



Michael Smith Foundation for
Health Research

A Synthesis of the Interviews Conducted
Regarding Health Human Resources
Research Priorities

Prepared for the Health Services and
Policy Research Support Network

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Executive Summary

Introduction

The Health Services and Policy Research Support Network (HSPRSN) has \$4 million in remaining funds for allocation to support research on topics identified as priorities by the leaders of health authorities and the BC Ministry of Health. After consultation with the health authority Executive Committees and the Executive of the Ministry of Health, the HSPRSN Steering Council agreed that planning and funds should be focused on identifying and addressing priority health human resources issues as they relate to how care/services are provided (i.e. better use of existing resources, developing new care models, etc) in ways that

- More effectively address client/population needs (at point of contact across the continuum) to improve outcomes, and
- Contribute, in the process, to improved levels of staff engagement and job satisfaction, which are essential underpinnings in retaining and recruiting a high quality, high functioning workforce.

As part of a process to validate and potentially to further narrow the health human resources topic, twenty telephone interviews were conducted with twenty-three key informants and one focus group meeting was held with five key informants from the Ministry of Health. The purpose of this process was to gather additional information to inform the HSPRSN planning process, specifically to:

- Validate the health human resources sub-themes identified in the national consultation (Listening for Directions 3)
- Ask their opinion about the top two priority health human resources issues for their organization
- Determine where the HSPRSN Steering Council priority “reconfiguring how care/services are provided” fits in the ranking of priority issues identified by the key informants
- Identify specific topics within the key informant’s priority health human resources issues that could benefit from being the focus of new research programs and/or knowledge translation activities.

Part 1 of this report contains findings from the individual key informant interviews. A report of the results of the MOH focus group appears in Part 2.

Methodology

Part 1: Telephone interviews, which took 30-60 minutes each, were conducted using an interview tool to guide the conversation. Specific comments made by the respondents are contained in the report.

Part 2: A focus group was held with five staff members in the Ministry of Health using the same interview tool to guide the conversation. Detailed notes of the comments offered in the focus group are also included in this report.

Summary of Feedback on Interview Questions

1. Feedback about the health human resource sub-themes identified in the national consultation

The first question respondents were asked to consider was the following. “The workforce and work environment issues were among the top preliminary research theme areas identified nationally in the 2007 “Listening for Directions 3” consultations. Within this overall theme, several “sub-theme” areas were identified that may benefit from research and strategies. In your opinion, should these sub-theme areas be priorities for research and strategies?”

Ten sub-themes were listed and informants were asked to respond yes or no to the question “in your opinion should this sub-theme be a priority for research or strategies?” Although most responded yes, or no, some said “maybe”. Almost all offered comments to explain their responses. Their comments provide insight into the way the sub-themes were interpreted by the respondents.

Issue	Yes/No/Maybe
a. Ways to better employ existing providers	16/4
b. Development of new models of staffing (e.g. new team mixes that include non- traditional health system workers)	20
c. Development of new models of practice (e.g. collaborative models of care, self care)	19/1/0
d. Innovative education and training programs to help providers adapt to new models (as well as training staff for the future)	18/2
e. Workforce migration, particularly in regard to the impact of in and out migration and recruitment and retention	6/2/12
f. Impact of an aging population of the type of workforce required	11/1/8
g. Impact of an aging of the workforce on the workforce and on the organization and delivery of care	15/1/4
h. Succession planning	14/6
i. Strategies to create and sustain healthy workforces	11/9
j. Strategies to create and sustain healthy work environments	11/9

Overall, there is a clear consensus that the first four sub-themes listed in the summary of HHR themes from Listening for Directions 3 are the priorities for the respondents. These four are:

- a. Ways to better employ existing providers**
- b. Development of new models of staffing (e.g. new team mixes that include nontraditional health systems workers.**
- c. Development of new models of practice (e.g. collaborative models of care, self care)**
- d. Innovative education and training programs to help providers adapt to new models (as well as training staff for the future)**

There was also complete agreement that sub- themes “i” and “j” - strategies to create and sustain healthy workforces and work environments – did not need additional research. Most respondents stated that there is ample evidence about this subject and that if they required any more information it would be about implementation and about why the strategies are not being incorporated into organizations. Those respondents who indicated that this did need more research all qualified their response with a comment. Overall, most think that the failure to implement what is known is not because of a need to translate the knowledge, but because of the lack of will to make the strategies a priority and alter the work places to incorporate the strategies identified in existing research information about these topics.

Participants in the Ministry of Health focus group also said that taken together the first four subthemes listed in the summary of health human resources themes from Listening for Directions are a priority. They stressed that in exploring ways to better use existing resources and developing new models of care delivery the focus must be on the needs of the patients/clients and that the success of any strategy ought to be measured by its impact on patient outcomes.

All but one of the MOH Focus Group participants concurred with the need to create and sustain a healthy workforce and healthy workplaces, but saw this as “an offshoot” of strategies that would need to be put in place to address items “a” to “d”. All stressed the need for building in mechanisms for evaluating and monitoring initiatives to determine whether they actually achieve the intended impact.

2. Reaction to priority defined by the HSPRSN Steering Council

The second question asked the key informants for their response to the following: “After consultation with the health authorities and Ministry of Health in BC in regard to priorities for attention, the HSPRSN Steering Council agreed that planning and funds should be focused on identifying and addressing priority health human resources issues as they relate to how care/services are provided (i.e. better use of existing resources, developing new care models, etc) in ways that

- More effectively address patient/client needs (at point of care across the continuum) to improve health outcomes, and
- Contribute, in the process, to improved levels of staff engagement and job satisfaction, which are essential underpinnings in retaining and recruiting a high quality, high functioning workforce.”

The respondents were asked if this decision made sense to them. **Fifteen respondents answered “yes. Four answered a qualified “yes” and indicated that some wording changes may be helpful or cautioned that the statements needed to be action oriented.** One respondent said “no” unless there were substantive changes made to the wording of these goals.

The interviewers asked if the “and” between the two statements “more effectively address patient ...” and contribute, in the process, to improved levels of staff engagement...” was required? **All respondents in the twenty interviews, including the “no” respondent, said that linking the outcomes of both addressing patient client need more effectively and contributing to improved levels of staff engagement was essential.**

Participants in the Ministry of Health Focus group agreed with the key informants that this decision made sense, but with the caveat that the terms used need to be precisely defined so everyone will understand what is meant by terms such as “staff engagement”. They also recommended that staff productivity be considered together with staff engagement. (...” and contribute, in the process, to improved levels of staff productivity, engagement and job satisfaction....”)

3. Top Health Human Resource Issues for Organization that could benefit from research

In the third question, key informant respondents were asked to identify the top two health human resource issues for their organization that could benefit from research or knowledge translation activities. In answer to this question, respondents listed a variety of different priorities, but many can be grouped into four thematic topics. **The first, and most frequent priority theme identified was related to work redesign and about models of care (18 respondents cited some variation on this topic as a priority).** The second thematic area, identified by seven people, was related to the need to understand more thoroughly how to effectively engage staff and how to retain them. A third thematic area, identified by six people, was related to the need for leadership and succession planning. In the fourth thematic grouping, four commented on the need to more deeply understand collaboration and teamwork. A number of other priorities unique to the respondent's organization were also mentioned as areas of interest for research or knowledge translation.

