



Lessons Learned from the Multidisciplinary Collaborative Primary Maternity Care Project Technical Report Five

Communicate, Communicate, Communicate

June 2006

Association of Women's Health, Obstetric, and Neonatal Nurses, Canada
Canadian Association of Midwives
Canadian Nurses Association
College of Family Physicians of Canada
Society of Obstetricians and Gynaecologists of Canada
Society of Rural Physicians of Canada

Jennifer M. Medves, RN, PhD
Wendy E. Peterson, RN, PhD
Barbara L. Davies, RN, PhD
Ian D. Graham, PhD

The analysis and conclusions presented in this report do not necessarily reflect the views of the members of the MCP² or their partner associations. Funding for the research was provided by Health Canada as part of the Primary Health Care Transition Fund. The views expressed herein do not necessarily represent the official policies of Health Canada.

We encourage readers to copy and distribute this material. No permission is needed. Electronic versions can be downloaded from www.mcp2.ca

Lessons Learned from MCP²

The Multidisciplinary Collaborative Primary Maternity Care Project is federally funded from the Primary Health Care Transition Funds, Health Canada. The mandate of the project has been to address the human resource shortage crisis that exists in the provision of intrapartum care to pregnant women. The overarching goal of MCP² has been to identify and reduce key barriers and facilitate the implementation of strategies to increase the availability and quality of maternity services for all Canadian women.

As part of the evaluation of the Multidisciplinary Collaborative Primary Maternity Care Project the evaluation team undertook a number of interviews to identify lessons learned from the project. These interviews were designed to elicit how the project proceeded through the time period, what could have been done differently, what worked and what changes we would make if we were to continue with this project in the future. This is an important part of any project, particularly one as complicated as MCP² because of the multiple care providers who are involved in care of women during pregnancy, birth and postpartum.

The evaluation team requested that members of the executive committee of MCP² and the project staff volunteer to participate in debriefing interviews. Some of these interviews were conducted in person and some by telephone. The questions for the debriefing session were straightforward and used as guides only. Participants were able to reflect back on the experience of the project and provide valuable information to the evaluation team.

Communication

The key to this project, and any project, is communication. Bringing together 30 maternity care providers, decision makers, and consumers requires an enormous commitment to communication. The misunderstandings that can affect any project if communication is not open and transparent cannot be overstated. For all project team members and those interviewed the ability of everyone to communicate their issues, worries, concerns, and beliefs about collaboration was paramount. Communication strategies such as clear expectations of the project team and national committee members, communication from the various sub projects to receive feedback, and communication back to the partner organizations evolved over the project. Ensuring that this continues will help maintain the interest across the country to explore collaborative models of practice that may work to provide primary maternity health care.

Several strategies were undertaken, including a monthly up date, personal one on one phone calls and emails, and inserts into professional journals to maintain open communication in this project. Conference presentations have allowed more feedback from partner organizations that have highlighted people's fears about collaboration and the changes needed, and have also informed maternity care providers of the major barriers to working together. Having the ability to communicate does not always mean people feel safe to say what they want to say but over the course of the project participants have become more comfortable to say what they want to say:

The goodwill of the participants and the understanding that there is a significant issue with the numbers and distribution of various maternity care providers and the willingness to look for more solutions to the problem than just increasing the number of physicians, and nurses and midwives.

Timelines of the Project

The MCP² was funded in the summer of 2004. The staff was hired over the summer and the first meeting of the national committee was held in Ottawa on January 12th 2005. The National Committee subsequently met in Ottawa on June 8th, September 14th, January 16th 2006, and will meet on May 2nd 2006 for a final meeting. The Executive Committee of the project held telephone meetings and in person

meetings eight times over the course of the project. Telephone meetings lasted about two hours and in person meetings were booked for four hours the day before the national meeting.

The cost of bringing committee members together more often would have been prohibitive and because of distance from Ottawa very time consuming. One member of the committee indicated that to get to Ottawa usually required a day of travel and depending on weather conditions could have been as much as a day and a half each way. The time of the project was very brief and committee members had to engage rapidly in the issues. It would have been easier to conduct the project if there had been more time to discuss the many issues related to multidisciplinary practice. The geography and distances in Canada make face to face meetings a real challenge, especially for members who face loss of salary if they participate. From the first meeting it was apparent that there were lots of issues to be discussed and resolved.

In most cases there was modelled a respect for each other in that generally the environment was a safe one in which to bring up sometimes contentious issues.

The project provided a unique opportunity to engage in discourse at a federal level and that there were many opportunities to collaborate in the future had been opened up to participants and their organizations. At the same time that MCP² was funded there were a number of provincial organizations who were engaged in evaluating maternity services. This demonstrated how crucially important maternity services are in Canada and the issues need to be resolved.

The MCP² Project was Worthwhile

The staff of the project believed the project had been worthwhile for a number of reasons. One participant said:

It's overwhelmingly been a positive experience and that includes the negative. I have a major appreciation and respect for everybody who came to that table attempting to find different ways of doing things.

