

DOCUMENT RESUME

ED 407 107

PS 025 310

AUTHOR Peter, Margo
TITLE Burning Bridges. Lessons Learned in Interprofessional Collaboration: Year One.
INSTITUTION Hawaii Medication Association, Honolulu.
PUB DATE Aug 95
NOTE 35p.
PUB TYPE Reports - Descriptive (141)
EDRS PRICE MF01/PC02 Plus Postage.
DESCRIPTORS *Agency Cooperation; Child Health; Communication Skills; *Cooperation; Delivery Systems; Early Childhood Education; *Family Programs; Health Services; *Integrated Activities; Integrated Services; Leadership Training; Personnel Selection; *Professional Development; Professional Training; Recruitment; Social Services; Young Children

ABSTRACT

This monograph chronicles the Health and Education Collaboration Project's (HEC) learning and development of family-centered interprofessional collaborative practices during 1994-95. The project involves the development and field-testing of a personnel preparation model for preservice and in-service professional training to provide family-centered, community-based, coordinated care, as well as dissemination of the best practices of family-centered interprofessional collaboration locally and nationally. Part 1 describes four Maternal and Child Health Bureau demonstration projects. Part 2 defines family-centered interprofessional collaboration, and Part 3 outlines its principles. Part 4 discusses each stage of the HEC project and what has been learned. Lessons learned from the five stages were: (1) collaboration is based on relationships, must occur at all levels, and functions best when it is the result of "bottom up" rather than "top down" efforts; (2) leadership sets the tone for the project; (3) staff personality should be considered in recruitment; (4) commitment to collaboration is essential; (5) training should be early and ongoing, should incorporate team-building skills, should emphasize both process and product, and should provide "in vivo" training models; (6) staff turnover compels supplementary training and attention to group process; (7) it is impossible to foresee all contingencies; and (8) dissemination of lessons learned through collaboration is essential to realize fundamental changes in service delivery systems. Appendices include a list of commission members and a discussion of the role of the medical home and interprofessional collaboration. (Contains 15 references.) (KDFB)

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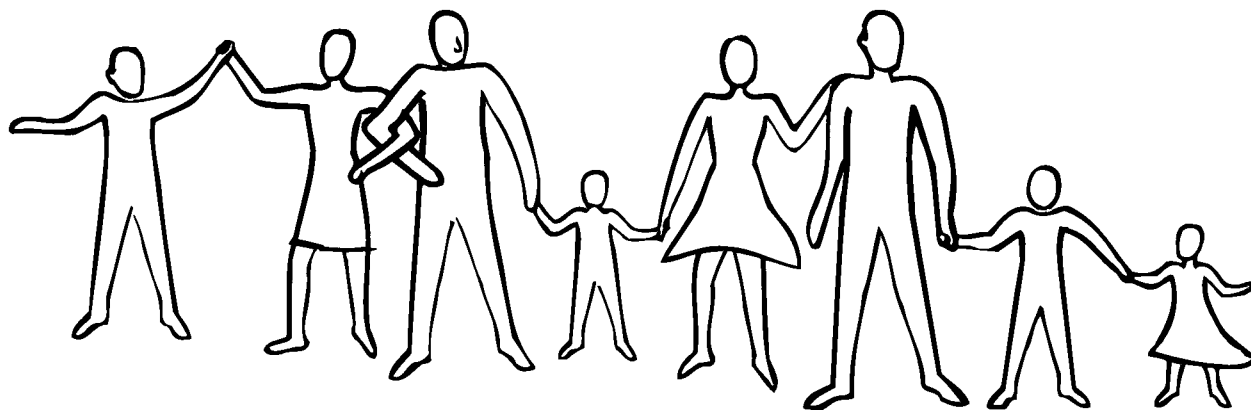
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BUILDING BRIDGES



LESSONS LEARNED IN INTERPROFESSIONAL COLLABORATION

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YEAR ONE

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Published by:

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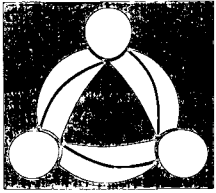
Sharon Taba
Project Director

This monograph is supported in part by project MCJ-155094 from the Maternal and Child Health Bureau (Title V, Social Security Act), Health Resources and Services Administration, Department of Health and Human Services.

BUILDING BRIDGES

LESSONS LEARNED IN INTERPROFESSIONAL COLLABORATION

YEAR ONE



Health and Education Collaboration Project

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On page 10 of the monograph, *Building Bridges: Lessons Learned in Interprofessional Collaboration, Year One*, the following reference for the definition of family-centered interprofessional collaboration was inadvertently omitted.

This definition for family-centered interprofessional collaboration was adapted from the definition for collaborations found in Kagan, S. L. & Rivera, A. M. (1991). Collaboration in early care and education: What can and should we expect? *Young Children*, November, 51-56

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Keely Luke Photographi'e

*"As the family goes, so goes the nation
and so goes the whole world in which we live."*

– John Paul II

ACKNOWLEDGEMENTS

This monograph is dedicated to all young children and their families at the Healthy and Ready to Learn Center.

Special thanks to Calvin C.J. Sia, M.D., the visionary who launched this journey toward creating a healthy, safe, and learning world for children in Hawaii.

This effort could not have begun without the support of the following people:

- Merle McPherson, M.D., Director, Division of Services for Children with Special Health Needs, Maternal and Child Health Bureau. Merle has supported family-centered care both locally and nationally and serves as an outstanding leader.
- The members of the National Commission on Leadership in Interprofessional Education (NCLIE) including the NCLIE Advisory Committee – Dean Corrigan, Chair, Vince Hutchins, Co-Chair, Merle McPherson, Tom Behrens, Calvin Sia, Kathy Kirk Bishop, J. Bud Fredericks, Barbara Burch, Diane Haas, Vic Baldwin, and Bonnie Strickland.
- The Healthy and Ready to Learn Collaborative – Calvin Sia of Hawaii Medical Association; Patti Lyons and Caroline Oda of the Consuelo Zobel Alger Foundation; Fran Hallonquist, Martha Smith, and Lynda Dybdal of Kapiolani Medical Center for Women and Children; Louise Iwaishi, M.D. and Lori Kamemoto, M.D., Medical Directors of Pediatrics and Obstetrics-Gynecology, University of Hawaii John A. Burns School of Medicine; and Rob Welch and Vicki Wallach of Child and Family Service.
- The 25 members of the Health and Education Collaboration Project Advisory Committee.
- The Healthy and Ready to Learn Staff – Audrey Ching, Program Director; Dianne Wakatsuki, Nurse Practitioner; Katharine Cochran, Early Childhood Educator; Mel Hayase, Social Worker; Blanche Butler, Medical Receptionist; and Allen Butler, Van Driver.
- The Health and Education Collaboration Project Staff – Alix Howard-Jones, Training Coordinator and Anne Ambrose, Administrative Assistant. A special aloha to you both for your creativity in editing, layout, and design of this monograph.
- Special thanks to Margo Peter who authored this monograph.
- And a final thanks to the photographers, Keely Luke and Philippe Gross, and graphic designer, Ann Wharton.

Much appreciation to those people who have helped in this collaboration. May this monograph create collaborative relationships that make a better place for all young families.

