Orientation Course on the Canadian Health Care System, Culture, and Context: The Design, Development, Implementation and Evaluation of a Curriculum for Internationally Educated Health Care Professionals

Prepared for External Stakeholder Distribution
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Table of Contents

Acknowledgements................................................................................................................................... 3
Executive Summary .................................................................................................................................. 5
Introduction............................................................................................................................................... 7
  Project Overview ................................................................................................................................. 7
  Project Goals .................................................................................................................................... 7
  Report Outline ................................................................................................................................. 7
  Background ....................................................................................................................................... 8
  Methods ............................................................................................................................................ 10
Curriculum Development ........................................................................................................................ 11
  Prior Recommendations .................................................................................................................... 11
  Iterative Design and Use of Existing Materials .................................................................................. 13
  Development Process ....................................................................................................................... 14
Program Delivery .................................................................................................................................... 19
  Site Selection ................................................................................................................................... 25
  Facilitators ....................................................................................................................................... 27
  Admissions Process .......................................................................................................................... 29
Attendance and Participation .................................................................................................................. 33
Outreach/External Requests .................................................................................................................... 34
Technology Enabled Education ............................................................................................................. 37
  Learning Management System .......................................................................................................... 38
  EPresence ......................................................................................................................................... 38
Program Impact Evaluation .................................................................................................................. 39
  Background ...................................................................................................................................... 39
  Methodology ..................................................................................................................................... 39
  Results ............................................................................................................................................. 40
  Interpretation ..................................................................................................................................... 40
  Conclusions ....................................................................................................................................... 41
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Executive Summary

Since 2003, representatives from the professions of pharmacy, nursing, physiotherapy, occupational therapy, medical laboratory technology and medical radiation therapy have been meeting to discuss issues of common interest related to integration of internationally educated individuals into their respective professions. As part of these discussions, a commonly expressed need was identified for development of an educational program to orient internationally educated health professionals (IEHPs) to the culture and context of the Canadian health care system. Given the common learning needs of IEHPs, and the desire to model interprofessionalism and collaboration that are gaining prominence in Canadian health care, a proposal was submitted to Health Canada to develop and pilot a curriculum.

In 2006, the University of Toronto was awarded funding to research learning needs, identify currently available educational resources, and develop and pilot a curriculum to orient IEHPs to the culture, context, and processes of the Canadian health care system. A working group was established with representatives from each profession as well as from provincial and the federal governments. An educational needs assessment report was delivered to Health Canada in March 2007, outlining a model curriculum, delivery options, and methods for integrating existing curricular resources into a new educational program aimed specifically at IEHPs in the identified professions.

In 2007, work began on development, implementation and evaluation of the program. The program consisted of 10 x 3 hour lessons, facilitated by a health care professional, with small groups of 10-20 IEHPs. A variety of teaching and learning activities were developed to encourage and model collaborative educational practice. Content for the program was developed by modifying/adapting existing curricular resources, as well as developing new materials to meet the needs of IEHPs as identified through the 2006/2007 learner needs assessment. In addition, recognizing that some professions already have bridging education programs in place, and that this content may be incorporated into these programs, individual lessons were designed to ‘stand alone’ (and be incorporated into existing bridging programs) or be aligned together as a coherent independent curriculum.

The pilot program was delivered bi-weekly in January and February 2008. In order to test various models of delivery and to optimize flexibility, the pilot was offered at sites across Canada in a face-to-face classroom setting. To ensure national access to the program, sites were selected in British Columbia, Alberta, Saskatchewan, Ontario, and New Brunswick. Despite concerted recruiting efforts, insufficient numbers of IEHPs were identified for the New Brunswick site and consequently this site was not able to participate in the pilot. In Ontario, however, there was a much stronger demand for the program, and consequently a second section was added to accommodate the extensive waiting list of learners. Simultaneously, and using various technology, an e-learning platform was also offered to allow IEHPs enrolled in the program to access learning supports electronically.

”Train-the-trainer” materials were also developed as part of the project, to support facilitators in delivery of the curriculum, and a virtual facilitator community was established to allow
individuals involved in delivering the program to share their experiences and learn from one another.

The curriculum was developed to introduce IEHPs to the workings and culture of the Canadian health care system. Consequently, the language requirements for the program meant that individuals enrolled were required to demonstrate English language proficiency at the equivalent of Canadian Language Benchmark (or equivalent) of 7 or greater. As the pilot progressed, however, some flexibility in this requirement was introduced to facilitate learner access. At the conclusion of the pilot, French language translation of much of the content (including learner and facilitator resources) was also undertaken. To provide context for the program, we expected that all IEHPs participating would have already begun the licensure process within their respective professions.

Several professions have expressed an interest in using this course as part of the compulsory requirements for licensure for IEHPs, while others have indicated this course will be part of a menu of educational offerings to assist individuals in meeting relevant standards of practice.

At the time of writing of this report, an innovative educational program (available in both a face-to-face classroom model with electronic learning supports) has been developed, piloted, and revised. A unique curriculum, based on overarching, common themes, has provided not only increased access to educational programming, but has resulted in the development of several communities of practice across Canada. The project has modeled effective stakeholder collaboration and an effective approach to implementation for such an ambitious undertaking. A centralized and coordinated infrastructure has been created for further delivery of the program that will meet the needs of IEHPs, regulators, and employers, governments, and Canadians.

Professions involved in this project recognize the importance of a structured and systematic orientation to the Canadian health care system as a necessary step in the licensure process. During the pilot, significant interest in the course was expressed by other professions, in particular respiratory therapists, midwives and physicians. While the pilot was targeted at IEHPs beginning the licensure process, we received expressions of interest from employers and those working with IEHPs. As a result of the pilot, there appears to be strong interest in and demand for the program.

Clearly, there will be an on-going need to refine and update the curriculum in light of on-going regulatory changes. Equally clearly, there will be a need to continue to offer the program across Canada as the number of IEHPs continues to grow. A proposal for additional funding has been submitted and approved that would allow for two Models of delivery: Model 1 will be a blended learning environment utilizing the existing face-to-face curriculum and a modified learner-management-system on-line support, and will be offered in six cities across Canada on two separate occasions during 2008-2009. Model 2 will utilize the content of the existing face-to-face curriculum and make it available in a distributed (e-) learning environment, offered on two separate occasions during 2008-2009 to two cohorts of approximately 20-30 students. We propose to utilize centralized recruitment, training, admissions and program delivery while partnering with local sites for Model 1. While some French language translation of materials will be undertaken, it is anticipated that all program delivery will be in English only at this time.
Introduction

Project Overview

This is the second in a series of reports on the work of the Internationally Educated Health Professionals (IEHP) Orientation Working Group (Phase 2). The group was organized in November 2006 as a result of funding from the Government of Canada through Health Canada to “develop an orientation program to help internationally educated nurses, pharmacists, physiotherapists, occupational therapists, medical laboratory technologists and medical radiation technologists to adapt to the many dimensions of practicing in the Canadian health care system.”\(^1\) Phase 1 of the project, chronicled in an earlier report, involved the identification of the need for a trial curriculum for the six professions listed above, utilizing a multi-professional approach, one that would complement (but not replace) profession specific bridging education.

Project Goals

Building upon the first phase of the project that had provided a starting point for the development of a curriculum that addresses identified needs, priorities and the means of delivering such a curriculum, this second phase and accompanying report will report on the following goals:

- Design and development of an Orientation program for internationally educated health professions (IEHPs)
- Modification of existing curriculum and the creation of new programming to form a finalized orientation program.
- Delivery of a classroom based program in 5 Canadian cities to groups of 15-20 IEHPs twice weekly for 5 weeks
- Development of an online program for IEHPs unable to access regional education
- Evaluation of learner satisfaction with the curriculum and process
- Evaluation of program impact
- Preparation of a final report

Report Outline

This report fulfils the last project goal as stated above. There are eleven sections:

- Background and Methods
- Curriculum Development
- Curriculum Delivery
- Site Selection
- Facilitators
- Admissions Process

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The narrative style of the report will provide descriptive information and details about the process in each of the sections. Where appropriate, evaluation data will be included in each section; lessons learned will be provided at the end of each section. Appendices are available, upon request, to provide further detail and elaboration of many of the issues that will be presented in the report.

**Background**

Earlier work in the project (Phase 1) resulted in the development of a proposed Trial Curriculum based upon a Curricular Map that compared IEHP stakeholder priorities with elements available in existing bridging and orientation programs, and other educational resources. Other program elements such as prerequisite requirements, method of delivery and course length were examined in this analysis phase, and were used as a point of department for the design, development, implementation and evaluation in Phase 2.