The benefits of the study and the findings can be used across health care especially practical tools. Discourse at a national level had allowed practitioners to discuss issues that are rarely discussed in clinical settings. Clinicians are often hard pressed to sort out clinical issues and so do not have discussions about liability, scope of practice, and collaboration at a policy level. The project brought together a diverse group of maternity care providers and consumers who were able to discuss issues at a policy level and identify potential solutions. It was also the first time there has been equal representation of all the professional groups.

Facilitators of the Project

The staff believed that the equal representation had been a successful facilitator to the project. In addition, each organization represented had to acknowledge that all professional groups would have to 'give up a little bit' but the end result is that there is more understanding between the groups about their issues and practice. How far people are willing to give up is not yet clear and as one person said

There were times in the discussion that it became clear that various people ...it wasn't one profession over another, assumptions that everybody else would change in collaborative teams but me.

As participants were able to recognize their assumptions they were able to understand that having all disciplines at the table helped facilitate the discussion.

I would also say that I think that the mix of people at the table in most cases was quite a good facilitator for the process.

The mandate to work across silos in this project was a facilitator to engage in appropriate discussions. The hierarchy has led to 'a lot of misconceived ideas about how each of the others professions are educated, trained and how they work with their clients'. The idea that clinicians are overwhelmed with practice in the day to day has meant that it needed a project such as MCP² to be recognized and funded nationally, and that recognition has been a facilitator in the process.

The project appeared to move forward with documents to review prior to meetings.

There was certainly a timely access to documents and developing documents...in most cases, reasonable time to digest them before meetings happen to have some input.

The crisis in maternity care has helped facilitate the project as:

You really only get tremendous success in a crisis or a pending crisis that unless you have that motivation to find a solution you don't always look for it, never mind find it.

There were times in the year, especially in the summer when project staff had to remind national committee members to review and respond. As the project had tight timelines, there were times when not all people had time to spend reviewing and responding as they would have done if they had not been covering for other members of their clinical teams.

Barriers to the Project

The biggest barrier to the project has been the enforced timeline. As decisions had to be made, without time to think and contemplate the issues, time became a barrier.

It's not as good of a product and when you have a product that people are fearful of and then you're pushing it fast as well I think it makes it even a stronger barrier'.

One staff member believes that we could have provided everyone with a good overview of each profession as there were people

Even though this is a group of people who self-identify as wanting to collaborate with one another, they hold really misconceived ideas about how each profession is educated and how they practice their philosophy of care.

Also identified is the lack of consistency of scope of practice across the country, and that midwifery is not regulated in some provinces.

The level to which each of the national committee members has been able to report back to the partnerships is not known. Communication has not always been easy and the staff members acknowledged that they may have needed to encourage more dissemination:

The project itself didn't make a good enough plan to make that happen as part of the agreement of the role of the members of the various committees.

The project team recognized that all information was not disseminated because of emails and phone calls they received questioning the output of the project available on the web site. The team discovered that the monthly updates were important and while there was not a lot of positive feedback about the project there was less negative feedback.

Imagining collaborative models that may work in your jurisdiction is difficult if you do not have all the professions and other maternity care providers available. Not only is midwifery not available in some provinces, primary health care nurse practitioners are not recognized and the acceptance of, and the role of, a Doula is not universal across the country. The issue of midwifery and universality was highlighted as the project appeared to have a strong midwifery focus, especially as the international scan was completed by midwives

When we looked worldwide [we] engaged a midwifery group to do it...It seemed to me that that led to a certain amount of disgruntlement in the sense not just amongst physicians but amongst nurses at the table that somehow there was a group that ... was acknowledged more important than any other at the table.

Discussions about remuneration have not been developed during the project as it is such a complicated issue.

I think remuneration is one we have not really addressed at all within the project.

As funding is provincially determined the MCP² project could at best put forward principles. There has been recognition that having professions in a team on different payment schemes will present many challenges.

One significant barrier to moving forward has been the apparent shift at Health Canada from an emphasis on primary health care transition to acute care issues and wait lists. This has meant that sustainability planning has not been forthcoming as this and other projects do not have money to continue with their agenda to find ways of working within primary maternity health care collaborations. In addition, a great deal of time was spent ensuring the budget was protected. The team spent too much time trying to ensure that they could keep year one money for year two and so were diverted from activities on the project.

Valuable Lessons Learned

For the staff the role of education, particularly education across professions is the most crucial lesson learned:

Many of the barriers are around not knowing how to work together, not knowing what the other person does, and how two people could, or a small group of people actually work together.

While attitudes to working together need to be congruent across the team, knowledge about the different roles that team members can bring to maternity care is crucial to developing collaborative partnerships. Having very clear terms of reference for each committee and allowing people to understand their commitment to the project at the beginning is an important lesson.