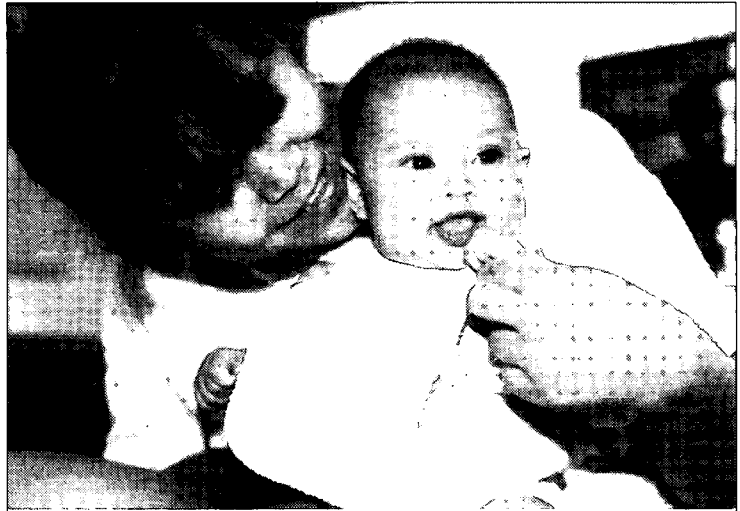
Sharon Taba
Program Director
Health and Education Collaboration Project



Philippe Gross



Philippe Gross



Philippe Gross

PREFACE

The impact of poverty, drug use, violence, homelessness, teen parents, and changing family structures has far reaching consequences for America's education, health, and human service delivery systems. The recognition in the past thirty years, that the chief causes of morbidity and mortality in children and youth have moved from a preponderance of acute conditions and infectious diseases to the "new morbidities," has required a reorientation of child health providers. Injuries, mental and emotional disorders, child abuse and neglect, and early sexual activity are increasing among children. The population of children and adolescents with special health needs due to illness or disability has also grown. Developmental problems, educational failure, low reading comprehension, immoderate risk taking, lack of supervision, and school drop out are almost commonplace in some neighborhoods. Although the first of the National Education Goals is that, by the year 2,000, all children in America will start school ready to learn, many children come to school today with a host of new problems that traditional educators are unprepared to address alone. Many of these problems have their roots, and potential prevention points, long before they appear at the schoolhouse door. Children also need to be healthy, a process that begins before they are born, and socially and emotionally ready for the world that will open up to them at school. To turn the tide, the landmark Carnegie report, *Starting Points: Meeting the Needs of Our Youngest Children*, found that families and providers must "1) promote responsible parenthood, 2) guarantee quality child care choices, 3) ensure good health and protection, and 4) mobilize communities to support young children and their families." Parental support, language stimulation, and positive social experiences with peers and adults are among the essentials that infants and pre-schoolers need. Unfortunately, traditional higher education provides no formal training regarding what it takes to collaborate with other professions serving these children and their families.

Until recently, the response to each concern has been to develop single issue or categorical programs. As these concerns have become more complex, it has become evident that many agencies are serving the same families while others go unserved or underserved. At the same time, the boundaries of professional responsibility have become uncoordinated, overlapping, and often dysfunctional.

With rapid changes occurring in the education and human service delivery systems, state and national policy makers are recognizing that we must develop new organizational relationships at the family and community levels among schools, health agencies, and other social service organizations. We must train human service providers to understand these cross-domain changes and to move across the domains of education, health, and social services to provide support to the families of today's children. Specifically, we must give providers a place to learn how to work collaboratively with each other.

In 1994, the Maternal and Child Health Bureau (MCHB) made Title V Special Projects of Regional and National Significance (SPRANS) funds available to create such collaborative health, education, and human service systems for children and their families, includ-



Keely Luke Photographie

ing children with special health care needs. The purpose of this funding is threefold:

- 1 demonstrate the ability of health, social service, and education professionals to work together in communities to foster successful physical, social, and emotional growth for children and their families;
- 2 assist in the development of curricula based on best practices learned in community settings; and
- 3 disseminate a collaborative model of personnel training and service delivery at the regional, state, and national levels.

Three demonstration projects have been funded under this initiative:

Health and Education Collaboration
Hawaii Medical Association
Principal Investigator: Calvin C.J. Sia
Project Director: Sharon Taba

Partnerships for Change
Department of Social Work
University of Vermont
Project Director: Kathleen Kirk Bishop

Higher Education Service Integration
Curricula Project
Teaching Research Division
Western Oregon State College
Project Director: Vic Baldwin

To assure broad dissemination, these demonstration projects will work closely with the National Commission on Leadership in Interprofessional Education (NCLIE). See Appendix A for a list of current NCLIE members. The purpose of the Commission is to bring the best community-based practices with children and families into university missions and programs. Through a family-professional partnership, the Commission will support the preparation of a new generation of interprofessionally oriented leaders in health, education, and social work who possess the knowledge, skills, and values to meet the needs of all children and families by creating, maintaining, and improving effective community-based integrated service delivery systems.

The purpose of this monograph is to introduce the MCHB demonstration projects mentioned above and briefly summarize to date the experiences of the Health and Education Collaboration Project.

“The time has come for us to stop tuning separate instruments and, together, to create a symphony.”

– Anonymous

THE MCHB DEMONSTRATION PROJECTS

*The following was excerpted from an article by
Dean Corrigan, Ph.D., titled
"Fostering Leadership in Interprofessional Education".*

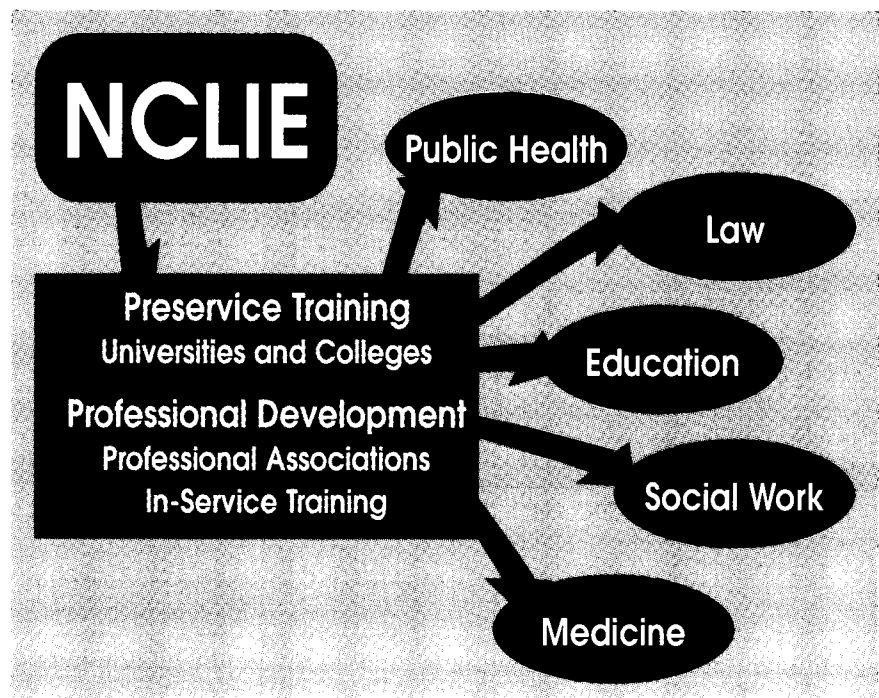
The National Commission on Leadership in Interprofessional Education. The National Commission on Leadership in Interprofessional Education (NCLIE) grew out of discussions at a March, 1990, Health/Education Symposium co-sponsored by the American Association of Colleges for Teacher Education, the American Academy of Pediatrics, and the Maternal and Child Health Bureau (MCHB). The Symposium provided a forum for representatives from the health and education professional communities to begin exploring innovative efforts to integrate service delivery and to develop guidelines for future collaborative efforts. Charging that the existing service delivery systems do not function in ways that cherish and provide for children and their families, keynote speaker and former U.S. Surgeon General, C. Everett Koop, called upon participants to shape a national agenda that would make coordinated, family-centered, community-based services a reality.

In the fall of 1992, through a planning meeting under the aegis of The Association of Teacher Educators, the National Commission on Leadership in Interprofessional Education was initiated. Fifty members, representing all of the professional partners working in the emerging collaborative system (social work, public health, law, medicine, and education)* were invited to serve on the Commission. The Commission's first meeting was held in Los Angeles on February 14-17, 1993. The common theme was to develop the capacity of future leaders in the education, health, and human services professions to view health, educa-

tion, and social problems from an interprofessional perspective that is broader, coordinated, family-centered, community-based, and culturally competent.