Recommendations from Phase 1 were that an Orientation to Canadian Health Care System program be created for IEHPs at any or all steps in their progress to licensure based upon the following principles;

1. **Course content**
   
   The curriculum should be developed based on the following modules:
   
   - **Canadian Health Care System 1**, comprised of concepts around health care delivery and methods of delivery, the organizational structure of Canadian health care, a history of health care in Canada, the roles of professional associations and certification bodies;
   - **Canadian Health Care System 2**, comprised of an introduction to regulated professions, interprofessional collaboration and scopes of practice;
   - **Provincial Delivery of Care**, comprised of an overview of factors influencing provincial health care delivery, labour mobility between provinces, understanding income taxes, EI, CPP, and so on;
   - **Cultural Diversity and Health Care Culture**, comprised of the topics of cultural awareness, cultural sensitivity, gender issues, professional Codes of Ethics and health care subcultures;
   - **Patient-Centered Care**, comprised of an overview of the significance, characteristics and benefits of patient-centered care;
   - **Professionalism**, comprised of the meaning and elements of professionalism, reflective practice, and standards of practice;
   - **Workplace Context**, comprised of an exploration of Canadian “work ethics,” professional/patient safety issues, and use of body language, nuance, figures of speech, and so on;
• Ethics and Liability, comprised of an introduction to health care ethics, personal ethical dilemmas, professional Codes of Ethics, professional liability and ethical decision making processes;
• Pathways to Licensure, comprised of an overview of the licensure and employment processes;
• Summary of the program and/or examination.

2. Course length
   In order to adequately cover the material covered in this program, ten three-hour sessions should be used.

3. Delivery method
   • The ideal method of delivery would be face-to-face classroom sessions held in regional centres in Canada;
   • A web-based program could be available for IEHP use in their country of origin before starting the licensure process in Canada;
   • A web-based program could be available for IEHP use if they live outside of a regional centre;
   • Use of video/DVD of the program’s in-class pilot project could be considered for use at the discretion of the professions.

4. Language benchmark
   In order to understand the concepts covered in the course, the language used in the program should be intermediate level of proficiency that is Canadian Language Benchmarks 7 or 8.

5. Use of Assessment
   Assessment of IEHPs knowledge of the program’s content will be at the discretion of the individual professions.

6. Licensure requirement
   Use of this program as a requirement for licensure will be at the discretion of the individual professions.

7. Long-term sustainability of the program
   A lead institution should be found that has expertise in health care education, is interprofessional, has a national focus, and that would be able to sustain this orientation program.

Challenges that accompany these goals include:
• Avoiding duplication of programs already available in jurisdictions across Canada;
• Reaching the largest number of IEHPs possible by identifying the most effective program delivery approaches;
• Developing effective approaches to project implementation;
• Developing a program that is sustainable over the long term once implemented;
• Maximizing the opportunities for collaboration between all jurisdictions, educational institutions and health care organizations in Canada;
• Building consensus among health care and IEHP stakeholders across Canada.

Lessons Learned:

Modification of existing resources was a key goal for the project

Access by the largest number of IEHPs across Canada through the selection of viable sites was an early priority

Frequent stakeholder communication was necessary to generate momentum and ensure the success of the project

Methods

A project manager was hired for Phase 2 of the project with responsibilities for the design, development, implementation and evaluation stages of the project. Work commenced in July 2007 and was completed by the end of March 2008; the working group was convened by teleconference on four occasions throughout these phases. Email correspondence and individual telephone conversations and meetings provided the group with updates, particularly during the implementation phase.

Priorities were determined early in Phase 2 and included:

• Identification of sites for classroom-based learning;
• Review of proposed curriculum and possible modifications;
• Agreement from programs with developed materials to modify and adapt for use, with consideration of intellectual property;
• Curriculum development;
• Recruitment, hiring and training of facilitators;
• Creation of website, learning management system for distance course, and multi-media learning objects;
• Admissions process for interested and qualified IEHPs;
• Response to external organizations and individuals to requests for information;
• Administrative and technical support staff for implementation stages;
• Communication plan for stakeholders and working group;
• Evaluation instruments and processes

Work commenced in many areas simultaneously, working with a planned course start date of January 14, 2008 in five cities across Canada. Lagging dependences were considered, such as the need for sites to be secured prior to posting information on the website, and the determination of class times and schedules through negotiation with sites and facilitators.
Implementation occurred on schedule in two cities (Toronto and Vancouver) the week of January; two sites started the week following (Edmonton and Regina), and all classes concluded by February 29, 2008. Evaluations were both formative and summative, with feedback obtained following the delivery of each unit, and an overall program evaluation conducted at the conclusion of the course. Evaluation of knowledge and behaviour shifts was also measured in a Program Impact Evaluation.

**Curriculum Development**

**Prior Recommendations**

The Working Group had previously developed a curricular outline for the project that included the following session components and learning outcomes:

1. **Cultural Diversity and Health Care Culture**
   The first session consists of an introduction to the program, its purpose and what expectations of/from the participants are. The session then addresses the topics of cultural awareness and why cultural sensitivity (as well as sensitivity to gender/sexuality issues) and cultural competence is a must in Canadian society. This session also asks what Canadian culture is; what does it mean to work in a diverse culture; what responsibilities come with social rights; and what are the reporting/management structures in Canada? Finally, the session addresses the ideas of workplace culture and health care subcultures. Use of a professional Code of Ethics, testimonials and other examples would benefit this session. At the end of this session, IEHPs will be able to
   - Identify what “culturally sensitive” means;
   - Identify ways of being culturally sensitive;
   - Illustrate the idea of cultural diversity;
   - Recognize the roles and responsibilities of other Canadian health care professionals;
   - Demonstrate an understanding of interprofessional collaboration and health care teamwork.

2. **Pathways to Licensure and Employment**
   This session is for IEHPs to talk about their steps in the process of obtaining licensure and employment (including interview, job search, and resume skills, but not examination formats). The concept of constructive feedback will also be discussed. This session would be a generic overview but would incorporate an extensive use of links to specific professions. At the end of this session, IEHPs will be able to
   - Explain the process for gaining licensure in their profession;
   - Define “constructive feedback” and provide examples of why this helps them professionally.

3. **The Canadian Health Care System I**
   This session explores key concepts around health care delivery and methods of delivery. Primary health care is discussed as a basic organizational structure of the Canadian health care system. An outline of the history of health care in Canada includes descriptions of the Canada Health Act and the relationship between and the differing responsibilities of the federal/provincial/territorial
governments. Also in this session is an explanation of the roles of professional associations and certification bodies, the roles of consultants (who are they? What do they do? Are they licensed in a profession?) and private sector practice (including practice ownership regulations).

At the end of this session, IEHPs will be able to

- List who is responsible for paying for health care in Canada;
- Describe the difference between private and public health care;
- Explain the structure and function of hospitals;
- Explain the structure and function of primary care;
- Explain the importance of the Canada Health Act;
- Recognize the difference between the levels of governments in Canada.

4. The Canadian Health Care System II
This session explores the relationship between professions in health care and introduces the concept of regulated professions, including delegated tasks, overlapping scopes of practice and the role of the advanced practitioner in health care.

At the end of this session, IEHPs will be able to

- Demonstrate an understanding of interprofessional collaboration and health care teamwork;
- Explain the roles and responsibilities of other health care professionals in Canada;
- Explain the function of regulatory bodies.

5. Provincial Delivery of Care
Included in this session is an overview of factors that influence the delivery of health care in the provinces. Various health care delivery models are identified, along with a description of the interdisciplinary/interprofessional team members who work in health care in the provinces. This session also discusses labour mobility in Canada and payment information (such as CPP, EI, income taxes, and so on). Extensive use of links to professions/provinces is recommended.

At the end of this session, IEHPs will be able to

- Describe the structure and function of licensing and regulatory bodies in Canada;
- Explain the role of professional associations;
- Explain the roles and responsibilities of other health care professionals in Canada.

6. Patient-Centered Care/Collaborative Practice/Relationship-centered Care
This session highlights the significance, characteristics, and benefits of patient-centered care and collaborative practice. Communication strategies with the patient/family and health professional team members are identified.

At the end of this session, IEHPs will be able to

- Demonstrate effective ways of communicating with clients/patients and caregivers;
- Explain what advocating for and with patients/clients means;
- Discuss what relationship-centered care means;
- Identify the elements of relationship building and negotiation;
- Demonstrate an understanding of interprofessional collaboration and health care teamwork.

