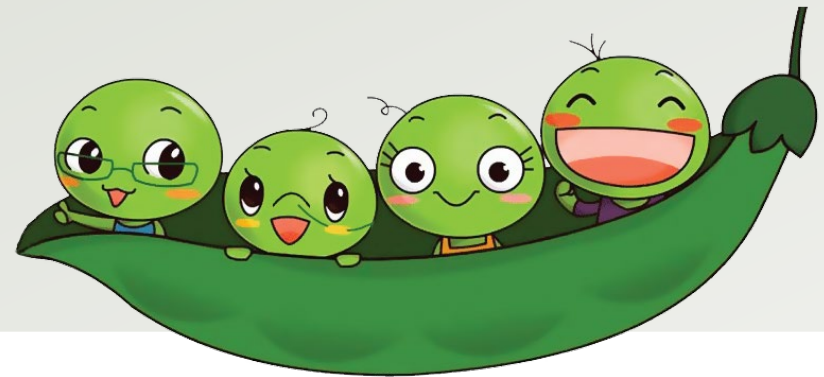


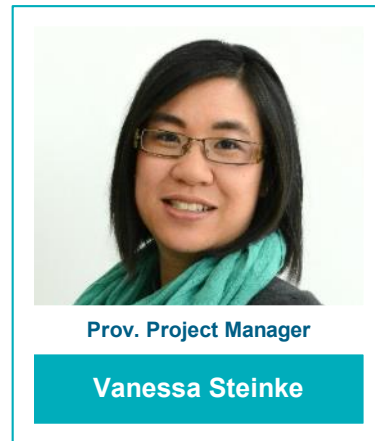
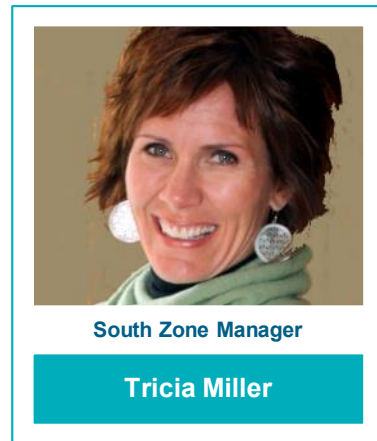
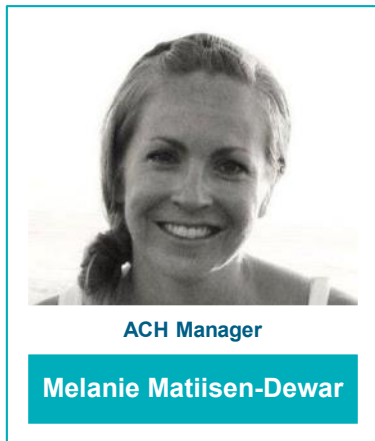
Collaborative Practice & Roles for Healthcare Providers

Pediatric Eating And Swallowing Provincial Project



Welcome

- Introductions & Objectives



Provider Training Dates

Topic	Audience	Dates & Times <i>(Choose 1 of each)</i>	
Overview & New Tools	Managers & Healthcare Providers	✓ Jul 21 11-12 pm	✓ Oct 21 3-4 pm
Clinical Practice Guide	Healthcare Providers	✓ Jul 23 3-4 pm	✓ Oct 28 3-4 pm
Collaborative Practice & Roles	Healthcare Providers	✓ Jul 30 3-4 pm	✓ Nov 5 2-3 pm

✓ Online recordings: <https://peas.albertahealthservices.ca/Page/Index/10176>



PEAS Provider Training: Overview & New Tools

The image shows a Zoom Webinar Chat window. The window title is "Zoom Webinar Chat". The chat area is currently empty. Below the chat area, there is a "To:" dropdown menu set to "All panelists and attendees" and a note that says "Your text can be seen by panelists and other attendees". At the bottom of the Zoom interface, there are three icons: "Chat", "Raise Hand", and "Q&A".

For Comments
Use the **Chat** and select "All panelists and attendees" for public comments.

For Questions
Use the **Q&A** or **Raise Hand**. We will address them at the end of the presentation

Audio Settings ^

Chat Raise Hand Q&A

Overview

Pediatric Eating And Swallowing Provincial Project



Project Scope

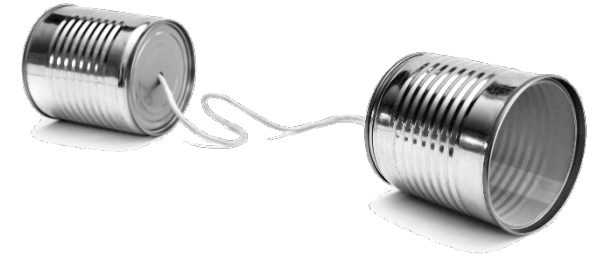
The Pediatric Eating And Swallowing (PEAS) Project is a provincial **quality improvement** initiative with the purpose of developing a provincial eating, feeding, and swallowing **clinical pathway** to standardize and improve care for children with a **pediatric feeding disorder**.¹

Target population: Patients receiving care from provincial Outpatient Clinics, Home Care, or Community Rehabilitation

¹ Goday PS et al. *Pediatric Feeding Disorder: Consensus Definition and Conceptual Framework*. J Pediatr Gastroenterol Nutr. 2019 Jan;68(1):124-129.