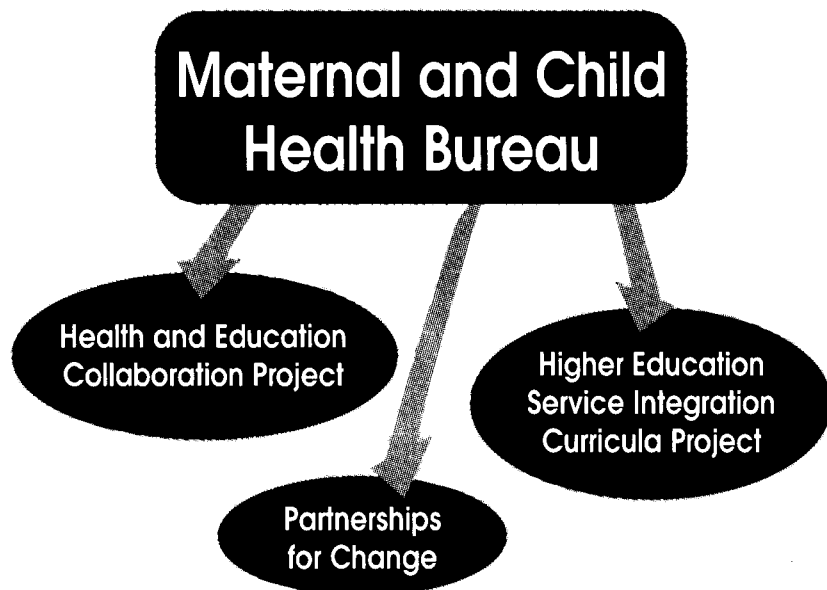
The Commission operates by sharing ideas on how participants view each others' roles, by identifying training needs to assist professionals to work together better, and by developing joint policies. Recognizing that the answers are not readily available, a "lessons learned" approach is being utilized. Movement toward achieving the Commission's goals will be enhanced by working with the three MCHB projects. From their settings in a College of Education and in a Department of Social Work in public institutions of higher learning and in a private medical association, they bring the diversity of thought and study that the Commission requires to meet its purpose. Through informed collaboration, diverse child providers will then have the potential to provide integrated services at the community level that can better serve children and their families. For additional information about the Commission, please contact: Dr. Dean Corrigan, Project Director, Texas A & M University, 100 Harrington, College Station, Texas, 77843-4241, 409-845-1558.

*This is not an all inclusive list, but these are the disciplines represented at the time of this writing.

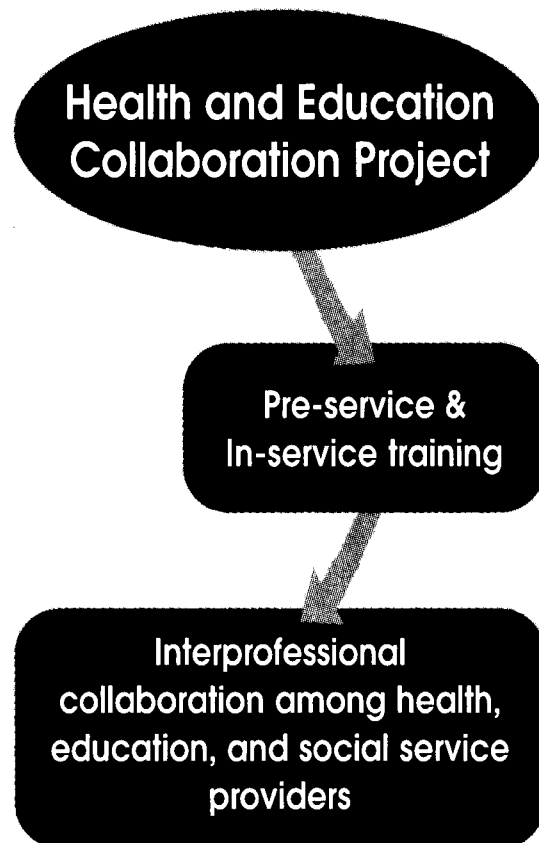


These three MCHB projects will work collaboratively with each other and with the Commission, and will help eliminate overlap and fragmentation of services to children and their families. This will be achieved by creating new community service systems by working together with health, education, and social service professionals.

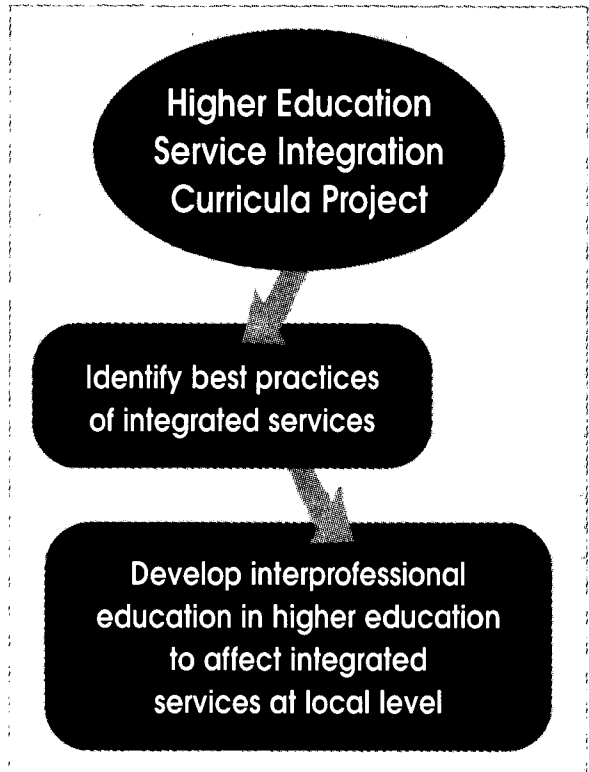
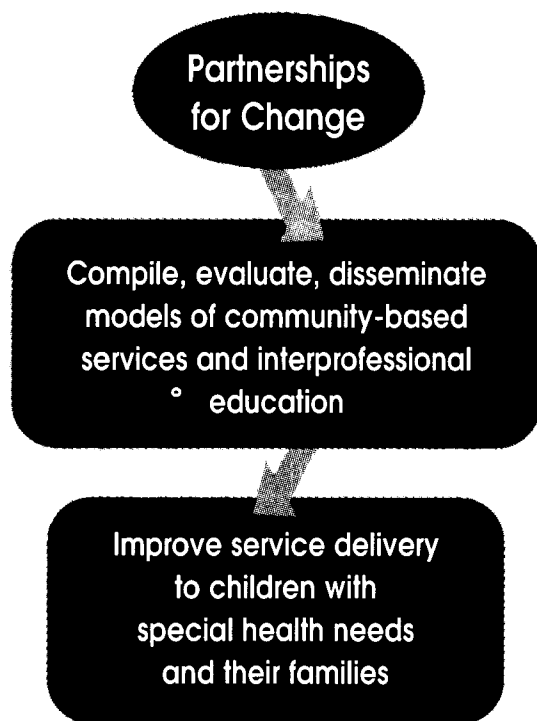
Create collaborative human services systems for children and their families.



Health and Education Collaboration Project. The Hawaii Project will be implemented within the context of the existing Healthy and Ready to Learn Center (HRTL), a "one stop shopping" health, education, and family support center serving culturally diverse families on the Leeward Coast of Oahu. The purpose is to promote collaborative working relationships among health, education, and social service providers serving young children and their families, including children with special health care needs. The project seeks to do this by developing a personnel preparation model for pre-service and in-service professional training to provide family-centered, community-based, coordinated care. Project staff will train regional HRTL staff to implement and field test identified elements of collaborative practice. Linkages will be created between HRTL and university training programs in order to offer interprofessional training opportunities to pediatric and ob-gyn residents and graduate students in education and social services at HRTL. For additional information, please contact: Sharon Taba, Project Director, 1360 S. Beretania, 2nd Floor, Honolulu, Hawaii, 96814, 808-536-7702.



