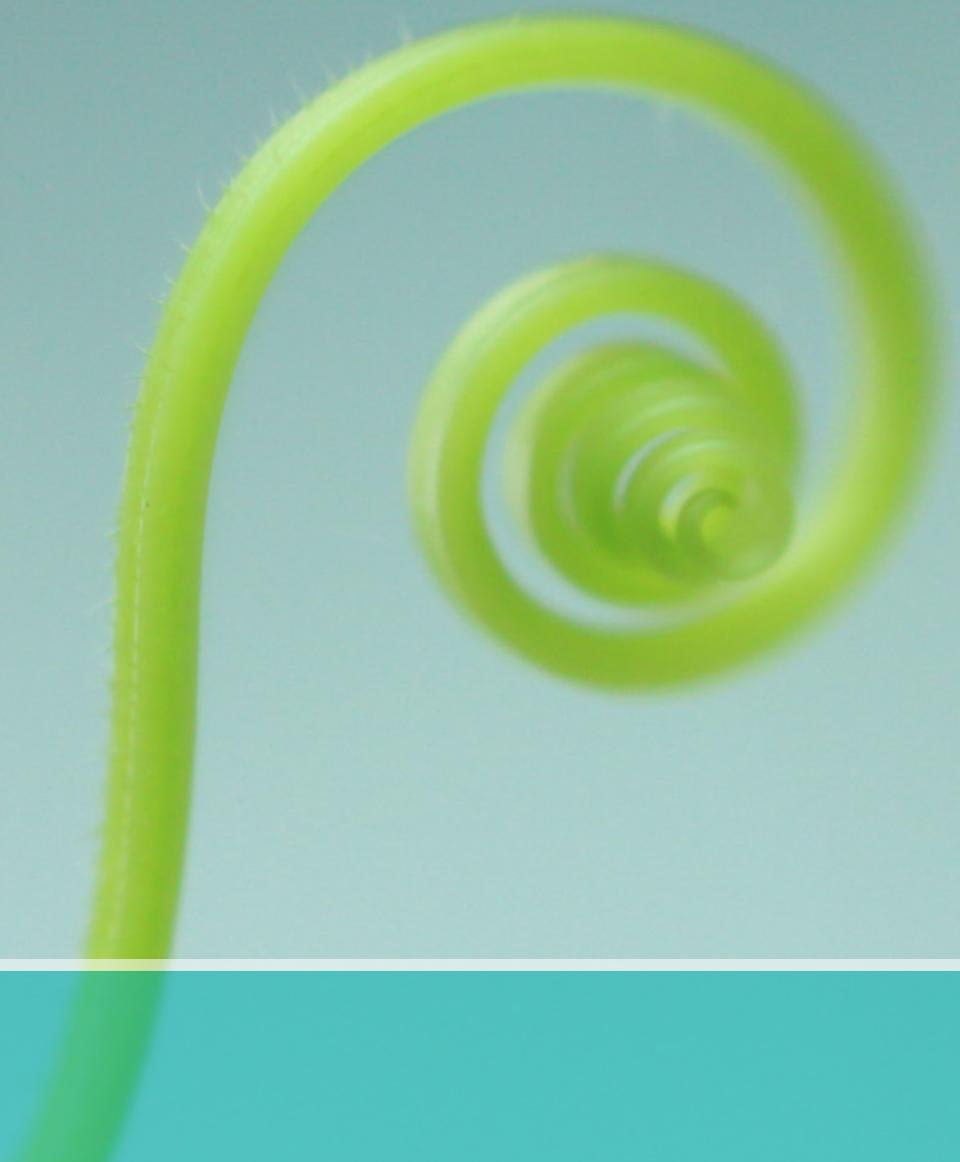


# Enhancing Interprofessional Collaboration in Maternity Care: Pathway to Positive Change

**COMMUNITY TOOLKIT**



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## Enhancing Interprofessional Collaboration in Maternity Care: Pathway to Positive Change Community Toolkit

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With special thanks to the Comox Valley Enhancing Perinatal Care Project Team for sharing their insights and knowledge, and to the many health care providers, health system leaders, researchers, administrators, community participants, and residents who work tirelessly to cultivate the necessary and ongoing relationships that enhance interprofessional collaboration across British Columbia.

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## Publication Information

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Published September 2018

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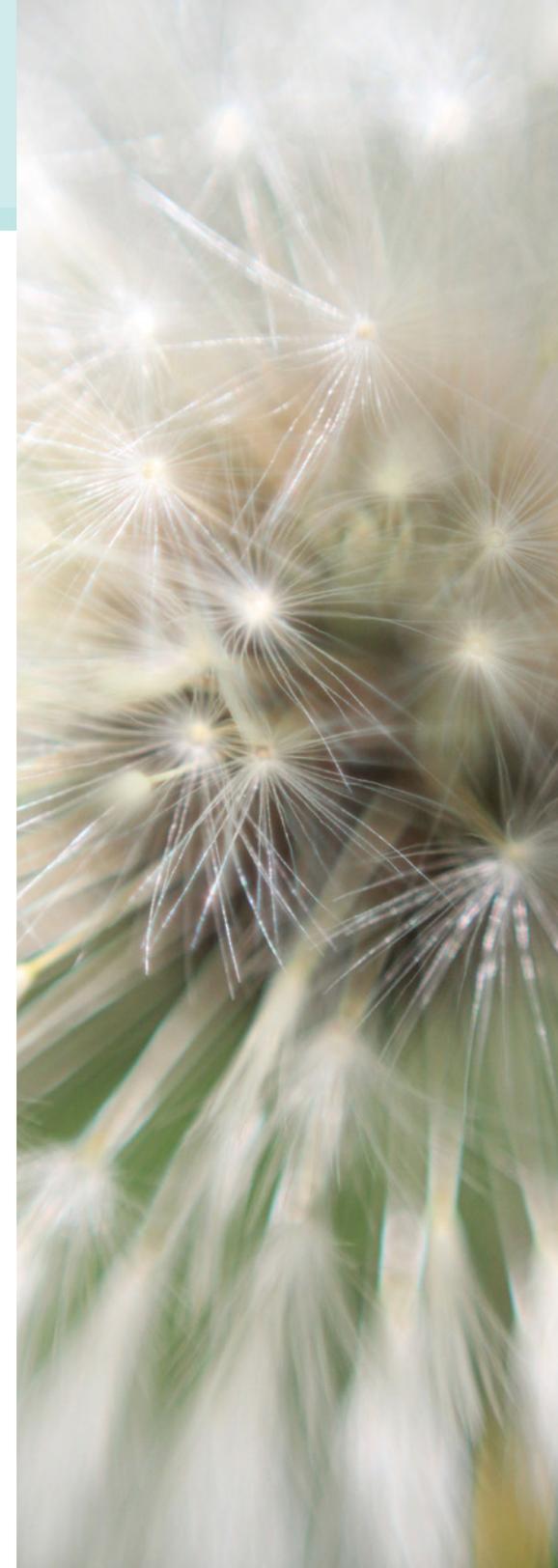
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# Foreword

*We come to know collaboration, in the fullest sense, by experiencing it.*

During a comprehensive consultation and research process, family physicians, obstetricians, registered midwives, and other allied health care providers identified support for enhanced interprofessional collaboration (IPC) in maternity care as a number one priority. Nationally and provincially, IPC is widely regarded as an effective and efficient way to improve the quality and sustainability of maternity care. It has been shown to increase women's access to care, to improve care quality, and to promote person-centered care that is responsive to the needs of communities.<sup>1</sup> Effective IPC has been linked to improved patient outcomes, decreased length of stay, fewer cesarean sections, enhanced patient and provider satisfaction, and lower costs.<sup>2</sup>

The core principle of respect and the common goal of enhancing person-centred care underpin the many definitions of IPC in health services. IPC is a process for communication and decision-making that enables the separate and shared knowledge and skills of different care providers to synergistically influence policy and practice through changed attitudes and behaviours, while emphasizing patient-centred goals and values.<sup>3</sup> In maternity, collaborative relationships are built on mutual respect, trust, and flexible, competency-based definitions of provider roles and responsibilities.<sup>4</sup>

## BRINGING COMMUNITIES TOGETHER

In June 2016, the Shared Care Committee engaged communities and stakeholders to address local maternity service gaps, while also facilitating the spread and sustainability of improvements in maternity care. Activities included:

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

1 Blanchard, M., & Kriebs, J. (2012). A successful model of collaborative practice in a university-based maternity care setting. *Obstetrics and Gynecology Clinics of North America*, 39(3), 367-372. <http://dx.doi.org/10.1016/j.ogc.2012.05.005>

2 Harris, S., Janssen, P., Saxell, L., Carty, E., MacRae, G., & Petersen, K. (2012). Effect of a collaborative interdisciplinary maternity care program on perinatal outcomes. *Canadian Medical Association Journal*, 184(17), 1885-1892. <http://dx.doi.org/10.1503/cmaj.111753>

3 Health Canada. (2010). Healthy Workplaces. Retrieved from: <https://www.canada.ca/en/health-canada/services/health-care-system/health-human-resources/strategy/healthy-workplaces.html>

4 MCP2 - Multidisciplinary Collaborative Primary Maternity Care Project. (2006). Final Report MCP2. Retrieved from <https://sogc.org/wp-content/uploads/2013/09/repFinHlthCA0606.pdf>

# Foreword

Communities such as Comox and South Vancouver have experienced improvements in patient care and satisfaction because of an interprofessional collaborative approach. Across the province, increasing numbers of health care providers and communities are interested in and working to enhance interprofessional collaboration in maternity care.

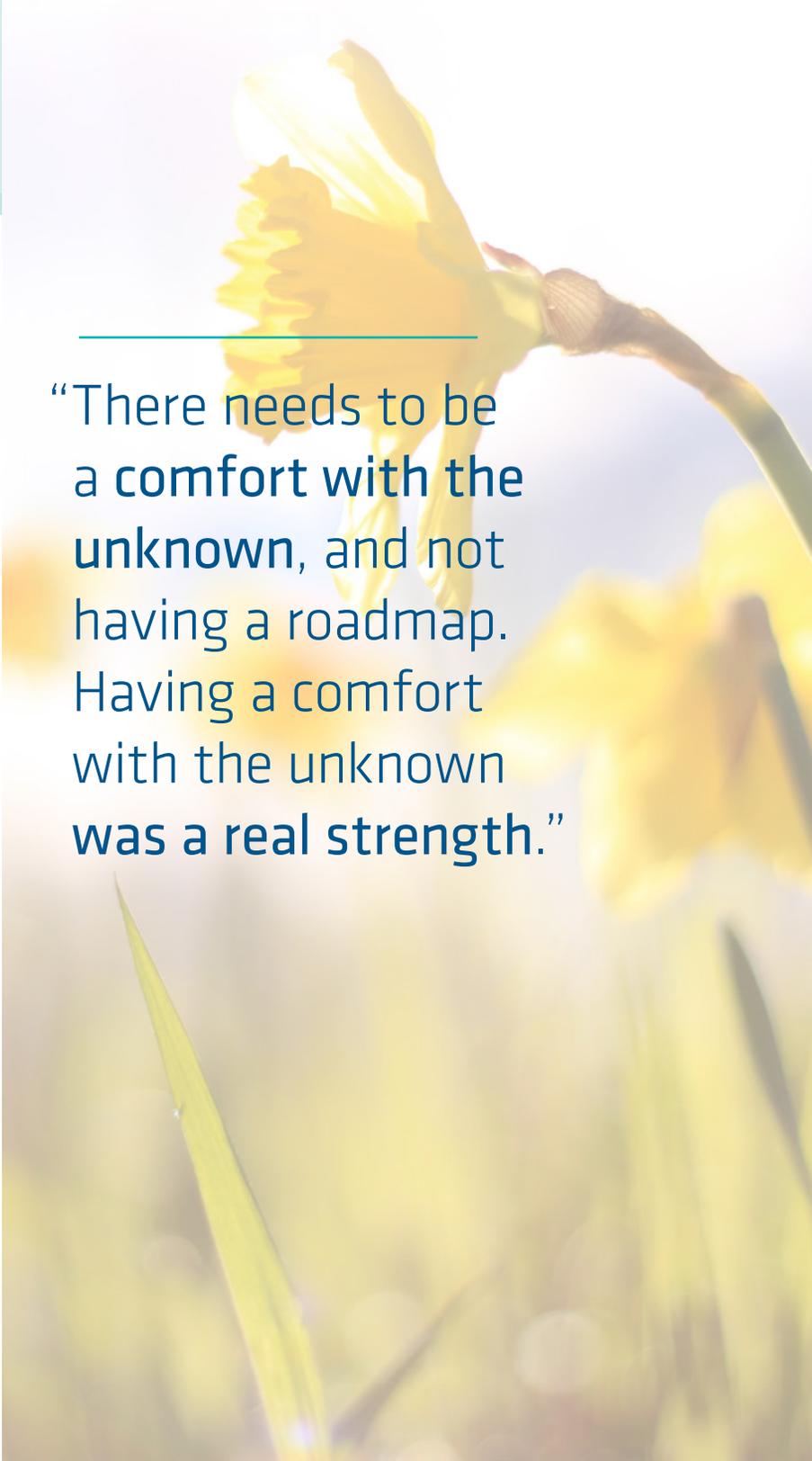
## SUPPORTING INITIATIVES

Ongoing and emerging initiatives that provide support, expertise, and knowledge translation for cultivating and guiding collaborative approaches to perinatal care in BC include:

- › Enhancing Perinatal Care in the Comox Valley
- › Interprofessional Collaborative Practice Development Workshop for Maternity Care Providers; May 26 & 27, 2017
- › Rural Coordination Centre of BC's Rural Surgical and Obstetrics Network project
- › Shared Care Committee's Provincial Maternity Network; an integrated spread model for enhancing IPC and maternity care in communities across BC
- › PSBC's Art of the Possible: Enabling Interprofessional Collaboration & GPSC's Models of Care Report
- › Creation of a provincial Community of Practice that will serve as a 'hub' for Maternity Collaboration

Enhancing interprofessional collaboration is a process and practice enabled by the sharing of knowledge, ideas, and resources so that new relationships across disciplines, between providers, practice groups, community partners, and families may develop. Underpinning this toolkit is the belief that, together, we can co-create new ways of working by harnessing our collective capacity to deliver safe, sustainable, person-centred maternity care.