7. Professionalism/Reflective Practice/Standards of Practice
This session explores the meaning of professionalism and elements of professionalism are described such as continuous learning and the value of mentoring relationships. It also introduces the concept of reflective practice and the standards of practice in health care professions.
At the end of this session, IEHPs will be able to
- Define reflective practice and ways of doing it;
- Explain the importance of continuing to learn;
- Explain the benefits of building supportive environments for practice;
- Explain the role of professional associations in ongoing competence;
- Explain the role of regulatory bodies in protecting the public.

8. Ethics and Liability
This session explores the concept of ethics in health care, personal ethical dilemmas and professional codes of ethics. The session also illustrates the process of how to make ethical decisions. Legal issues in health-care related matters and professional liability are also explained.
At the end of this session, IEHPs will be able to
- Recognize ethical dilemmas in health care;
- Discuss and resolve hypothetical ethical dilemmas;
- Reflect on the individual professions and identify potential liability or malpractice situations;
- Explain their professions code of ethics.

9. Workplace Context
This session explores Canada’s “work ethic” (including patient volume in a practice, hours worked, work stress and means of dealing with this), and resulting safety issues in health care. This session also explores issues such as body language, nuance, figures of speech, professional acronyms, and so on.
At the end of this session, IEHPs will be able to
- Compare (the differences and similarities) the workplace context of their country of origin and Canada;
- Demonstrate an understanding of professional responsibilities and accountability in ensuring patient safety through clear language and communication styles;
- Recognize potential patient safety issues;
- Discuss and offer solutions to patient safety issues.

10. Summary
This session looks back at the material previously covered. IEHPs are also encouraged to discuss new developments on their pathway to licensure. An exam, if applicable, could be administered during this session.

Iterative Design and Use of Existing Materials

In July and August, the project manager revisited the proposed outline. Several suggestions were recommended, including decoupling the topics of patient-centered practice and collaboration to allow for more elaboration through two separate units, and the compression of the sessions on the structure and function of the federal and provincial health care systems from three units to two (with the integration of the licensing process into the unit on professionalism). Further, the session on workplace context was expanded to include emerging technologies, such as the Electronic Health Record. It was also recommended that the sessions be designed in a manner that would foster inter-professional education, as an organizing epitome for collaboration.
Finally, a session on Career Planning was recommended to complement the discussions on the licensing process, so that IEHPs could avail themselves of this skill in future. A revised outline was circulated and approved by the working group.

In Phase 1, three programs had been identified that contained elements that would be suitable for adaptation. These programs were:

- Registered Nurses Professional Development Centre (Nova Scotia): Orientation to Canadian Health Care for Internationally Educated Health Care Professionals
- The Association of Faculty of Medicines of Canada (AFMC): A Faculty Development Program for Teachers of International Medical Graduates; and
- Michener Institute (Ontario): Access and Options.

Each program was contacted and discussions occurred that would allow for agreements to be negotiated that would preserve the integrity of the materials as intended by the original authors while allowing the IEHP Orientation Course to adapt and modify the materials in order to integrate with the proposed curriculum. Agreements were reached with the Nova Scotia and AFMC programs and materials were shared freely between the IEHP project and the two organizations. This significant contribution was notable and allowed development of the curriculum to be undertaken in an effective and efficient manner.

**Development Process**

Once consent had been obtained to utilize previously developed materials, a Call for Developers was prepared and circulated. The scope of the work to be contracted was stated as:

Individuals or teams are being sought to develop classroom-based materials for the topics listed. Ideally, subject matter expertise will determine the number and type of topic(s) to be developed by individuals. Working with previously developed materials as content objects, and in close conjunction with the project manager, the CDv is responsible for the development of a curriculum of interactive classroom based sessions that will include:

- Information architecture of subject matter (outline of unit sub-topics, sequencing, rationale for inclusion, key points, summary, strategies for learning activities, following standard “events of instruction”)
- Learning objectives (based on identified unit and course outcomes)
- Power-point presentation (using template provided)
- Speaker’s notes (including options for possible activities depending on context, time, and classroom management strategies)
- Learning activities (including instructions for facilitators, suggested time intervals, handouts, and any accompanying resources or materials)
- Assessment items (aligned with learning objectives, both formative and summative, to include multiple choice, True/False, short answer)

In an iterative manner, the CDv will provide content for the curriculum based on his/her subject expertise and will liaise with the project manager and other curriculum developers involved in the project to ensure seamless integration of the curriculum with other project
deliverables. Deliverables must be on time, within budget and aligned with the project work plan. It is anticipated that 8-10 hours of development will be required for each Unit.

Criteria to be used in the evaluation of candidates were:

- Prior experience in curriculum development
- Expert knowledge of subject matter
- Understanding of the challenges facing newcomer integration
- Familiarity with the concepts of inter-professionalism, patient centered care and health care culture
- Demonstrated success in teams and project management

Several applications were received and reviewed. All developers were contacted and interviewed. C & C Consulting was retained to develop the materials and work commenced, with final outputs expected by the end of November. The design that was proposed was based on the outline that had been previously developed, with the addition of a “Capstone” project to foster collaboration. Dedicated class time would be included to ensure that learners were not overly burdened with the demands of the course. As well, the developers proposed that pre-readings be prepared for each unit and that each class would be spent applying what had been read in advance. The developers proposed the following structure for the curriculum for each 3-hour unit within the curriculum:

- 20 minutes review/advance organizer;
- 40 minutes theory burst;
- 20 minute break;
- 20 minute dedicated capstone time;
- 40 minutes application/learning activity;
- 20 minutes to summarize/prepare for next class.

Draft materials were received by mid-December and each Unit consisted of:

- Power Point Presentation Slides
- Facilitator Guide
- Pre-Reading

Materials were reviewed by the project coordinator and further developed to ensure integration with project outcomes and session objectives. Additional learning activities were then added, copy-editing undertaken, and materials were circulated to the facilitators for review prior to implementation. The final curriculum outline is presented below:

**Orientation to the Canadian Health Care System, Culture, and Context**

A pan-Canadian Course for Internationally Educated Health Care Professionals

**Curriculum Outline**

The goal of this course is to provide a structured, systematic orientation to the Canadian health care system and culture for internationally educated health care professionals (IEHPs). IEHPs bring a diversity of practice experience and education to Canada, which are highly valued.
However, not all prior experience is transferable to the Canadian system due to systemic and cultural differences. While many professions provide “bridging programs” aimed at profession-specific technical and regulatory requirements, a broader overview of system-wide issues is required to ensure that IEHPs are better able to meet the demands of professional practice related to collaboration, teamwork, and patient-centered care. This course was developed to meet this need and consists of ten three-hour units, with overarching themes of patient safety, communication, and inter-professionalism woven throughout the curriculum.

**Unit 1: Cultural Competence**

This session addresses the need for cultural competence in Canadian health care practice. The unit examines what is meant by Canadian culture and what it means to work in a diverse culture. The importance of communication and the essential skill of active listening are emphasized, as well as the need to consider patients’ cultural values. This unit also serves as a general orientation to the course and its goals. Ground rules for participation and collaboration are reached by consensus.

At the end of this session learners will be able to:

- Understand the meaning of “culture”
- Understand why it is important for health professionals to be culturally competent
- Identify steps they can take to increase their own cultural competence
- Describe the idea of diversity and its role in Canadian culture
- Accept that patients make decisions about their health care within the context of their own cultural values

**Unit 2: The Canadian Health Care System Part 1—The Role of the Federal Government in Health Care**

This unit explores the function and structure of Canadian health care. The history of health care in Canada is examined and the roles of the federal and provincial/territorial governments are outlined. Public health care is distinguished from private health care, and attitudes surrounding the health care system are discussed. The term “health” is defined and the determinants of health are introduced. The primary health care model is described, and the idea of health promotion is discussed.

At the end of this session learners will be able to:

- Define “health”
- Understand the determinants of health
- List the five principles of the Canada Health Act
- Understand how health care is paid for in Canada
- Describe the difference between private and publicly funded health care
- Appreciate the importance of Canadians’ attitudes toward the Canadian health care system
- Understand the concepts of health promotion and primary health care
Unit 3: Patient Safety, Electronic Health Records, and the Workplace

This session explores the Canadian “work ethic” and its impact on patient safety. Factors such as patient volume/load, hours worked, and stress management are examined in light of patient care. The emergence of electronic health records and their impact on patient safety as well as the primacy of patient privacy and confidentiality are discussed. Government legislation surrounding occupational health and safety is introduced.