Partnerships for Change. The overall goal of the Vermont Project is to improve service delivery to children with special health needs and their families through two objectives: 1) to compile, evaluate, and disseminate exemplary models of community-based services and 2) to compile, evaluate, and disseminate exemplary models of interprofessional education. The major collaborative groups of the project are families, students, and university faculty. The process will move from family-professional collaboration to interprofessional education to family and interprofessional education and practice approaches. The Vermont Project has assembled a literature review of documented collaboration and is working with the Oregon Project on expanding this body of information. For additional information, please contact: Dr. Kathleen Kirk Bishop, University of Vermont, 228 B Waterman Building, Burlington, Vermont, 05405-0160, 802-656-1156.



Higher Education Service Integration Curricula Project. The overall goal of the Oregon Project is to assist selected colleges and universities to develop educational offerings that will cross train their students in the various disciplines so that upon graduation they can affect integrated services at the local level. This will be accomplished by identifying across the nation family-centered, community-based projects that have been successful in integrating services that benefit at-risk families, children, and youth. The knowledge and skills of the staff of these projects will be studied. In addition, with the assistance of the Commission, four to six colleges/universities will be identified that agree to develop curricula and training programs for integrated services that are based on the best practices found in the community. Project staff, with the four to six colleges/universities, will prepare individual plans that will assist them to achieve their goal of enhanced curriculum. Project staff and the Commission will provide technical assistance to help implement the plans. For additional information, please contact: Dr. Vic Baldwin, Project Director, Teaching Research Division, Western Oregon State College, 345 N. Monmouth, Monmouth, Oregon, 97361, 503-838-8401.

WHAT IS FAMILY-CENTERED INTERPROFESSIONAL COLLABORATION?

Simply put, family-centered interprofessional collaboration refers to efforts that unite and empower individuals, families, and organizations to accomplish collectively what they could not accomplish independently. This philosophy is grounded in the fact that the cumulative efforts of professionals and families working together are greater than the sum of their individual contributions. It is an ideal whose time has come. Unfortunately, it has come mostly in the form of position papers, invited lectures, and rhetorical publications. Living examples of family-centered interprofessional collaboration are few and far between. Where they exist, they provide a beacon signaling the direction of change for future systems of social service. The Health and Education Collaboration Project represents one such effort to implement this simple yet profound ideal in delivery of services to young children and their families.



*“Perhaps the greatest social service
that can be rendered by anybody to the country
and to mankind is to bring up a family.”*

– George Bernard Shaw

PRINCIPLES OF FAMILY-CENTERED INTERPROFESSIONAL COLLABORATION

The following principles were adapted from principles developed by Kathleen Kirk Bishop, D.S.W., Josie Woll, and Polly Arango and published in the monograph, "Family/Professional Collaboration for Children with Special Health Needs and Their Families" as well as those developed by Katharine Hooper-Briar and Hal A. Lawson which were published in the monograph, "Serving Children, Youth and Families Through Interprofessional Collaboration and Service Integration: A Framework for Action."

Family-Centered Interprofessional Collaboration:

- ◇ promotes a relationship in which family members and professionals work together to ensure the best services for the child and family and plans for interagency cohesion around family-centered support initiatives.
- ◇ recognizes and respects the knowledge, skills, and experience that families and professionals from all disciplines bring to the relationship and elicits every family member's perceptions of relevant needs, problems, aspirations, and solutions.
- ◇ acknowledges that the development of trust is an integral part of the collaborative relationship.
- ◇ facilitates open communication so that families and professionals feel free to express themselves.
- ◇ creates an atmosphere in which the cultural traditions, values, and diversity of families and professionals are acknowledged and honored and assists families to develop their own preferred solutions, take immediate action steps, and identify pathways to success.
- ◇ recognizes that negotiation is essential in a collaborative relationship.
- ◇ brings to that relationship the mutual commitment of families, professionals, and communities to meet the needs of children and their families and moves from an exclusive focus on problems and needs to a shared goal or vision as to how things could be different and better.

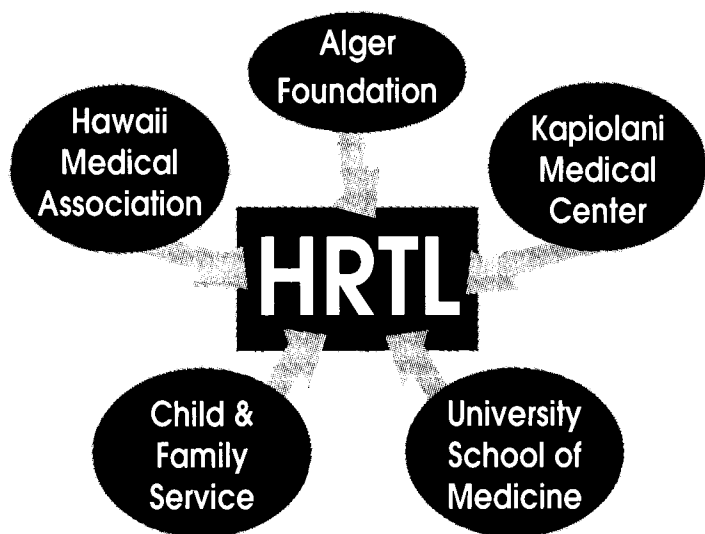
THE HEALTH AND EDUCATION COLLABORATION

Background

The Health and Education Collaboration (HEC) project was created to identify, develop, and promote key aspects of training for collaborative interprofessional practice. HEC staff has identified the community-based Healthy and Ready to Learn Center (HRTL) as a key training and program development site for their project. HRTL provides direct services to families with special needs. These services include prenatal and postpartum care, family planning, routine well-child care, child development information, parent-child activities, supportive counseling, and referral services. Proponents of collaboration first envisioned the concept for HRTL in 1992 and for the next two years played an integral role in seeing that concept become reality. HEC staff was responsible for program development at all levels including building the initial coalition between supporting agencies, as well as the hiring and training of HRTL personnel. In addition, HEC is responsible for ongoing staff development activities which assure that clinic services are provided within the context of a family-centered interprofessional collaboration. Thus, the two programs work hand in hand to assure that families have access to an array of important services that are delivered in a caring and coordinated manner.

HEC brought together a consortium of sponsors for HRTL. It includes five primary supporting agencies. A brief description of their roles is listed below.

Consuelo Zobel Alger Foundation. Alger, the operating foundation for the Center, manages the program. Its budget for the first 8 years includes facilities construction and operations. The Alger Foundation, headquartered in Honolulu, operates child abuse prevention programs in Hawaii and the Philippines.



Hawaii Medical Association (HMA). HMA, a professional physician organization, has agreed to administer, develop, and operate the program. Based on past service, Dr. Calvin Sia, principal investigator, is heading HEC and HRTL.

Kapiolani Medical Center for Women and Children (KMCWC). KMCWC, a teaching hospital, provides preventive health clinical services which include physician coverage and staffing of a nurse practitioner and a medical receptionist/billing clerk. KMCWC also provides equipment and supplies for clinical services. The administrative staff and departments have donated many hours to planning and implementing HRTL services.

University of Hawaii John A. Burns School of Medicine, Departments of Obstetrics-Gynecology and Pediatrics. The School of Medicine Chairs of the Departments of Obstetrics-Gynecology and Pediatrics have assigned faculty and residents to HRTL for a family-centered, interprofessional practicum within their clinical rotations.

Child and Family Service (CFS). CFS, the largest private social service agency in Hawaii, is planning to open the first comprehensive family center on Oahu, where HRTL will be housed in the future. CFS provides a social work consultant to HRTL.

Implementation of Family-Centered Interprofessional Collaboration: Year One

Although there has recently been a groundswell of support for the idea of interprofessional collaboration, few programs have actually translated the philosophy into direct service. Much must be done in order to bring the collaborative philosophy into a working reality. Families, professionals, and institutions must develop new relationships that allow them to work together in unprecedented ways. Old assumptions must be challenged and changed and new partnerships must be forged that foster new ways to share resources and enhance services.

During this first project year, HEC staff worked with HRTL sponsors and staff to identify and implement key elements of collaboration. In addition, HEC launched efforts to promote integrated services within the community serving young children.