**This is a living document. Updates and additions are welcome.**



---

“There needs to be a comfort with the unknown, and not having a roadmap. Having a comfort with the unknown was a real strength.”

# Using This Toolkit

## Engage, Explore, Evolve.

By no means is this an exhaustive collection of resources and tools. The goal is to give you some ideas to explore and things to dip into along the way.

As you will likely discover, moving from the idea of interprofessional collaboration, to developing collaboration as an intentional practice, involves a few changes. Unique challenges arise when people come together to co-create new ways of working. In his article [Transformative Scenario Planning: Working Together to Change the Future](#), Adam Kahane illustrates how developing shared understanding and purpose helps people transform their relationships and thereby their environments, especially in polarized situations. In other words, as we learned from the experiences of the people at the heart of the Comox Project, **the process is the project**. Their story is shared later in this toolkit. **The Key Steps for a Shared Care Collaborative Initiative are outlined first. This Community Toolkit has been prepared to support your work as you progress through the steps. It is divided into three sections:**

## GETTING STARTED

This section of the toolkit offers a short introduction and a few building blocks to help get your initiative off the ground. Key principles and concepts related to collaborative practice, social innovation, and community building are presented. As you become more familiar with them, you will notice where they intersect and how each is integral to enhancing a collaborative approach.

## THE COMOX STORY: ENHANCING PERINATAL CARE IN THE COMOX VALLEY

Supporting local spread is a core component of the Shared Care Committee's provincial maternity initiative and integrating an iterative and reflective evaluation and learning process is part of the project framework. The initial goal of the Comox Project was to establish strategies for ongoing collaboration that would enhance the quality of maternity care in their community. Being the first maternity project group funded through the Shared Care Committee, members from the project's Core Team have shared their learnings, insights, and resources so that future project teams may use these pearls of wisdom and later share insights from their own path to collaboration.

At the core of Comox's Maternity Project, inclusion and diversity were enabled by a concerted effort toward community engagement and a focus on seeking regular input from local physicians, midwives, and other community stakeholders. Core Team members spent more than 70 hours engaging with 21 family physicians and specialists, 7 midwives, and 41 community partners and agencies. After reviewing the Key Steps for a Shared Care Collaborative Initiative, watch for related guideposts as you read the Comox Story. As you proceed, keep in mind that collaboration itself is generative and emergent, and rarely follows a linear process. Over time, the conditions for healthy collaboration will emerge as patterns of communication and decision making evolve along your own pathway to positive change.

Watch this short highlight video, [Perinatal Perspectives – Maternity Care Through the Lens of the Social Determinants of Health](#) from the Comox Team for more information.

## TOOLS AND RESOURCES

The appendices at the end of this Community Toolkit provide tools and resources to support your collaborative initiative. Watch [Shared Care's Maternity Network page](#) to keep up to date with information and activities from across the maternity network.

The background of the slide features three smooth, grey, rounded stones resting on a light-colored wooden surface. The stones are arranged in a loose cluster, with one in the foreground and two slightly behind it. The lighting is soft and natural, creating gentle shadows on the wood. The overall aesthetic is clean and minimalist.

# Key Steps in a Shared Care Collaborative Initiative

The process  
is the project.

# Key Steps in a Shared Care Collaborative Initiative

## 1. IDENTIFY AND BRING TOGETHER YOUR *WHO*

- › Aim for inclusive representation on your interdisciplinary Advisory Team. **Submit your Expression of Interest to Shared Care.**
  - Who will be the primary people involved in your initiative?
  - Who are your clinical co-leads? For maternity initiatives, identify a family physician, registered midwife, and obstetrician.
  - Who else needs to be at the table early on? Identify relevant and affected stakeholders.
  - Have you considered inviting participation from other health professionals, health administrators, health policy makers, academics, community organizations, and patients?

## 2. DISCOVER YOUR *WHY*

- › Co-create the vision and values for your initiative and articulate your shared purpose. Describe what matters. Stand in inquiry.
  - Why has this group come together? What are our local aspirations?
  - Why does it matter to me? Why do we care? Why do I value that which I do?
  - Where do we differ? Where are we similar? What assumptions exist?
  - What information do we have? What do we think works well? What do we think needs attention?
  - What do we want to know more about?
  - What will hold our group together?

## 3. ASSESS COMMUNITY NEEDS

- › Launch patient and provider surveys provided by Shared Care.
  - How will you outreach and follow-up in your community to ensure an adequate response rate?
- › Connect with the Shared Care team to make meaning from your survey results.
  - What do the survey results tell us about the needs of patients and providers in our community?
  - What is working well? What is not working? Where is attention required?
  - Are there patient or provider needs that differ from what we first thought? If so, what and how?
  - What key themes are emerging?
- › Connect with the Shared Care team for support on how to convey this to your larger stakeholder group and to prepare for your community engagement event.

## 4. COMMUNITY ENGAGEMENT EVENT – SHAPE *WHAT YOUR INITIATIVE WILL FOCUS ON AND WHY*

Invite stakeholders and community members to a patient-focused event to exchange ideas, make meaning, and determine what you will do to make a difference for the future.

- › Develop a shared understanding of needs, opportunities, and relevance from the key themes.
  - Do you have new insights about what is needed or where attention is required?
  - What can we influence now? Where are our local leverage points? What capacity do we have?

# Key Steps in a Shared Care Collaborative Initiative

- › Explore the group's priorities and select what to focus on.
  - What goals, priorities, and plans are emerging? Why are these significant?
  - What priority actions will we take to improve patient care? What is the purpose of those actions?
  - How might we structure ourselves to do this work? How will we involve people from our wider community?

## 5. ACTION PLANNING – DETERMINE *HOW AND WHEN*

Organize your efforts for doing the work and **submit your Action Plan Template to Shared Care**. Consider Step 6 (Implementation) and Step 7 (Impact Evaluation) as you proceed.

- › Establish your plan from the priorities and actions that emerged during the engagement event.
  - What primary activities will we undertake? What impacts and outcomes do we anticipate?
  - How will we utilize interdisciplinary teams or task groups in a participative process?
- › Lay out a workplan, timeline, and budget.
  - How will we achieve the identified outcomes? Is it possible with our resources, time, and people?
  - What roles and responsibilities will people and groups have?
  - How will we foster shared accountability for our action plan and the work ahead?
  - How will we track progress and communicate between groups?

## 6. IMPLEMENTATION

- › Put your plan into action.
  - What ideas do we have for maximizing success?
  - Do we need to engage any new stakeholders or partners to support or assist our plan for action? What are we doing to engage and involve patients?
  - What is our plan for sharing information and project updates with stakeholders and community members?
- › Integrate spread, sustainability, and adaptive evaluation in your workflow.
  - How will you use PDSA (Plan, Do, Study, Act) or reflective cycles to enhance your workflow and activities?
  - Have participants been given regular opportunities for evaluation and process feedback? How is this information being reviewed, integrated, and shared?
  - What steps are you taking to capture and record your journey and to identify key learnings?

## 7. IMPACT EVALUATION

- › Review the Evaluation Framework and Plan provided by Shared Care.
- › Conduct pre-initiative patient and provider surveys to inform your needs assessment (step 3). The provider survey will also serve as your baseline measurement. Conduct a post-initiative provider survey to measure change in your community.
- › Connect with Shared Care's Project Evaluator to identify evaluation activities specific to your community's initiative.
- › Summarize and document your process, activities, outcomes, and lessons learned to demonstrate and share your unique path to positive change.

# Key Steps in a Shared Care Collaborative Initiative

**Additionally, the following integrative activities should happen throughout your initiative:**

## **SUSTAINABILITY AND SPREAD**

Inclusive and adaptive change processes enable sustainability and spread.

- › Through every step, consider how you will sustain your work. Building in sustainability from the onset is crucial.
  - What systems and behaviours are we changing to produce improved outcomes?
  - What new patterns of shared understanding and decision-making are we co-creating?
  - How will we maintain these changes to sustain the improvements?
- › Spread is an outcome of continuous learning environments enabled by reflective evaluation loops, open communication, and sharing insights. Spread occurs both internally and externally.

### **Internal spread:**

- What evaluation and feedback processes have we implemented? How are we using the information?
- Are we taking adequate time to reflect and adapt? How are we documenting our process?
- What are we doing to share progress and learnings between task groups and with the Advisory Team?

### **External spread:**

- How are we keeping our wider community of stakeholders and patients informed and engaged?
- What key learnings can we share with other communities?
- › Visit the [Shared Care Learning Centre](#) to learn more and look at the Sustainability and Spread toolkits. Connect with your SCC Liaison for additional information.

## **REFLECTIVE EVALUATION**

Each cycle helps teams understand group dynamics, recognize emergent patterns, evaluate their processes and actions, and adapt to improve.<sup>5</sup> Becoming adaptive enhances long-term sustainability.

- › Consider regular points through your initiative where you will implement reflective evaluation. It may be during engagement activities, after team meetings, or at certain time intervals, such as monthly or quarterly.
  - What is working well? What needs attention?
  - What have we learned?
  - As a group, are we satisfied with our progress?
  - How can we adapt our process or what can we modify to improve our work?

<sup>5</sup> Olson, E., Eoyang, G. (2001). *Facilitating Organization Change: Lessons from Complexity Science*. San Francisco: Jossey-Bass/Pfeiffer

# Getting Started

When we cannot  
see the future,  
where do we begin?

# Getting Started

## When we cannot see the future, where do we begin?

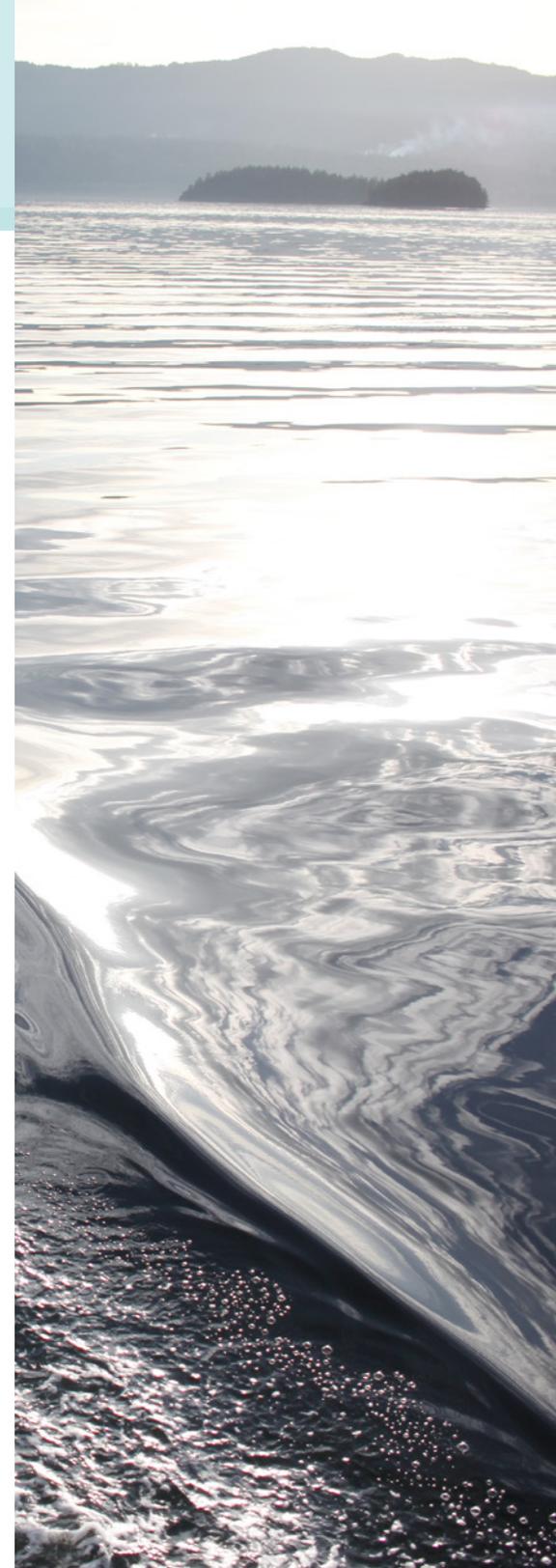
At its heart, effective collaboration relies on human interaction and relationships, thus “transforming systems is ultimately about transforming relationships among the people who shape those systems.”<sup>6</sup> Innovative and sustainable change is possible only when people actively engage in a process that enables open dialogue and the evolution of shared understanding. It begins with uncovering the characteristics and values of the people involved.