At the end of this session learners will be able to:

- Understand how the healthcare work environment affects patient safety
- Understand professional responsibilities and individual accountability in ensuring patient safety
- Recognize potential patient safety issues and offer solutions
- Discuss issues associated with electronic health records and other emerging technologies in the healthcare workplace
- Understand government legislation impacting workplace safety

Unit 4: The Canadian Health Care System Part 2—Provincial Delivery of Health Care

Building on Unit 2, this unit explores the provincial delivery of health care. Health care delivery models are outlined, emphasizing the continuum of care, and health care resources in learners’ region or province are identified. A distinction is made between institutional and community health care delivery. The role of public health is explored.

Note: This session is designed to allow for an exploration of regional or province-specific issues.

At the end of this session learners will be able to:

- Describe health service delivery models
- Understand the continuum of care
- Identify health care resources available in their region
- Discuss issues related to the delivery of health care in their region

Units 5: Patient-centered Practice

This unit focuses on the significance, distinguishing characteristics, and benefits of patient-centered care. The importance of communication with patients and families as well as with other members of the health care team is emphasized, and patients’ expectations of their health care providers are outlined. The idea of cultural diversity is revisited. Patient advocacy is examined, and the importance of self-care as a key component of patient-centered practice is emphasized.

At the end of this session, learners will be able to:

- Define patient-centered care
- Understand the contribution and involvement of patients and their families
- Demonstrate effective ways of communicating with patients and family members
- Explain the concept of patient advocacy
- Understand the importance of self-care as a key component of patient-centered practice
Unit 6: Collaboration Among Health Care Providers

This unit highlights collaboration among health care providers as an important part of health care in Canada and a key component of patient-centered practice. Both the benefits and the challenges of collaborative care are discussed. Communication strategies for improving collaboration are introduced and conflict resolution strategies are discussed and practiced.

At the end of this session, learners will be able to:

- Define collaborative practice and understand its role in providing patient-centered care
- Identify the benefits of collaborative practice for patients
- Identify potential sources of conflict in collaborative practice
- Use conflict resolution techniques effectively

Unit 7: Professionalism, Reflective Practice, and Lifelong Learning

This unit examines principles and elements of professionalism, including the attributes of professionals and the importance of reflective practice. The role of regulatory bodies in organizing health professions is discussed, and standards of practice and reporting requirements are highlighted. The importance of lifelong learning is explored, and the concept of inter-professionalism is revisited.

At the end of this session learners will be able to:

- Explain the importance of lifelong learning for health professionals
- Define reflective practice and discuss ways of doing it
- List the defining attributes of professionalism
- Explain the role of professional associations in maintaining a health provider’s professional competence
- Explain the roles of regulatory bodies in protecting the public

Unit 8: Ethics and Liability

This session explores the concept of ethics in health care, touching on the resolution of personal ethical dilemmas and the importance of professional codes of ethics. A process for making ethical decisions will be presented, and legal issues related to professional liability are explained.

At the end of this session learners will be able to:

- Recognize ethical dilemmas in Canadian health care
- Explain their own profession’s code of ethics
- Understand the importance of informed consent
- Discuss and resolve a hypothetical ethical dilemma
Unit 9: Pathways to Successful Employment

Successful employment for internationally educated health professionals may encompass a range of opportunities from entry-level positions to clinical placements. The focus of this session is on planning for successful employment, both in finding appropriate employment (including interviews, job search strategies, and résumé-preparation skills) and successfully retaining employment.

At the end of this session learners will be able to:

- Plan for successful employment by engaging in a career planning process
- Identify local community resources to assist with job search
- Gain self-awareness of career needs by completing the Canadian Work Preference Inventory
- Use effective job search techniques
- Understand the elements of a successful résumé and job interview

Unit 10: Capstone Session

This unit reviews themes highlighted throughout the course. Specific regional issues may be explored in more detail. Learners may present team projects or, in some instances, an examination may be administered.

Lessons Learned:

The work in Phase 1 allowed for the development of a rapid prototype

Access to previously developed materials resulted in an efficient development process
Iterative design principles (revision through formative feedback) resulted in a final curriculum

The final curriculum is a unique product, does not duplicate existing programs, and integrates principles of active learning and interprofessional education

Program Delivery

The implementation phase commenced the week of January 14, 2008 and all sites concluded classes by February 29. The following section provides a summary of issues that occurred in the delivery of the program in various areas. It should be noted that the implementation phase was intense due to its compressed nature, and inclement weather had a slight impact on the critical path of the project.

Sequence and Format

The working group had recommended that the following sequence be followed in the curriculum delivery:
1. Canadian Health Care System 1
2. Canadian Health Care System 2
3. Provincial Delivery of Care
4. Cultural Diversity and Health care Culture
5. Patient-Centered Care
6. Professionalism
7. Workplace Context
8. Ethics and Liability
9. Pathways to Licensure
10. Summary

It had been indicated, however, that sessions 4-9 could be placed in any order. As it happened, the order of sessions was revised, due to the need for more extensive development of some sessions, coupled with the decision to produce a video-clip on patient centered practice and collaboration that was not quite ready for distribution when scheduled due to post-production requirements. However, the curriculum was designed so that each Unit was a stand-alone unit. Despite the changes in order at some of the sites, this did not seem to impact learner satisfaction.

However, it was observed that some sessions were more likely to result in the learners’ capacity for focusing on patient care, rather than individual and collective concerns, such as the fairness of the licensing process, the perception that the health care system’s health human resources issue is easily resolved by licensing IEHPs; these contentious issues were problematic at the course outset, but a turning point was reached in each class’s sensibility when the units on patient-centered practice and collaboration were presented.

Concern had also been expressed by the working group about the scheduling of two sessions per week, with some committee members suggesting that once weekly sessions might better fit the needs of the IEHPs, many of whom might have family or work commitments. The following evaluation data indicates that twice-weekly sessions were well received; when classes were cancelled due to weather in several instances, learners commented too much time had elapsed between sessions. During the evaluation, questions were also asked about the number of topics, length of sessions, and appetite for online education as an alternative, or as an additional part of the classroom learning.
Qualitative feedback
More multimedia presentations should be included, with real-life examples
Addition of a site visit or experiential component would be helpful
An exclusively online course would not be as effective because of lack of interaction
and losing a layer of communication (e.g. facial expressions, tone)
Two sessions of 3h weekly are okay, but once weekly sessions may be more convenient for commuters
Access to internet and computers during the class would be useful

Lessons Learned:
Learners were strongly supportive of twice weekly sessions of 3 hours duration
Most learners favour the addition of an orientation session before the first unit of instruction
Preference was expressed for classroom based instruction vs. online, although the majority of learners would support a blended learning environment
The majority of learners felt that the number of topics was appropriate
The order of topics should be revisited, based on unit evaluations and classroom dynamics

Course Materials and Learning Activities
Meeting the needs of learners was a goal of the program. Concern about whether the IEHPs would be likely to complete pre-reading had been expressed, as well as their ability to adapt to a more interactive teaching and learning style, as opposed to a more traditional lecture format. Evaluation data indicate that the learners were largely able to complete the pre-readings in time for class (although some facilitators experienced a lack of preparedness by the learners, particularly at the course outset), and provide strong evidence that a social learning environment was preferred.
Qualitative feedback
Notes were organized and well-prepared but lectures sometimes felt like direct repetitions of the printouts
Experts in relevant fields should be invited to speak
Capstone project required too much time to do
Materials and topics were relevant and interaction with classmates & facilitator was helpful
Lessons Learned:

Pre-readings and handouts were highly valued by participants

Materials and website URLs will be utilized by most IEHPS in future

The use of video-clips (multi-media) enhanced learning

Learners overwhelmingly preferred interactive sessions, although lectures were also valued

Case-based learning was preferred by most as a method of application

Capstone projects were not as well received as an effective use of classroom time compared to other teaching methodologies

Learning Objectives and Goals

A further goal of curriculum development is the preparation of materials that are relevant to learners and result in increased knowledge and skills. Evaluation data on the course outcomes both overall and by individual unit confirm that learners’ needs were met and that better understanding of individual unit topics was professed to have occurred. Learners were also asked to provide suggestions for additional topics. Detailed unit evaluations are available upon request. It is worth noting that the relative degree of satisfaction increased as the course progressed, perhaps denoting the formation of learning communities and cohesion within the groups at each site.