The Ministry of Health Focus group participants identified productivity of the workers as the number one priority, followed by redesign of service delivery, including exploration of models of care, skill mix, and consideration of new types of workers as priority two. A third priority for the Ministry participants was the need to develop better models for predicting service demand.

4. Ranking of Priority identified through the HSPRSN Steering Council

In question four, respondents were asked if the priority identified through the HSPRSN Steering Council consultation process ranked in their list of priorities, and if so - where. **Seventeen respondents said "yes" the priority identified by the HSPRSN Steering council process ranked first, or high in their own list of priorities. Two respondents responded with a qualified yes.** One stated that his/her priorities were sub sets of the larger overarching theme, and thought that the statement was too broad. Another wanted implementation and evaluation added to the wording. One respondent would not support the HSPRSN Council priority unless it was substantively reworded.

The Ministry of Health Focus group participants agreed that their priorities were more focused sub-sets of the broader HSPRSN Steering Council priority, but also thought that with the focus on productivity they may have expanded the goals somewhat.

5. Activities underway to address these priority issues and awareness of the work of others

All respondents described some of the initiatives that were currently underway in their organizations. The list is incomplete; undoubtedly many more activities are underway than were reported in this survey. However, the responses indicate that all are engaged in a number of initiatives related to health human resources. **Although there are a number of common themes, with a few exceptions the initiatives are not coordinated across, or sometimes even within, health authorities. Most are not even defined in a similar way and respondents frequently used quite different words or terminology to describe what may be very similar projects. Although anecdotally, there is some awareness of what others are doing, there are minimal formal links between projects at any level.** As one respondent outlined:

"There is a lack of knowing what everyone else is doing in the province. There is no central repository, no coordination of what is happening across different groups, including in the government. We need some kind of an awareness center, so groups can feed off one another. Everyone seems to speak a different language. I think everyone wants the best health care for those in BC, but we need clear communication. It would really be a stretch for every one to really understand how the various activities fit together. The MOH

has many departments and (they) don't always seem to talk (to each other). The HAs don't seem to talk to each other or even within each HA (either)."

All stated that evaluation was a part of all the initiatives they were doing. There were also a few projects reported, either in planning or in progress, that are part of formal research activities. Among key respondents there was limited awareness, as mentioned, as to what other organizations were doing similar work in the province with the exception of two or three collaborative projects that are underway. Few respondents were specifically aware of initiatives similar to their own going on in other parts of Canada or elsewhere, although one mentioned that the Western Assistant Deputy Minister (ADM) group that includes the four Western provinces and Ontario is trying to stimulate more opportunities for working together.

The Ministry of Health Focus Group participants and their departments are engaged in several initiatives in partnership with the health authorities or specific professional groups on initiatives such as: productivity in rural and remote health care (awaiting funding); interprofessional practice evaluation; demonstrating physician assistant models; piloting new education models (BCIT 3-year Nursing Education pilot); and modeling and forecasting of HHR resource needs.

The participants are aware of a number of initiatives both nationally and internationally that are addressing the same issues. These include the initiatives to mount joint projects or create solutions to staffing led by the Western Forum (Western ADM) group; CIHR projects in regard to optimizing competencies; "scoping" and modeling of demand and utilization – being led by the Atlantic provinces and the Conference Board in Ontario; and work being done in the UK and Australia on productivity.

6. Is the priority research into barriers to implementation and change management?

Throughout all of the interviews all respondents were clear that if any research is needed it should be action research. There was a general sense of urgency among all respondents, with an expressed wish for evidence that could be quickly produced and readily adapted for use in a variety of work settings.

There was a mixed response to the question about whether the statement "Some informants feel that there is sufficient evidence about best practices to proceed to address the issues and that the most pressing need is for research into barriers to implementation and change management" was true. Five said yes, five said no, and ten qualified their answer with the statement that this may be true for some but not all of the issues.

A mixed response was also received to the question: Do you have sufficient evidence to support the priority activities underway in your organization? Seven indicated "yes", six indicated "no" and seven qualified their response as "partially", and "depends on which issue".

Two respondents indicated that the priority ought to be research into barriers and strategies for the implementation of change. Six indicated "no" this is not required. The remaining 12 were mixed in their responses. They did want to learn how strategies could be readily implemented but they were also anxious for information about care delivery systems, and would not make research to inform the implementation of change a priority at the expense of work on care delivery systems and service redesign.

The Ministry of Health Focus Group participants also agreed that research to inform the implementation of change should not be a priority. They did agree that the research may not have been well enough synthesized into a form that decision-makers can use. They stated that the issue may be that the leaders (change agents) may not be skilled at change management.

The Ministry is proposing that a capacity-building centre be established to assist and support health authority managers.

Conclusion

Overall there is a clear consensus that the first four sub-themes listed in the summary of HHR themes from Listening for Directions 3 are the priorities for the respondents (health authority and MOH). Further, seventeen (of 20) health authority respondents confirmed that the priority identified by the HSPRSN Steering council process ranked first, or high in their own list of priorities. The Ministry of Health Focus group participants agreed that their priorities were more focused sub-sets of the broader HSPRSN Steering Council priorities.

A number of respondents commented on the need for sharing of learning among the various organizations and for usable, reality-based strategies.

The process of validating the health human resource sub-themes described in the “Listening for Direction” process with key informants and the staff from the Ministry of Health in British Columbia did help to further clarify and narrow the focus in regard to the health human resource issues that should be considered for research with HSPRSN funds. The explanatory comments provided by the respondents about the Listening for Direction 3 health human resources subthemes - particularly those focused on the four identified as their top priorities - offer additional information to assist the HSPRSN and Michael Smith Foundation for Health Research in planning the next steps.

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Introduction

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- Validate the health human resources sub-themes identified in the national consultation (Listening for Direction 3)
- Ask their opinion about the top two priority health human resources issues for their organization
- Determine where the HSPRSN Council priority “reconfiguring how care/services are provided” fits in the ranking of priority issues identified by the key informants
- Identify specific topics within the key informant’s health human resources priority areas that could benefit from being the focus of new research programs and/or knowledge translation activities.

Part 1 of this report contains findings from the individual key informant interviews. A report of the results of the focus group appears in Part 2.

Methodology

Part 1: Telephone interviews, which took 30-60 minutes each, were conducted using an interview tool (See Appendix B) to guide the conversation. Detailed notes of the interviews were taken and are included in the report.

Part 2: A focus group was held with five staff members in the Ministry of Health using the same interview tool to guide the conversation. Detailed notes of the comments offered in the focus group are also included in this report.

Part 1: Key Informant Interviews

1. Feedback about the health human resource sub-themes identified in the “Listening for Direction 2007” consultation

The first question respondents were asked to consider was the following. “The workforce and work environment issues were among the top preliminary research theme areas identified nationally in the 2007 “Listening for Directions 3” consultations. Within this overall theme, several “sub-theme” areas were identified that may benefit from research and strategies. In your opinion, should these sub-theme areas be priorities for research and strategies?”