Likely, informal conversations about enhancing interprofessional collaboration are already happening in your community. Who begins or leads these conversations? Who are your local collaborative champions? Perhaps you're one of them? What characteristics, qualities, and values make you think of people as collaborative champions?

**As you read the Comox Story, you'll learn that identifying local collaborative champions from each discipline is a crucial first step.** Local champions are the people whose vision, passion, commitment, and contributions are necessary to move interprofessional collaboration from idea to action. Often in their communities, collaborative champions will have the experience, professional network, and tact to effectively bring a team together. Having champions from each discipline co-lead your initiative models collaboration and embodies the vision that motivates others. A few years ago, an experienced midwife in BC said *“I think if you're going to do a collaboration, you need champions from each discipline. You can't have only physician champions trying to bring on the midwives – and vice versa, midwife champions alone won't be able to get the doctors on board.”* This is a key factor for success in communities where tension between health disciplines may persist.

Just as you would for assembling any structure, creating a strong foundation for your collaborative initiative is essential. As you identify the Who and bring together the local champions who will become your Advisory Team, making time for them to develop relationships, foster trust, and learn to navigate conflict is crucial. This early groundwork cannot be undervalued. You'll see the significance illustrated in the Comox Story and captured again in the key learnings shared by the Comox Team.

<sup>6</sup> Senge, P., Hamilton, H. & Kania, J. (2015, Winter). The dawn of system leadership. *Stanford Social Innovation Review*. Retrieved from [https://ssir.org/articles/entry/the\\_dawn\\_of\\_system\\_leadership](https://ssir.org/articles/entry/the_dawn_of_system_leadership)



# Getting Started

## DISCOVER THE POWER OF WHY

Now that you've identified local interdisciplinary champions and garnered excitement for your collaborative initiative, it can be compelling to jump right into the what and how of your initiative. Moving quickly to action is the approach many of us have learned yet, it sidesteps the **power of Why**.

Conventional problem-solving approaches work well for scientific and technical issues; problems based on static change that can be predicted and repaired, much like fixing the stalled engine of a car. By contrast, enhancing interprofessional collaboration is a socially complex challenge. Likewise, collaborative environments are **evolving social systems**. Effectively enhancing IPC means shifting from familiar patterns of conduct toward a new mindset that favours relationship-centred approaches across the continuum of care. These new approaches open the door for local, participatory and collaborative, patient- and community-centred processes.

In systems with social complexity, inviting responses to the *Why* questions early on – why does this matter to me, why do we care, why do I value what I do – facilitates participation and dialogue. Rather than diminishing difference as a tactic for avoiding conflict, engaging in *Why* dialogue gives voice to each person, so their experience and values may be heard openly and without judgement.

**Difference becomes a resource for change.** Neurobiologist Dr. Daniel Siegel suggests that exploring the *Why* is an act of social integration.<sup>7</sup> Along with contributing to healthy differentiation among team members, it fosters connection and collaboration through shared humanity, vulnerability, needs, and stories. **This is your team's heart work.**

At the same time, your stories may reveal patterns of the past. Where conflict exists, people's *Why* stories can uncover deeply held narratives that underpin

interdisciplinary tension.<sup>8</sup> In order to begin the process of social change, the hidden assumptions and beliefs need to be surfaced. Indeed, making commonalities and differences, myths and misperceptions visible early on helps create the relational conditions that are essential for effective IPC. It also sets the foundation for ongoing engagement.

Ultimately, engaging early in the *Why* conversation is vital for developing the vision, aim, and guiding principles that will create coherence throughout your initiative. It is important this work is not done in haste.

Further along in the toolkit you will read about the Comox Team's early visioning sessions and the Advisory Team's work to set their vision, goals, and guiding principles. The Comox Team's guiding principles were essential for both their process and engagement. One of the key learnings this group articulated, and a success factor in their project, was ensuring from the beginning that the Advisory Team was comprised of an inclusive group of people whose passion and skills aligned with the values embedded in their guiding principles.

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“What helped me endure was an **undying belief** held by the team members that **the vision we had for the future was possible.**”

<sup>7</sup> Siegel, D. (2010). *Mindsight*. New York, NY: Random House.

<sup>8</sup> Rothman, J. (2012). Engaging the painful past and forging a promising future. In J. Rothman (Ed.), *From identity-based conflict to identity-based cooperation: the ARIA Approach in theory and practice* (pp. 3-20). New York, NY: Springer Science + Business Media

# Getting Started

## COLLABORATIVE CO-LEADERSHIP

Decades of research in organizational development have taught us about 'top-down' approaches to change management and how the qualities of leaders impact the effectiveness of individuals, teams, and organizations. More contemporary evidence integrates complexity theory, community capacity building, and social change into health system transformation efforts and illustrates how the leadership landscape is shifting. Not only are we seeing the emergence of interprofessional collaborative care models across the health care continuum, we are also experiencing a rise in approaches for collaborative leadership.

Existing literature makes little distinction between collaborative co-leadership and collective leadership. For the most part, these terms are used interchangeably. The concepts of participatory leadership and distributed leadership also fall within this emerging cluster. Behind any of these shared leadership styles is the idea that both formal and informal leaders work collaboratively to influence change by fostering collective action.<sup>9</sup> Newton (2015) reports that effective collaborative leadership fosters increased interaction among team members, greater collaboration, coordination, and cohesion, as well as novel and more innovative solutions.<sup>10</sup> Successful collaborative leadership is also a positive predictor of team effectiveness.

As with enhancing interprofessional collaboration at the frontline of health service delivery, **collaborative co-leadership exists as a relational practice within an evolving social system.** It requires the cultivation of trust and cohesion between individuals, groups, and health disciplines and compels team members to take individual and collective responsibility for working together toward the greater good of the populations they serve. While they may not always agree, collaborative co-leaders are skilled professionals able to engage in respectful and constructive dialogue, recognize the interdependence of their goals, and find common ground in their principles and values. Their relationships form a model

for collaboration that transcends conventional organizational structures to create synergies and innovation across multiple levels of service.

Shared Care recognizes that collaborative co-leadership is integral to enhancing an interprofessional collaborative approach to the effective delivery of current and future health care services. Clinical and health system leaders have a pivotal role in cultivating change and must work collaboratively to co-create and sustain an effective culture of engagement and a continuous learning environment. In the Comox Story you will read about the group's commitment to ensuring broad and inclusive representation on the Advisory Team with necessary clinical co-leadership from a family physician, obstetrician, and registered midwife.



9 Ekert, R., West, M., Altman, D., Steward, K., Pasmore, B. (2017). *Delivering a Collective Leadership Strategy for Healthcare (White Paper)*. A Collaboration Between the Centre for Creative Leadership and The King's Fund. Retrieved from: <https://www.kingsfund.org.uk/sites/default/files/2017-05/delivering-collective-leadership-ccl-may.pdf>

10 Newton, R. (2015). How To Co-Lead a Team. *Harvard Business Review*. Retrieved from: <https://hbr.org/2015/07/how-to-co-lead-a-team>

# Getting Started

## ENGAGEMENT: BETTER TOGETHER

The World Health Organization defines community engagement as **“a process by which people are enabled to become actively and genuinely involved in defining the issues of concern to them, in making decisions about factors that affect their lives, in formulating and implementing policies, in planning, developing and delivering services and in taking action to achieve change.”**<sup>11</sup>

11 World Health Organization. 2002. *Community participation in local health and sustainable development: Approaches and techniques*. Retrieved from: [http://www.euro.who.int/\\_data/assets/pdf\\_file/0013/101065/E78652.pdf](http://www.euro.who.int/_data/assets/pdf_file/0013/101065/E78652.pdf)

Meaningful and effective community engagement will be a cornerstone of your work to enhance an interprofessional collaborative approach to care in your community. Described as a collaborative and ongoing relationship between healthcare providers, stakeholders, patients and families to improve health through dialogue, **community engagement is a process rather than an end point**. Engagement is a continuum of community involvement that will happen across multiple levels of your collaborative initiative and each interaction offers an opportunity for learning, discovery, and capacity building.

There are many ways to think about community. In engagement literature, the term community is commonly used to refer to people grouped around geography, common interest, identity, or interaction. In *community organizing*, groups are helped to identify common needs and goals, mobilize resources, and develop and implement strategies to reach goals they have set collectively. Likewise, *community building* is about discovering why and how members in a shared community engage collaboratively toward the process of change.

The essential elements of effective community engagement emerge from the underlying values, principles, and relationships involved. Through a process of co-discovery, you may find some of your team's core values include authenticity, humility, honesty, openness, respect, and transparency. Principles of engagement include diversity, inclusivity, accessibility, and accountability. Personal attributes and attitudes are reflected in the quality of relationships that develop within the engaged community. In their organization's work to enhance *adaptive capacity*, the Human Systems Dynamics Institute suggests engaging through a process of inquiry that fosters humility and openness to the unknown.<sup>12</sup> When we **stand in inquiry** we:

- › Turn judgement into curiosity
- › Turn defensiveness into self-reflection
- › Turn disagreement into shared exploration
- › Turn assumptions into questions

Determining the initial people and stakeholder organizations that will be part of your engaged community is one of the first steps in your collaborative initiative. As we heard from the Comox Team, intentionally casting a wide net in a deliberate effort to be open and inclusive was a key principle of their engagement efforts. In his article, *Caring for a Common Future: Medical Schools' Social Accountability*, UBC Professor and family physician, Dr. Robert Woollard (2006) recommends community engagement efforts include people from each of the five 'pentagram partners' in health: health professionals, health administrators, health policy makers, educators and researchers, and communities and patients. In Comox, broad and inclusive engagement from the beginning enabled the team to build initial awareness for the initiative, forge new relationships, and reinforce others.

12 Human Systems Dynamics Institute. 2016. *Inquiry*. Retrieved from: <https://www.hsdinstitute.org/resources/resources-inquiry.html>

# Getting Started

## APPRECIATIVE INQUIRY AND QUALITY IMPROVEMENT

### Learning by doing.

There is an important relationship between interprofessional collaboration and quality improvement. By working together to influence change, competent interprofessional teams can effectively address quality issues in any practice context, along the spectrum from simple to complex.

Appreciative inquiry employs a collaborative approach to quality improvement and aligns with the Institute of Healthcare Improvement's [Model for Improvement](#). Underscoring appreciative inquiry is the premise is that in any system there will be something working already. Change occurs by identifying what works, building on those assets and strengths, and adapting them to improvement initiatives. The transformative effect of appreciative inquiry lies in stretching, spreading, and sustaining what is working. At the same time, creating the future from present successes gives people the opportunity to believe, from experience, that change is possible. Participants can visualize the change, know what it feels like, and the team can move toward a co-created and shared vision of what lies ahead.

By using appreciative inquiry, action learning and action research frameworks integrate reflective evaluation cycles in quality improvement initiatives. Group members are encouraged to build on strengths, learn reflectively from challenges, and share insights with others. Collaborative inquiry is organized around issues and topics, rather than by discipline or theory, so that **people can think, learn, and work through an open, participative, and creative process to co-construct new ideas and co-develop solutions**. It is 'learning by doing' and embraces Shared Care's philosophy '*nothing about me, without me.*' Most notably, the process results in both quality improvement actions and *social impact* – which is essential for enhancing a collaborative approach to delivering health services in your community.

Not only will you read about the Comox Team's use of action research as a guiding methodology, you will also learn about the team's unwavering commitment to diversity and inclusivity, their open curiosity, and their desire to learn, from each other and from their

PROBLEM SOLVING FOCUS:	APPRECIATIVE INQUIRY FOCUS:
<p><b>Doing less of something we do not do well</b></p> <p>Identification of problem</p> <p>▼</p> <p>Analysis of causes</p> <p>▼</p> <p>Analysis of possible solutions</p> <p>▼</p> <p>Develop an action plan ► <i>"the fix"</i></p>	<p><b>Doing more of what works</b></p> <p>Appreciating and valuing the best of <i>"what is"</i></p> <p>▼</p> <p>Envision <i>"what might be"</i></p> <p>▼</p> <p>Design through dialogue <i>"what should be"</i></p> <p>▼</p> <p>Innovate <i>"what will be"</i> and co-construct the future</p>
<p><b>Basic Assumption:</b></p> <p>There is a problem to be solved – if we find the problems we can fix them</p>	<p><b>Basic Assumption:</b></p> <p>There is potential to be discovered – a web of strengths can be built on and developed</p>

Adapted from: Cooperrider, DL., & Srivastva, S. (1987). [Appreciative Inquiry in Organizational Life](#). In W.A. Pasmore & R.W. Woodman (Eds.), *Research in organizational change and development*, Volume 1 (129-169). Bingley, UK: JAI Press.