![Comments about Course Outcomes]

- 26. The sessions met my learning needs.
- 27. The sessions will increase my personal and professional confidence while undergoing licensure
- 28. Having the sessions with other health care professionals was helpful.
- 29. I have a better understanding of the framework of the Canadian Health Care System (Federal)
- 30. I have a better understanding of the framework of the Provincial Health Care System
- 31. I have a better understanding of Patient Safety and Electronic Health Records.
Qualitative feedback
Program was very helpful in understanding the Canadian health system and culture
More cases and reading materials would aid in understanding
Site visits to see real topic relevance would be helpful
Capstone project feedback would help students improve communication/understanding

Lessons Learned:
The vast majority of participants felt the sessions met their learning needs and increased their personal and professional confidence in undertaking the licensure process

Strong agreement was expressed for the inter-professional nature of the learning environment

Eighty-percent of participant strongly agreed with the statement on recommending the course to newly arrived health care professionals

Learners reported better understanding in all units of the curriculum

Giving feedback on the capstone projects should be considered

Additional topics and suggestions are provided below. In many instances, these involve more elaboration and would likely involve extension of the course and certainly more planning at local levels. In any event, the comments provide further evidence of its value to learners and are a testament to the level of interest in the program.

Topic Suggestions
New regulations for licensure and approaches to updating knowledge
Project management
Specific application on Electronic Health Records and relevance to each profession
Layman's terms, slang, jargon
Discussions about specific professions
Hospital tour
Canadian health promotion strategies

**Other Suggestions**
- Internet access in classrooms
- Newsletter to keep program graduates updated
- Invite speakers from various professions
- Inclusion of actual clinical experiential component
- Consideration of culture/religion and scopes of practice at work
- Greater patient-centered focus, consideration of patient privacy and advocacy
- Communication and collaboration in teams, especially interprofessional
- Understanding and working within the rules of the Canadian health care system

**Lessons Learned:**

Future curriculum revisions should consider the invitation of regional guest speakers and site visits

The development of an alumni association or communication vehicle for maintaining contact should be considered

**Site Selection**

Early in Phase 2, the working group deliberated about the type and location of sites for the pilot curriculum. It had been agreed that the course would be offered across Canada, and the expectation was that the course would be offered in large cities in various provinces to allow for access by the largest number of IEHPs. Research was undertaken to determine where the need for the program was greatest in each region. As well, consideration was given to the type of setting where the learning would occur. The working group decided to explore alternative types of sites for the pilot project, in order to determine where the learners’ needs would be best met, including access by local transit. A variety of settings, from universities and colleges to settlement agencies serving new immigrants were investigated.

With input from members of the working group, a number of organizations were approached to host the pilot course, with the understanding that admissions and administration would occur centrally. Criteria were created to serve as a basis for decision-making and included:

- Sensitivity to the needs of new Canadians, and IEHPs in particular
- Classroom space for 15-20 participants for ten 3-hour sessions
- Two afternoons or evenings weekly from January 15 – February 16, 2008
- Ancillary support services (settlement, employment, language) are desirable
- Audio-visual equipment (computer, projector, screen, speakers)
- Internet access in classroom
The following cities and sites were selected to host the pilot curriculum; times and days of the week are also provided that were a result of discussions between the sites, project manager, and facilitators;

**Vancouver, British Columbia**  
**Kwantlen University College**  
*Tuesdays and Thursdays 4 pm - 7 pm*

**Edmonton, Alberta**  
**Bredin Institute**  
*Mondays and Thursdays 5:30 pm - 8:30 pm*

**Regina, Saskatchewan**  
**Saskatchewan Institute of Applied Science and Technology**  
*Mondays and Wednesdays 4 pm - 7 pm*

**Toronto, Ontario**  
**Access Centre for IEHPs, HealthForce Ontario, at Ryerson University**  
*Mondays and Wednesdays 6 pm - 9 pm*  
*Tuesdays and Thursdays 3 pm - 6 pm*

**Fredericton, New Brunswick**  
**Multicultural Association of Fredericton**  
*Tuesdays and Thursdays 4 pm - 7 pm*

A stipend of $1,250.00 was offered to offset overhead administrative costs, and sites were asked to invoice the IEHP office for photocopying costs. Letters of understanding were sent to the sites, and signed copies returned and kept on file in the office.

Despite concerted efforts by central and local staff, the project was not offered in Fredericton (this will be discussed further in the section on Admissions). Prior to the start of classes, Ryerson University was forced to withdraw its offer to participate, based on the inability to offer audio-visual access; although alternatives were explored with the Access Centre for IEHPs, a suitable classroom for a group of 20 was simply not available. The decision was made to offer the Toronto class at the University of Toronto. Since two sections of classes were offered in Toronto (to offset the lack of an offering in Fredericton, and to respond to a large demand in Toronto), it was necessary to book classroom space for a combined four time slots on short notice.

Various site issues emerged during implementation, although none were insurmountable. It was apparent to the facilitators that the learners were in need of additional support, such as career counseling, and assistance with the regulatory process; at the same time, IEHPs were pleased to be attending classes in higher education institutions. In all circumstances, however, learners identified the need for improvement to facilities, such as access to computers, the availability of food and beverages through a cafeteria or cafe, and reliable audio-visual capacity.
The evaluation data concerning sites is provided; although the feedback was generally positive, the degree of satisfaction with the sites is not as robust as satisfaction with other elements of the pilot.

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Comments about the Site

- **20. The location was convenient and easily accessible.**
- **21. The environment (seating, room temperature, lighting) was appropriate for learning.**
- **22. The audio-visual equipment and multi-media (laptop, projector, video clips) was reliable.**
- **23. The site facilities (washrooms, cafes) were acceptable and met my needs.**
- **24. Additional services available at the site would be helpful e.g. career planning, settlement services, language training**

Qualitative feedback

- Room temperature was usually too cold
- Cafeteria, computers, and printers should be available for student use
- Some rooms were too small and not conducive to learning
- Seating arrangements that allow face-to-face contact with classmates and facilitators are good

Lessons Learned:

- Sites play a critical role in the creation of an optimal learning environment; sufficient time for planning should occur
- Audio-visual capacity and computer access must be conditions for future sites
- Site visits should be considered to ensure compliance with letters of understanding

Facilitators

Contiguous with site planning, the search for facilitators ensued. The working group had agreed that facilitators should be experienced educators, and health professionals. A Call for Facilitators was created; criteria were established and circulated to stakeholders as below;

Recognizing the need for meeting the needs of local learners and balancing the program needs for consistency in curriculum delivery across multiple sites, facilitators are sought who possess:
• Superior classroom facilitation skills
• Expert knowledge of most subject matter
• Understanding of the challenges facing newcomer integration
• Familiarity with the concepts of inter-professionalism, patient centered care and health care culture
• Creativity and flexibility in teaching practice

Criteria to be used in the evaluation of candidates include:

• Demonstrated teaching experience in post-secondary education settings
• Experience working with internationally educated learners
• Health care background in one of the six professions is preferred
• Demonstrated success working in teams
• Experience with distance education delivery is desirable

A number of applications were received and all potential candidates were contacted for a telephone interview. A sub-committee reviewed the resumes of the candidates, and results of the interviews. Offers of employment were made to the following individuals:

Julia Gajewski-Noel (Fredericton, Nurse)
Angela Cuddy (Toronto, Dietician)
Certina Ho (Toronto, Pharmacist)
Bonnie Raisbeck (Regina, Nurse)
Dolores Paul (Edmonton, Medical Radiation Technologist)
Lori Shortridge (Vancouver, Nurse)

A small community of practice was created amongst the facilitators. Initial correspondence was by email; introductions were made, and curriculum materials were forwarded upon finalization. Training occurred by archived videotapes (to be discussed under the section on technology). A discussion forum was set up on the Learning Management System (LMS) prior to implementation, which not only served as a rich repository of information on the implementation phase, but also facilitated sharing successful, and less than successful, approaches to teaching and classroom management. In addition to the group discussion forum, each facilitator contacted the project coordinator on a regular basis, by email or telephone, partly to deal with local sites administrative issues, and also partly to discuss issues that ought not be in a public forum (members of the working group were invited to view the discussions).