HEC staff found that collaboration is not always easy. It required that individuals change the way they were used to thinking and behaving. The requisite changes were both revolution-

ary and evolutionary. The revolution largely involved changing convention-bound policy and procedures. Administrators and program planners were asked to challenge traditional practice by abandoning conventional lines of power and turf in order to reduce duplication and pool resources. The evolution occurred over time as administrators and professionals struggled to implement a collaborative philosophy in day to day activities. Professionals were trained in the skills of collaboration and charged with developing new ways to work together that maximized those skills.

The first project year was a learning experience for everyone involved. HEC staff learned through successes as well as failures. This section chronicles the learning and outlines the initial stages of development of the family-centered interprofessional collaborative team. It should be noted that collaborative efforts are, by nature, individualized by the needs of the families they serve. Hence, there is no "right" way to implement interprofessional collaboration. It is hoped, however, that the following will provide useful guidelines for others interested in initiating similar efforts.

"Old assumptions must be challenged and new partnerships must be forged...to share resources and enhance services."



Keely Luke Photographie

Developmental Stages and Lessons Learned

- **Stage 1** Building a shared vision
- **Stage 2** Staff Recruitment
- **Stage 3** Training
- **Stage 4** Monitoring, Evaluation and Refinement
- **Stage 5** Dissemination

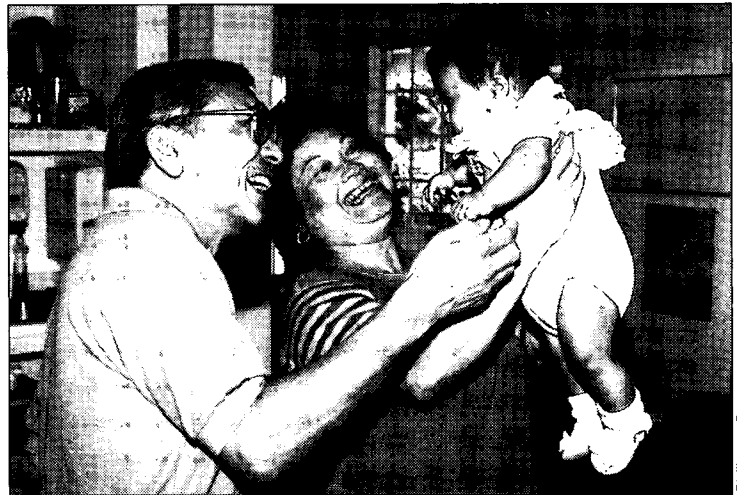
Stage 1 *Building a Shared Vision*

Identifying a shared vision and common goals for participants provides a foundation for collaboration. While especially important to early stages of collaboration, this process is crucial for all phases of interprofessional collaboration. During the initial phases of a collaborative venture, developing a mission statement and drafting operational goals help clarify roles and responsibilities of those involved. Perhaps more importantly, this process allows individuals to get to know one another on a more personal basis by providing time for communicating perspectives, beliefs, and attitudes. In addition, over time, it will enable participants to monitor and evaluate the relative success of their collaborative venture. To this end, collaborators should be encouraged to ask themselves, "How will we know if this collaboration is working?". The answer to that question will assist individuals in staying on task in their planning as well as provide a blueprint for evaluating progress along the way. This is especially important if, as with HRTL, the collaboration involves multiple agencies with differing missions, or, as is also true with HRTL, the collaboration involves professionals from very different disciplinary cultures.

Five agencies were involved in the administrative collaboration which provided the foundation for HRTL. This meant that before the direct service interprofessional team could be created, an interagency consortium had to be developed.

(A list of those agencies involved and description of each is outlined on page 12.) HEC staff met individually and collectively with representatives from each agency at least 36 times during the first project year. These meetings served three important functions: 1) to develop a shared vision and mission statement, 2) to clarify roles and responsibilities, and 3) to define a timeline for progress.

Each agency agreed to commit specific resources, which include funding, space, and personnel, to the collaboration. They also agreed to a timeline for identified goals.



Philippe Gross

"How will we know if this collaboration is working?"

The vision and mission statements developed by the interagency consortium are as follows:

Vision and Mission of HRTL Collaborative

We envision communities throughout the world where families have children who are ready to maximize their learning upon entering their education system.

By ready, we mean that children up to five years old are stimulated, mentally challenged, healthy, emotionally adjusted, and developmentally on target so that they maximize the benefits of their formal education system.

The mission of the HRTL interprofessional collaborative is to

- identify families with potential special needs with or soon to have infants, toddlers, and preschool children.
- provide and integrate health, education, and human services for families with high risk preschool children.
- integrate with other existing programs as necessary; develop programs if needed while avoiding duplication of, and competition with, these programs.
- promote collaboration among professionals of health, education, and human services in applying the holistic preventive approach for family wellness.
- assure that this collaborative, integrated system of care is institutionalized in Hawaii by the year 2002.
- assure the sustainability and replication of the HRTL program .
- advocate for a collaborative, integrated system of care.

Lesson 1

Collaboration is based on relationships.

“Time spent developing relationships should be considered a valuable investment.”

The success of a collaborative venture rises or falls based on the nature of the relationships established. Moreover, the quality of collaboratives reflects the characteristics of the relationships of team members. The process of identifying shared goals based on compatible values allows relative strangers to join one another to work toward a common goal. Time spent developing relationships between individuals should be considered a valuable investment for future interactions. The interpersonal joining inherent in developing shared visions and goals may well provide the glue that holds individuals together when inevitable differences arise.

Lesson 2

Collaboration must occur at all levels.

“Turf battles and their concomitant dissension will filter down to all team members and undermine stability of team functioning.”

It should also be noted that the process of developing a sense of shared mission needs to occur at both administrative and service delivery levels. It is essential that the interprofessional team have a solid, collaboratively established administrative foundation if different agencies or departments are planning to work together. Turf battles and their concomitant dissension will filter down to all team members and undermine stability of team functioning. In addition, goals for collaboration need to be developed and consolidated by those involved in direct service delivery. This means incorporating time for interprofessional team members to discuss and develop mission statements as well as identify goals for working together. To validate and emphasize the importance of collaborative practice, elements of collaborative practice should be included in job descriptions and performance evaluations for all staff.

Lesson 3

Collaboration functions best when it is the result of "bottom up" rather than "top down" efforts.

Collaboration cannot be imposed from above. While it is important that collaboration is supported and promoted administratively, it is critical that collaborative working relationships evolve from the ground up. Line staff should be empowered to create and implement their own team policies and procedures. Team building, then, must be sanctioned as a legitimate and necessary component of service delivery. This means that time must be set aside for team members to cultivate and improve their working relationships with one another. The time commitment will be greatest in the early phases of team development, but ongoing opportunities for team building should be incorporated into the regular staff routine. Facilitated group process may be useful if it is conducted in a professional manner that guarantees safety and confidentiality for participants. Outside consultants may be useful as facilitators; however, care should be taken to clearly stress their role as consultants to the team rather than program managers or evaluators. In addition, team members should also be provided with the opportunity to evaluate the usefulness of such meetings and to suggest modifications along the way.

HEC staff initially met with HRTL staff three hours a week to provide training in family-centered collaborative practice. Currently, 12 hours of staff time is allocated per month for skill acquisition and team building. During this time, HEC staff provides didactic training as well as opportunities for team members to practice communication and problem solving skills.

Stage 2

Staff Recruitment

Collaboration is not for everyone, and not everyone is well suited for team work. Performing effectively on an interprofessional team requires a unique set of professional skills, and in order for the team to function optimally, individual team members must possess the capacity to work within such a model. Recruitment, then, takes on enhanced significance in the building of interprofessional teams.

"Collaboration is not for everyone, and not everyone is well suited for team work."

HEC staff found that the quality of leadership set the tone for team interactions, that personality variables were important to overall team functioning, and that individual team members had to be committed to the team concept.



Keely Luke Photographie

Tips from the Field

- Sanction it as a legitimate activity.
- Set time aside to cultivate relationships.
- Structure training to pair didactics with real world experience.
- Use other people's problems as a safe strategy for conflict resolution.