# Getting Started

community. In the *Tools and Resources* section of this toolkit you will find additional information on appreciative inquiry, community engagement, needs-based planning, and evaluation.

To help you get underway, here are some sample questions phrased using an appreciative inquiry approach. You may find it useful to adapt some of these questions for your team's "Why" conversation. Additional questions can be found in "Key Steps" section of this toolkit and in the sample engagement agenda from the *Comox World Café* event in Appendix 1, as well as through the resources listed in Appendix 2.

- › What is working in our community? What makes that work as well as it does?
- › What do you value most about working with your interprofessional colleagues? Why?
- › Think back through your time as a maternity care provider in this community and locate a moment when you felt most effective and engaged. Describe how you felt and what made that situation possible.
- › What do you value most about providing maternity care and practicing in this community?
- › Think of the last time you were working in the hospital. Who was the last person to make you smile? Why?
- › Describe a time when you were proud to be a member of a team. What specifically made you proud?
- › Think of a colleague whom you admire for his or her integrity and a specific incident where you saw this person demonstrate their integrity. Describe the circumstance and the consequences.
- › Describe a time when you were part of a team that had a high level of trust and respect among members. What did trust look like? How was trust and respect communicated? What else made it possible to establish trust in the group?
- › Describe a time when you were part of an extraordinary act of cooperation or collaboration. What was your part in this? What other factors made the collaboration possible?
- › Tell us a time you were treated with kindness by a colleague. What were the circumstances? What was the impact on you?
- › Every person is unique. Think of a time when a colleague showed you they recognized and appreciated your uniqueness. What did your colleague do? How did that impact you and your work?
- › As a group, what did we do well in this meeting? What conditions were present that allowed each person to speak and their ideas to be heard?



# The Comox Story:

Enhancing Perinatal Care  
in the Comox Valley

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“Collaboration is the piece that continues, so that is why **collaboration is most important**. If people are collaborating better – then the other things, like equal access and standardization, and knowledge – will continue to improve BECAUSE there is better collaboration.”



# The Comox Story

On October 27th 2017, 3 individuals from Shared Care and 4 individuals from the original Comox project team gathered to discuss the Comox Valley's Shared Care maternity project. The participants from the Comox team included:

- › **Theresa**, a family doc who has been on the Comox team since it started.
- › **Liz**, a midwife who started working with the project in 2016 after she moved to the valley in 2015. Soon after arriving she found her way into the project as a way of connecting with her community.
- › **Jackie** started out as the Project Assistant and Evaluator. She has become Project Manager for their next phase.
- › **Maureen** began the project as the Project Manager and is now working with the hospital transition.

The intention was to talk with the team about learnings and insights from the Comox Maternity Project. It was an attempt to offer those outside the project an alternate way to access the knowledge earned over the 2 years of their Shared Care project. The insights from this conversation are shared here, along with some key take-aways from the project's evaluation report.

We are aware that the resources of time, effort, good intention, interest - and of course dollars - are precious and in short supply. This is a way to make sure that other project teams might learn from the path that this team took, potentially utilizing some of this wisdom and applying it to their own project planning and execution.

At the same time, we recognize that no two communities will have identical needs or paths. Whether rural, urban, or isolated - differences in population size, demographics, topography, the mix of providers and their experiences, local services and resources, and the existing environment for collaboration will make your local challenges and opportunities unique. Sharing the Comox story isn't intended as a panacea that will fix every pressing issue. Many hard questions persist and new questions will surely arise. It is an invitation to discovery, as we learn by doing, out loud and together.

**We hope that you find this useful.**

## PROJECT AIM:

To develop a collaborative multidisciplinary approach to perinatal care in the Comox valley by addressing collaborative practice between specialists, family physicians, midwives, and other perinatal service and care providers.

## PROJECT GOAL:

To collaborate with key stakeholders in a meaningful way to establish strategies that will enhance the quality of perinatal services and care in the Comox valley.

*"Knowing you won't accomplish everything you want. You can affect change, and you won't be able to do it ALL. That's not the goal. Rather, it's about listening to your community and sifting through what made most sense."*



# The Comox Story – In the Beginning

## IN THE BEGINNING

### *What do you wish that you had known when you started this project?*

- › How long it would take to get people in a place where they could come together to have conversation.
- › **Everything will take longer than expected.** It was good for us not to have any goals in the beginning.
- › Since I was new to healthcare, I wish I had known how complicated the system is. I wish I had been less bright-eyed and bushy-tailed... there is complexity with relationships, billing, patients.
- › I don't wish to have known anything because **it was great to see the path as it unfolded.** I don't wish to have known because that was what made it such an interesting project to be part of.
- › You can't underestimate the value of having people together in a room. The more people the better.

*Where you go – may not be where you expected you would go.*

*Often times we said “well, the project has basically just been having people together in a room, communicating.”*

## ESSENTIAL ELEMENTS FOR SUCCESSFUL COLLABORATION:

In May 2017, at the *Interprofessional Collaborative Practice Development Workshop*, 75 physicians, midwives, and health administrators gathered to explore interprofessional collaboration in maternity care, including members from Comox Valley's Shared Care Maternity Project. In one workshop exercise, participants articulated the following essential elements for collaborative success:

- Create an open collaborative community
- Physical space – for getting together, working together, making things happen
- Willingness to understand and make a connection
- Openness for working together and learning
- Tolerance
- Being non-judgemental and having acceptance for each other's differences
- Open communication
- Commitment to the long game – hold the space for later adopters to come aboard
- Recognition and acknowledgment of each other's skills and assets
- Intentional understanding of each other's scope and role
- Understand the extent to which your organization supports your participation
- Courage
- Cultivate a culture of respect and a safe environment to learn
- Make time to reflect on what has been said and heard
- Celebrate what is going well
- Acknowledge the elephant in the room
- Persistence
- Humour
- Honesty
- Listening with intention to understand
- Engage respectfully
- Enthusiasm
- Ask curious questions
- Be transparent
- Learn from other experiences



# The Comox Story – Early Steps

## EARLY STEPS

### How did your collaborative project begin?

- › One of our GPs went to a **collaborative care conference** in 2013, hosted by Perinatal Services BC and the South Community Birth Program and came back energized and excited. She suggested we do a project and we put the idea to the Division.
- › We extended an invitation to anyone that we thought might have an interest in being involved; **we wanted the invitation to feel open and inclusive**. We met at the hospital and at that meeting it was mostly midwives, OBs, and family doctors. We just threw the idea of a project out there, wanting to be inclusive. **We were intentional about asking all stakeholders**.
- › There was definitely enough interest to submit a project proposal to the Shared Care Committee.
- › We did an early visioning session with broad representation. Different people representing different professions and groups contributed our vision.
- › Our goal was to establish strategies for ongoing collaboration to enhance the quality of perinatal services and care in our community.
- › Soon after the funding was approved, we struck the interdisciplinary advisory team.

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“I can remember so many conversations where we tried to go to action but where we didn’t have the information we needed to move to action... and **we had to become comfortable with not knowing everything**; not having all the information before moving forward. We talked about it a lot at the advisory committee. We experienced that and then took that learning to the other committees.”



**Identify local champions from each discipline**

*We met with Perinatal services BC early on and I remember her saying “maybe that’s where your community will end up... but maybe you will end up somewhere else.”*

*I [project manager] met with every single person and we co-created the Shared Care Committee proposal. I’d meet with one person, and then I would take it to the next person. And then I’d meet with Theresa [Family Physician] and Matthew [Obstetrician] and they’d review it. So, the proposal for the project was created collaboratively even though we weren’t in the same room writing it. It went through all the iterations with stakeholders, so everyone had ownership.*



# The Comox Story – Phase 1

## PHASE 1 – THE ADVISORY TEAM, NEEDS ASSESSMENT, AND COMMUNITY ENGAGEMENT

### Establishing an Interdisciplinary Advisory Team:

- › I think people were excited about improving the way we worked with women and their families. We needed something to improve the scenario, and to empower women more in our community.
- › We spoke with a lot of stakeholders and asked who would be strong individuals to involve. The choices for the Advisory Team participation was based on:
  - An individual's ability to see possibility,
  - The fact that they were a key stakeholder in the community in their area of work and had influence in their area,
  - That they were a representative of a certain group of people who would round out an inclusive team.
- › We were very deliberate to make the advisory team inclusive and broad. We made sure that it had a registered midwife, a family doc, an obstetrician, but also the nursing director of mat/child health at the hospital, our Aboriginal liaison at the hospital, and the head of public health nursing so we could develop the project together.
- › We were having the lunch time meetings and slowly co-creating the proposal that we put into the Division about the potential Shared Care project. It outlined some of the challenges we perceived.

### What were the competencies, skills, qualities that developed over the course of the project?

Members of the Advisory Team all had or developed certain leadership qualities; many came with a lot of these skills too:

- › the ability to engage others and build relationships
- › can envision the future
- › holds balance between task orientation but not at risk of relationships.
- › respected by their peers



*Co-leading and co-discovering*

*I think there were at least 3 or 4 advisory team meetings before we even got the surveys out.*



*The process is the project.*

*Each Advisory Team member had a desire to learn from each other.*

# The Comox Story – Phase 1

- › possessed the ability to influence their peers and others
- › has the capacity to listen to others
- › is flexible and has a willingness and openness for change
- › has respect for each other's roles, skills, talents, and abilities
- › remembering "it's a process, it's a process, it's a process"
- › knows that "it will go slow and that's okay, but we need to take the time to hash things out"

## KEY LEARNINGS:

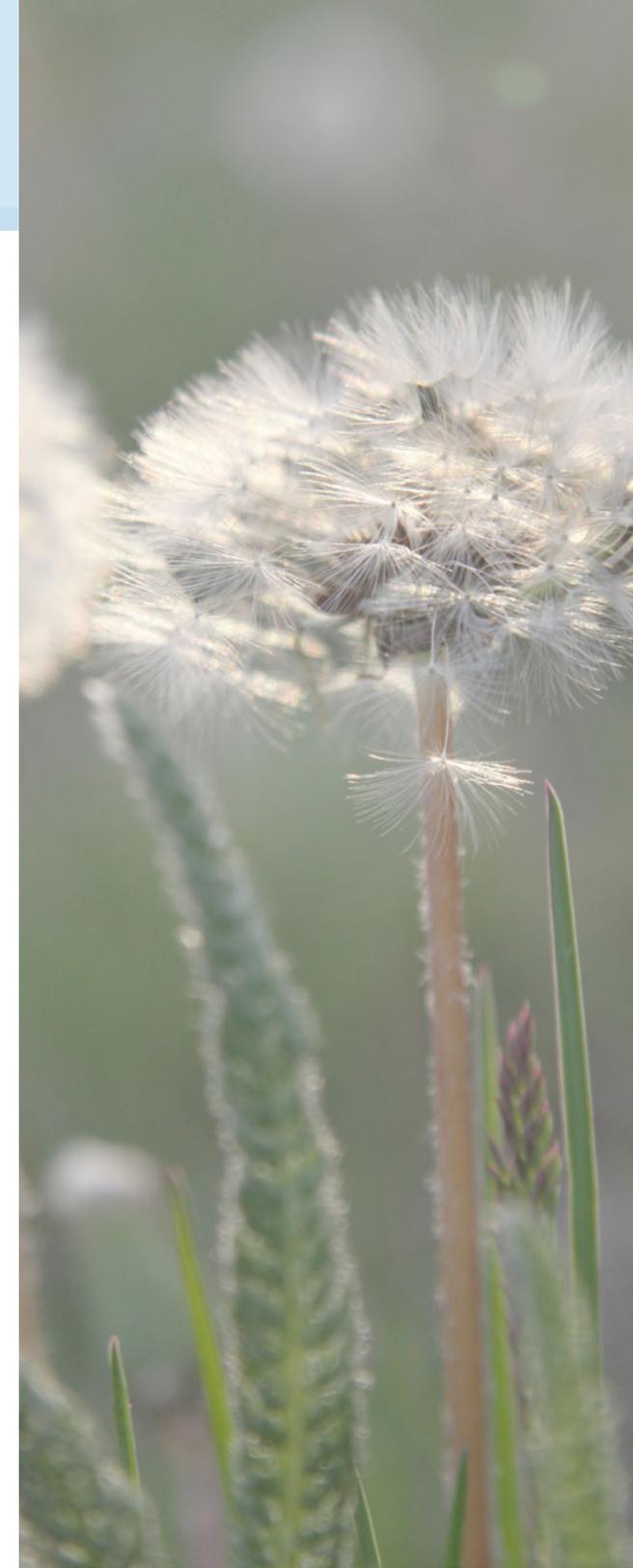
### Ensure you have the right people leading your project:

- › Do the initial work to find the right people who are willing to be on the advisory committee and who will be committed to leading the project. **They are the champions who have passion.** This also brings continuity to a project.
- › On the Advisory Committee, **you need everyone on the bus and going in the same direction.** If we had had someone who had their own agenda, then we would have needed to make some hard decisions because it would have really been disruptive to our team.
- › As well, it's important to invite in "new blood". Look for people who are willing and able to come in with no pre-conceived notion of the past and offer a fresh perspective.