Evaluation data about the facilitators confirms the pivotal role played by these individuals in the success of the course, acting as both a local resource for the learners, and liaising with the Toronto office on a number of issues. In some instances, facilitators were employees at the sites, and this often aided immeasurably in trouble-shooting, such as for audio-visual issues or class cancellations.
Qualitative feedback
Facilitators were well-prepared, professional, approachable
Discussions were sometimes uniprofessional
Encouraged discussion and answered questions satisfactorily

Lessons Learned:
Effective facilitation was a critical factor in the success of the pilot
Despite the compressed nature of the course, all facilitators were committed and resourceful, and succeeded in creating supportive learning environments
More time for training should be considered in future, particularly in the areas of interprofessional education
Future iterations should include facilitators in the redesign of the course

Admissions Process
Centralized administration of admissions occurred at the University of Toronto. A website was created (IEHP Canada, www.iehpcanada.utoronto.ca) that served as both a repository of information about the course, and a portal for instructions about the admissions process. The course URL was forwarded to stakeholders through the working group (professional regulatory authorities, associations, licensing boards, and settlement agencies), with the request that any questions or concerns be directed to the central office. A list of external organizations was used for outreach purposes.

The application form was available as a downloadable word document that could be posted (mailed) or emailed to the office. Due to the need for two pieces of supporting documentation, IEHPs were also asked to provide evidence of status and language fluency as photocopies by
mail. IEHP office staff promptly acknowledged applications, and letters or email offers of admission were sent pending confirmation of eligibility.

On average, 4-6 emails were received daily, and approximately the same number of telephone calls occurred in any given day (a toll-free number in Canada was provided on the website). Ninety-four applications were received in total. The closure of the University over the holidays was not a deterrent due to the fact that program staff provided information and responses to requests by email during that time; the website indicated the modified process for applying during the period from December 21st to January 7th. Given the anticipated start dates of January 14, this lack of interruption of service was critical.

The course was made available to the following professions; medical laboratory technology, medical radiation technology, nursing, occupational therapy, pharmacy and physiotherapy at any stage of licensure. The IEHP working group had specified that a Canadian Language Benchmark (CLB) of 7 or 8 would be required to optimize participation in the course, and that participants be Permanent Residents or Canadian Citizens. Over the course of the implementation, several issues emerged related to each of these requirements and are discussed in the sections below.

**English Language Fluency**

Early in the implementation feedback was received from British Columbia and Ontario (Douglas Fir College and Access Center for Internationally Trained Health Professionals, respectively) that IEHPs at a CLB were likely to be enrolled in bridging programs, or close to licensure. It was decided that candidates at a benchmark of 5 or 6 would be accepted. In discussing this decision with the working group, it was noted that, for certain professions, other criteria were applied; if a candidate was educated in English, objective evidence of fluency did not have to be present for licensure. In view of that difference between professions, it was determined that offers of admission were to be made.

A number of candidates were not able to access Benchmark testing, particularly as the course implementation date loomed and testing dates were not available. It should be noted that each of the cities involved in the pilot did offer CLB testing, but that a charge is applied if a candidate attempts the test more than once in a particular time period. In future, planning should consider the implications of admissions in this event.

A number of candidates presented other evidence of English language fluency e.g. IELTS, TOEFL, CanTest. In those instances, the IEHP office referred to a document provided by CSMLS that allowed for mapping of different language assessment instruments against the CLBs. This document was used for internal processes only; although external requests were made to share the levels, particularly by settlement agency, CSMLS had not released it for this use. It should be noted that this document was very useful in determining comparability of test scores.

The differing levels of fluency were apparent in the classroom setting. Some learners struggled with comprehension. As a result, some classroom discussions were repetitive and, at times frustrating, for those more fluent learners. Further, some learners identified that the pre-reading was difficult for them to comprehend, while this was not the case for others.
Proessions and Other Interested Groups
Over the course of the project, requests to attend were received from professions other than the six accommodated by the grant; physicians, midwives and respiratory therapists expressed interest in taking the course. Further, several requests emerged from settlement agency staff, and human resource professionals that are involved in working with IEHPs. This interest was noted; interested candidates received an explanation about the pilot nature of the project and its primary audience at this time.

Status in Canada
Permanent residency or Canadian citizenship was required in order to participate in the course. Several requests were received from individuals on visitors’, students’, and employment visas. Unless application had been made for permanent residency, attendance by these individuals was not possible and an explanation provided to those individuals.

Stage of Licensure
The application process did not explicitly capture each applicant’s stage of licensure. This information was requested from participants following the conclusion of the course. Although all learners that responded were at various stages of licensure, it is safe to generalize that many of them are well underway with document or credential evaluation, and some are attempting penultimate examinations. Most have contacted their regulatory authority, although some had not yet done so.

Several requests were received from employers about the availability of the course to employees that were struggling in the workplace. These requests were noted; and an explanation provided about the pilot nature of the project. At the Saskatchewan site, provision was made to allow 4 post-licensure nurses to attend the course.

Administrative Issues
Trends emerged during the implementation phase that had been anticipated. Demand in Toronto was high; a class of 20 filled very quickly and an additional session was added. Despite a concerted effort in Fredericton, there was a lack of qualified candidates. The deadline for admission was extended in Regina, Fredericton and Edmonton, which allowed classes in Regina and Edmonton to proceed, but only one qualified applicant in Fredericton resulted in the cancellation at that site.

The working group had recommended that a course materials fee of $50 be charged, partly to circumvent individuals from registering, and not attending, thereby preventing other qualified IEHPs from participants. There was a caveat made that individuals that could not afford the fee would have it waived, and several individuals made this request. However, it was also the intent of the working group that the funds would be returned at the completion of the project as recognition for their participation in the pilot. Unfortunately, there was substantial confusion about the materials fee; some IEHPs paid cash (notwithstanding instructions), creating an administrative burden for facilitators, others did not pay at all, resulting in inconsistent application of this policy. Those individuals that paid the fee had it returned to them with their Certificate of Completion.
Evaluation Data
An overall program evaluation indicated that the majority of participating IEHPs found the application process manageable, program staff quick to respond and the website useful. The centralized nature of administration was aided by the cooperative role the facilitators played in providing a link to the Toronto office.

Qualitative feedback
Website was easy to navigate and sufficiently informative
Applying online was easy
Inquiries were responded to quickly and comprehensively

Lessons Learned
A centralized system of administration for admissions, and information provision by website, telephone and email was developed and effectively implemented

IEHPs were satisfied with the process, and did not find it burdensome

Risk management of holiday closures was a factor in the success of the admissions process; in future more realistic scheduling would prevent this need

Despite concerted efforts, one site was not able to offer the course, and two sites started one week past the originally planned start of classes

Clear criteria for admissions were important, although modification was necessary in specific instances
**Attendance and Participation**

A total of 70 IEHPs participated in the pilot in 4 cities, in 5 sections. The following table provides a breakdown by profession and site. Medical laboratory technologists were the profession most represented, followed by pharmacists. All six professions were represented in the final cohort, and the working group was active in promoting the program to their respective constituencies.

<table>
<thead>
<tr>
<th>Profession</th>
<th>Toronto (2 classes)</th>
<th>Vancouver</th>
<th>Edmonton</th>
<th>Regina (3+4*)</th>
<th>Profession Totals</th>
</tr>
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<tbody>
<tr>
<td>Nurse</td>
<td>1</td>
<td>7</td>
<td>7 (4+4)</td>
<td>8 (4+4)</td>
<td>25</td>
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<td>16</td>
<td>6</td>
<td>2</td>
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* = post licensure RNs

Attrition was very low. Three IEHPs withdrew in the first week of classes (2 in Toronto, and 1 in Vancouver), citing other work and study commitments. One individual was commuting from Windsor, and found the driving untenable (although he had been advised during the admissions process that this might be problematic).

Attendance was consistent; all participants qualified for a Certificate of Completion that was offered to individuals attending 7 out of 10 classes. In fact, only two learners attended as few as seven classes; the majority of individuals attended all sessions, and several missed only one or two units. Given the extreme weather conditions, this result was very edifying. Classes were cancelled on one occasion in all sites, with the exception of one Toronto section (Tuesday and Thursday afternoons), which definitely set the pace for implementation in a “best-case” scenario; learners in this section were asked if they would like a respite, and the consensus was that they wished to keep learning.

As noted in the admissions section, the Regina site included 4 post-licensure RNs. The facilitator noted that their presence was very edifying and that they often confirmed the importance and relevance of the topics for the pre-licensure group, contributing anecdotal evidence of situations. The employer was extremely positive about the impact of the course on the employees that were encouraged to attend.