Ten sub-themes were listed and informants were asked to respond yes or no to the question “in your opinion should this sub-theme be a priority for research or strategies?” Although most responded yes, or no, some said “maybe”. Almost all offered comments to explain their responses. Their comments provide insight into the way the sub–themes were interpreted by the respondents.

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- d. Innovative education and training programs to help providers adapt to new models (as well as training staff for the future)

There was also complete agreement that sub- themes “i” and “j” - strategies to create and sustain healthy workforces and work environments – did not need additional research. Respondents stated that there is ample evidence about this subject and that if they required any more information it would be about implementation and about why the strategies are not being incorporated into organizations. Those respondents who indicated that this did need more research all qualified their response with a comment. Overall, most think that the failure to implement what is known is not because of a need to translate the knowledge, but because of the lack of will to make the strategies a priority and to alter the work places to incorporate the strategies identified in existing research information about these topics.

COMMENTS:

Priority Sub-Themes:

- a) Ways to better employ existing providers
 - b) Development of new models of staffing (e.g. new team mixes that include nontraditional health system workers)
 - c) Development of new models of practice (e.g. collaborative models of care, self care)
 - d) Innovative education and training programs to help providers adapt to new models (as well as training staff for the future)
- Will be different with different populations. It’s not just about how we use one type of role, although that may be part of it; also need to look at the various types of care providers involved, and how you can effectively meet the patient/client need with fewer people used in more efficient ways. This will not be homogenous across the populations or communities. For example, in the community, could the home care nurses also be involved with the public health? Do we need the home care worker, LPN, and RN all involved or could that care be streamlined? Even in high acuity areas, there is room for streamlining.
 - Definitely “a” is a high priority, especially when you look at primary care, and how the roles could be altered to better meet the health care needs. For example: Home care nurses say, “I am a nurse who does ABC.” They don’t see themselves as taking on other roles or work. We need to reduce these silo ideas, let go of this narrow focus, and get a new identity that is broader and more flexible. We do need areas of expertise and specialty, but much fewer than we have. How do we develop different skill sets and areas of shared work?
 - “b”, “c” and “d” are the most pressing questions I face in my role. We are not clear about the evidence. I can’t emphasize enough how we need to know and understand more about those topics.

- “b”, if we do research on this topic, it must include the use of “new” types of providers (such as physician assistants) and focus on understanding issues related to staff mix and outcomes of changes in mix.
- “c”, If this means exploring and testing ways of providing care then yes....but begin by defining what is meant by a “model of care”. I am not convinced that self care has any real potential given that the biggest users of health care are the elderly and those with mental health issues. Neither group is really able – nor do they have the resources – to take care of their own needs.
- Information about new models of staffing would be very valuable. The shortage is just on the leading edge. There will not be sufficient workers to address population needs.
- Identifying the boundaries of practice is critical to blending roles, and using professionals differently.
- We need to change the care delivery models. We need to be less rigid about who does what. I think there are 37 different scopes of practice. We need to blend some of those. We need to be innovative in education - learn, work, learn, work - more co-op type models.
- “a”, “b” and “c” are all important. We must do something about how we are staffing since the projects show the current vacancies will triple in the next 3 years in nursing and quadruple in pharmacy etc. We will need to redesign how we do our work and how we support people to do what they have been educated to do, looking for efficiencies of care through the use of equipment and supports and also weave the themes of safe care throughout. Key drive now seems mostly to be about cost. We need to change this to make ethical decisions about how to provide safe care and treat our people well. Plus the “millennial” worker is not prepared to work the same way as the boomers. The literature says it will take 3 millennials to replace 2 boomers. This will compound the problem.
- “a”, “b” and “c” are linked and are a big priority. We need to unhook from the current “status quo” and make changes in how we do things. We know a lot about what needs to be done but there are a lot of barriers – mostly because we don’t want to change. We need more research into the blockers to change that are present in health care. I suspect it is rooted on our history and socialization into how things “ought to be”. (“Our” being all the major players – managers, unions, professional orgs/groups, the MoH etc).
- “a” through “d” are priorities because we are now on a burning platform in regard to the sustainability of the system if we don’t pay attention to fundamentally re-thinking the way we provide care. I am not convinced that we actually have enough research on how we might fundamentally change the system; most of it recommends minor adjustments (tinkering at the edges) instead of tearing the thing down and rebuilding.
- “a”, “b” and “c” are all related. Can’t do “b” and “c” without doing “a”.
- “d”, a little later, follows the work of “a”, “b”, “c”
- We are not doing a good job in inter-professional teams .We use the terms but still operate in silos.
- First three are important and absolutely critical, as there seems to be little research or information.

- In regard of “b” and “c”, we ought to focus on getting the groups we have now collaborating well together in the delivery of care before we start adding more providers into the mix.
- “a”, “b” and “c” are sort of the same theme. And yes – these need to be studied since we are facing such shortages. We need to think about doing things differently. We have a finite number of staff, so I think we need to focus on new models of practice. I mean collaborative models. Ownership doesn’t just rest with one discipline: we all own part of the care and parts of the care of many disciplines overlap. We need to feel secure in our piece of the practice and what we can all share and not duplicate. There is enough work for all.
- We don’t understand how the environmental needs and program planning needs interact, the processes of how the programs run and how they interact. That is the model of practice. The way people work within their environments and deliver, or not deliver programs. Maybe this is just in mental health and addictions, but sometimes the way people are leads to discouragement by the people that are working with them. My plug is to look through a broad lens, and get an ecological view that shows the interactions.
- Number one risk to sustaining health care is that there will not be enough staff. We know that we are not using them now to their capacity in their present roles. We also know that whatever we do about increasing the numbers by educating more, and by doing a better job of retaining staff will not resolve the shortages. Given the demographics, without change, within 15 years we will need to rely on immigration to provide providers to deliver the services. So, we know that we need to do care delivery differently. We have little information about how, so care delivery model research is very important.
- We only know the skills required by health care providers today. The skills required in the future may be very different, and we aren’t really considering those.
- I am looking at collaborative practice models. We need to integrate professional frontline workers and integrate practice better; not continue the silos of different professions. The team outlines possible services and then the client/patient is involved and decides the services and which plan of care. Traditionally there were nurse managers; I don’t necessarily think this is healthy if we are moving to collaborative practice. But managers with other backgrounds, in fact all the other professionals, need to know what happens in the ongoing direct communication with the patient throughout their in-patient stays. They (occupational therapists, physiotherapists, psychologists, etc.) need to work shifts and shadow the nurses, both as new graduates, and maybe when they are students.
- We need implementation information, action research, evaluation of implementations of different care models, not theoretical information.
- One of the greatest barriers to “a”, “b”, and “c” is, and will continue to be, unless they are educated differently, the providers themselves. Without improvements in attitudes about skill changes, the changes required in “a”, “b”, and “c” will have difficulty being successful. An inter-professional type of experience or exposure during the education phase is essential.
- “d” follows “c” – we need different education models when we have different care approaches.