### Ensure excellent process, project, and group skills:

Look for people and process skills that align with the values embedded in the guiding principles. In our case this included:

- › **Ability to listen** to all group members and hear different perspectives
- › Action based methodology
- › Reassuring everyone that "it's a process, it's a process, it's a process"
- › Hold the right balance between getting the project tasks attended to and ensuring that there is time for **relationship building**
- › Ability to keep the **momentum** going

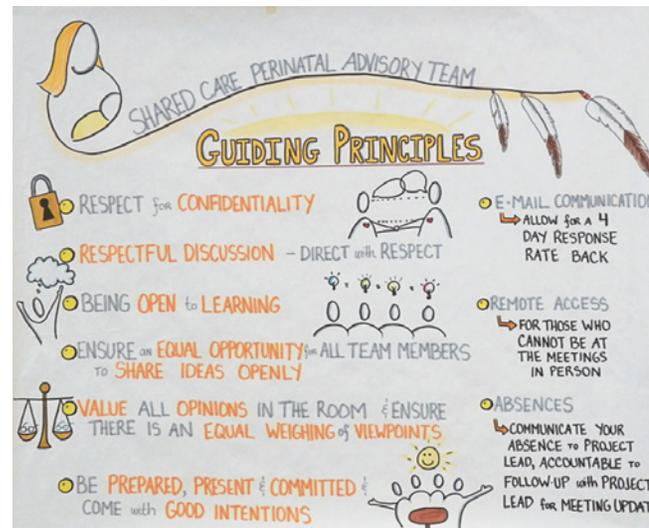




# The Comox Story – Phase 1

## Establish Guiding Principles:

- › The initial work of the Advisory Committee was to set our goals: brainstorming what we thought by getting together and visioning.
- › One of the tools we used in the early meetings was that we had graphic facilitation posters created to capture our vision, goals, and guiding principles. And we would bring those to every meeting and put those up on the wall... just as a reminder of what the broader aim of the work was.



*What principles will guide your project and teamwork?*

*When we finally sat in a room and talked about it, we all had similar concerns... and we all respected each other.*

## KEY LEARNINGS:

### Make time to co-create:

- › Within the project design, enable members of the Advisory Team, and those that are closest to the work, the opportunity to co-create the project's guiding principles, values, and goals

### Make the most of the time people have in the room together:

- › It's about balancing getting stuff done and getting things down on flip chart paper, with **creating space for conversation**, the opportunity for talk with each other, and **building relationships**.

*We had guiding principles, terms of reference, and goals for each working group. And agendas and minutes for every meeting... and communicated those out after every meeting.*



# The Comox Story – Phase 1

## Assessing community needs:

- › We always wanted our process to be **needs-based** so we were really open to if we found something new. We were really trying to guide our next steps based on what we heard instead of going in with a specific agenda about what we thought or what we wanted.
- › There was a pre-existing bent amongst providers to **use data to help in decision making**. Everyone agreed about using data rather than their own opinions or biases.
- › You can't help but go into something like this in some way saying "well, we think we know what people want" but then, when they came out and told us what they really want, we were compelled to focus on what patients wanted – not what we thought they needed.
- › Ultimately, everyone agreed to consistently keep coming back to '**patient-centred care**' – it was the unifying point for all of us.

## What methodology did you use?

- › We didn't formally name **Action Research** as our approach - we just did it that way. You don't go around saying "... hey, you know what we are doing..." because people start to pay more attention to the labels and it stops having the same effect. Or, they start pulling from here and there and then there isn't congruency between the tools they are using and the outcomes they are intending.

## The survey results provided an anchor:

- › People on the advisory team were committed to being patient-centered and being focused on delivering patient-centered care. And so, when we designed the survey we really went at it collectively. It wasn't a forced decision; we all really agreed: **we really did want to find out what women and families needed and wanted**.
- › We did **provider and patient surveys** to collect information:
  - We made considerable efforts to outreach, to ensure that **we reached out to those who had barriers to participation**. And that we ensured that they were well resourced so that we could hear their voice as well.



*Survey the community and use data to inform your actions*

*Using the principles of action research as the guiding methodology, we undertook a needs-based assessment using patient and provider surveys, interviews, and focus groups.*



*How will you outreach to your community?*

*It helped us to engage local physicians in the work as well as their MOAs, and we incented patients by having each office do a draw for a gift basket.*



# The Comox Story – Phase 1

- Our Project Manager and our Aboriginal liaison nurse **met with a lot of women** who were struggling with the social determinants of health and may not have been able to complete a paper-based survey, to really be deliberate about getting voices who we may not have heard from otherwise.
- We went out and **enlisted medical office assistants and physician offices**, to collect patient surveys for us. They would ask their maternity patients to complete the survey for us and we would go around once a week and collect them. And then we would then enter the responses into the software.
- We involved all the community groups who support women, to help collect data too.
- › The survey timeline was extended and was open 6 – 8 weeks to get a statistically reliable response rate:
  - We got 250 patient surveys back. Especially as we have 500 births a year, roughly.
  - And, of the provider surveys, we got 92. 51 were family and specialist physicians. And 41 came from midwives, Island Health, and community partners.

## We used the data well:

- › When we first got the data, some of it validated what we already knew, and we discovered things that were going on in the community that we didn't know about!
- › **There was information that was new to us.** That drove some of the people who thought that they knew, **toward what was needed** versus what we thought that we should do. And ultimately, it meant **we all changed a little bit on our team**
- › When we had a question, we would go back to the data and ask **“well, what did the patients tell us?”** or **“What do the providers want?”**

## KEY LEARNINGS:

### Effective meetings supported by strong project management:

- › Have regular meetings (using doodle polling to find workable dates) and ensure as many Advisory Committee members are able to attend as possible
- › Ensure meetings are supported with effective chairing and administration so that agendas, minutes, and action items are communicated in a timely manner.
- › You can't expect providers doing clinical work to do the project management work.



Analyse data to identify needs, gaps, and issues

## PATIENT SURVEYS: 254

### Key themes

- Prenatal resources
- Information on breast feeding and postpartum depression
- Finding a family physician after the birth of baby
- Scheduling and getting appointments
- Getting to appointments
- Choice of care provider
- Personalized and non-judgmental relationship with care provider
- Prenatal relationship with public health nurse
- Collaborative relationship between care providers

## PROVIDER SURVEYS: 92

(51 physician responses and 41 responses from midwives, Island Health, and community partners)

### Key themes

- Standardized framework for care
- Professional development and CME
- Consolidated and accessible resources
- Provision of non-judgmental care
- Low risk, multidisciplinary care
- Collaboration with community partners
- Collaborative maternity practice
- Collaboration with community partners and other care providers



# The Comox Story – Phase 1

## Engagement: the World Café event

- › The Advisory Team spent a lot of time collecting and looking at the data and identifying themes. From there our core team compiled the data from provider and patient surveys and identified four specific, visionary themes that fed back into the bigger project vision.
- › We then **brought those four themes to the world café** – and we hosted an engagement event that was **awesome**. It was probably one of the most important parts of our entire project, because the whole community of providers, stakeholders, and some patients attended and actively participated in identifying and creating the project.
- › And it was from there that the **working groups were born**.

## At the engagement event we struck three working groups, in addition to the advisory team:

### CARE PROVIDER COLLABORATION AND STANDARDIZATION

To create opportunities for maternity care providers to build relationships and explore possibilities for future collaborations.

### EQUAL ACCESS TO CARE

To create opportunities for primary care providers and key stakeholders collaborating to explore improvements and access to maternity care in the Comox Valley.

### PATIENT AND PROVIDER INFORMATION AND KNOWLEDGE

To create a streamlined process for all maternity care providers and patients to have easy access to resources while ensuring that the physician population has available learning opportunities to enhance knowledge of first trimester care.

- › The working groups would meet on different weeks from our advisory team (i.e. a 4-week cycle), with agendas and minutes for every meeting. We would bring the learnings and information from each working group back to the Advisory Team. We had some basic project management structures in place to provide that continuity.



**What steps have you taken to plan for your primary engagement event?**

*The project started in October 2014 and the world café was in spring (May) of 2015.*



**Co-sensing and co-creating**



*And the best thing that was happening was that **we were all sitting in rooms together** and getting to know each other and understand each other better.*



# The Comox Story – Phase 1

- › **Each WG had a minimum of one physician, one midwife, and one community member.** So, there was always a physician voice and a midwife voice in each of our working groups. We structured them the same way as the Advisory Committee. We picked people we thought would make a great team (looked for diversity); we sought these people out.
- › Each group had their own **Terms of Reference, guiding principles** and **goals**, as well as sub committees that evolved out of those groups - where people went away and worked on stuff.

## What else supported engagement and communication through the project?

- › The ones who were directly involved were really engaged and talking regularly. I wouldn't say that the whole community was constantly talking about the project – by any stretch – that being said, those who were present and engaged were proactive in **communicating with their professions** – like midwives taking it back to other midwives. [The project co-leads] were communicating it back to their groups and bringing it up at meetings – like the department of obstetrics meetings.
- › We were in the room together having the fun, getting to know each other – **establishing the relationships**. But back at the office my colleagues were thinking “what’s going to happen now? Is there a collaborative care project – and who’s going to be invited? How’s this going to work? Will there still just be a midwifery clinic?”
- › So, **there was a lot of reassuring** at the same time. I mean we were really excited, but there were a lot of people in the background [...] scared, for what the [midwifery] profession could be turning into, and in what direction it was heading. And they didn't feel that they had much of a voice.
- › And then Jackie put together and distributed **newsletters**:
  - I'd knock on the clinic door, always hoping that one particular person would answer the door and I could be that friendly face. “I'm from the project if you want any information.” Just trying to be **open and available** for people who might be right on the edge of not sure if they really liked what was happening. Especially if it was because they didn't know what was going on.
- › What helped was to **reassure people** that everything happens slowly and that nothing would happen without peoples understanding and comfort. And no matter what came out of it, **everyone would get to have a voice and feel like they were invited.**



Seeding change through engagement and dialogue

*[Jackie] I remember hearing about some of the concerns from individuals in the community. So, I would hand deliver a newsletter so that I could be the face of the project out in the clinics... and would provide that individual connection.*



# The Comox Story – Phase 1

- › These messages were **consciously conveyed** by the Advisory team. But sometimes it just got shoved under the rug; you get busy. In retrospect it would have been nice to have **prioritized it a little bit more than we did**. So, I think being more intentional about it would be helpful.

## KEY LEARNINGS

### Strong commitment to **broad and meaningful engagement:**

- › Ensure that key stakeholders are represented at both the Advisory Team and Working Group levels
- › Create opportunities and develop practices that will engage women and families to learn more about their experiences
- › Continue to cultivate opportunities for all care providers, family physicians, specialists and midwives, to work together, to learn from each other, and to build trust and respect
- › Ensure a wide spectrum of stakeholders from both the community and governmental organizations are involved. Use these opportunities to meaningfully engage stakeholders, leverage decision makers, and inform policy.
- › Establish a solid partnership with First Nations Health Authority and their work in maternity care

### Find ways to ensure that as many **people as possible understand what's going on:**

- › Ensure there is ongoing dialogue about project goals and guiding principles
- › Utilize posters that visually illustrate goals and guiding principles and put them up at every meeting
- › Distribute regular newsletters and continue to communicate both at the community level, regionally, and across the Health Authority with those who have influence over program areas related to maternity care
- › Ensure there is deliberate, regular, and ongoing communication with colleagues about developments and changes, especially those who are most affected. Meet people where they are at.