Given the concern the advisory groups had concerning English fluency and its impact on participation, evaluation data was captured on the learners’ perception of its impact on their educational experience. The vast majority felt that their comprehension was not problematic, with the exception of a few qualitative comments concerning the use of idioms and expressions.
Qualitative feedback

Very clear, straightforward except for the occasional slang or less-common word (e.g. “puke”, “gingerly”)

Lessons Learned:

Relevant programming and positive learning environments resulted in excellent retention rates

Learners reported a lack of problems regarding comprehension, demonstrating that the language level of the materials was appropriate

English language proficiency was somewhat problematic for facilitators; a CLB below 6 should not be considered for admission to the program

Outreach/External Requests

Once details regarding dates, sites, locations and admission criteria had been determined, a “one-page flyer” was created and circulated to relevant organizations through the working group members.

As noted in the section on admissions, the website was developed early in Phase 2, once sites and admissions details had been finalized. IEHP Canada Website: http://www.iehpcanada.utoronto.ca/

The project received a number of requests for information and clarification from individuals and organizations over the course of Phase 2. The following section highlights the origin and nature of the requests, in chronological order.

Sandy Berman, Consultant, British Columbia

Ms. Berman is working on multi-level model of language training involving 3 colleges, 2 immigrant serving agencies, 3 health regions (employers) and 1 union, likely to be funded early November. She requested access to the IEHP curriculum in order to thread through the language curriculum they are adapted. Given the timing of the request (mid-October), and the fact that the curriculum was not yet developed, we were able to provide her with the Enhanced Language Training program for pharmacists developed at the University of Toronto.
Monica Testa-Zanin, Consultant, Toronto, Ontario
Ms. Testa-Zanin was working on a funding proposal on behalf of Ryerson University and Physiotherapy to develop a management structure and umbrella for resources available for Internationally Educated Physiotherapists. There are also plans to develop an exam readiness course, and she was interested in the status of the project in order to include it as a program element for the proposal. A letter of support was requested for the funding proposal and was provided.

Wayne Oake, Director, Access Centre for Internationally Educated Health Care Professionals, Toronto, Ontario
Mr. Oake contacted the project on behalf of the Cultural Competence Working Group, who had identified the need for a broad sector approach to concerns about cultural communication. At that time, the curriculum was in development and an outline was forwarded to the course. Subsequent to their meeting, Mr. Oake conveyed the message from the group that this approach was desirable, and ought to be continued as the best approach to address gaps.

Maha Sarani, Canadian Immigration Integration Project (CIIP)
Ms. Sarani felt that the tools and resources developed would be ideal for the work of the CIIP. At the time of the request, the course had not yet been piloted but the project manager is a member of the Pre-Arrival Working Group organized by the Access Center for IEHPs in Toronto, and a subsequent teleconference provided an opportunity to update the CIIP staff on the progress of the Orientation course.

John Pugsley, Pharmacy Examining Board of Canada (PEBC)
Dr. Pugsley requested an update on the project for the PEBC board. A report on its status was provided.

Manuela (Ella) Klick, Career Consultant, Working Solutions for Skilled Immigrants, ABC Skills Connect Program, The Training Group, Douglas College
Ms. Klick contacted the office on behalf of clients at Working Solutions. Her agency referred many applicants to the Vancouver site.

Harry Karlinsky, Coordinator of Medical Education/Professional Development
Richmond Mental Health Services, Director of CME and Professional Development, Dept of Psychiatry, University of British Columbia
Dr. Karlinsky is developing a 2-day orientation and support workshop for IMGs in British Columbia, and wondered about the suitability of the Orientation course material for use in this context.

Pat Semeniuk, Regional Director, Learning and Career Development, Vancouver Coastal Health, Vancouver, British Columbia
Ms. Semeniuk was interested in the course for the IENs being recruited by VCH. The timing was not convenient for them for the pilot. Further, the nurses would not have been eligible, due to their arrival with employment visas. However, Ms. Semeniuk expressed interest in the course being available to post-licensure RNs.
Shirley Meyer, Deputy Registrar, College and Association of Registered Nurses of Alberta (CARNA)
Ms. Meyer contacted the office to clarify the English Fluency requirements for attendance and, in particular, the level of the CELBAN that would be accepted. Ms. Meyer was not provided with the equivalent score, in the interest of confidentiality requested by CSMLS, but was assured that CELBAN scores would be accepted.

Sheila Hellier, Facilitator/Counselor, Career Transitions for International Medical Doctors, Skills for Change, Toronto
Ms. Hellier wondered about the suitability of the course for physicians.

Erin O’Neil, LINC Assessor, YMCA of Greater Toronto
Ms. O’Neil inquired about the level of English fluency required, on behalf of a client.

Karen Jenkins, Team Lead - Directions for Immigrants, Bow Valley College, Calgary, Alberta
Ms. Jenkins asked if her and her colleagues could visit the program to learn more during a planned trip to Toronto in February to attend a conference. They were able to do so, attending a portion of a class, and meeting with the Project Manager.

Paulette Blais, Consultant
Ms. Blais contacted the program on behalf of an Orientation Program being created for Respiratory Therapists. She wondered about its availability for access by this group, recognizing that it is a small profession, but signaling the express interest in the course for this cohort.

Kristina Diplock, Senior. HR Consultant, Calgary Laboratory Services
Ms. Diplock contacted the program to inquire about its availability in the workplace, and various scheduling configurations, in order to accommodate the learning needs of shift workers.

Randa Palfy, IMG Coordinator, College of Medicine, University of Saskatchewan, Regina General Hospital
Ms. Palfy expressed interest in the course for IMGs in Saskatchewan. She was connected with Wayne Oake in Toronto, to share issues of mutual concern.

Lisa J. Fleet, Research Coordinator, Professional Development & Conferencing Services (PDCS), Faculty of Medicine, Memorial University of Newfoundland
Ms. Fleet was conducting an environmental scan of online ethics courses available for IMGs in Newfoundland and Labrador.

Amir Sheik-Youseff, Membership Chair, AIPSO (Association of International Physicians and Surgeons of Ontario)
Dr. Sheik-Youseff contacted the project on the suggestion of Dr. Maxine Mott from Kwantlen University College, to discern its suitability for IMGs. A meeting was held in Toronto to further elaborate on the project, and determine its suitability for physicians. Dr. Sheik-Yousseff was to liaise with the AIPSO board.

Sandy Berman, National Midwifery Regulators Consortium
Ms. Burman contacted the project about the online aspect of the course, on behalf of Midwifery Regulators, to be used as part of a planned bridging program.
Maria Burgar, Health Sciences Advisor, Working Solutions, Douglas College, British Columbia
Ms. Burgar asked to attend the course to assist her in the work advising IEHPs. Although she was not able to do so, she followed up with correspondence indicated that her clients had many positive comments about the learning experience.

Hugo Lavoie, Producer, Current Affairs, CBC Regina
Mr. Lavoie was interested in producing a story that would focus on internationally educated nurses in Saskatchewan. The project manager spoke with him at length, and was assured that the intent of the program would be positive. A film crew attended one of the classes at SIAST, and was accommodated by the facilitator and IEHPs. Despite repeated requests by the project to be apprised of the segment’s viewing date, it was aired without prior notification. However, a transcript was obtained by Health Canada.

Vicky Schultz, Nursing Student, SIAST
Ms. Schultz was writing a paper on internationally educated nurses and culture shock. Her research questions centered on the reasons for developing the course; correspondence ensued.

Pat Saunders, Consultant
Dr. Saunders works with a number of organizations in Atlantic Canada, and in particular, an umbrella group for regional associations has expressed interest in the project. She expressed a willingness to support its further diffusion.

Lessons Learned:

A coordinated and centralized approach to outreach and responding to external requests for information was utilized

Future iterations can build upon the interest generated in Phase 2 through the use of list-serves etc

The IEHP office should approve requests from media at the time of request

Technology Enabled Education

Work in Phase 1 identified the preference of most stakeholders for classroom-based learning, although a number of organizations and individuals also expressed interest in having the course available in distance education formats. Therefore, the working group suggested that a web-based delivery model also be developed that would enable access for IEHPs either pre-arrival or for those IEHPs unable to access education at regional centers.

Phase 2 of the project allowed for the development of learning objects, and the creation of an Information and Communication infrastructure for future iterations.
**Learning Management System**

Moodle, an open-source learning management system (LMS) that is compatible with most browsers, spare in appearance (easy to navigate, intuitive), and reliable, was chosen to develop the online course. ²

A course shell was developed (http://142.150.146.254/) and learning activities that were developed for the classroom-based sessions were converted to an online format. User testing did not occur, although the project coordinator did receive several requests from individuals who were interested in accessing the program in this delivery format.