Role Clarity & Communication

Sample Feedback from World Cafes (Fall 2018)



“Families don't know **who provides what?**”

“Discussions happen in **siloed** clinics.”

“We lack common **goals** and a common purpose.”

“Transitions - who makes the *next* **decision** about care?”

“Certain disciplines carve out their areas and can create **systemic issues** and historical roles within a site or service.”

“Lack **multidisciplinary visits** to see the big picture, usually there isn't a ‘team.’”

Find relevant information

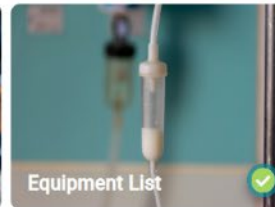
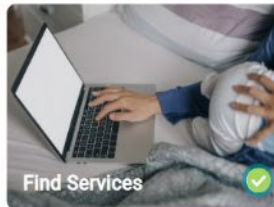
For families and care providers of children with an eating, feeding and swallowing disorder

FOR FAMILIES

FOR PROVIDERS

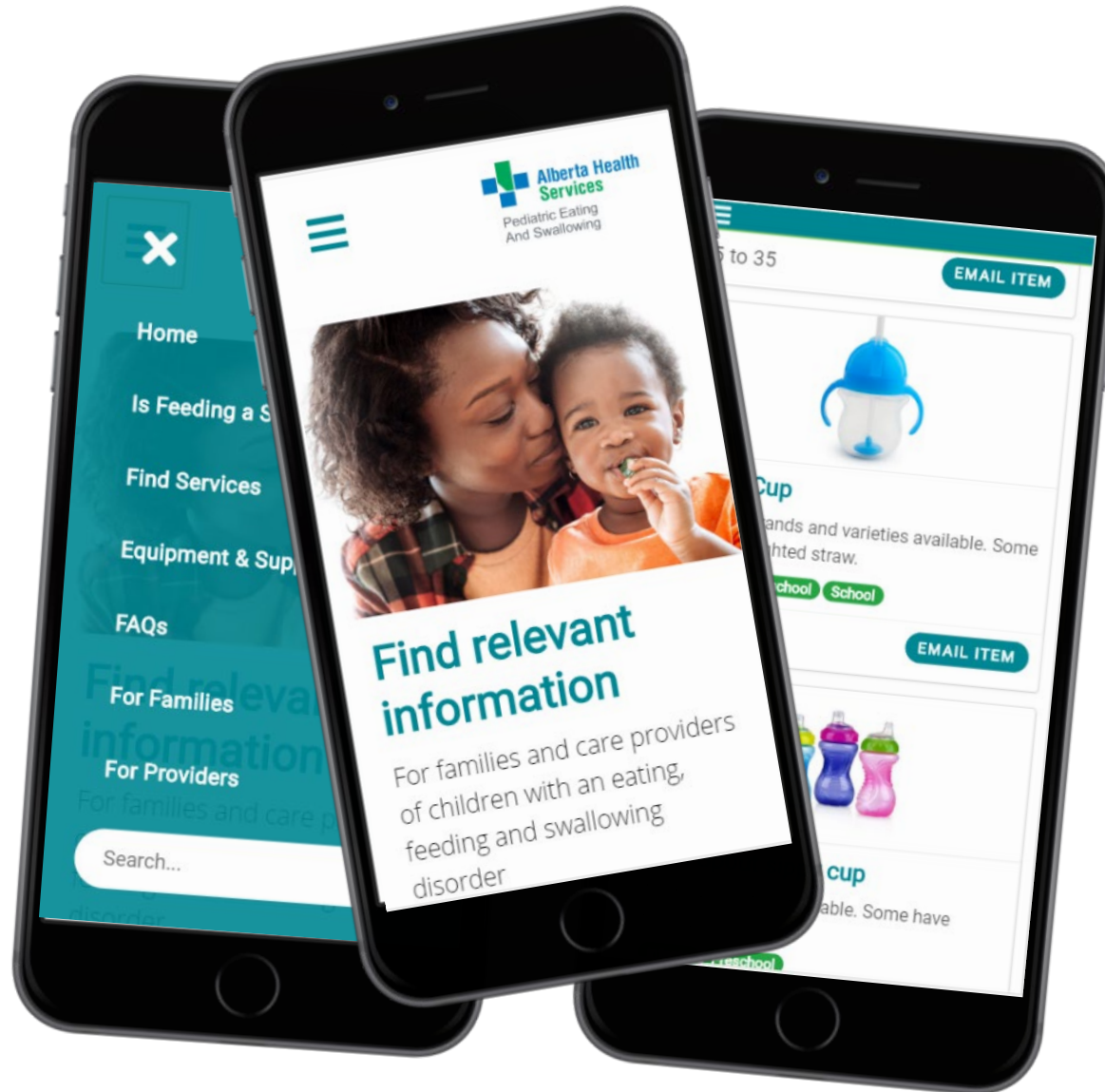


Popular Resources for Families



PEAS Collaborative Practice & Roles

- ✓ Mobile responsive



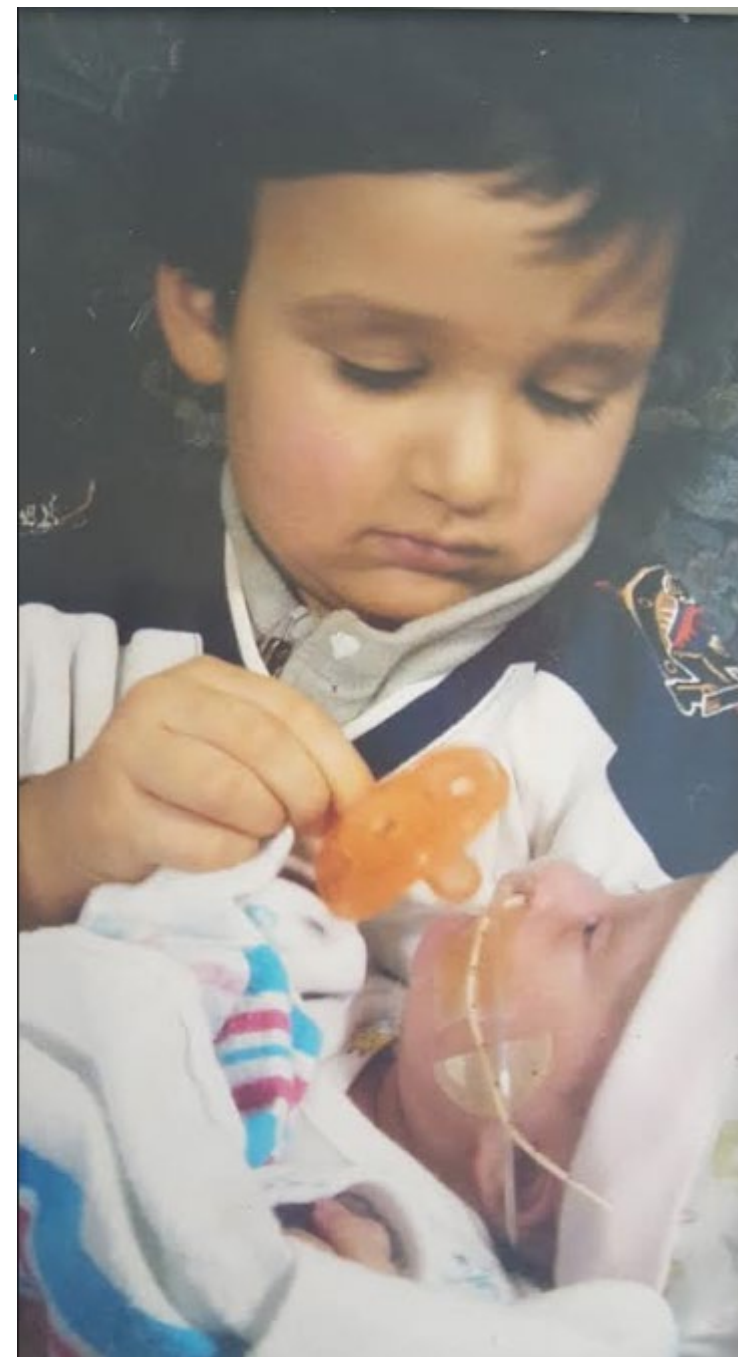
Family Story

Mona Dhandra

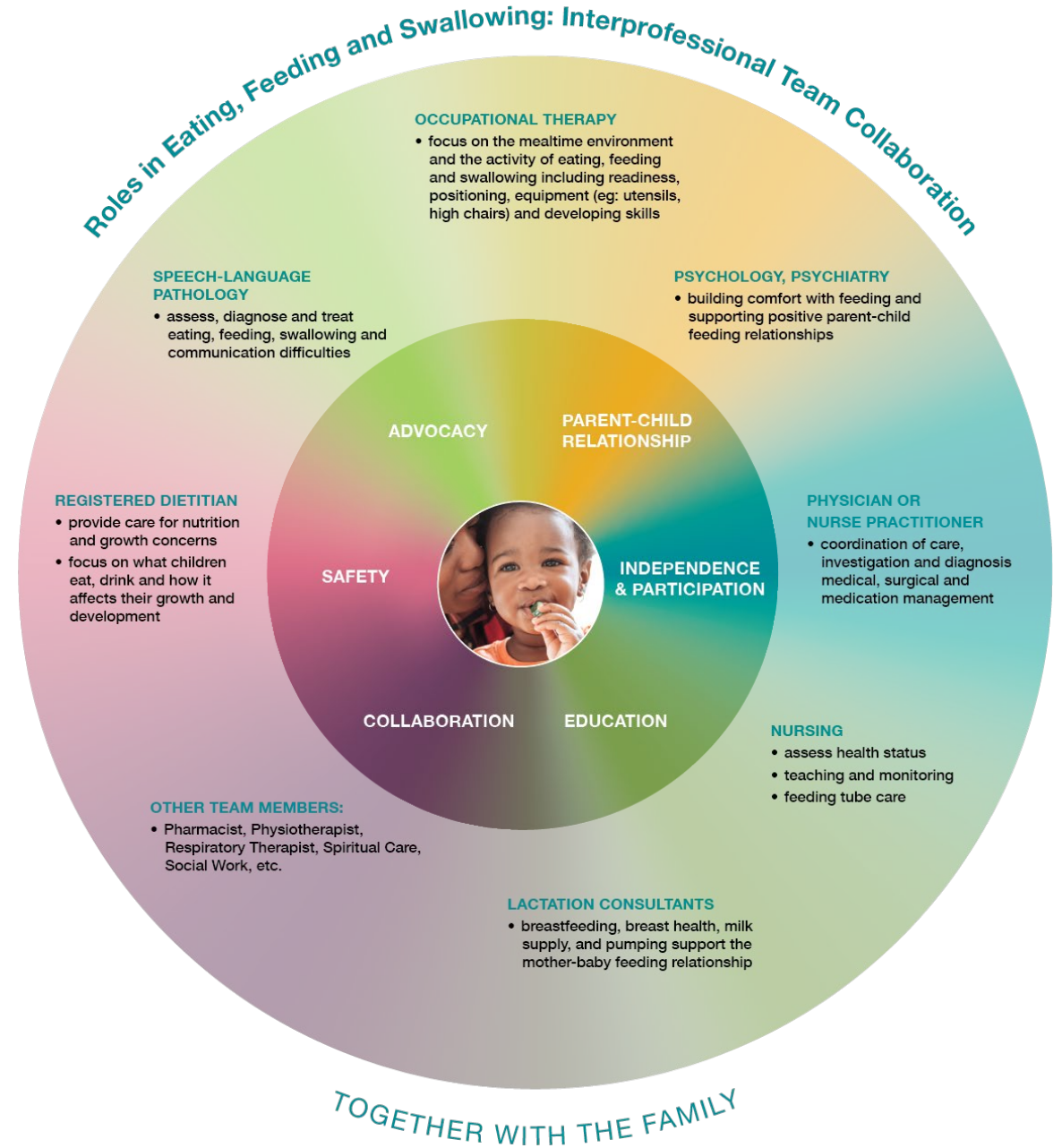
Eisha – Age 8



Eisha – Birth Story



Eisha – The first year



Eisha - Transition to solid food - Daycare and School



Eisha – Appropriate eating and non food items

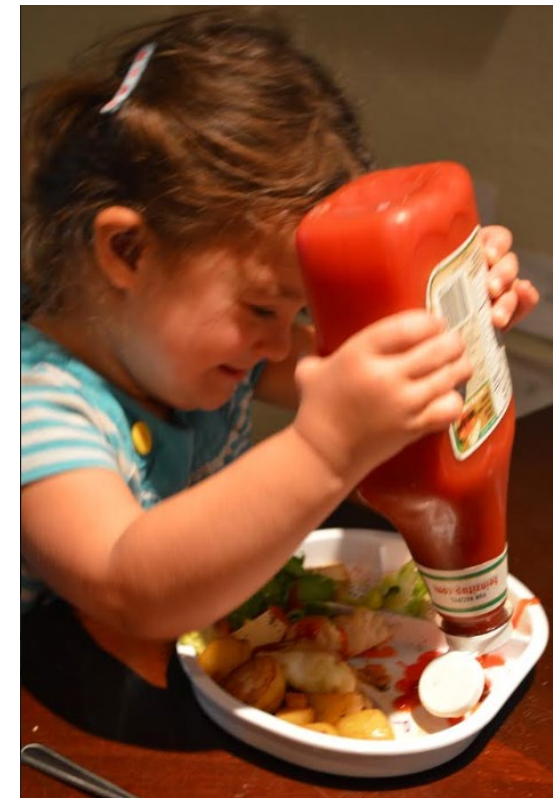


Family Goal Setting

Objectives	Strategies to Achieve Objectives	Person(s) Responsible with Role Assumed