*What will you do to keep your community informed?*

*Right off the bat we created two very important **email lists** – that grew and grew and grew:*

*The ‘Super Important People who needed to know about the project but might not ever read the email’ list and the ‘Important People who really need to know about the project’ list.*

*One of the things that we could have built into Roles and Responsibilities of the Advisory Team was the **role to formally communicate out**.*

# The Comox Story – Phase 2



## PHASE 2 – ACTION, IMPACT, AND EVALUATION

### What initiatives did the working groups come up with?

- › After the World Café event, the three working groups went away and created several initiatives that were implemented in the Comox Valley throughout the year:

#### CARE PROVIDER COLLABORATION AND STANDARDIZATION

- ▶ Physician and Midwife Wine & Cheese Social
- ▶ Maternity Care Provider Workshop on the PSBC Framework for Antenatal Care
- ▶ Pregnancy Journal
- ▶ Group Care Model

#### EQUAL ACCESS TO CARE

- ▶ Comox Valley Pregnancy Care Pathway
- ▶ Enhancing the Community Navigator Role
- ▶ Right from the Start Campaign

#### PATIENT AND PROVIDER INFORMATION AND KNOWLEDGE

- ▶ Perinatal Perspective learning event
- ▶ “But I don't do maternity care!”
- ▶ Collaboration with Valley Child

- The initiatives helped providers enhance existing relationships and develop new ones
- We had strong project management, not only from our own leads, but also shared in relationships with community partners and stakeholders, to ensure effective implementation of the initiatives from each working group. It really was a team effort from the whole community. Each initiative also has a plan for ‘next steps’ or ‘sustainability.’
- The pregnancy journal was piloted by 40 patients and feedback will be incorporated into a revised 2nd edition



*How will you implement and sustain your initiatives?*





# The Comox Story – Phase 2

## The role of evaluation:

- › We began with evaluation **at the start of the project**, like any good project should. You decide what and how you are going to evaluate upfront and then design your project around that evaluation.
- › We had smaller evaluations that came out of each working group and we assessed the Advisory Team's impact through regular meeting evaluations using the collective impact framework.
- › A short survey was developed, based on the 5 conditions of success for collective impact, that we administered at the end of meetings. It was a relatively small part of the work that was always going on in the background.

## Ongoing communication and engagement:

- › So, **every time we did a newsletter we did a mass communication out** to the world: medical directors, department heads, leaders across the island, specific committees, shared care people, people who we came into contact with who wanted to know what we were up to, all the working group participants, community people.
- › We completed the project with a [final evaluation summary](#) that we also circulated to all of our stakeholders. Our project manager also did a presentation that was based on the final report and showcased our project and the process.

## In summary, what would you offer as advice of where others should put their time, effort and money?

- › **Make the best use of your time together.** Ensure you have really good structure for getting people together for meetings and meaningful agendas.
- › Identify the right people to participate and make sure they are at the table. Facilitate them getting there and participating. Do this at the front end – **reach out and get inclusive.**
- › Hand-pick your team to ensure that they are in alignment with the project values. Do this by asking around as you are starting the project and see who gets put forward by their colleagues.
- › Find out what patients want and then focus on that.
- › Be flexible in how you work with people.
- › Meet participants “where they are at”.



*What steps can you take to integrate an iterative and reflective evaluation and learning process?*

*While the project took a very “developmental” route it was guided throughout by the evaluative framework.*



*Continue engagement and conduct advocacy*

*Another milestone was the wine & cheese for midwives and GPs, hosted at a GP's house. It was an opportunity for *informal dialogue*, like a meet and greet.*

*If you don't have the *right people at your table*, work with them to identify the barriers preventing them from getting on board.*

# The Comox Story – Phase 2

## KEY LEARNINGS:

### We needed to do **patient involvement** differently

- › We didn't have a patient voice on the Advisory Team. We only had one patient on the equal access working group. Other than this, patients were not involved in the project, other than through surveying.
- › I distinctly remember looking at that person's evaluations ... and comments like "I'm happy to be here, but I'm not sure what I can contribute, or what's being talked about. Or what I can add." I so admire that woman for coming to so many meetings. Even though she wasn't sure what her role was, she would continue to come.
- › In the future, we need to be really mindful about having the patient being involved more directly - and they need support to fully participate; we can't expect them to show up and keep up with the conversation.

### Learn from others and let others learn from us

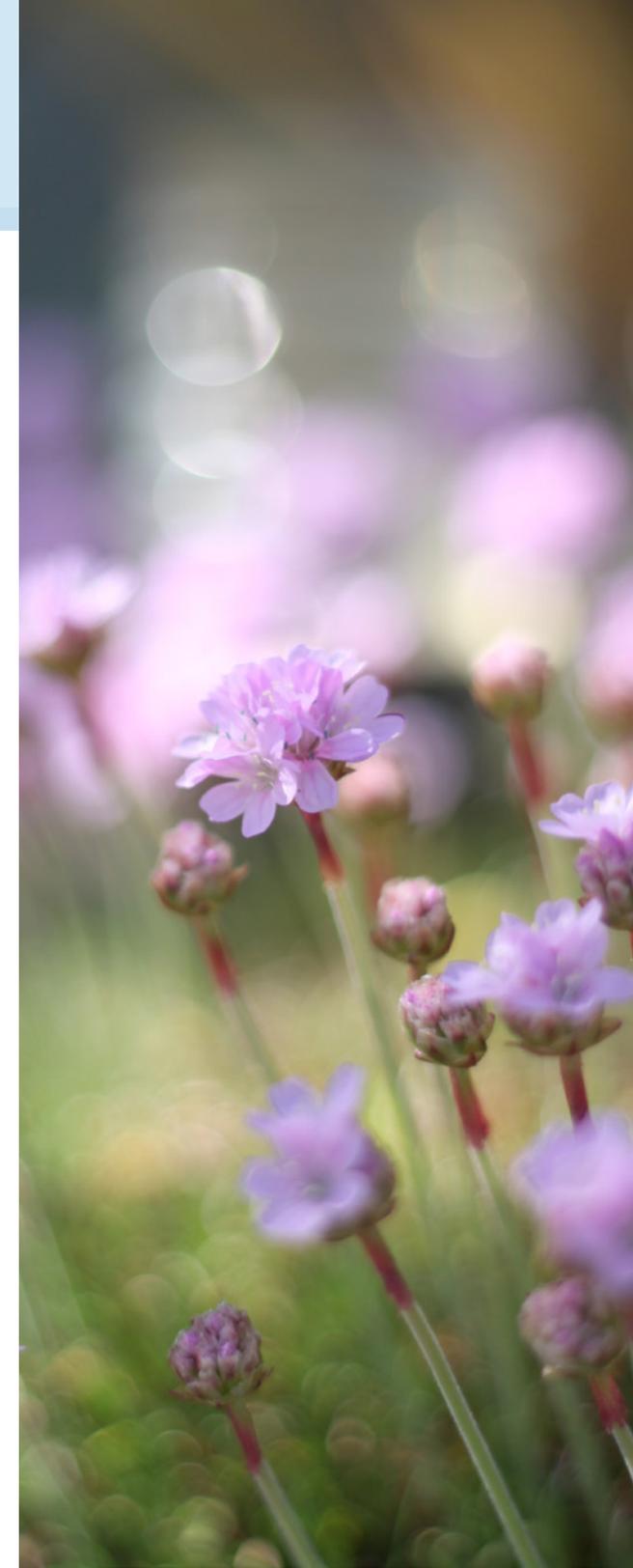
- › Consider site visits and face to face meetings with other communities that are doing innovative work, such as Apple Tree Clinic in Nelson, and the South Community Birth Program in Vancouver, as well as other communities and providers, so we can keep growing.

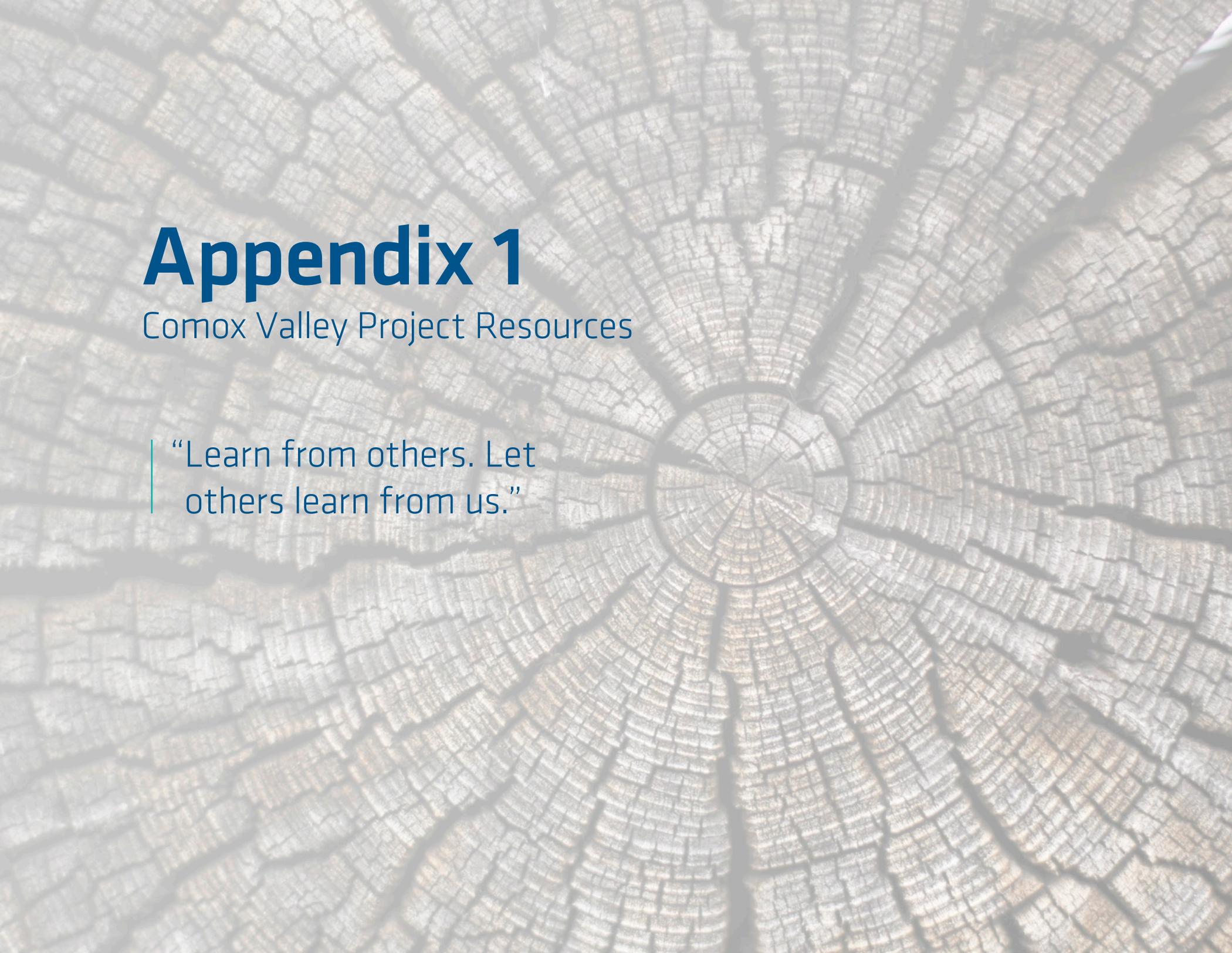
### Sustainability and continuity

- › Ensure discussion and planning for the sustainability of the project's initiatives occurs right from the beginning. It needs to be part of the project, not an afterthought.



*How will you meaningfully involve patients in your project?*



The background of the entire page is a close-up, top-down view of a tree trunk's cross-section. The wood grain is highly detailed, showing concentric growth rings and radial lines. The colors range from light tan to dark brown, with a central pith area visible. The texture is rough and natural.

# Appendix 1

## Comox Valley Project Resources

“Learn from others. Let  
others learn from us.”

## ENHANCING PERINATAL CARE IN THE COMOX VALLEY – SHARED RESOURCES

This 2016 presentation, *Enhancing Perinatal Care in the Comox Valley*, outlines key milestones of the Comox Maternity Project and provides a brief overview of the initiatives completed by the Project's working groups. In it you will learn more about the Family Practice and Midwifery Wine & Cheese engagement event, the [Pregnancy Journal](#) pilot project, the Comox Valley [Maternity Care Pathway and Poster](#), local frameworks for antenatal care, the enhanced role of the Community Navigator, and see below for videos from the engagement event *Perinatal Perspectives – Maternity Care Through the Lens of the Social Determinants of Health*.

The Comox Maternity Project Team has shared detailed information on the project's goals, participation, results, and next steps in these documents:

- [Phase I Evaluation Summary](#)
- [Accomplishments & Key Findings](#)
- [Care Provider Collaboration & Standardization](#)
- [Equal Access to Care](#)
- [Patient and Provider Information & Knowledge](#)
- [Collective Impact](#)

To enhance ongoing communication, regular newsletters provided project updates:

- [Shared Care Update – April 2017](#)
- [Shared Care Update – October 2016](#)
- [Shared Care Update – January 2016](#)
- [Shared Care Update – August 2015](#)
- [Shared Care Update – March 2015](#)

Watch the highlight video or any of the full sessions from the event, *Perinatal Perspectives – Maternity Care Through the Lens of the Social Determinants of Health*, that was held April 16, 2016. This event engaged over 100 maternity care providers and community partners from the Comox Valley, Campbell River, and North Island. After the presentations, interdisciplinary table conversations were arranged around themes of story-telling, social determinants of health, community and collaboration, vulnerability and resilience, relationships, and reconciliation.