Lesson 1 Leadership sets the tone.

"True leaders inspire people to do great things, and, when the work is done, their people proudly say, 'We did this ourselves.'"

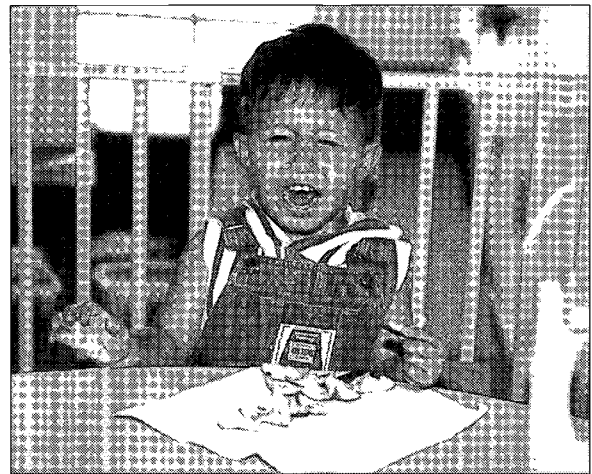
– Lao-Tzu

Strong leadership is essential to facilitating a collaborative model. The role of management shifts, however, from an authoritative to consultative one. A good leader must be able to tolerate ambiguity and to take risks while encouraging others to do so. In addition, an administrator must be able to recruit, select, and supervise staff collaboratively. Perhaps the most important element of this is the capacity to win the trust of those he or she supervises. It is also essential that managers be comfortable saying "I don't know, but I'll find out" and deferring to other team members when it will enhance team functioning. In this way, management "walks the talk" of collaboration and creates an environment conducive to effective team building.

Lesson 2 Personality counts.

It takes a special kind of person to work effectively on an interprofessional team, and staff recruitment should be conducted with this in mind. During personnel selection, careful consideration should be given to the collaborative skills as well as the clinical skills of an applicant. A team member must possess solid professional and personal skills that will allow him or her to function effectively within the field of professional expertise as well as the capacity to work with others in such a way as to enhance overall team functioning. When hiring, it is a good idea to rate applicants on traits like patience, persistence, initiative, flexibility, risk-taking, empathy, self-assurance, and self-realization. Many of the attributes that contribute to strong team leadership including the ability to tolerate ambiguity and the willingness to experiment and take risks are important for team members. In addition, team members who are non-defensive and open to other points of view, who are aware of their own personal biases, and who reflect respect for differences will contribute to a collaborative envi-

ronment. Those who tend to shift blame to others, are blind to their own issues, or who perceive their way as the only way become obstacles. There are also certain non-tangible qualities including the capacity to convey a sense of personal warmth and trustworthiness that contribute to effective collaborative practice. A good sense of humor will go a long way to defusing the inevitable conflicts that arise. Unfortunately, failure to pay attention to these personality variables can have long term consequences. One toxic team member can compromise the efficacy of the entire team, and there is a danger that team functioning will "level down" to the functioning level of the weakest team member.



Keely Luke Photographie

Lesson 3 Commitment to collaboration is essential.

If collaboration is to work, each individual team member must be committed to the process. When hiring staff, it is crucial to put special emphasis on the collaborative aspects of the team philosophy and to outline expectations for team performance. It is useful to explore an applicant's experience and expectations with regard to interprofessional collaboration. Dissatisfaction with traditional role bound models, motivation to develop new ways of working, and willingness to learn by "groping along" can all be positive indicators of someone who will commit to the team process. Moreover, there should be a "goodness of fit" between an applicant's personal

and professional goals and the program's philosophy and mission. The desire for a challenge, an interest in program development, and a perception of the positive personal benefits of collaboration contribute to a team member's ability to commit to the process. Early discussions regarding inevitable conflict should be initiated prophylactically to elicit commitment to work collaboratively toward resolution. Such commitment to the model provides the staying power when problems become overwhelming.

Tips from the Field

Look for traits of patience, persistence, flexibility, empathy, and self-assurance.

Hire those who are non-defensive, who are aware of their own biases, and who respect differences.

Select people who are non-traditional, motivated, and willing to learn as they go along.



Keely Luke Photographie

Stage 3

Training

Early, appropriate training is central to a successful shift from traditional to interprofessional modes of service delivery. In order for professionals from various disciplines to provide services from a collaborative model, they must equip themselves with the attitudes, knowledge, and skills requisite to working within this new model.

"Training activities can help to tease out necessary distinctions between disciplines."

HEC staff identified five domains of training for HRTL staff. These featured 1) an introduction to family-centered practice, 2) the elements of interprofessional collaboration, 3) the importance of early childhood education, 4) the role of the medical home in prevention and treatment of the new morbidity (See Appendix B), and 5) interprofessional communication skills. HEC staff provided 96 hours of training to HRTL team members during the first project year. Part of this training was provided by well-recognized local and national experts. Several of these speakers were parents who lent their unique expertise as consumers. In the second project year, interactive training is scheduled. A training workbook is currently being developed containing curriculum guidelines and problem-solving activities mirroring real life situations.

An important aspect of initial training is that the professional "culture" of each discipline must be examined and modified to allow a sense of interdependence between professionals to evolve. This requires that discipline driven differences in rules, roles, and expectations must be considered and dealt with. The goal is not to diffuse the unique contribution each discipline makes to the overall care of a child and family. Appropriate differentiation of roles is important to effective team functioning. It should be expected, for example, that different disciplines will have varying ethical codes and goals for treatment. However, training activities can help to tease out necessary distinctions between disciplines and identify needless sources of conflict between the various professional cultures. Forewarned is forearmed. An open discussion

5 Domains of HRTL Training

Family-Centered Practice

Elements of Interprofessional Collaboration

Role of the Medical Home

Importance of Early Childhood Education

Interprofessional Communication Skills

during training about possible points of difference can prevent problems or at least provide a foundation from which to work when differences threaten to compromise quality care.

In sum, HEC staff learned that training should be early and ongoing, incorporate team building skills, and integrate didactic and process components. Ideally, training would be conducted within an "in-vivo" environment where trainees can learn by example and immersion.

Lesson 1 Provide training that is early and ongoing.

Because interprofessional collaboration represents a new mode of professional functioning, training is necessary at the outset. The evolutionary nature of team building means that ongoing training is also essential for continued use of interdisciplinary team skills. Initial training provides exposure to new concepts and attitudes, while ongoing training allows team members to integrate and consolidate their new knowledge into day to day clinical practice.

Training takes time. Administrative leadership is vital to ensure that training is framed as indispensable and that time is sanctioned for training activities. Resistance to training will increase over time as the press of direct service provision increases. The frequency and duration of training sessions may be reduced following initial training, but there is a need for ongoing

opportunities for team members to examine their efforts to implement these new ideas and practices. It is up to program administrators to recognize and counterbalance resistance and assure that training is provided on an early and ongoing basis.

Lesson 2 Incorporate team building skills.

Interprofessional collaboration requires training in relational skills including constructive communication, negotiating, problem-solving, and decision-making. These should be incorporated into formal training activities and field tested informally during day to day team interaction. Regular training meetings provide team members the opportunity to review and hone their newly acquired skills for maximum effect. If properly facilitated, this process becomes a circular one in that the mutuality of the training sessions consolidates and reinforces team functioning.

It should be remembered that trust between team members is essential to all of the above. Trust promotes mutuality and exploration. Trust building, then, is a fundamental part of training and a safe environment for participants should be established as the context of training. This can be accomplished by addressing issues of confidentiality between team members, importance of respect for differences, and mutuality of goals.

Lesson 3 **Emphasize process as well as product.**

Effective team functioning requires the ability to implement collaborative concepts. Trainees should be encouraged to develop a heart-felt understanding of collaboration through application, and time should be allotted for practicing with team members. Pair didactics with real world experience, and provide group facilitation as necessary to assure that the process of working through conflict promotes positive growth among team members. The use of case examples involving situations similar to the trainees' can be helpful if the issues at hand are too sensitive to work with directly. Discussing strategies for resolving other people's problems can provide opportunities for doing process work by displacement.

