PHASE 1 CHAMPIONS' FINDINGS

February 2007

Barriers, Facilitators & Recommendations about Implementing Planned Evidence-Based Action on Client-Driven Care (CDC)

1. KNOWLEDGE TRANSLATION ON *CLIENT –DRIVEN CARE* IS NOT A MAJOR PRIORITY:

BARRIERS:

- Staff turnover and inconsistent participation disrupts the KTA (knowledge to action) strategy implementation;
- "too much to do" / time limitations;
- Other organizational agenda items and priorities undermine focus on KTA on CDC;
- Reorganization of CCAC is a pre-occupation;
- The much larger SW-CCAC organizational structure will create road blocks to aligning KTA on CDC across all components of this organization;
- If this research does not lead to more money for the community, what's the point?
- KTA consumes time away from clients;

FACILITATORS:

- Create the perception that senior management are open to value and appreciate grass roots efforts;

RECOMMENDATIONS:

- Provide time and staffing for team meetings and case conferencing;

2. COMMUNICATION & COORDINATION CHALLENGES ARE AN ISSUE:

BARRIERS:

- Difficulty in connecting with managers and other agencies; being "out of the loop",
- Driving "all over the country" means less pay and leads to recruitment and retention problems;
- Differing organizational cultures are now amalgamated but still unknown to one another, creating limitations to mutual understanding and attention to the differences that need consideration in KTA on CDC;
- Limited outreach to others;

PHASE 1 CHAMPIONS' FINDINGS

February 2007

Barriers, Facilitators & Recommendations about Implementing Planned Evidence-Based Action on Client-Driven Care (CDC)

FACILITATORS:

-direct recommendations to the right people (ie, those who could bring about the desired change);

RECOMMENDATIONS:

- Continue team meetings and opportunities for front-line providers to give input to change
- Look at…the workers and what they're doing and how they're organized to promote CDC;
- Refine a committee structure or operating practices to promote communication from grass roots to senior administration;
  - Have meetings on a quarterly basis just to enhance partnerships;
  - Continue with in-home "message centers"
  - Work out an effective team communication process for providing in-home client care;
  - Consider improved IT to enhance communication;

3. KTA ACTION GROUPS HAD IMPLEMENTATION CHALLENGES:

BARRIERS:

- Difficulties in involving both grassroots providers and managerial decision-makers to ensure well informed, optimal implementation on CDC;
- Inadequate group facilitation (e.g., no notification re KTA meetings; no one identified as responsible for communicating meeting times; poor communications amongst participants, especially with those who miss meetings; inadequate administrative planning to ensure participation & simultaneous client service delivery; KTA can not be arranged without prior managerial sanction; KTA group needed administrative direction to function fully;);
- Confusion about the task at hand;
- Providers more accustomed to working independently;
- Summer timeframe not good;
- Linking research with practice is not achieved "by commissioning another research study";
- Having to give up day off to participate in KTA action group activity;
- Limited outreach to others;

FACILITATORS:

- Good face-to-face communication;
- The opportunity to get to know one another

PHASE 1 CHAMPIONS' FINDINGS

February 2007

Barriers, Facilitators & Recommendations about Implementing Planned Evidence-Based Action on Client-Driven Care (CDC)

- Having everybody on board;
- Involve a good mix of providers and different levels of workers;
- Regularly scheduled meetings;
- An organized strategy for communication about meetings;
- Self-directedness of individuals ultimately promotes strong team effort;
- Engaging participants in critical reflection, bringing up questions without giving any answers, enabling participants to come up with the answers;
- Skilled facilitation with a synthesis, summarization and overview of the group's decisions and directions throughout the process;
- Perseverance of participants;
- Accepting human error as inevitable;
- Aligning KTA on CDC with other work efforts;

RECOMMENDATIONS:

- Continue the KTA process;
- Provide more time for KTA;
- Provide KTA print materials presenting the results of Phase 1 – "why we've done what we've done" in proceeding to Phase 2;
- Review and pre-plan for the availability of providers to participate in KTA;
- Engage system decision-makers;
- Capitalize on people's interest in learning and in doing a better job;
- Implement KTA strategies more universally, sorting out which are the best methods;
- Begin each KTA meeting with a summary of the last one;
- Provide more direction re how to get organized & how to go about the group process;
- Improve channels for input on and support for partnering decisions and directions;
- Empower KTA participants to make recommendations to "the partnership meetings"
- Have researchers present and involved at grassroots level to enhance their understanding of policy, admin, & practice issues and challenges so they will know what to study;
- Build a relationship and foster relationships between in-home providers and researchers to develop beset practices;
- Expand the KTA on CDC to include physicians, recognizing that this direction needs to occur over time in small steps;
- Create a sustained team effort

- Ensure that the participants see change resulting from the research
- Evaluate the process outcomes as well as the ultimate outcomes of KTA on CDC;

4. POLICY AND PROCEDURE ISSUES NEED TO BE ADDRESSED:

BARRIERS:

- Bureaucratic red tape impeding planned strategies for KTA on CDC;

FACILITATORS:

- Recognition of the potential of current procedures and forms (e.g., the in-home record) to be refined and/or promoted as vehicles for KTA on CDC;

RECOMMENDATIONS:

- Involve all categories of providers in evolving organizational structures, procedures and policies for promoting CDC;
- Develop indicators of client need for case conferencing and a Standard Operating Procedure that providers and case managers can use to implement appropriate CDC case conferencing;
- Sort out service providers' assignments to minimize individual provider travel distances (i.e., trade assignments of providers across agencies, not take business away from any one agency, to achieve for cost-efficient and cost-effective allocation of human resources to direct client care);
- Consider the contracts with agencies – which are serving what areas; potential for Trading clients to minimize provider travel between clients
- Develop policies and procedures for flex care areas;
- Review the issue of meeting time for teamwork: resource and money allocation?

5. THERE ARE MANY FRONT-LINE PRACTICE CHALLENGES:

BARRIERS:

- Used to own practice approach;
- Old (ie. previously established) attitudes and ways (ie., practice approaches & patterns);
- Expert stance;
- Clients' expectations of professionals as experts;
- Ageism;
- Thinking we're already doing this and are as good as we can be instead of focusing on the aim of continuously striving for excellence in CDC;
- Inadequate team communication
- Hierarchical reporting
- Simple focus on outcomes to exclusion of paying attention to service delivery & care processes;

FACILITATORS:

- Coming together as a provider team is a necessary step toward engaging client's input in care;
- Inform practitioners regarding how to use the research evidence in practice;

PHASE 1 CHAMPIONS' FINDINGS

February 2007

Barriers, Facilitators & Recommendations about Implementing Planned Evidence-Based Action on Client-Driven Care (CDC)

RECOMMENDATIONS:

- Provide education on everyday- CDC practices to front-line providers;
- Educate all involved regarding the roles of all provider categories;
- Use Interagency team meetings and educational sessions to share information about the principles of implementing empowering partnering strategies;
- Find way to educate service providers so that they can initiate case
- conferences;
- Use a train the trainer model, have videotapes and handouts available in advance for educational sessions;
- Work with the grass roots people at the front-line sites;
- Have the research evidence available so that people can come together and discuss what the care and service delivery concerns are and apply the research evidence in looking at a better practical model;
- Take team meetings into the client's home for case conferencing to achieve "truly… client driven care;"
- Continue team meetings and opportunities for front-line providers to give input to change