1. By March 2017, Eisha's family will learn about communication outcomes for children and discuss ways to evaluate the changes in her communication and participation at home.	Discussion of the Focus on the Outcomes of Communication Under Six (FOCUS-34) parent questionnaire before completion Completion of the FOCUS-34 Discussion of results of the FOCUS-34 after scored by SLP	SLP- discussion, providing information, scoring parent questionnaire Parents- discussion, questions, filling out parent questionnaire
2. By March 2017, Eisha's family will learn about tactile kinesthetic cueing approaches, such as PROMPT, in order to support her speech sound development.	Trial of PROMPT therapy Discussion of the Motor Speech Hierarchy and Conceptual Framework Teaching broad-based parameter PROMPTs to family members the importance of turn-taking in and practice actice embedded in motivating activities isha with specific feedback during and collaboration in choosing target words and phrases	SLP- education and discussion on tactile-kinesthetic learning Parents- discussion and practice of strategies during motivating activities & daily routines SLPa- practice of strategies during motivating activities and daily routines
	ual cues to separate question types f functional questions es to encourage complete answers (e.g. "ords" or "all your words") omemade books for motivating practice ersonal pictures on of wh-question teaching hierarchies:	Family – Questions, Discuss Strategies SLP – Modelling, Coaching and Discussion SLPA – Practice, Introduce Activities



Eisha – Specialized Services and taking chances on food



Health Professions Strategy & Practice Key Messages



Practice Director, Provincial
Speech-Language Pathology

Julie Evans



Practice Director, Provincial
Occupational Therapy

Carmen Lazorek

Child & Family First



Client-centered approach

What matters to you?

Professional Practice in Action

Strong “I” + Strong “We”
= *Excellence in Care*

<https://insite.albertahealthservices.ca/about/vmv/Page14149.aspx>



Collaborative Practice

“ Collaborative Care is a healthcare approach in which **interprofessional teams** work together in **partnership** with **patients and families** to achieve optimal health outcomes. ”

– AHS CoACT

Current State

Teams according to **discipline**



Teams according to **geographic area**



Teams according to **clinical program**



Future State

Collaborative Care Team



The **care team** is built **around the child and family** and **from their perspective**, rather than by discipline, geographic area, or clinical program.