- “d” is a big issue too – there seems to be a lot of change resistance – and change fatigue among people in health care and we need to find ways to build people’s resilience – so first we need to understand what builds resiliency in people.
- “d”, the innovation needs to be about how education and practice work together, both within themselves and with each other, and not how to adapt to new models of care.
- We will need to teach people how we want them to do things differently.
- We may need to change the faculty not necessarily the content of the education programs. This is because I think the faculty are invested in the old paradigms and are socializing new professionals into their roles using this framework. This is making it challenging to get people to shift away from the “what is” to the “what could be” and this is part of the barrier to change. We should be charging them with preparing students to provoke and lead change effectively. In addition to commenting on the four priority themes noted above, respondents provided information about the other sub-themes.

These as well as general comments are summarized in Appendix C.

2. Reaction to priority defined by the HSPRSN Steering Committee

The second question asked their response to the following: “After consultation with the health authorities and Ministry of Health in BC in regard to priorities for attention, the HSPRSN Steering Council agreed that planning and funds should be focused on identifying and addressing priority health human resources issues as they relate to how care/services are provided (i.e. better use of existing resources, developing new care models, etc) in ways that

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The respondents were asked if this decision made sense to them. Fifteen respondents answered “yes”, four answered a qualified “yes” and indicated that some wording changes may be helpful or

cautioned that the statements needed to be action oriented. One respondent said “no” unless there were substantive changes made to the wording of these goals.

The interviewers asked if the “and” between the two statements “more effectively address patient” and contribute, in the process, to improved levels of staff engagement....” was required? All respondents in the twenty interviews, including the “no” respondent, said that linking the outcomes to both addressing patient client need more effectively and contributing to improved levels of staff engagement was essential.

Comments from those who answered, “yes” to the question, why, and is the “and “needed

- It makes sense, as there is a relationship between how people show up, and the relationship to staff being engaged and having a sense of satisfaction. If you feel valued in the place you work, regardless of what you do, you feel proud and have a sense of satisfaction. Part of job satisfaction is being clear about why you’re here and feeling good about the work and making a difference, in this case it is the patient care.

- It is overarching to most of the sub themes in question one.
- These are very broad headings and really encompass all the themes in question one. Agree that it is AND. They are both necessary – really these are interconnected.
- The two outcomes need to go together. Development of models is a priority. While we need to put the greater weight on patient outcomes, if we don't have engaged staff we won't get far.
- These are interrelated and we need to do both but the focus on "job satisfaction" is a red herring. People can be very satisfied but still not be very productive. The focus ought to be on "engagement" and that satisfaction will follow.... and so will good patient outcomes.
- This is and must be "and". I am glad to see putting patients first! We would be better off to focus on optimization of the use of people's skills and abilities for patients rather than holding on to the issue of staff satisfaction as a key indicator. That said, staff need to feel good about what they are doing and be satisfied that they are doing it well.
- The first part is the first three subtopics in question one; looking at how the work gets done. Engagement is fundamental to getting employees staying in their organization and getting the work done and therefore, closely linked to the ability to do the first part.
- Engagement and outcomes of care go together, looking at both areas at the same time.
- These are interrelated and we need to do both. If we focus only on patient outcomes and ignore staff needs the staff will soon feel used and believe that the most important thing for policy makers is the bottom line ...and then we lose them...and if we do we can't give good care and achieve good outcomes.
- The "and" is needed as I wouldn't sacrifice one for the other. Both addressing patient need effectively and improving staff engagement are needed although they aren't necessarily attached to each other.
- Yes, it relates to both recruitment and retention efforts. We need the latest research to help improve outcomes. The 'and' absolutely makes sense. To provide care effectively you need engaged staff. The Gallop survey showed for many of the HA's staff are not very engaged.
- It is a fair statement. Staff engagement is highly correlated with staff retention. Without the staff you cannot address patient/client needs, so the two points are tightly linked.
- Follows what the health authorities are struggling with. Absolutely whatever is done must impact positively on patient care delivery and staff engagement /satisfaction. They go together. Many of the HA's were surprised with the poor results of the Gallop survey information on staff engagement.
- Yes, the wording encompasses the previous sub –themes of "a, b, c, h, l, j". Without doing things differently, there will not be sufficient staff to meet the population needs.
- The "and" is necessary. You cannot deliver more effective care with an angry staff, and if you simply improve staff engagement without improving care, you are not focusing on our core business. Can't disconnect; they are the two sides of the business.

Comments from those who answered a qualified “yes” and their responses to why “and” is needed

- Yes, the statement makes sense. It doesn't reflect a proactive view though. We need to anticipate needs and consider healthy populations, not just those with care needs.
- Initially this respondent said no, but changed to a yes after the interviewer outlined that the question was about different ways of doing things, not the focus on the bullets. Query, clarity of statement?)
- Yes, however the wording is a little confusing and the intent may be buried. The wording suggests that the theme is to identify and address priority human resource issues. The two bulleted points are outcomes and perhaps need to be worded as that. Concern expressed that if the work gets focused into patient/client outcomes (more effectively address patient/client needs) the HR priority may be lost as the focus will be on the population groups being served. Both the outcomes, patient/client needs being addressed and staff engagement should be included in the evaluation.
- I am not 100% sure this should be the priority, but I am in substantive agreement. We need to be more specific and explicit. Today, and for at least the next 25 years, we don't have enough health care providers. We need to create extenders for physicians and nurses. Now the physicians control entry to the system: that has to change. We need multiple entry and exit points in the system.
- The “and” in the statement is essential. Improved staff engagement and trust is the way you start, and then get to productively and the outcomes we want. Again my caution as in the first question – don't study too much. There is a sense of urgency. We need to begin implementing. The studies need to show us how to do it and how to manage the change implementation.

Comments from the respondent who answered “no”, not unless it was changed substantively

- The statement sounds a bit like motherhood and apple pie, without the words of implementation.
- With the skill shortages that are coming, we need to be including new technologies, changing roles and collaboration.
- The statement needs to specify to better use HUMAN resources, not just resources.
- There needs to be a bullet about productivity, and efficiency.
- We can't do as we currently have been, but what we are capable of doing could be greatly assisted through technology. For example, automated meal delivery, clinical signs automatically recorded by monitoring machines and integrated into the electronic record, IV pumps that automatically recalculate as needed. Those types of technologies would increase productivity, without adding staff.
- Staff engagement and satisfaction are empirically related.
- The engagement bullet needs rewording, to show it is specific to the work redesign. The whole team needs to be engaged in the redesign processes of how care is provided. With their engagement and smoother processes, you can achieve the same or better patient outcomes, staff satisfaction and cost reductions.