The LMS was, however, greatly utilized by the facilitators as a discussion forum for the units as they unfolded. Other than some assistance getting started and logging on, all facilitators navigated the LMS with no difficulty and contributed substantially to the repository of implementation documentation.

**EPresence**

The project purchased video-archiving and web-casting hardware that is supported by open source software ³ that would allow for taping of lectures at various sites, providing not only access to classes that learners may have missed, but will build a repository of learning objects for online delivery. The EPresence Media Archives are available at http://iehpcanada.kmdi.utoronto.ca/

Capstone presentations were recorded and uploaded to the system in Toronto, and shared with all members of the working group, and were distributed (with consent) to all IEHP participants. Further, facilitator training occurred through video-archives, with the developers providing an overview of the structure of the course, and details of each unit.

**Multi-media Learning Object**

A 15-minute video-clip of Patient Centered Practice and Collaboration was produced with the cooperation and participation of the Office of Interprofessional Education at the University. The scenario had been created for 1st year undergraduate students and depicted the discharge process in the hospital, followed by a team discharge meeting. The video-clip was very well received by IEHPs and facilitators alike.

<table>
<thead>
<tr>
<th>Lessons Learned:</th>
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<tbody>
<tr>
<td>The capacity and infrastructure for distance education was created in Phase 2.</td>
</tr>
<tr>
<td>Future iterations of the classroom-based format can utilize the Learning Management System for journaling activities and discussion forums, providing increased student-student, student-instructor and student-content interaction</td>
</tr>
<tr>
<td>The pilot created the capacity for re-purposing the course to an online format, enabling increased access</td>
</tr>
</tbody>
</table>

² More information about Moodle can be found at http://moodle.org/
³ Please see http://epresence.tv/ for more information and archived presentations.
Program Impact Evaluation
Z. Austin, Principal Investigator

Background

The IEHP Orientation program consisted of a variety of teaching and learning activities, structured around a traditional face-to-face educational model. In order to evaluate the impact of this program on participants’ knowledge, comprehension, and awareness regarding structure and function of the Canadian health care system, an impact evaluation research project was undertaken.

Methodology

A pre-post survey design was utilized. Participants in the IEHP program were randomly allocated to receive the evaluation instruments either before OR after attending the program (thereby minimizing the number of surveys participants would have to complete, reducing “participant fatigue” in studies such as this). Survey results from the PRE program group were compared with the POST program group using inferential statistical tests. This design, therefore, assumes that any differences between PRE and POST were attributable to the program itself, since randomization processes utilized assumed demographic comparability of each group.

This design is useful in identifying the impact of an educational intervention on a large group of diverse individuals but does not provide any indication of how identifiable or specific individuals were impacted by the program, nor whether specific individuals actually acquired new knowledge or skills as a result of the program.

Instruments Utilized

1. The Diversity in the Workplace Inventory was based upon the work of Hofsted, and consisted of 26-items. Five sub-scales were isolated, corresponding to each element of Hofsted’s model of culture. Of the 26 survey questions, 4-6 specific questions were asked to assess participants’ knowledge, comprehension and awareness of the following facets of culture:

<table>
<thead>
<tr>
<th>Cultural Facet</th>
<th>Traditional/High Context</th>
<th>Modern/Low Context</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relationships with others</td>
<td>Collectivist</td>
<td>Individualistic</td>
</tr>
<tr>
<td>Risk/Uncertainty Avoidance</td>
<td>Extensive</td>
<td>Limited</td>
</tr>
<tr>
<td>Hierarchy</td>
<td>High</td>
<td>Low</td>
</tr>
<tr>
<td>Time Orientation</td>
<td>Long-term</td>
<td>Short-term</td>
</tr>
<tr>
<td>Activity Orientation</td>
<td>Process</td>
<td>Outcome</td>
</tr>
</tbody>
</table>

2. The Attitude Toward Health Care Teams (ATHCT) instrument is a 20-item measure of general attitudes that uses a 6-point Likert Scale. The ATHCT possesses two distinct subscales – Quality of Care/Process and Physician Centrality (i.e. how central
the role of a physician should be in a health care team). High scores in the Quality subscale indicate the perception that teams provide higher quality care than individuals, while high scores on the Centrality subscale indicate support for a physician-dominated or lead decision-making process within teams.

3. The Team Integration Measure (TIM) is a 19-item instrument demonstrating good reliability and validity, and measuring level of integration within a team as perceived by its members. Within the TIM, the Team Collaboration Index (TCI) measures the following: approach to problem solving through team-based support/integration; openness and ability to engage in authentic communication, and knowledge-based risk taking behaviours.

4. The Collaboration Satisfaction About Care Decisions (CSACD) scale is a 9-item instrument measuring collaboration and satisfaction within group processes; higher scores indicate higher perceived collaborative practice and satisfaction with processes.

**Results**

A total of 38 participants responded (response rate: 80.9%). Eighteen participants responded PRE, while 20 responded POST. Since randomization was used for survey distribution, no demographic data was collected on survey respondents; however, given the high response rate it is likely that respondents represented a range of professions and experiences.

Statistically significant differences (p<0.05) between PRE and POST groups were noted in the following areas:

a) Diversity in the Workplace Inventory:
   - relationships with others, hierarchy, time-orientation, activity orientation

b) Attitudes Towards Health Care Teams:
   - Quality of Care/Process, Physician Centrality

c) Team Collaboration Index:
   - openness and ability to engage in authentic communication

d) Collaboration Satisfaction About Care Decisions

No statistically significant difference was noted between PRE and POST groups in other areas, indices, or subscales.

**Interpretation**

These results suggest that the Orientation program had a statistically significant impact on participants’ knowledge, comprehension and awareness regarding key elements of the Canadian health care system. The strongest impact was identified in areas related to diversity competencies, in particular understanding of the nature of diversity within Canadian health care and how health professionals respond. Other areas of significant impact related to changes in
perceptions of physician centrality and quality of care/processes, as measured by the ATHCT. The PRE group indicated that physician centrality and adherence to processes/rules defined effective clinical practice, while the POST group indicated less adherence to physician-centric models of practice and supported the importance of outcomes in evaluating the impact of care.

Though statistically significant, differences between the PRE and POST group related to the Team Collaboration Index were somewhat less marked than those with the Diversity and ATHCT scales. The only element of the TCI that was statistically different between groups related to ability and willingness to engage in authentic communication. Caution must be exercised in interpreting this result however, since participants were asked to speculate upon, rather than demonstrate how, they would communicate within a team-based clinical environment. Nonetheless, this score does indicate that the POST group was more willing to express dissent or disagreement, more willing to provide evidence to support their contention, and better able to work collaboratively to achieve a positive outcome than the PRE group.

Differences between the PRE and POST group in the Collaboration Satisfaction About Care Decisions scale suggest that the POST group placed a higher value on collaborative, patient-centered practice models, and understood that these models provide for better decision making, and more comprehensive access to evidence and information. Results from this scale cross-tabulate with the physician centrality subscale of the ATHCT instrument, and again indicate that POST participants recognize physician dominance is not necessary for effective and safe patient care.

Conclusions

This study suggested that the Orientation program had a positive impact on participants in increasing their knowledge, awareness, and understanding of key facets of the Canadian health care system. The magnitude of this impact was greatest in areas related to diversity competencies and physician centrality. Based on this evaluation, the program appears to have been successful in meeting its objectives for providing a structured orientation to the Canadian health care system’s culture and context for internationally educated health professionals.
Overall Evaluation and Summary

As noted by the program impact evaluation, the program resulted in a positive impact on participants. Beyond the study results, the strongest endorsement comes from the learners themselves, with 100% stating that they would recommend the course to a colleague, and the vast majority of IEHPs rating the course experience as “very good” or excellent”.

Given the results of the evaluations, and the “lessons learned” compiled through the production of this report, the Orientation to the Canadian Health Care System, Culture and Context Program was successful in achieving its goals of development and implementation to IEHPs across Canada, and has increased access to this educational programming.

**Recommend Course to Colleague?**

![Graph showing 100% of respondents recommending the course to a colleague.]

**Overall Impression of Program**

![Graph showing the distribution of responses to the overall impression of the program.]

*Qualitative feedback*

- Good opportunity to interact with other healthcare professionals & learn about other professions
- Well-organized, interesting and relevant topics
- Increased awareness of cultural diversity, interprofessional collaboration
- Increased understanding of the Canadian health care system