CoACT Collaborative Care Elements for Pediatric Eating And Swallowing



Collaborative Care Team

The entire care team, including patients and families. Inter-professional competencies are demonstrated, and high quality, proactive, integrated care meets patient needs and achieves the best possible health outcomes.



Assignment of Care

A discussion involving shared decision-making and negotiation of who is most appropriate to provide various child and family care activities.



Team Charter

Description of Collaborative Care team members' responsibilities, accountabilities and working relationships in the care environment.



Collaborative Care Leadership

Frontline teams that support successful implementation and sustainability of Collaborative Care, and Quality Culture.



[FOR PROVIDERS](#)[CLINICAL PRACTICE GUIDE](#)[CLINICAL TOOLS & FORMS](#)[COLLABORATIVE PRACTICE](#)[Collaborative Care Primers & Resources](#)[Role Descriptors & Tasks within Full Scope](#)[Additional Resources](#)[Definitions](#)[PROFESSIONAL DEVELOPMENT](#)[COMMUNITY OF PRACTICE](#)[FAMILY RESOURCES](#)

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Collaborative Practice

"Unity is strength... when there is teamwork and collaboration, wonderful things can be achieved."

As a healthcare organization, Alberta Health Services (AHS) is dedicated to providing the highest quality care. The Pediatric Eating and Swallowing (PEAS) Project's mission is to capture the spirit and harness the power of collaboration to enhance and standardize interdisciplinary practice in the area of eating, feeding and swallowing (EFS), in order to attain the best outcomes for our patients and their families.

Team members from multiple disciplines play a critical role in the provision of care in the area of eating, feeding and swallowing. The following are a collection of resources to help healthcare professionals enhance collaborative practice and communication amongst team members including the child and their family.

Collaborative Care Primers & Resources

"Collaborative Care is a healthcare approach in which interprofessional teams work together in partnership with patients and families to achieve optimal health outcomes." – CoACT

Together with AHS Co-ACT, the PEAS Project has developed a number of resources to support collaborative practice in Eating, Feeding and Swallowing:

- Team Charter
- Collaborative Care Team
- Assignment of Care
- Collaborative Care Leadership

[READ MORE](#)

Role Descriptors & Tasks within Full Scope

Together with families, clinicians, AHS Health Professions Strategy & Practice (HPSP), AHS Co-Act, and professional colleges, the PEAS Project has developed the PEAS Role Descriptors and Tasks within Full Scope for healthcare providers to:

- Provide EFS clinicians with an **adaptable tool** to use as a way of highlighting, communicating, and clarifying overlaps and gaps within each individual team.
- Promote **interprofessional care** bringing together the unique perspectives of varied disciplines regardless of whether people work in co-located teams or are geographically spread out.
- Focus members of a care team on their **collective team competence** to address child and family centered goals for EFS.
- Provide a tool to **identify and cover gaps** in service (e.g. referrals and consultation with other care teams, training, recruitment, etc).

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1. Team Charter

 [Team Charter Primer](#) [Team Charter Development Guide](#)[Team Charter Template](#) [Team Charter template](#)[Examples](#) [EFSS Team Charter](#) [Inpatient EFS Team Charter and Roles](#) [EFS Lead Team - Team Charter](#)[Additional Resources](#) [Word Cloud generator](#)

2. Collaborative Care Team

 [Collaborative Care Team Primer](#)

Current State

Teams according to **discipline**



Future State

Collaborative Care Team



Team Charter

Key Components include:

- Team Vision or Purpose
- Mutual Expectations
- Team Members Roles and Responsibilities
- National Interprofessional Competencies*
- Accountability and Sustainability Agreement
- All members of the Collaborative Care Team sign the Team Charter.



Team Charter

Why a Team Charter?

Teams work more effectively when they are united towards a common purpose, when individual responsibilities are known, and when all team members are clear about their roles and expectations. A Team Charter facilitates ownership of collaborative working relationships in the care environment. It enables the team to function in an empowered manner and provides a link between the team's goals and the over-arching AHS mission, vision and goals.

What is a Team Charter?

A Team Charter is a collaboratively developed description of the team member's responsibilities, accountabilities and working relationships in the care environment. It defines the purpose of the team, team values, operating rules, and accountabilities. It provides the scope and approach to collaboration, outlines expectations, behaviours, and commitments. It also provides an agreed-upon process to resolve interprofessional conflict.

CONT. →

CHILD & FAMILY EXPERIENCE	PROVIDER EXPERIENCE	OPERATIONAL LEADERSHIP
My care team works well together.	I am part of a team that works well together.	I'm confident we hold ourselves accountable to function respectfully in the workplace.



Team Charter

- ✓ Examples
- ✓ Templates
- ✓ Tools



Eating, Feeding, Swallowing Service Team Charter

Purpose: We serve children and their families who have challenges with eating, feeding and swallowing, providing high quality, patient & family-centered, evidence-based assessment and treatment in order to empower our families and caregivers to have a positive feeding relationship with their children, and to make their lives easier.



Value Statement: The Eating, Feeding, Swallowing Services team will work with patients and families to

- meet them where they are;
- collaborate and partner with families;
- respect, trust and value all members of the team, with families being at the center;
- empower caregivers to promote a positive feeding relationship and experience;
- take the stress out of eating, feeding and swallowing.