Other Comments:

- One of the things I think about with new models of care is that we still seem to be still looking at the processes of work from the disciplines' perspectives. We say we philosophically support patient/family centered care, but we don't start looking at the processes from that view. I think we would structure the care processes and care models differently if we did that.
- It is important in the new models to consider the relationship of the professionals and the para professionals. The fact that often the voices of the paraprofessionals don't get heard is problematic. For example, laboratory assistants have concerns about their education, practicum's, and they think they may be able to take on additional tasks, but they aren't consulted when the work processes are reviewed. There are many parallels, where the professional or the researcher does not hear their voices, even though they are part of the work unit.
- A lot could be done that would make a big difference to efficiency and work commitment. They do go together. So much is in how people work together. In 2001, HEU did a study looking at long term care injury rates and the work environment. In units where staff perceived that their input was valued, where the staff helped each other, where they reported that they felt valued, there were lower injury rates. It almost seemed like a circle, because the managers of the positive areas also saw ways to add staff when needed, which reduced the workload.
- It would be useful to understand better that relationship between staff engagement and better patient outcomes and how they reinforce each other.
- Some research has been done on this but a lot more is needed to understand how to optimize and engage people. They may be okay with what they are doing – but it is just that what they are doing may be the wrong or at least unnecessary thing and these processes have not been challenged.... but they need to be.
- One respondent reported on the results of a recent Gallop poll done across most BC health authorities. The Gallop poll is widely used in many industries including health care across North America to measure staff engagement (linked to staff retention) . BC employees scored in the bottom 20th percentile of Health Care organizations across North America that were involved. Health care usually scores lower than other industries, and BC was in the lowest level of the health care ones.
- In my experience, when we are looking at the clinical pathway across the continuum, we focus too much on needed medical care and not enough on health. We need to redevelop the community models. Balance the formal and informal supports that are there. We need healthy living environments.
- There are a lot of interesting innovations happening now in the health authorities and we need to examine them and consider how to spread the learning and changes that work
- Recent literature (ref. Beuhalt?) outlines that nurses are not dissatisfied with their own working conditions (pay, hours of work), but continue to be concerned about patient /staff ratios and not being able to meet patient needs consistently).
- The right people, in the right jobs with the right skills and right commitment are needed for system sustainability and effectiveness. Both staff satisfaction and patient safety are essential: the two are intertwined and we need to do both.

- Any calls for grants need to stipulate that proposals must be framed within these two overarching expectations and be designed to demonstrate the impact of the project on both components. It would also be useful to require that health authorities applying for these grants partner with other health authorities so the research is done in several places at once and there is a “critical mass” achieved in regard to understanding the impact on these two components as well.

3. Top health human resource issues for organization that could benefit from research

In the third question, respondents were asked to identify the top two health human resource issues for their organization that could benefit from research or knowledge translation activities. In answer to this question, respondents listed a variety of different priorities, but many can be grouped into four thematic topics. The first, and most frequent priority theme identified was related to work redesign and about models of care (18 respondents cited some variation on this topic as a priority). The second thematic area, identified by seven people, was related to the need to understand more thoroughly how to effectively engage staff and how to retain them. A third

thematic area, identified by six people, was related to the need for leadership and succession planning. In the fourth thematic grouping, four commented on the need to more deeply understand collaboration and teamwork. A number of other priorities unique to the respondent’s organization were also mentioned as areas of interest for research or knowledge translation.

Comments on the first priority theme (work redesign and models of care) are summarized here.

Models of Care

- Model of care work. Understanding who can most effectively meet the patient/client needs for care, and in so doing how do we ensure that the work is aligned with their training, scope of practice, and would also enrich their work lives?
- How are we going to sustain care: work redesign, focus on safe and reliable health care that is patient centered, efficient, and uses staff effectively.
- Care delivery models and service delivery options: how to use human resources properly/effectively/creatively to meet the needs of the people we serve.
- Redesign of work – unless we reorganize and rethink how we do our work we are in real trouble since soon there will not be enough people to do it like we do it now. Same as first three subtopics in question one, and question two- How we can reconfigure how care /services are provided, paying attention to the outcomes and staff engagement. I am monotonously consistent, but different ways to use different roles and skill sets, either by demonstrating in pilots or synthesizing information from around the world is critical information we don’t have. We know we will not have sufficient staff to keep doing things the same way but have no real information about how to do them differently.
- Systematically evaluating the models of care and practice that are being implemented currently.
- New models of care using collaborative approaches.
- Models of care – We don’t have it right.

- Innovative models of care. Specifically, how can we blend roles, especially those of nonregulated staff?
- Another issue right now in the Fraser Health Authority is how we will do clinical integration in the acute sector. You can't really talk about that without talking about the care models.
- Application of care delivery knowledge. How should the care models change? What is the impact of changing care models? How can providers acquire new skills? What are the best ways of determining change readiness?
- Staffing services redesign. Right people, right place, right time, right way. From question 1, "a, b, c, g, i and j" are sub-themes. It is difficult to tease out as they all have an effect. This is really six sub themes, but all are interrelated.
- Models of care, especially for Provincial Health Service Authority's diverse patient populations.
- Practice models – what works and what doesn't in regard to supporting the workforce and delivering safe care (e.g. models to retain "over 55" workers; use the 80/20 model developed at the University Health Network in Toronto (80% clinical, 20% indirect care work such as planning).
- Models of practice in light of an aging population and workforce, including education of all in regard of new ways of being and doing.
- How to actually use care providers differently. Links to interprofessional practice. How and where do you use position extenders? There is not good information about this that has researched the effectiveness.

Redesign, but more focused on the how to do this work

- How do you redesign? What are the most effective strategies and processes for redesigning work and roles? This is an ongoing cyclical process, and needs to be sustainable and become just a way of doing business, part of our competencies, and the organization's way of doing. How do you do this redesign function at the same time as delivering care?
- Moving evidence into action – implementation of change and introduction of new ways of providing care. Any research done in this area must be applied research, taking into account the different and multiple interactions in the clinical settings. It is a challenge to be doing redesign work, evaluating the outcomes, and deliver care all at the same time.

4. Ranking of priority identified through the HSPRSN Steering Council

In question four, respondents were asked if the priority identified through the HSPRSN Steering Council consultation process ranked in their list of priorities, and if so - where. Seventeen respondents said "yes" the priority identified by the HSPRSN Steering council process ranked first, or high in their own list of priorities. Two respondents responded with a qualified yes. One stated that his/her priorities were sub sets of the larger overarching theme, and thought that the statement was too broad and another wanted implementation and evaluation added to the wording. One respondent would not support the HSPRSN Council priority unless it was substantively reworded.

Comments included:

- We need to be more precise with the phrase model of care. It seems to be interpreted in very different ways by different people, and have a variety of foci and expected outcomes from the work.
- The other thing is the slow adoption of existing literature on the retention topics, and nearly everything. I think it may have to do with people's abilities to understand the priorities and where they are situated in their culture.
- We knew this was coming years ago and have done some work as a province and country to mitigate the effects – and so has the system.... But we have not been “serious” about it. People are now starting to get serious because they are realizing that the crisis is on us now.
- Consider adding words implement and evaluate as well as identify and address to the statement.
- Yes, I think so. They are about how care and services are delivered and engagement. My priorities are both about staff engagement in the work and satisfaction.
- As I said earlier, is a broad statement of focus, and we need to get quick implementation information.
- The design of new models must first to be based on the needs of the population being served, and will be different across the continuum. Won't necessarily be transferable across populations.

