



geriatrics
interprofessional
interorganizational
collaboration

Geriatrics, Inter-Professional Practice, and Inter-Organizational Collaboration: The GiiC Initiative

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PROJECT BACKGROUND

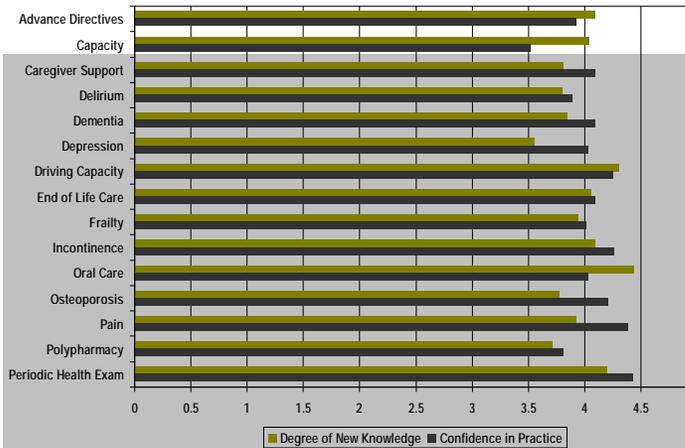
While geriatrics, inter-professional practice and inter-organizational collaboration (GiiC) are essential elements of the care of frail seniors, health professionals continue to graduate with little training in these core competencies. The GiiC initiative is a collaboration of the Regional Geriatric Programs of Ontario, the Center for Education and Research in Aging & Health at Lakehead University and the North East Ontario Specialized Geriatric Services interest group. A provincial team of GiiC consultants has invited family health teams (FHTs) and community health centers (CHCs) from across the province to nominate a member of their staff to participate in two days of orientation and training on the use of a GiiC toolkit. The toolkit is available in web and usb formats and it is hoped that with several months of coaching and support from the GiiC consultants, the participating health professionals will help their organizations in enhancing the collaborative shared care of their frail senior patients. The initiative has achieved excellent participation rates – a total of 374 participants attended GiiC workshops across the province, representing 71% of FHTs and 85% of CHCs. This poster provides an overview of the initiative and the edumetric elements of its evaluation plan along with a preliminary look at participants' perceptions of the GiiC knowledge-to-practice process.

The RGPs of Ontario, CERAH, and the North East SGS are grateful to the Health Force Ontario branch of the Ministry of Health and Long Term Care for funding this initiative under the auspices of their Interprofessional Blueprint for Care. To the project's evaluation team from the Arthritis Community Research and Education Unit, and to the Hamilton Family Health Team and the Anne Johnston Health Station, whose directors sit on the GiiC initiative steering committee.



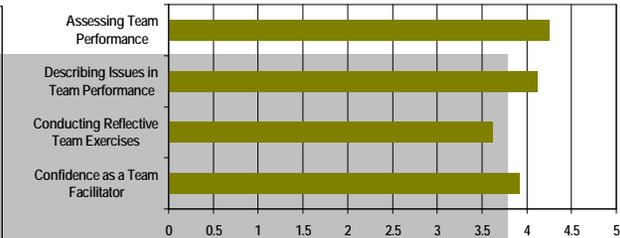
EVALUATION OF LEARNING OBJECTIVES AND TEAMWORK

Geriatrics

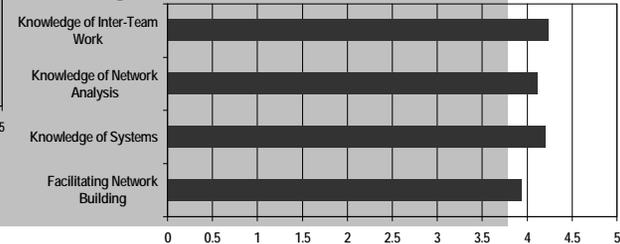


Participants were asked to rate, on a scale from 1 to 5, their knowledge uptake in the listed learning objectives.