Lesson 4 **Provide "in vivo" models of training.**

Unfortunately, interprofessional training opportunities are extremely limited, and without exposure to an interprofessional model of successful service provision, professionals will be forced to fall back on conventional ways of addressing clients' needs that are more narrow and limited.

For this reason, HEC has an added component designed to expand training to trainees from the university schools of social work, medicine, and early education. Select students

will be given the opportunity to accomplish a training rotation within HRTL. In this way, HRTL team members become trainers in their own right. During year one, HEC initiated medical resident rotations as part of two University of Hawaii training programs within the John A. Burns School of Medicine. Residents from the Pediatric and Obstetrics-Gynecology (OB-GYN) departments. Nine pediatric residents worked in the clinic four hours per week for eight weeks, and three OB-GYN residents worked in the clinic four hours per week for four weeks to complete their rota-



Philippe Gross

tions. Initial contact has been established with the University of Hawaii College of Education and School of Social Work, and HEC staff will work to cultivate those relationships in the coming year.

Stage 4

Monitoring, Evaluation, and Refinement

Interprofessional collaboration is an interpersonal process, and as such, it is constantly changing. To stay vibrant, it requires regular monitoring and cultivation. Therefore, building a collaborative team is a continuing process. Program development, team building, and attention to morale are ongoing in a vital interprofessional process. Monitoring and evaluation allow team members to identify obstacles as well as celebrate their successes. In addition, process evaluation suggests necessary modifications and enhancements. Process oriented evaluations conducted by HEC staff throughout the year highlighted the importance of revising training to compensate for staff turnover and respecting the need to "grow as you go."

Lesson 1 **Staff turnover compels supplementary training and attention to group process.**

Inevitably there will come a time when staffing patterns change and original team members are replaced by new employees. Staff turnover at HRTL highlighted two related points. First, supplementary training must be developed for new team members. Joining an existing team may feel a bit like boarding a fast-moving train for the newest member(s). They must assimilate relevant training material while acculturating to established and ongoing team norms and practices. Training may be modified so that newly hired employees will be exposed to fundamental philosophies and attitudes while allowing them to develop necessary relationships with existing team members. The key to integrating new team members is to make sure they are engaged with others in the learning process. It is insufficient to hand them a manual of policies and procedures and expect them to absorb the essence of family-centered interprofessional collaboration. Enlist other team members to advance the learning of their new colleague and structure interactive discussions with program administrators and team members regarding the mission and goals of the project.

It is also important to remember that any-

time there is a change to group constellation, there will be corresponding changes in group process. Attention to group process is especially important at this point. Old conflicts may be revisited and new ones emerge as team members re-establish their equilibrium within the group. Working through this process will facilitate group cohesion as well as reinforce the principles of team collaboration.

Lesson 2 **Respect the need to "grow as you go."**

It would be impossible to foresee and prepare for all possible contingencies of a collaborative venture. The program will continually evolve in response to changing needs and group dynamics. Accepting this fact will allow administrators to meet and treat problems as they arise, tailoring program development to immediate needs of team participants and consumers. It will also allow team members to play an active role in problem resolution which will reinforce team strength and commitment.

Tip from the Field

Enlist other team members to advance the learning of a new colleague.



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Stage 5

Dissemination

Dissemination of lessons learned through collaborative ventures is essential if we are to realize fundamental change within our systems of service delivery. Unfortunately, while the concept of interprofessional collaboration is gaining momentum, gaining access to information about other collaborative ventures can be tedious and labor intensive. Information about innovative programs often goes unpublished or is disseminated only within traditional disciplinary tracts.

HEC staff found that broad dissemination of collaborative strategies serves two purposes. First, expanded communication flow to a larger network will reduce duplication and decrease the likelihood of re-inventing the wheel. Second, it is important to plant seeds that will establish roots of collaboration within the community. This will assure broad based and continued local support. In addition, the more firmly concepts of interprofessional collaboration are rooted in the community, the more likely it is that they will thrive in a wider number of settings.

HEC staff has initiated or participated in a number of efforts geared toward dissemination. To raise public awareness within the local community, a lecture series was launched featuring several prominent speakers including Michael Levine, Ph.D., Program Officer, Carnegie Corporation of New York; Robert Haggerty, M.D., Executive Director, International Pediatric Association and Professor Emeritus, University of Rochester School of Medicine & Dentistry; Katharine Hooper-Briar, Ph.D. and Hal Lawson, Ph.D., co-authors of the innovative and authoritative monographs, "Serving Children, Youth and

"Dissemination of lessons learned... is essential if we are to realize fundamental change."

Families Through Interprofessional Collaboration and Service Integration: A Framework for Action," and "Expanding Partnerships: Involving Colleges and Universities in Interprofessional Collaboration and Service Integration"; and Governor Howard Dean, M.D., current governor of the state of Vermont. These speakers have championed the practice of interprofessional collaboration with legislators, foundation officers, public and private providers, and CEO's of major health care systems in the country.

To further dissemination efforts, HEC has participated in five

NCLIE meetings. HEC and the NCLIE are sharing information to develop recommendations regarding the knowledge, skills, and values that should be included in the respective training and research programs of the participating professions. Corresponding changes in these programs will contribute to development of leaders who can create a collaborative education, health, and human service system.



Philippe Gross

DEVELOPMENTAL STAGES AND LESSONS LEARNED

Stage 1 *Building a Shared Vision*

- Lesson 1** Collaboration is based on relationships.
- Lesson 2** Collaboration must occur at all levels.
- Lesson 3** Collaboration functions best when it is the result of “bottom up” rather than “top down” efforts.

Stage 2 *Staff Recruitment*

- Lesson 1** Leadership sets the tone.
- Lesson 2** Personality counts.
- Lesson 3** Commitment to collaboration is essential.

Stage 3 *Training*

- Lesson 1** Provide training that is early and ongoing.
- Lesson 2** Incorporate team building skills.
- Lesson 3** Emphasize process as well as product.
- Lesson 4** Provide “in vivo” models of training.

Stage 4 *Monitoring, Evaluation, and Refinement*

- Lesson 1** Staff turnover compels supplementary training and attention to group process.
- Lesson 2** Respect the need to “grow as you go.”

Stage 5 *Dissemination*

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*This is not an all inclusive list, but
this is the membership reported by the
NCLIE at the time of this writing.

APPENDIX B: THE ROLE OF THE MEDICAL HOME AND INTERPROFESSIONAL COLLABORATION*

The following article was written by Calvin C.J. Sia, M.D., Sharon C. Taba, Alix Howard-Jones, M.Ed.

Calvin Sia, M.D. is a practicing pediatrician in Honolulu and past HMA President and AAP Hawaii Chapter President. Currently, Dr. Sia is principal investigator of the Healthy and Ready to Learn Center, Health and Education Collaboration Project and Healthy Start Evaluation. Sharon Taba is the project director of the Health and Education Collaboration Project. Alix Howard-Jones is the training coordinator of the Health and Education Collaboration Project.

*"The whole is greater than the sum of its parts."
– Unknown*

Imagine a health center where families coming for a health care visit are welcomed by an early childhood educator, nurse practitioner, and social worker. As the families come in for their half-hour appointments, they can expect staff to offer them a snack or a brief discussion on a typical prenatal or infant care concern. The child and parent are accompanied to the examination room by the nurse practitioner and medical resident where they can talk about the parents' concerns, priorities, and resources. Gradually, a feeling of trust is established between the family and the interprofessional team.

Through this interprofessional collaborative, families learn to become responsible partners in their child's health care. This collaborative center, known as the Healthy and Ready to Learn Center (HRTL) in Ewa, seeks to support the community physician in providing a medical home through interprofessional collaboration.