5. Activities underway in organizations to address these priority issues and awareness of the work of others may be doing on these issues

All respondents described some of the initiatives that were currently underway in their organizations. The list is incomplete; undoubtedly many more activities are underway than were reported in this survey. However, it gives some indication that all are engaged in a number of initiatives related to health human resources. Although there are a number of common themes, with a few exceptions, the initiatives are not coordinated with each other or even defined in a similar way. Respondents often did not even use the same words or terminology to describe what may be very similar projects. Although anecdotally, there is some awareness of what others are doing, there are minimal formal links. As one respondent outlined:

“There is a lack of knowing what everyone else is doing in the province. There is no central repository, no coordination of what is happening across different groups, including in the government. We need some kind of an awareness center, so groups can feed off one another. Everyone seems to speak a different language. I think everyone wants the best health care for those in BC, but we need clear communication. It would really be a stretch for every one to really understand how the various activities fit together. The MOH has many departments and (they) don't always seem to talk (to each other). The HAs don't seem to talk to each other or even within each HA (either).”

All stated that evaluation was part of the initiatives they were doing. There are a few projects that are part of formal research activities either in planning or in progress.

There was limited awareness, as mentioned, as to who was doing similar work in the province with the exception of two or three collaborative projects that are underway. Few were specifically

aware of initiatives similar to their own going on in other parts of Canada or elsewhere, although one mentioned the Western ADM group that includes the four Western provinces and Ontario that is trying to stimulate more opportunities for working together.

Respondents' comments about activities related to models of care/ collaborative practice projects are summarized here.

A. Models of care/collaborative practice projects:

- Vancouver Coastal Health (VCH)
 - VCH Vancouver Acute Collaborative Practice Model is a process for reviewing staffing models to ensure safe patient care by the right provider within various acute care clinical settings. The RN scores the patient using a patient acuity tool and the Patient Care Coordinator uses the score to make or adjust patient assignments. Teams of participating units use a 5 page unit baseline assessment survey, the acuity score, pie graphs, and a competency tool to work with staff to review their current staffing model and to determine a future model for staffing. They have implemented staffing huddles during the day in which the staff who are working on a team review their patient assignment, determine what is the same or what has changed, and revise their assignments as appropriate. Measurement for success includes measures of nurse sensitive patient care indicators using the Global Trigger Tool as well as overall performance and satisfaction indicators.
 - Changing staff mixes by adding LPN's and care aides where they haven't traditionally worked, in higher acuity areas.
- Interior Health (IH)
 - Looking at the RN/LPN roles in a variety of settings across IHA (in less depth than the models of care work), and finding ways with them so that they can work more effectively together.
 - Models of care. We are calling it "partnerships in care" and we are viewing the patients as partners with the care providers. This is the only real "formal" project. On two units at different hospitals we are focusing on the work that each discipline is doing (for example, RN, LPN, Care aide, OT, PT, Pharmacist). The physicians are aware, and helped design the project but aren't included yet. The point of reference is the patient /family, and their needs for care as a baseline. This approach is helping to remove the discipline biases around structure and processes of care. Then who can best deliver the care to most appropriately address the need? This is being done in the context of the total patient care being achieved through a team approach. The two outcomes we want is to have the care needs of the patient met by the most appropriate provider and that the providers have more enriched jobs.

Both Vancouver Coastal Health (VCH) and Vancouver Island Health Authority (VIHA) are doing work about models of care. As I mentioned earlier, we do have to be precise about what we are really trying to achieve. Our focus is on meeting patient needs by the most appropriate provider and enriching the work life of the staff. I have heard VCH say they are looking at efficiency and increased productivity. I am not sure that is the same, so we do need to be careful in generalizing. Interior Health (IH) is more closely aligned with the work being done in VIHA and we are exploring partnering with them.

- Vancouver Island Health Authority (VIHA)
 - In the process of a total care delivery system redesign - everywhere and across all sectors. There are too many to be specific about the many demonstration projects and simulations are either in the works or being planned to get this started and to evaluate whether it works. Evaluation is part of this and we have received some grant money. We are building on the work that has been done by others (J Bessner in Calgary, Tim Porter O'Grady, in the US, etc). We are also linking to work done by Dr S. Nelson in Toronto and John Gilbert re interdisciplinary education approaches and tracking what is happening elsewhere as well.

- Provincial Health Services Authority (PHSA)
 - Cross functional teams at Women's and Children's, Sunny Hill
 - Developing an engagement model for patient care delivery. We tried for a grant and hope to resubmit. This model recognizes that many clients have been traumatized and endeavors to not traumatize them further while they are in care. It involves reducing restraint and seclusion use and engaging them actively in their care. Also, developing a tool kit to help families with their child who has psychiatric illness. This type of client approach is used in some centers in and engaging them actively in their care. Also, developing a tool kit to help families with their child who has psychiatric illness. This type of client approach is used in some centers in Washington State and Jack Ledger House. The approach will make the environment a better place for staff.
 - BC Cancer Agency initially joined in the quality of work environment, moral distress, and ethical decision-making, part of the collaborative participative action study with the Chief Nursing Officers (CNO) of the health authorities and University of Victoria (Jan Storch) and Paddy Rodney from UBC. This led us to a different lens of looking at care processes and the nurses' role and now the rest of the team. We now have a grant from the Canadian Nurses Foundation to continue the work and research. The research focus has given validity and the physicians have also now joined in. From this, we are now developing new models of practice. It started at one center, but is now spreading across the others and we will start the new Abbotsford center with this approach. From the cancer outpatient care perspective, for the models of care work we are informing others nationally and internationally. By looking at these changes starting from the issue of moral distress, we are leading the way.
 - Evaluation of addition of nurse practitioner roles

- Northern Health (NH)
 - Assessment of our current models of care, where they are and what they are. We will move then to review and maybe change the staff mix and levels.
 - Reviewing how to organize more collaborative models of primary care
 - Evaluation of addition of nurse practitioner roles, especially in primary care settings

- BC Nurses Union (BCNU)
 - Are part of a proposal to look at Community Health Centers as a model of care and consider governance issues in collaboration with _____ (CPPA)

- Fraser Health (FH)
 - Following up on the Partnerships for Health System Improvement Project (with Jan Storch , UVic)

6. Is the priority research into barriers to implementation and change management a priority?

Throughout all of the interviews all respondents were clear that if any research is needed it should be action research. There was a general sense of urgency among all respondents, with an expressed wish for evidence that could be quickly produced and readily adapted for use in a variety of work settings.

There was a mixed response to the question about whether the statement “Some informants feel that there is sufficient evidence about best practices to proceed to address the issues and that the most pressing need is for research into barriers to implementation and change management” was true. Five said yes, five said no, and ten qualified their answer with the statement that this may be true for some but not all of the issues.

A mixed response was also received to the question: Do you have sufficient evidence to support the priority activities underway in your organization? Seven indicated “yes”, six indicated “no” and seven qualified their response as “partially”, and “depends on which issue”.

Two respondents indicated that the priority ought to be research into barriers and strategies for the implementation of change. Six indicated “no” this is not required. The remaining 12 were mixed in their responses. They did want to learn how strategies could be readily implemented but they were also anxious for information about care delivery systems, and would not make research to inform the implementation of change a priority at the expense of work on care delivery systems and service redesign.