Inter-Professional



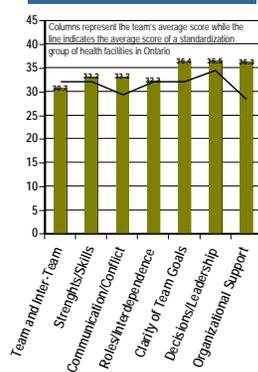
Inter-Organizational



The Edumetric Process

We coined the term "edumetrics" to refer to the process in which research data is fed back to participants in a way that helps them to learn. In GiiC we invited family health teams and community health centers to complete two edumetric surveys: 1) the Dimensions of Teamwork Survey developed for health care teams by Dr. Ryan, GiiC's lead investigator, and 2) a network analysis that provides insight into the teams of referral and information exchange networks. Forty-seven teams elected to complete the surveys. Here you can see an abbreviated edumetric report. It includes a summary of the results from each survey with independent commentaries by Dr. Ryan and Dr. Cott, the GiiC evaluation lead, and a short list of topics recommended for team reflection. From time to time, survey's find teams in difficulty and recommendations are provided for engaging external facilitators. In most instances however, teams appear sufficiently robust that they can conduct the reflective exercise themselves though each team can call upon the assistance of their GiiC consultant should they wish.

DTEAM SURVEY RESULTS EXAMPLE



Team members' responses suggest that this is a team with many strengths and is well on the way to achieving high levels of performance.

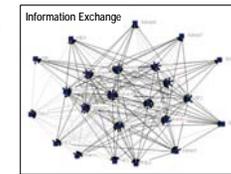
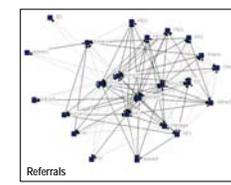
The strengths that team members identify are in the domains of decision-making, leadership, accountability, organizational support, clarity of team goals and the team's capacity to convene effective meetings. Team performance is substantially above average in these areas.

Responses also indicate above average performance in the domain of communication and conflict management but subgroups may have formed within the team

Similarly the team appears above average with regard to the skills and knowledge of its staff, though it might benefit from reflection on opportunities role sharing; important steps in the transition to a more inter-professional style of practice and on whether it is appropriate for team members to "develop their care-plans independently of other team members".

Finally, the team's patient focus is strong but its relationships with other care providers in the community might provide an opportunity for improvement.

SOCIAL NETWORK ANALYSIS EXAMPLE



Network Density: how many connections there are between network members compared to the maximum possible number of connections that could exist.

Network Density is high for exchange of information (74.1%) and low for referral patterns (36.8%).

Centralization of a Network: extent to which the network is centralized around one or a few actors.

Team does not seem to be centralized around a particular actor for exchange of information, as there are frequent interactions amongst most team members. There are frequent referrals made to NP2, RPN1, RPN2, Admin4 and Admin6.

Strength of Ties: ranges from weak (interactions that are infrequent, once per week or less) to strong (frequent interactions, at least several times per week).

There are frequent interactions for exchanges of information. However, for referral patterns, the strength of ties is low to moderate.

Reciprocity: refers to the extent to which relationships are two-way.

The majority of ties are reciprocal for exchange of information but only half are reciprocal for referral patterns.

TEAM REFLECTION QUESTIONS

Reflection on the following questions in a team meeting might prove helpful to team development:

How well do the Dimensions of Teamwork and Network Analysis summaries capture the quality of engagement on your team? In what ways do you disagree with the summaries?

Does it make sense that while information exchange is strong and reciprocal amongst team member's referral exchange appears less so?

Is it okay that team members report developing "their care-plans independently of other team members"? Are there instances in which this style of practice has been a challenge? Is there anything that the team can do or wants to do about this practice element?

Is there anything that the team can do to develop its collaborations with other health service providers in the community?