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2. Collaborative Care Team

[Collaborative Care Team Primer](#)

Current State

Teams according to **discipline**



Future State

Collaborative Care Team



Primers

- ✓ 2 page resources
- ✓ Practical concepts, suggestions and steps



Collaborative Care Leadership

Why Collaborative Care Leadership?

Collaborative Care Leadership fosters an environment of ongoing learning, sharing, mentorship, and support to ensure excellence in collaborative practice. Effective Collaborative Care Leadership is critical to the successful implementation and sustainability of collaborative practice, collaborative processes and quality culture.

What is Collaborative Care Leadership?

Collaborative Care Leadership means that all leaders—regardless of their role, or position in the health system—must be able to lead themselves, engage others, achieve results,

develop coalitions, and conduct systems transformation in order to create the Canadian health system of the future. To create a leadership culture, each person in the system, regardless of position or title, must exercise leadership when it is required. This is distributed leadership (adapted from LEADS Framework).

Collaborative Care Leadership Process

Who

Collaborative Care Leadership can be modeled by individuals in formal or informal leadership positions. Leadership [CONT. →](#)

CHILD & FAMILY EXPERIENCE	PROVIDER EXPERIENCE	OPERATIONAL LEADERSHIP
I am confident that my team has the right skills to meet my needs.	I am clear and competent in the activities I need to do to address the child and family's needs.	I'm confident my staff are enabled to perform at their full capacity.



Roles

“ A **team-based or multidisciplinary** approach to feeding and swallowing assessment in children is **consistently recommended** because of the **complexity of dysphagia** and to ensure care is **coordinated appropriately.** ”

CADTH. (2017) Feeding and swallowing assessment services for pediatric populations in Canada: Service provision, practice models, and assessment tools.

Role Resources for:

- ✓ Healthcare Providers
- ✓ Families





Role Descriptors & Tasks within Full Scope

“A **team-based or multidisciplinary approach** to feeding and swallowing assessment in children is **consistently recommended** because of the complexity of dysphagia and to ensure care is coordinated appropriately.” (CADTH, 2017, p. 20)

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- Provide a tool to **identify and cover gaps** in service (e.g. referrals and consultation with other care teams, training, recruitment, etc).

Download the Guide:



[PEAS Role Descriptors and Tasks within Full Scope](#)



Role	Assessment	Diagnosis	Management	Education	Research	Quality Improvement	Leadership	Collaboration	Advocacy	Professionalism
Physician	+	+	+	+	+	+	+	+	+	+
Physiotherapist	+	+	+	+	+	+	+	+	+	+
Speech-Language Pathologist	+	+	+	+	+	+	+	+	+	+
Registered Dietitian	+	+	+	+	+	+	+	+	+	+
Occupational Therapist	+	+	+	+	+	+	+	+	+	+
Nurse	+	+	+	+	+	+	+	+	+	+
Pharmacist	+	+	+	+	+	+	+	+	+	+
Psychologist	+	+	+	+	+	+	+	+	+	+
Other	+	+	+	+	+	+	+	+	+	+

Roles diagram for Healthcare Providers:

FOR PROVIDERS

[CLINICAL PRACTICE GUIDE](#)

[CLINICAL TOOLS & FORMS](#)

COLLABORATIVE PRACTICE

[Collaborative Care Primers & Resources](#)

[Role Descriptors & Tasks within Full Scope](#)

[Additional Resources](#)

[Definitions](#)

PROFESSIONAL DEVELOPMENT

COMMUNITY OF PRACTICE

FAMILY RESOURCES

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Role Descriptors & Tasks within Full Scope

- provide EFS clinicians with an **adaptable tool** to use as a way of highlighting, communicating, and clarifying overlaps and gaps within each individual team
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-