The Ministry of Health Focus Group participants also agreed that research to inform the implementation of change should not be a priority. They did agree that the research may not have been well enough synthesized into a form that decision-makers can use. They stated that the issue may be that the leaders (change agents) may not be skilled at change management. The Ministry is proposing that a capacity-building centre be established to assist and support health authority managers.

Part 2: Ministry of Health Focus Group

1. Feedback about the health human resource priorities identified in the “Listening for Direction 2007” consultation

The same ten sub-themes were listed and participants were asked to respond yes or no to the question “in your opinion should this sub-theme be a priority for research or strategies?”

Overall, there was consensus that the first four sub-themes listed in the summary of themes from Listening for Directions 3 are the priorities for the Ministry. These four are:

- a. Ways to better employ existing providers
- b. Development of new models of staffing (e.g. new team mixes that include nontraditional health systems workers).
- c. Development of new models of practice (e.g. collaborative models of care, self care)
- d. Innovative education and training programs to help providers adapt to new models (as well as training staff for the future)

There was also agreement that sub- themes “i” and “j” - strategies to create and sustain healthy workforces and work environments – were off-shoots of work that would evolve from work done on items a – d.

COMMENTS:

Priority Sub-Themes:

- a. Ways to better employ existing providers
 - b. Development of new models of staffing (e.g. new team mixes that include nontraditional health system workers)
 - c. Development of new models of practice (e.g. collaborative models of care, self care)
 - d. Innovative education and training programs to help providers adapt to new models (as well as training staff for the future)
- Utilization of existing providers:
 - There are not enough workers or leaders
 - Leaders need to be included in any planning
 - An increase in supply will not meet the needs (demand growing too fast)
 - Need to increase productivity of all providers (by ½ % per year) is the key to sustainability (source: Steven Birch)
 - Need everyone to work to full scope of their competencies
 - “a” and “b” are about the provider, “c” is about the patient – we need to focus on both. Using an HR lens alone to address this challenge will not address the needs of patients.
 - Jeannne Besner’s work on the role of nurses and other providers to meet current needs of patients is useful (She is working in the Calgary Health Region in Alberta)
 - Also need look at appropriateness of care and examine what we do that is not helpful: e.g. unnecessary surgeries (uptake of CPGs show that up to 50% of care currently provided is not appropriate)
 - New models of practice need to focus on what patients need
 - Interprofessional education (d) needs to be monitored and evaluated

- Issue is not about education for sake of education – it needs to be grounded and done in partnership with employers so it is relevant.
- Education for practice needs to be cheaper and production needs to be faster. MoH Research Advisory Council (RAC) is developing indicators for linking education and practice.
- We need to evaluate and learn from the evidence which models work best and why.
- HHR needs do impact on education output but response is slow.
- We have made lots of changes in the past but have not monitored them well and even with big changes we have not imposed a need to evaluate impacts as part of agreements.
- We need frameworks to do good evaluations and allow course corrections along the way.

Additional comments on sub-themes “e”-“j” are summarized in Appendix C.

2. Reaction to priority defined by the HSPRSN Steering Committee

The second question asked their response to the following: “After consultation with the health authorities and Ministry of Health in BC in regard to priorities for attention, the HSPRSN Steering Council agreed that planning and funds should be focused on identifying and addressing priority health human resources issues as they relate to how care/services are provided (i.e. better use of existing resources, developing new care models, etc) in ways that

- More effectively address patient/client needs (at point of care across the continuum) to improve health outcomes, and
- Contribute, in the process, to improved levels of staff engagement and job satisfaction, which are essential underpinnings in retaining and recruiting a high quality, high functioning workforce.”

The respondents were asked if this decision made sense to them. They responded yes but recommended that productivity also be a measure of interest in the second part of the statement: “...and contribute, in the process, to improved levels of staff productivity, engagement and job satisfaction...”

3. Top health human resource issues for organization that could benefit from research

In the third question, respondents were asked what the top two health human resource issues were for their organization that could benefit from research or knowledge translation activities.

Productivity:

- The whole issue of productivity related to client outcomes for the health sector needs to be understood. One example is rural and remote service delivery – how to do it, recruitment and retention issues, models of care, use of technology.
- This is not just efficiency.
- We need to define this for health care – how do we measure this?
- Could benefit from good synthesis of the research.

Models of Care

- This includes staff mix, services redesign, new types of workers.
- One size does not fit all – context matters.
- Present model not sustainable so need to look for new ways of doing things.
- Modeling needs to be based on patient needs.

Modeling to predict demand

- Really need to model this using a methods that accurately predict demand based on a vision of the future (patient centred demand).

4. Ranking of priority identified through the HSPRSN Steering Council

In question four, participants were asked if the priority identified through the HSPRSN Steering Council consultation process ranked in their list of priorities, and if so - where.

They said their priorities were sub sets of the larger overarching theme. They felt that their priorities were more specific. They also suggested again that the second part of the statement was too narrow and should be broadened to include productivity of workers, so thought in this way their priorities may expand on the HSPRSN statement.

5. Activities underway in organization to address these priority issues and awareness of the work of others may be doing on these issues

The participants described some of the initiatives that they are currently involved in doing in partnership with the health authorities or others. As with the key informant reports, this list is no doubt also incomplete. The initiatives underway in the Ministry are coordinated with those of the health authorities, although they did not necessarily use the same terminology as the key informants to describe projects. The Ministry is also, not surprisingly, aware of or involved to a much greater extent in national initiatives.

The initiatives mentioned are as follows;

- A research synthesis considering rural and remote productivity (Under a CHSRF Grant – BC portion has not yet been funded)
- Interprofessional practice and education evaluation project
- Physician Assistant demonstration project in Interior Health
- Forecasting and modeling project: HHR planning
- Education models pilot: BCIT 3 year nursing program; variable entry points projects

The Ministry is aware of and engaged in a number of initiatives with national counterparts through the Western DM Forum. They are also considering the results of the CIHR Optimizing Competencies project, the productivity work going on in the UK and Australia and the modeling work in the Atlantic Provinces and Ontario.

Part 3: Additional Comments

Some of the key informants offered additional remarks reaffirming the need for sharing of learning among the various organizations and the wish for usable, reality-based strategies. The Ministry of Health Focus Group participants echoed this and requested that the feedback gathered in this process be shared.