According to the American Academy of Pediatrics (AAP), the role of the primary care pediatrician is to assure a medical home for every child. A medical home involves providing pediatric primary health care that is comprehensive, continuous, family-centered and coordinated.¹ Primary health care as defined by the AAP is accessible, affordable, first contact, continuous, comprehensive, and coordinated to meet the health needs of the family and individual.² Because of the dramatic social and economic changes in today's families and communities, providing a medical home is a formidable challenge facing the physician. Moreover, in the wake of health and school reform, medical homes are being asked to increase their involvement with children at risk of school failure. School readiness and optimal health require a combination of medical care with health and social services both to prevent problems and to

improve the effects of negative conditions.³ One way of prevention which is gaining public attention is interprofessional collaboration, whereby professionals and organizations agree to work together to improve health, education, and social services for these children and families.

Unlike primary care clinics, HRTL complements the medical home-community physician with services such as referral, consultation, and training. This collaboration between public and private providers of personal health services is a way of ensuring comprehensive health care. HRTL staff provide physicians with patient information as well as professional-specific information for patient management. Professional-specific information can include developmental expertise from the early childhood educator and domestic violence information from the social worker. Another collaborative service of HRTL is to routinely fax timely information on patients' visits to doctors' offices – the medical home. Facsimile machines are offered by HRTL to physicians interested in using HRTL services to gain physician buy-in to the program. Gaining physicians' participation, establishing trust and respect, and listening to family concerns using jargon-free language are interprofessional collaborative elements supporting the medical home

Why should physicians be interested in the medical home and interprofessional collaboration?

*"Every child deserves a medical home."*⁴ With this vision the Hawaii Medical Association, the Hawaii Chapter American Academy of Pediatrics, the Department of Health and the University of Hawaii, Department of Pediatrics adopted their 1979 Child Health Plan. The Plan called for an integrated system of care for infants and young children. Following this plan, a series of programs and landmark legislation were initiated building on this integrated system of care for prevention and early intervention for young children and their families in this state. It began with the Hawaii Healthy Start Project for child abuse prevention and positive child development and the Medical Home Project which targeted physician involvement and education in the "new morbidity."⁵⁻⁶ In 1989, early intervention services for infants and toddlers were placed in the Department of Health Zero-to-Three Hawaii Project and Hawaii's State Law, Act 107-89, was added to broaden the integrated system of care for children.⁷ In 1989, President Clinton, then the chair of the National Governors' Association, developed the National Educational Goals, which stated "All children will be healthy and ready to learn when they enter school by the year 2000."⁸ David Hamburg, MD. of the Carnegie Foundation of New York and Ernest Boyer, distinguished educator and author of *Ready to Learn*, emphasized that the health and education of young children are inseparable.⁹ Hamburg and Boyer recognized that health and education workers must join forces to prevent poor health and school failure par-

ticularly for young children at risk.

Increasingly, pediatricians are expected to function as medical specialists on diagnostic and evaluation teams or school individual educational plan meetings for children with special health needs. The team expects the pediatrician to provide not only medical expertise but also developmental and behavioral knowledge. In keeping with the current trend to collaborate on health and education initiatives, pediatricians need the support of the community to provide health and education services to families at risk. The community can support the physician by educating at-risk families to become competent health care partners. On this basis HMA developed its two newest initiatives: the already mentioned Healthy and Ready to Learn Center and the Health and Education Collaboration Project as service delivery and training projects.

Interprofessional Collaboration in Service Delivery

"It takes a whole village to raise a child."

--African Proverb

The HRTL program concentrates on the problems that families face in the service delivery system. Melaville and Blank point out significant barriers preventing a coordinated system.¹⁰ These are poor access to health care, a lack of shared information and coordinated services between providers, and a lack of interprofessional training opportunities for physicians, social workers, and educators. Chaotic circumstances inherent in crisis management can prevent families from getting the appropriate services they need when they need them. The current service delivery system lacks the ability to go beyond specialized fields to meet the multiple and pervasive problems facing families today.

HRTL seeks to demonstrate a family-centered, interprofessional collaboration approach to at-risk pregnant women, mothers, and children from birth to five years in Leeward Oahu. Through interprofessional collaboration, the program is exploring ways to deliver integrated health care and education services by an interprofessional team. The interprofessional team consisting of nurse practitioner, early childhood educator, and social worker, will work jointly to provide an array of services. These include prenatal and postpartum care, family planning, routine well child care, child development information, parent-child activities, supportive counseling and referral services.

What role do physicians play on the interprofessional team?

The physician takes on different roles--consultant, medical professional, facilitator, or educator. Interprofessional collaboration focuses on the interrelationships among the pediatrician, nurse practitioner, social worker, and early childhood educator. In the

community, the pediatrician provides the medical home for families while relying on HRTL staff to expand their support via classes in child safety, parenting, prenatal care, and family planning. Through these classes, families learn responsible, preventive health care and ultimately, to select a community physician as their medical home.

Intercollaborative work presents many challenges and benefits to the physician. Some of the challenges are overlapping skills and unclear roles of the professionals, varying philosophical and language differences, and inherent hierarchical medical models which can interfere with collaboration.

Some of the benefits are derived by shifting families from an illness orientation to cost effective, well-care orientation. But physicians need help in educating families to eat right, parent effectively, make and keep appointments, follow through on medication, and become responsible patients.

How professionals resolve the challenges and maximize the benefits of interprofessional collaboration depends on appropriate training.

Interprofessional Collaboration in Training

The Health and Education Collaboration project (HEC), a four-year federally funded training project will be targeting pre-service professional levels, specifically the pediatric and obstetrics and gynecology residents and early childhood and social work doctoral students. Currently, HEC and Dr. Louise Iwaishi, director of the pediatric residency program at UH, are developing resident training on family-centered interprofessional collaboration. In the pediatric residency program, the training is included in a two-month developmental adolescent rotation. One challenge that faces residents is assimilating family-centered collaborative concepts and applying these concepts in their clinical experience. The training focuses on residents promoting the medical home, empowering families, learning the integrated roles of the professional staff (nurse practitioner, social worker, and early childhood educator), and understanding the importance of early childhood education.

The resident training experience is composed of several parts. In supporting the medical home, the resident learns about the family in pre and post-conferencing with the HRTL team. Each member of the team provides a unique perspective specific to his or her discipline. Equipped with this information, the resident listens to the family's concerns, priorities, and resources thus practicing family-centered care. Next the resident assesses the well-care needs of the patient and provides developmental information to the parent. This includes the importance of early childhood education.

One of the innovative features of the training is the importance of early childhood education. A recent Carnegie report states that "the quality of young chil-

dren's environment and social experiences has a decisive, long-lasting impact on their well-being and ability to learn."¹¹ Increasingly, the research crossing all professional lines documents that a quality early childhood education can reverse the adverse effects that compromise a child's development.¹²⁻¹⁵ The educator's role at HRTL is to encourage families to recognize a variety of early childhood education experiences better prepares the parent and the child for the experience of school.

Further pre-service training will be based on the collective expertise of HEC staff and the members of the Commission in Leadership for Interprofessional Education.¹⁶ This Commission, formed in 1990 and headed by Dean Corrigan of Texas A & M, is composed of deans, administrators, and professors from universities interested in advocating for the development of interprofessional education. Through the Commission, the Project will create linkages between the local university and HRTL. HRTL will serve as a practicum site not only for pediatric residents, but also for ob-gyn residents and graduate students in social work and education.

HEC will field test collaborative strategies among the professionals at HRTL. Based on these experiences, HEC will disseminate both locally and nationally information on the best practices to promote family-centered interprofessional collaboration.

Conclusion

The medical home plays a critical role on the inter-professional team to improve the well-being of at-risk children (birth to five) and families to improve school success. School success and optimal development for children require not only medical care but also health and social services to both prevent and counteract negative conditions. Through such initiatives as the HRTL collaborative and the HEC project, the medical home and interprofessional collaboration can be fostered. Shifting direction from the traditional deficit models of care to comprehensive and preventive ones will increase accessibility to services for families most in need.

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Sia, C. J., Taba, S. C. & Howard-Jones, A. (1995). The role of the medical home and interprofessional collaboration. *Hawaii Medical Journal*,





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