Have your terms of reference very, very clear constant reminding people what they agreed to, when they committed to them.

In addition to clear terms of reference, language must be clear and definitions of key concepts need to be agreed early so that everyone is using the same definition and that there are no language difficulties.

Each professional organization has a different structure and that means that reporting to each organization and expecting feedback will be very different as the process can be quite varied. Some organizations make decisions using email while others like to reserve decisions until they have a face-to-face meeting.

The project has allowed the participants to reflect on what they as individuals would bring to a team in a collaborative model and that it would be different depending on the team circumstance. The personal commitment to this project should not be underestimated

That whole commitment to understanding that teams take a lot of work and they took a lot of personal work as well as interpersonal work.

Evaluation Team Comments

As evaluators for the project the team has been challenged to keep clear comments on tape and comments made in confidence or in passing. All of the technical reports quote respondents who have provided permission to tape their responses or they have provided written comments on the survey tool. It has been a pleasure to be involved in this project and we believe most valuable that we have been part of the team. The challenge for evaluators is whether to be 'from the inside' or a total outsider. As the timelines were extremely short being an insider was really the only way to conduct the evaluation research so that we were able to provide time for feedback. As we are all academics we are required to clear any research through official channels including research ethics boards. This takes time and required English and French versions of every survey, focus group and interview questionnaire, consent forms and information sheets. As a result, we believe we have produced findings that are publishable in peer-reviewed journals that may help researchers and clinicians in the future to evaluate maternity care and collaborative practice. We have contributed to the body of knowledge in these areas and will be able to keep the subject of collaborative maternity care on the agenda of provincial/territorial and federal governments as well as the professional organizations.

Conclusions

The lessons learned approach allowed all those involved to reflect on the project and provide feedback to the evaluation team. Barriers and facilitators to collaboration have been identified and discussed, some at great length. The value of communication cannot be over stated and the project staff spent many hours trying to ensure information was timely, unambiguous and appropriate for health care providers, consumers, and policy makers. Some barriers have been difficult to address, particularly remuneration, team liability, and hierarchy but have been recognized as such and in the future will be easier to address. The take home message is that to develop new models we have to spend time developing teams and reflecting on our position within teams and communicate openly and completely to our colleagues. We should also celebrate our achievements and share our successes so that others do not have to go through the same development as we may have had to do. There is support for working in collaborative teams in maternity and working on new models that will provide women with quality sustainable care. The project has demonstrated the enormous good will between the health care professionals to work together communicating – and collaborating.

About the Investigators

Jennifer Medves, RN, PhD

Assistant Professor, School of Nursing, Queens University
Senior Scientist and Director Practice and Nursing in Research Group
Career Scientist, Ministry of Health and Long-Term Care, Ontario

Mailing Address

School of Nursing, Queens University
92 Barrie Street, Kingston, Ontario, K7L 3N6
Phone: 613-533-6000 extension 74740
Fax: 613-533-6770
Email: medvesj@post.queensu.ca

Barbara Davies RN, PhD

Associate Professor, Faculty of Health Sciences, University of Ottawa
Career Scientist, Ministry of Health and Long-Term Care, Ontario
Associate Investigator, Clinical Epidemiology Program, Ottawa Health Research Institute
Scientist, Institute of Population Health, University of Ottawa

Mailing Address

School of Nursing, University of Ottawa
451 Smyth Road, Ottawa, ON, Canada, K1H 7E6

Phone: 613-562-5800, ext 8436
Fax: 613-562-5443
Email: bdavies@uottawa.ca

Wendy Peterson RN, PhD

Postdoctoral Fellow
School of Nursing
University of Ottawa

Mailing Information

Community Health Research Unit
University of Ottawa
451 Smyth Road, Ottawa, Ontario, K1H 8M5

Phone: 613-562-5800 ext 8040
Fax: 613-562-5658
Email: wpeterson@www.health.uottawa.ca

Ian D Graham, PhD

Associate Professor, Faculty of Health Sciences, University of Ottawa
Senior Social Scientist, Associate Director, Clinical Epidemiology Program, Ottawa Health Research
Institute

Associate Professor: Medicine; Epidemiology and Community Medicine; University of Ottawa
CIHR New Investigator

Mailing Address

Clinical Epidemiology Program
Ottawa Hospital, Civic Campus
1053 Carling Ave.,
Admin Services Building Room 2-008
Ottawa, K1Y 4E9

Phone: 613-798-5555 x18273

Fax: 613-761-5402

Email: igraham@ohri.ca

LESSONS LEARNED QUESTIONS

1. Please tell me about how worthwhile the MCP2 project has been over the past two years
2. What have been the facilitators to successful implementation of the project?
3. What have been the barriers to successful implementation of the project?
4. Please tell me about strategies/approaches used to overcome the barriers
5. Please tell me about the strategies used to reinforce the facilitators
6. What do you see as the most valuable lessons learned from MCP2?