiopulmonary resuscitation on newborns, trauma victims, and people with heart and lung disease, etc.;
- assists with transport of high-risk patients; and
- assists with high-risk deliveries;
- assists anaesthetists in the operating room; and
- provides respiratory care to patients in their home.

**Social Service Worker:**

- assesses social problems by obtaining case history and background information;
- assesses for eligibility of social benefits;
- counsels the individual, couple, family and/or group; and
- case management, including linkages to community resource.

**Social Worker:**

- assesses, diagnoses, treats and evaluates individual, interpersonal and societal problems;
- restores, maintains and enhances emotional and social functioning by mobilizing strengths, supporting coping capacities, and modifying ineffective patterns of relating and behaving;
- links people to appropriate resources;
- assists with environmental stressors;
- provides psychosocial education related to wellness and subjective well-being; and
- individual, couple, family and group counseling and psychotherapy.

**Speech Language Pathologist:**

- evaluates, diagnoses and treats speech, language, voice, swallowing, and fluency disorders caused by accidents, genetic disorders such as cleft palate, or by delayed development;
- develop individualized care plans for the communication needs of children and adults;
- conducts screening programs for early detection of communication delays/disorders in young children;
- selects and develops communication methods including visual, tactile, or auditory system that either add to or replace normal speech and/or writing, for example, automated devices and sign language;
- collaborates with other professionals such as physicians, psychologists, social workers, nurses, audiologists, teachers, occupational therapists, physical therapists, and counselors;

- and provides research on the complex processes of speech, hearing, and language in order to understand their causes, symptoms, and improved methods for evaluation and treatment.