- [Highlight Video](#)
- [Session 1 – Chief Dr. Robert Joseph and Shelley Joseph – Reconciliation in Canada and Relationship Building in Health Care](#)
- [Session 2 – Liz McKay and Jenny Nijhoff – Mother's Story: a nurse's approach to care for women at risk of vulnerability](#)
- [Session 3 – Dr. Don Wilson – Social determinants of health through the lens of maternity care](#)

***Stay tuned for updates on the next steps in Comox's collaborative initiative.***

## WORLD CAFÉ FLORENCE FILBERG CENTRE MAY 14TH 2015

### THE WORLD CAFÉ IS...

ACCORDING TO BROWN AND ISAACS

“The World Cafe is an innovative yet simple methodology for hosting conversations about questions that matter. These conversations link and build on each other as people move between groups, cross-pollinate ideas, and discover new insights into the questions or issues that are the most important in their life, work or community. As a process, the World Cafe can evoke and make visible the collective intelligence of any group, thus increasing people’s capacity for effective action in pursuit of common aims.”

“My family doctor and her physician colleagues were very knowledgeable and compassionate every step of the way. Asking my desire and plan for birth was very reassuring and I felt they always had my best interests at heart.”

“My Doula has been amazing and has answered questions up until now and our baby is 9 months old.”



### Maternity Care in the Comox Valley

- ▶ Enhancing perinatal care
- ▶ Collaborative practice

## WELCOME TO THE WORLD CAFÉ FLORENCE FILBERG CENTRE MAY 14TH 2015

### CAFÉ ETIQUETTE

- Focus on what matters
  - Contribute your thinking
  - Speak your mind and heart
  - Listen to understand
  - Link and connect ideas
  - Listen together for deeper insights and questions
  - Play, doodle, draw and record your ideas
- Have fun!**

### MENU

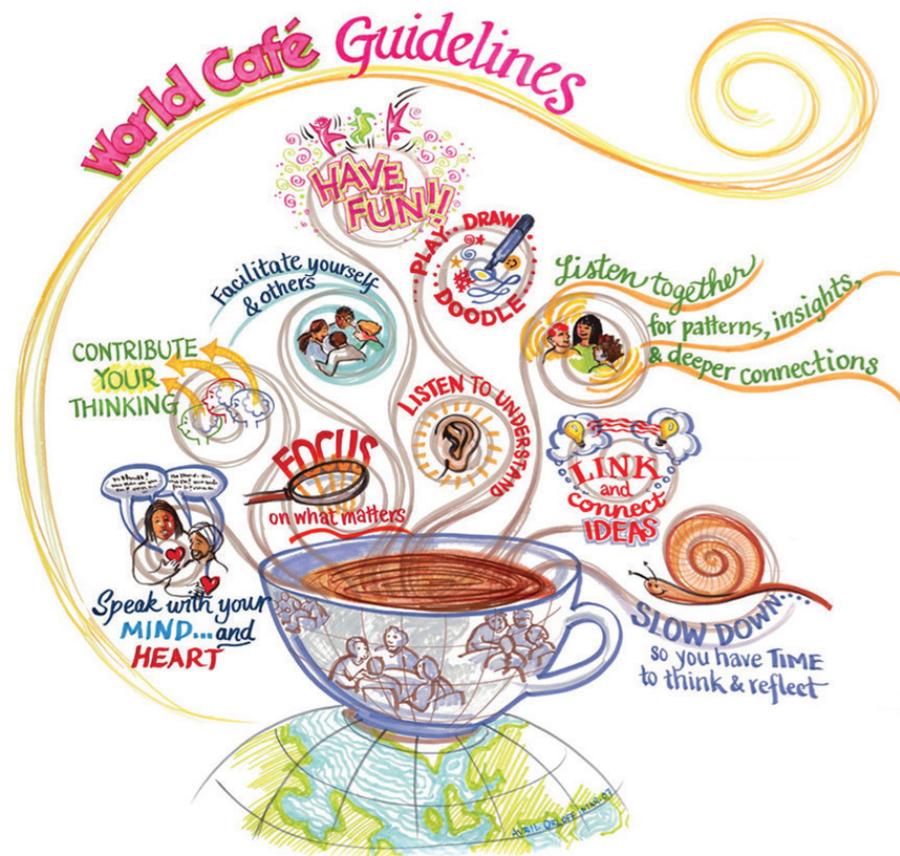
Dinner and Connections	5:00 to 5:30
Welcome and Overview	5:30 to 5:45
Round 1 Dialogue	5:45 to 6:15

### WALK AROUND

Round 2 Dialogue	6:20 to 6:50
Break	6:50 to 7:00
Round 3 Dialogue	7:00 to 7:30

### WALK AROUND

Dessert	7:35 to 8:15
Report Out	8:15 to 8:45
Closing Comments	8:45 to 9:00



# Appendix 1 – Sample Engagement Agenda: Comox World Café Event

## CAFÉ 1

CAFÉ COLLABORATIVE PRACTICE (INTER PROFESSIONAL RELATIONSHIPS)

Patients said:  
*"I find there is a general disconnect and lack of professionalism between the midwives and obstetricians. It is obvious that they differ in opinions, methods, and calls in situations. This should be understood... but professionally, they must work together to support the patient."*

Care Providers said:  
*"It would also be nice to know what your doctor knows about your pregnancy and birth etc. It would be nice to see your chart that is transferred when you leave midwives care, so you know what gaps to fill in for the doctor"*

Over 60% of Care Provider respondents suggested that inter professional collaboration was one of the challenges in the provision of adequate care to maternity patients in the Comox valley.

When patients were asked about what they would like to see changed if they were to have another baby, 11% stated that there needed to be better communication between care providers.

## CAFÉ 1

CAFÉ COLLABORATIVE PRACTICE (INTER PROFESSIONAL RELATIONSHIPS)

Inter professional collaboration is seen as a priority by care providers and patients/clients. Please engage in a dialogue with the following questions as your guide:

### APPETIZER

The intent is to create a perinatal care environment where all care providers can collaborate.  
What does collaboration mean to you?  
What is working well in your current collaborative relationships?

### SOUP

If working collaboratively is the goal –what new and unusual partnerships could you create, that will enhance the health outcomes of your patients/clients?

*Be innovative, think outside the box here.....*

### MAIN COURSE

What steps can you take, that will directly address enhance collaboration between you and/or your practice partners and other care providers?  
Be specific, what are your big ideas?  
What do you need to leave behind in order for this to take place?

*"It would also be nice to know what your doctor knows about your pregnancy and birth etc. It would be nice to see your chart that is transferred when you leave midwives care, so you know what gaps to fill in for the doctor"*

# Appendix 1 – Sample Engagement Agenda: Comox World Café Event

## CAFÉ 2

### KNOWLEDGE NOSH CAFÉ

Patients said:  
*"Being a first time parent is overwhelming and you have lots of questions regardless of the amount of preparing and reading one does."*

Care Providers said:  
*"Challenges with transportation, housing, relationships, learning, finances, ... all can challenge accessing, utilizing, understanding, and retaining perinatal services, knowledge, and behaviours."*

*"More CME on current standard of practice as it seems to evolve quickly; clear information about what tests are required and when, this seems to change frequently"*

Patients said that it was important to have information and support on:

- ▶ how to care for a newborn (72.6%),
- ▶ depression during pregnancy and post partum depression (77.5%)
- ▶ how to feed and care for a baby (67.5%).

Of Family Physicians providing standard care, 32% feel that a standardized process and tools for perinatal care would improve their comfort level. 32% of Family Physicians providing standard care felt that ongoing updates for clinical practice guidelines would help improve comfort level.

## CAFÉ 2

### KNOWLEDGE NOSH CAFÉ

#### APPETIZER

The survey data suggests that more patient and care provider knowledge and information is needed to have a positive impact on health outcomes of maternity patients/clients.

What is working well in our community in how we provide perinatal knowledge and information to Patients/Clients?  
How do you know this is working well?  
What evidence do you have?  
What actions can we take specifically to improve this?

#### SOUP

What is working well in our community in how we provide perinatal knowledge and information to Care Providers?  
How do you know this is working well?  
What evidence do you have that supports your position?

#### MAIN COURSE

Family Physicians that provide standard care were moderately comfortable or moderately uncomfortable in providing care to maternity patients in the first trimester. It was suggested that a standardized process and tools for perinatal care in the Comox valley would improve comfort levels in providing care enhancing continuity of care for patients/clients.

Describe how you see this being created?  
Describe who might be involved in creating this standardized process?  
What would be included?  
What core elements of this process should we pay attention to?

# Appendix 1 – Sample Engagement Agenda: Comox World Café Event

## CAFÉ 3

### THE ACCESSIBILITY BANQUET

Work schedules (21%) and transportation (or money for) (12%) are barriers for patient in attending their maternity appointments. Patients identified timing of appointments (11%) the location of the clinics (8%) and child care availability (10%) as barriers to care.

27% of patients stated they wanted access to resources on perinatal care during pregnancy and 18% suggested access to breastfeeding and lactation support. When asked what would make it easier to get help, 22% stated easily accessible and endorsed resources. Home visits were also important to patients that responded to the survey (15%).

Care providers suggested that the best approach to address the needs of patients is communication and collaboration between care providers (14%) and to provide awareness of and access to resources and support (12%) 20 % of care providers suggested that a centralized low risk multidisciplinary clinic would address the barriers women face. Care providers felt that a centralized space for accessing maternity resources, care and education (60%) could enhance care for women and families in our community.

Patients said:  
*"Trying to get immediate help for breast feeding difficulties was hard.... Having to leave my house to go to public health was very difficult because of my emotional state and having a new baby"*

*"Having more in-home visits would be helpful, especially with specific agendas (ie: breastfeeding help, checking the baby's sleeping arrangements etc.)."*

## CAFÉ 3

### THE ACCESSIBILITY BANQUET

#### APPETIZER

Care providers and patients/clients acknowledge that accessibility is a barrier to care. Brainstorm the opportunities here to improve access for patients to maternity care services and resources...there are no limits – think in terms of possibilities.

#### SOUP

What is working well currently with regards to access to maternity care services and resources for patients/clients in our community?  
What can we build upon?

#### MAIN COURSE

Are there other ways to promote access to maternity care services for patients/clients that we have not thought about?

Please think of some short term wins that would support patients/clients in the short term, things we could implement quickly.

Please think of some long term wins that would support patients/clients, things that may require a long term plan.

Care Providers said:  
*"In general, all women should be offered the same level of perinatal care... but some will require more understanding and more knowledge on the caregiver's part ...to help them deal with issues that may not be directly related to their pregnancy"*

# Appendix 1 – Sample Engagement Agenda: Comox World Café Event

## CAFÉ 4

### RELATIONSHIP RECIPES CAFÉ

90% of patients feel it is important or very important that they know the care provider who attends their labour and birth. When patients were asked what made their experience positive, a caring and supportive relationship with their care provider (59%) along with good communication with care providers (14%) was reported. When asked why they may not have felt consulted by their care provider, of those that responded 37% stated there was a lack of support and 29% stated a lack of effective communication.

The provision of non-judgemental care is important to patients and very important to care providers (14%) who felt that the provision of non-judgemental needs based care was a way to address barriers to care.

Patients said:  
*"I loved seeing the same person (or few people). I am very happy and content with the care how it is"*

Care Providers said:  
*"Women will not have a positive perinatal experience if they do not feel accepted and listened to, this in turn will affect the children they will be raising"*

## CAFÉ 4

### RELATIONSHIP RECIPES CAFÉ

#### APPETIZER

What are the core elements of non judgemental care?  
How do they make their way into your practice?  
What practices do you use to build relationships with your patients/clients?

#### SOUP

Describe how you have seen this improve your relationships with patients/clients?  
What positive outcomes have you seen as a result of your efforts to provide non-judgemental care?

#### MAIN COURSE

What strategies do we need to develop to create opportunities for patients/clients to have access to group care?  
What would it look like in action?

*"I thought the pregnancy care was very good. The nurses in hospital were organized with regards to paperwork, discharge planning etc. The public health nurse in the community gave me a nice phone call, very supportive, not rushed."*

*"I don't think anything could have made my experience better. I had a wonderful team."*

## Comox Valley Pregnancy Care Pathway

**Do you think you  
might be pregnant?**

### DO A PREGNANCY TEST

- at your family doctor's office
- at a Midwifery Clinic
- OPTIONS for Sexual Health Clinic
- at a walk-in clinic
- at home

### I'm pregnant and need a Maternity Care Provider?

In British Columbia, women have options available for who cares for them during their pregnancy. The BC Medical Service Plan (BC MSP) will cover the cost of your maternity care. In the Comox Valley, you can choose a family physician or a registered midwife as your maternity care provider. In some circumstances you may be referred to an obstetrician for your primary care.

FAMILY DOCTOR  
(MATERNITY)

OR

MIDWIFE

### Find a Maternity Care Provider at

[www.divisionsbc.ca/  
comox/matcarepathway](http://www.divisionsbc.ca/comox/matcarepathway)

or scan the QR



### This is what your pregnancy care might look like in the Comox Valley



Visit Valley Child for resources in the Comox Valley  
for pregnancy, children and families

[valleychild.ca](http://valleychild.ca)

# Appendix 2

## Tools and Resources

The courageous conversation is the one you don't want to have.