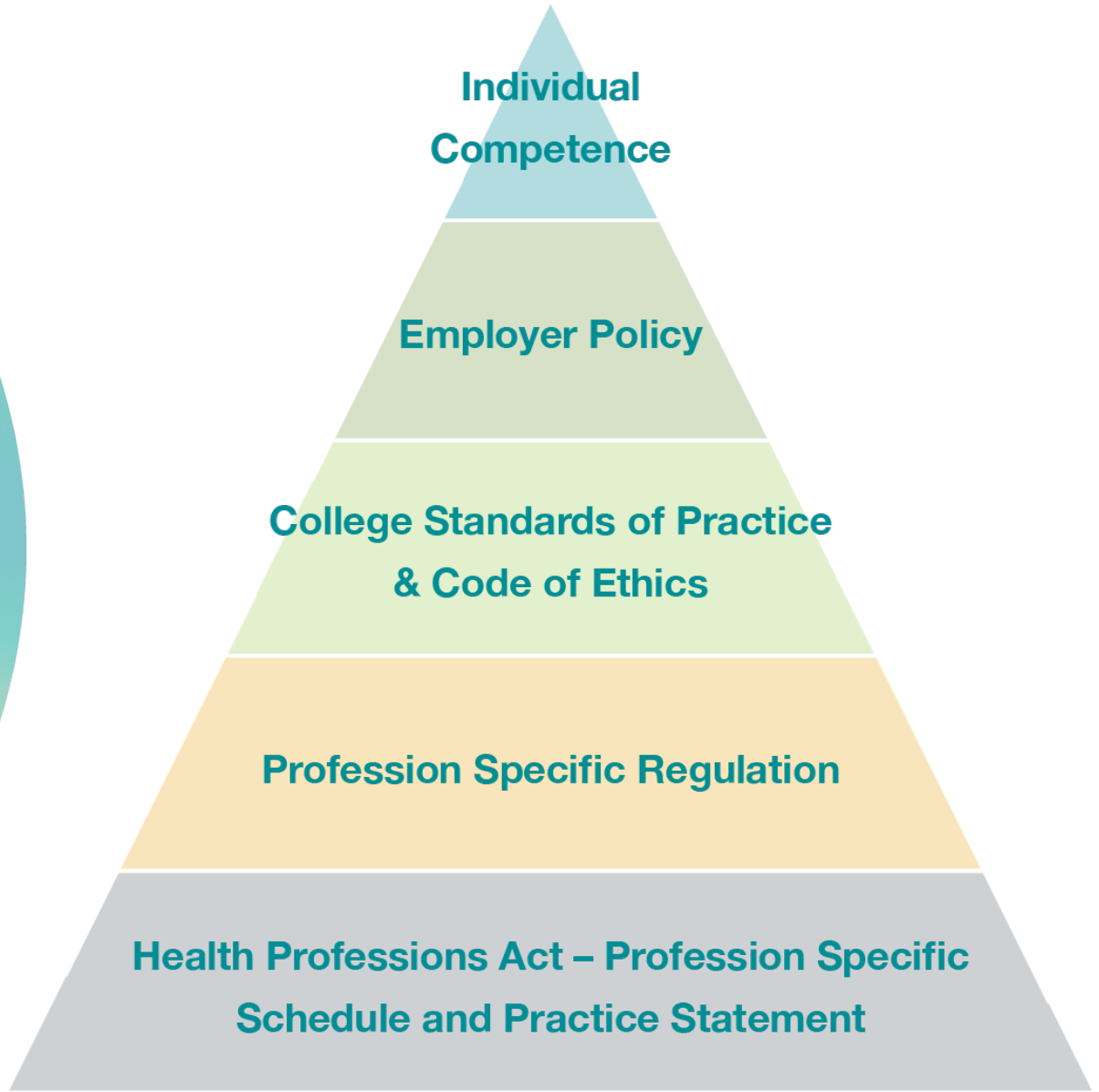
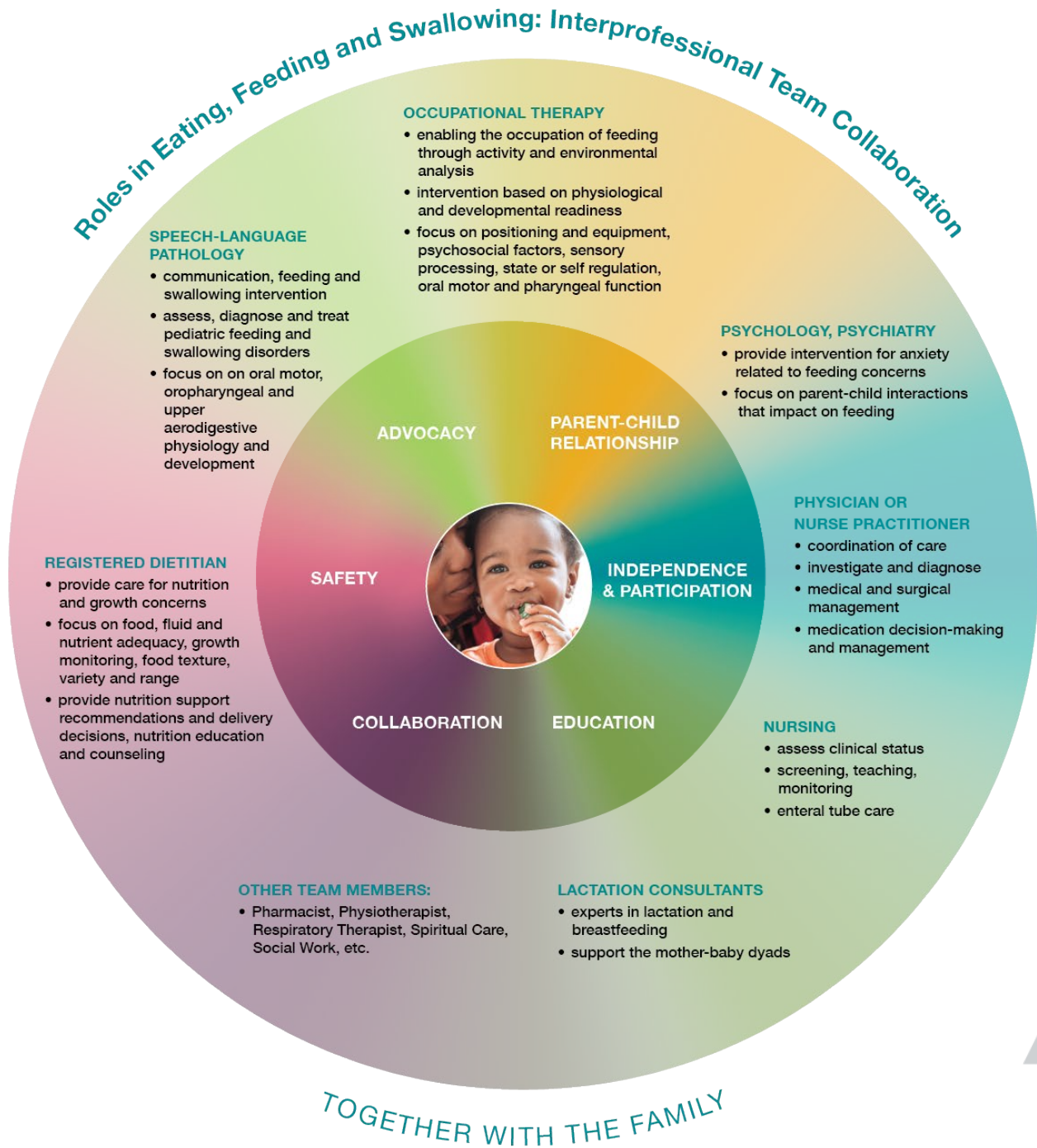