- It would be useful to engage those who were involved in these interviews, and reflect back the findings.
- We need better ways of learning from each other. The work that is going on in Vancouver Island Health Authority is very labour intensive, seeing how staff actually spend their time. Will the outcomes of those reviews be able to be generalized to other similar units? There is considerable work going on in redesign in many places across BC. It would be useful to share how different groups are going about this. What models of change management work most effectively? How can we take the best practices from the individual work without losing the bottom up energy, but not just leave it as smallscale experiments?
- There is a pressing need to implement what we know. We know it is hard to make changes and usually we understand why this is so. It would be helpful however, to make it a condition of the grant process to require that a parallel evaluation of the change processes/strategies used is done along with the outcomes of the change that was made.
- I am glad to see this issue is getting some attention and hope that there will be wise use of the resources available to support implementation of evidence-informed sustainable change
- We ought to also explore how to “embed” scientists in our institutions. Physicians get support to be clinician scientists but the other disciplines don’t. If we could employ our newly minted PhDs in nursing and other disciplines it would help a lot with knowledge transfer and with research into issues of importance to sustainability
- Glad this is happening – It’s a good use of the funds.
- Worthwhile project.
- There is a real need for leadership and commitment if we are going to make the changes necessary to make and sustain change. This is true from the policy making level, through the HAs and at all levels. Accountability for making and evaluating change should be part of the system deliverables.
- Let’s just get on with it instead of talking about it!
- I hope this will lead to some funding for some “grounded” evaluation and support for implementation.
- Really is desperately needed. Let’s get on with it – creating usable approaches.
- I don’t know exactly what needs to be done, but I think we need action research, not “pure” research and long-term studies. Needs to be timely research, reporting out quickly so we use it. We need to take action on what is already known that we have evidence about. I hope there is a feedback loop with results. And that the outcome is reality based.

Part 4: Conclusion

Overall there is a clear consensus that the first four sub-themes listed in the summary of themes from Listening for Directions 3 are the priorities for the respondents (health authority and MOH). Further, seventeen (of 20) health authority respondents confirmed that the priority identified by the HSPRSN Steering council process ranked first, or high in their own list of priorities. The Ministry of Health Focus group participants agreed that their priorities were more focused subsets of the broader HSPRSN Steering Council priorities.

A number of respondents commented on the need for sharing of learning among the various organizations and for usable, reality-based strategies.

The process of validating the themes described in the “Listening for Direction” process with key informants and the staff from the Ministry of Health in British Columbia did help to further clarify and narrow the focus in regard to the health human resource issues that should be considered for research with HSPRSN funds . The explanatory comments provided by the respondents about the Listening For Direction 3 HHR themes, particularly those focused on the four identified as their top priorities, offer additional information to assist the HSPRSN and Michael Smith Foundation for Health Research in planning the next steps.

Appendix A - Interview Guidelines

Questions for the Health Services and Policy Research Support Network (HSPRSN) Project

1. The workforce and work environment issues were among the top preliminary research theme areas identified nationally in the 2007 "Listening for Directions 3" consultations. Within this overall theme, several "sub-theme" areas were identified that may benefit from research and strategies. In your opinion, should these sub-theme areas be priorities for research and strategies?

Issue	Yes/No
a. Ways to better employ existing providers	
b. Development of new models of staffing (e.g. new team mixes that include non-traditional health system workers)	
c. Development of new models of practice (e.g. collaborative models of care, self care)	
d. Innovative education and training programs to help providers adapt to new models (as well as training staff for the future)	
e. Workforce migration, particularly in regard to the impact of in and out migration and recruitment and retention	
f. Impact of an aging population of the type of workforce required	
g. Impact of an aging of the workforce on the workforce and on the organization and delivery of care	
h. Succession planning	
i. Strategies to create and sustain healthy workforces	
j. Strategies to create and sustain healthy work environments	

Reference: Preliminary Research Theme Areas, Listening for Directions 3, CHSRF

2. After consultation with the Health Authorities and Ministry of Health in BC in regard to priorities for attention, the HSPRSN Steering Council agreed that planning and funds should be focused on identifying and addressing priority health human resources issues as they relate to how care/services are provided (i.e. better use of existing resources, developing new care models, etc) in ways that
- More effectively address patient/client needs (at point of care across the continuum) to improve health outcomes, and
 - Contribute, in the process, to improved levels of staff engagement and job satisfaction, which are essential underpinnings in retaining and recruiting a high quality, high functioning workforce.

Does this decision make sense to you?	Yes/No
Why/why not?	

3. In your opinion, what are the top two health human resource issues for your organization that could benefit from research or knowledge translation activities? Why?

I.
II.

4. Does the priority identified through the HSPRSN Steering Council consultation process rank in your list of priorities?

- Yes? No?
- If so, where does it rank?
- If not, why not?
- Would they fit within this definition?

5. Are there any activities already underway in your organization to address these priority issues? (e.g. pilot programs, demonstration projects, research studies)

- What are they?
- Is research/evaluation a component of these activities?
- If not, why not?

6. Are you aware of others who are working on these same issues outside your organization

- In the province?
- In Canada?
- Elsewhere?

7. Some informants feel that there is sufficient evidence about best practices to proceed to address the issues identified as priorities in Listening for Direction and that the most pressing need is for research into barriers to implementation and change management. Do you feel that this is true?
 - Do you have sufficient evidence to support the priority activities underway in your organization?
 - Do you feel that research into barriers and strategies for the implementation of change ought to be the priority?
8. Is there anything else you would like to tell us about this subject?

Appendix B – Key Informants

Council of Chief Nursing Officers:

- Barbara Mildon, Chief Nurse Executive & Vice President, Professional Practice and Integration, Fraser Health Authority
- Tom Fulton, Leader, Professional Practice & Chief Nursing Officer, Interior Health Authority
- Suzanne Johnston, Vice President, Academic Affairs & Regional Development and Chief Nursing Officer, Northern Health
- Sherry Hamilton, Chief Nursing & Liaison Officer, PHSA
- Amy McCutcheon, Executive Lead, Professional Practice, and Chief Nursing Officer, Vancouver Coastal Health
- David Byres, Chief of Professional Practice and Nursing, Providence Health Care
- Lynn Stevenson, Chief of Professional Practice and Nursing, Vancouver Island Health Authority

Ministry of Health Representatives:

- Judy Thompson, Director, Allied Health Human Resources, MoH
- Libby Posgate, Director, Physician Human Resource Planning, MoH
- Gulrose Jiwani, Executive Director, Nursing Directorate, MoH
- Peter J. Gibson, Executive Director, Western & Northern Health Human
- Patricia Coward, Michael Smith Foundation (recorder)

VPs, Human Resources:

- Geoffrey Crampton, Vice President, People & Organizational Development, Fraser Health
- Patrick Doyle, Chief Human Resource Officer, Interior Health Authority
- Jane Lindstrom, Vice President, Human Resources, Northern Health
- Mark Allen, Chief Human Resources Officer, PHSA
- Anne Harvey, Vice President, Employee Engagement, VCH
- John Johnston, Vice President, Human Resources & Organizational Development, VIHA

Union Representatives:

- Patricia Wejr, Senior Policy Analyst, BCNU
- Marcy Cohen, Research Director, HEU

Other:

- Becky Palmer, Chief of Nursing, C&W
- Fiona Bees, Chief Nursing Officer, BCCA
- Karen Jewell, Senior Consultant, Advocacy/Special Projects, Health Employers Association of BC
- Jennifer Baumbush, Director of Research, Professional Practice (with Amy McCutcheon, VCH)
- Pat Semeniuk, Regional Director, Clinical Education (with Anne Harvey, VCH) Rena Van der Wal, Director, Clinical Practice (with Anne Harvey, VCH)