—David Whyte



### GUIDING PRINCIPLES AND GROUP AGREEMENTS

- Web:** [\*Group Agreements for Workshops and Meetings: A Short Guide\*. Seeds for Change, UK.](#)
- Web:** [\*For Great Teamwork, Start with a Social Contract\*. Harvard Business Review. \(2012\)](#)
- Web:** [\*Standing in Inquiry – Why it serves us well in our work and in our life\*. Human Systems Dynamics Institute. 2018](#)
- Web:** [\*Creating and Maintaining Partnerships. A Toolkit\*. Community Tool Box. Centre for Community Health and Development. University of Kansas. 2018](#)
- Video:** [\*Bob Keiller: Doing Core Values and Understanding Your ‘Why.’\* TEDxGlasgow 2017](#)

### COLLABORATIVE CO-LEADERSHIP

- PDF:** [\*West, M., Ekert, R., Steward, K., Pasmore, B. \(2014\). Developing Collective Leadership for Health Care\*. The King’s Fund.](#)
- PDF:** [\*Open Mindsets: Participatory Leadership for Health\*. World Health Organization and the Alliance for Health Policy and Systems Research. 2016](#)
- Web:** [\*Building Leadership. A Toolkit\*. Community Tool Box. Centre for Community Health and Development. University of Kansas. 2018](#)
- Video:** [\*Michael West: Collaborative and Compassionate Leadership\*](#)
- Video:** [\*The Story of Turtle and Rabbit \(The New Version\)\*](#)
- Video:** [\*Leadership from a Dancing Guy\*](#)
- Video:** [\*Margaret Heffernan: Super Chicken \(aka: Forget the Pecking Order at Work\)\*. TEDWomen 2015](#)
- Video:** [\*Simon Sinek: How Great Leaders Inspire Action\*. TEDxPuget Sound 2009](#)
- Article:** [\*How to Co-Lead a Team\*. Harvard Business Review. 2015](#)
- Article:** [\*Are You a Collaborative Leader?\* Harvard Business Review. 2011](#)
- Article:** [\*Leadership Styles for Success in Collaborative Work\*. W. Roger Miller and Jeffrey P. Miller. The Tamarack Institute.](#)

### COMMUNITY ENGAGEMENT

- PDF:** [\*Culture Change Toolbox\*. BC Patient Safety & Quality Council. 2018](#)
- PDF:** [\*Creating Containers and Co-Design: Transforming Collaboration\*. Liz Weaver, Tamarack Learning Centre. 2018](#)
- PDF:** [\*Leadership and Engagement for Improvement in the NHS\*. The King’s Fund Leadership Review. 2012](#)
- PDF:** [\*Lessons from Changing CARE – The Discovery Phase of Experience-Based Co-Design\*. The Change Foundation. 2018](#)  
\*the section of this document on Engagement Planning is particularly useful



- PDF:** [A Checklist for Encouraging People \(to Be \(and Stay\) Involved in your Group\)](#), Seeds for Change, UK.
- PDF:** [A Framework for Community Engagement in Primary Health](#). Primary Health and Chronic Disease Management, Saskatoon Health Region. 2012
- PDF:** [Principles of Community Engagement. 2nd Edition](#). US Department of Health and Human Services. 2011
- PDF:** [Community Engagement Framework](#). Vancouver Coastal Health. 2009
- PDF:** [Patient Engagement: Heard and Valued. A Handbook for Meaningful Engagement of Patients that Have Not Traditionally Been Heard in Healthcare Planning](#). Fraser Health. 2013
- Web:** [Community Engagement. Resources from the Tamarack Institute](#).
- Web:** [Managing Participation – Including More Marginalized Voices](#). Learning for Sustainability: Supporting Collaboration and Adaptation. 2018
- Video:** [Gretchen Krampf: Bringing it Home – Lessons on Community Engagement](#). TEDxSanJuanIsland

### APPRECIATIVE INQUIRY

- Web:** [The Centre for Appreciative Inquiry – Resources](#)
- Web:** [The Appreciative Inquiry Commons](#)
- Video:** [Appreciative Inquiry: A Conversation with David Cooperrider](#)
- Article:** [Bushe, G. \(2007\). Appreciative inquiry is not \(just\) about the positive. \*OD Practitioner\*, 39\(4\), 30-35.](#)
- Article:** [Trajkovski, S., Schmied, V., Vickers, M. & Jackson, D. \(2012\). Using appreciative inquiry to transform health care. \*Contemporary Nurse\*, 45\(1\), 95-100.](#)
- Article:** [Moorer, K., Kunupakaphun, S., Delgado, E., Moody, M., Wolf, C., Moore, K. & Eamranond, P. \(2017\). Using appreciative inquiry as a framework to enhance the patient experience. \*Patient Experience Journal\*, 4\(3\), 128-135.](#)

### NEEDS-BASED ASSESSMENT AND PLANNING

- PDF:** [Needs-Based Planning Framework](#). Perinatal Services BC. 2015
- PDF:** [Needs-Based Health Human Resources Planning: The Challenge of Linking Needs to Provider Requirements](#). The Canadian Nurses Association and the Canadian Medical Association. 2007
- PDF:** [Assessing Community Needs and Resources](#). Canadian Mental Health Association. 2017
- PDF:** [Community Health Needs Assessment Guidelines for New Brunswick](#). New Brunswick Department of Health. 2013
- Web:** [Assessing Community Needs and Resources \(Chapter 3\)](#). Community Tool Box. Centre for Community Health and Development. University of Kansas. 2018
- Web:** [Conducting Needs Assessment Surveys \(Section 7\)](#). Community Tool Box. Centre for Community Health and Development. University of Kansas. 2018
- Article:** [Yeboah, D. \(2005\). A framework for place-based health planning. \*Australian Health Review\*, 29\(1\), 30-36.](#)



### EVALUATION

- PDF:** [\*Developing Evaluations that are Used\*](#). Tamarack Institute. 2017
- Web:** [\*Evaluating the Initiative. A Toolkit\*](#). Community Tool Box. Centre for Community Health and Development. University of Kansas. 2018
- Web:** [\*Using Evaluation to Understand and Improve the Initiative \(Chapter 39\)\*](#). Community Tool Box. Centre for Community Health and Development. University of Kansas. 2018
- Web:** [\*Evaluating Impact: Resources\*](#). Tamarack Institute. 2018
- Web:** [\*Shared Care Learning Centre – A Guide to Enabling Spread and Sustainability of Successful Shared Care Projects\*](#). Shared Care Committee. 2018
- Video:** [\*Developing an Evaluation Plan\*](#). The Tamarack Institute. 2018
- Article:** [\*Eoyang, G., Oakden, J. \(2016\). Adaptive evaluation: A synergy between complexity theory and evaluation practice. Emergence: Complexity and Organization. doi: 10.emerg/10.17357.e5389f5715a734817dfbeaf25ab335e5.\*](#)

### INTERPROFESSIONAL COLLABORATION

- PDF:** [\*A Collaborative Maternity Care Clinic in Nelson, BC – Apple Tree Maternity\*](#). PowerPoint presentation. 2016
- PDF:** [\*Starting a Community Birth Program – Program Manual\*](#). Perinatal Services BC. 2013
- PDF:** [\*A National Interprofessional Competency Framework\*](#). Canadian Interprofessional Health Collaborative. 2010
- PDF:** [\*National Interprofessional Competency Framework – Quick Reference Guide\*](#). Canadian Interprofessional Health Collaborative. 2010
- PDF:** [\*Core Competencies for Interprofessional Collaborative Practice. 2016 Update\*](#). Interprofessional Education Collaborative. Washington, DC.
- Web:** [\*IPC on the Run\*](#). University of British Columbia. 2014
- Web:** [\*Collaborative Toolbox\*](#). Child and Youth Mental Health and Substance Use Collaborative, a partnership of Doctors of BC and the BC government
- Web:** [\*Collaborative Toolbox – Collaborative Practice and Pathways to Care\*](#). Child and Youth Mental Health and Substance Use Collaborative, a partnership of Doctors of BC and the BC government
- Web:** [\*Teamwork and Communication Action Series\*](#). BC Patient Safety & Quality Council. 2018
- Web:** [\*Interprofessional and Team Based Care: Resources\*](#). Canadian Foundation for Healthcare Improvement (CFHI). 2018
- Web:** [\*Recommendations for Action: Getting the Most out of Interprofessional Primary Health Care Team\*](#). The Conference Board of Canada. 2014
- Web:** [\*National Centre for Interprofessional Practice and Education: Resource Centre\*](#). University of Minnesota. 2018
- Article:** [\*Harris, S., Janssen, P., Saxell, L., Carty, E., MacRae, G., & Petersen, K. \(2012\). Effect of a collaborative interdisciplinary maternity care program on perinatal outcomes. CMAJ, 184\(17\), 1885-1892.\*](#)



### CONNECTING PREGNANCY AND GROUP CARE MODELS

- Web:** [Connecting Pregnancy. Resources from Perinatal Services BC](#)
- Web:** [Resources from Connecting Pregnancy Group Sessions. South Community Birth Program, Vancouver](#)
- Web:** [Connecting Pregnancy information from Birth Docs, the Family Practice Maternity Service at BC Women's Hospital](#)
- Web:** [Connecting Pregnancy Notebook. Birth Docs, the Family Practice Maternity Service at BC Women's Hospital](#)
- Web:** [Centering Pregnancy. Canadian Best Practices Portal, Public Health Agency of Canada. 2016](#)
- Web:** [Centering Pregnancy. Centering Healthcare Institute. Boston, MA.](#)
- Video:** [Centering: The Future of Prenatal Care. Centering Healthcare Institute. Boston, MA. 2014](#)
- Video:** [Centering Pregnancy Group Prenatal Classes. Emory Healthcare. 2009](#)
- Video:** [Centering Pregnancy – Building Community Through Prenatal Care. Nurse Midwives of San Francisco Gate Hospital. 2013](#)
- Article:** [Group Prenatal Care: ACOG Committee Opinion. American College of Obstetricians and Gynecologists. 2018](#)
- Article:** [Thielen, K. \(2012\). Exploring the group prenatal care model: a critical review of the literature. \*J Perinatal Educ.\*, 21\(4\), 209-218.](#)
- Article:** [Tilden, E., Hersh, S., Emeis, C., Weinstein, S., & Caughey, A. \(2014\). Group prenatal care: review of outcomes and recommendations for model implementation. \*Obstet Gynecol Surv.\*, 69\(1\), 46-55.](#)

### TELE-MEDICINE AND TELE-MATERNITY

- PDF:** [Telehealth/Telemedicine: e-enabling our health system. Dr. Halpenny, Interior Health. 2014](#)
- Web:** [MOBILE Maternity \(MOM\) Project: using telehealth to integrate care. Specialist Services Committee and Interior Health Authority](#)
- Web:** [MOBILE Maternity \(MOM\) Project information from UBC's Centre for Rural Health Research](#)
- Web:** [Telehealth. Rural Coordination Centre of BC.](#)
- Video:** [Telehealth to bridge the healthcare gap: Dr. Pawlovich. 2013](#)
- Video:** [First Nations Interactive Telehealth. Presentation by Dr. John Pawlovich. 2011](#)
- Video:** [Why Tele-maternity in the Kootenay Boundary? A short video from the Kootenay Boundary Division of Family Practice and Shared Care. 2017](#)
- Article:** [Going "virtual" for the health of mom and baby. Doctors of BC. 2015](#)
- Article:** [Telehealth in Rural BC by RHSRNbc. 2015](#)
- Article:** [Toh, N., Pawlovich, J., & Grzybowski, S. \(2016\). Telehealth and patient-doctor relationships in rural and remote communities. \*Canadian Family Physician\*, 62\(12\), 961-963.](#)
- Article:** [Holyk, T., Pawlovich, J., Ross, C., & Hooper, A. \(2017\). The role of telehealth in improving continuity of care: The Carrier Sekani Family Services primary care model. \*BCMJ\*, 59\(9\), 459-464.](#)



### RURAL MATERNITY CARE

**PDF:** [Community Toolkit for Sustainable Rural Maternity Care](#). UBC Centre for Rural Health Research. 2016

**PDF:** [1A Community Symposium Proceedings](#). UBC Centre for Rural Health Research. 2018

**Web:** [Applied Policy Research Unit. Reports on Rural Maternity and Rural Transport Services](#). UBC Centre for Rural Health Research.

**Web:** [Building Blocks for Sustainable Maternity Care: The North Island Project](#). UBC Centre for Rural Health Research. 2018

**Web:** [Rural Obstetrics](#). Rural Coordination Centre of BC.

**Web:** [Rural Maternity and Surgical Services](#). Perinatal Services BC.

**Article:** [Graves, L. New approaches for rural maternity care. Canadian Family Physician, 58\(10\), 1067-1068.](#)



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