FIGURE 1: SCOPE OF PRACTICE

AHS Examples



FOR PROVIDERS

CLINICAL PRACTICE GUIDE

CLINICAL TOOLS & FORMS

COLLABORATIVE PRACTICE

Collaborative Care Primers & Resources

Role Descriptors & Tasks within Full Scope

Additional Resources

Definitions



PROFESSIONAL DEVELOPMENT

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Additional Resources



AHS Interprofessional Regulatory Affairs FAQs for EFS Teams

Legislative, Regulatory, Organizational and Individual Competency Guidelines for Eating, Feeding, and Swallowing (EFS) Teams

[AHS Rehabilitation Conceptual Framework](#) (AHS staff login required)

AHS Rehabilitation Model of Care [Resource Site](#) (AHS staff login required)

This site includes multiple resources such as:



Pediatric Collaborative Goal Setting Practice Support

Canadian Interprofessional Health Collaborative (CIHC)

[Framework](#)

[Quick Reference Guide](#)

The CIHC National Interprofessional Competency Framework describes the competencies required for effective interprofessional collaboration. Six competency domains highlight the knowledge, skills, attitudes and values that together shape the judgments that are essential for interprofessional collaborative practice. These domains are:

- Role Clarification
- Team Functioning
- Patient / Client / Family / Community-Centred Care
- Collaborative Leadership
- Interprofessional Communication
- Interprofessional Conflict Resolution

AHS Role Clarity

[For Allied Health Professionals](#) (AHS staff login required)

[For Health Professions](#) (AHS staff login required)

AHS Collaborative Practice Consultation Triggers



AHS Collaborative Practice Team Consultation Triggers

Video on Collective Competence | Dr. Lorelei Lingard | TEDxBayfield | 20 min

Interprofessional Regulatory Affairs FAQ

- Restricted Activities
 - To diagnose – not a restricted activity
 - Health Professions Act
 - Collaborative Competence
 - AHS role in directing how professions practice
-

[FOR PROVIDERS](#)[CLINICAL PRACTICE GUIDE](#)[CLINICAL TOOLS & FORMS](#)[COLLABORATIVE PRACTICE](#)[Collaborative Care Primers & Resources](#)[Role Descriptors & Tasks within Full Scope](#)[Additional Resources](#)[Definitions](#)[PROFESSIONAL DEVELOPMENT](#)[COMMUNITY OF PRACTICE](#)[FAMILY RESOURCES](#)

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Additional Resources

PEAS Frequently Asked Question related to Professional Roles (coming soon)

Note: resources are being developed by Interprofessional Regulatory Affairs

[↗ AHS Rehabilitation Conceptual Framework](#) (AHS staff login required)

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Summary:

[FOR FAMILIES](#)[ORAL FEEDING](#)[TUBE FEEDING](#)[FAMILY LIFE & SELF-CARE](#)[Self-Care](#)[Family Life](#)[Finding a Support Network](#)[YOUR CARE TEAM](#)[CARE COORDINATION](#)[TOOLS & TEMPLATES](#)

QUICK LINKS

[✓ IS FEEDING A STRUGGLE?](#)[✓ FIND SERVICES](#)[✓ VIRTUAL HEALTH](#)[✓ EQUIPMENT & SUPPLIES](#)[✓ FUNDING INFORMATION](#)[✓ FAQs](#)

Family Life & Self-Care

Families can often experience stress and anxiety about their child's eating and feeding as mealtime is an important part of daily life and health. There are resources and people available to help you and your family. Some of these people might be part of your current healthcare team, while others might be available to you as a referral if you need one.

Social workers can assist you and your family with the burdens of coping with stress and financial concerns. They can help you access other services and resources in the community. If you have homecare services in place, you will most likely have access to a social worker or to other team members who can help in this regard.

Spiritual care providers offer spiritual, emotional and religious support to families. They can also help you access other faith-based groups in your own community. Consider connecting with one if this sounds important to you.

Mental health supports are also available. Your primary care provider or a healthcare team member can also provide you with information about support services in your community.

Additional Resources:

- **Inform Alberta** is a provincial directory of community, health, social and government services available in your area

Self-Care

To help others, we must first take care of ourselves. Here are some things you can do for yourself and may also help to boost your family's resiliency:

[READ MORE](#)

Family Life

Day-to-day life can be more challenging when your child has feeding difficulties. Please know that you are not alone and there are many resources, supports and ideas to help you and your family. The following are some resources on the following topics:

- Involving family, friends, caregivers, and school
- Supporting my child's siblings and peers

[READ MORE](#)

Finding a Support Network

- Social Media

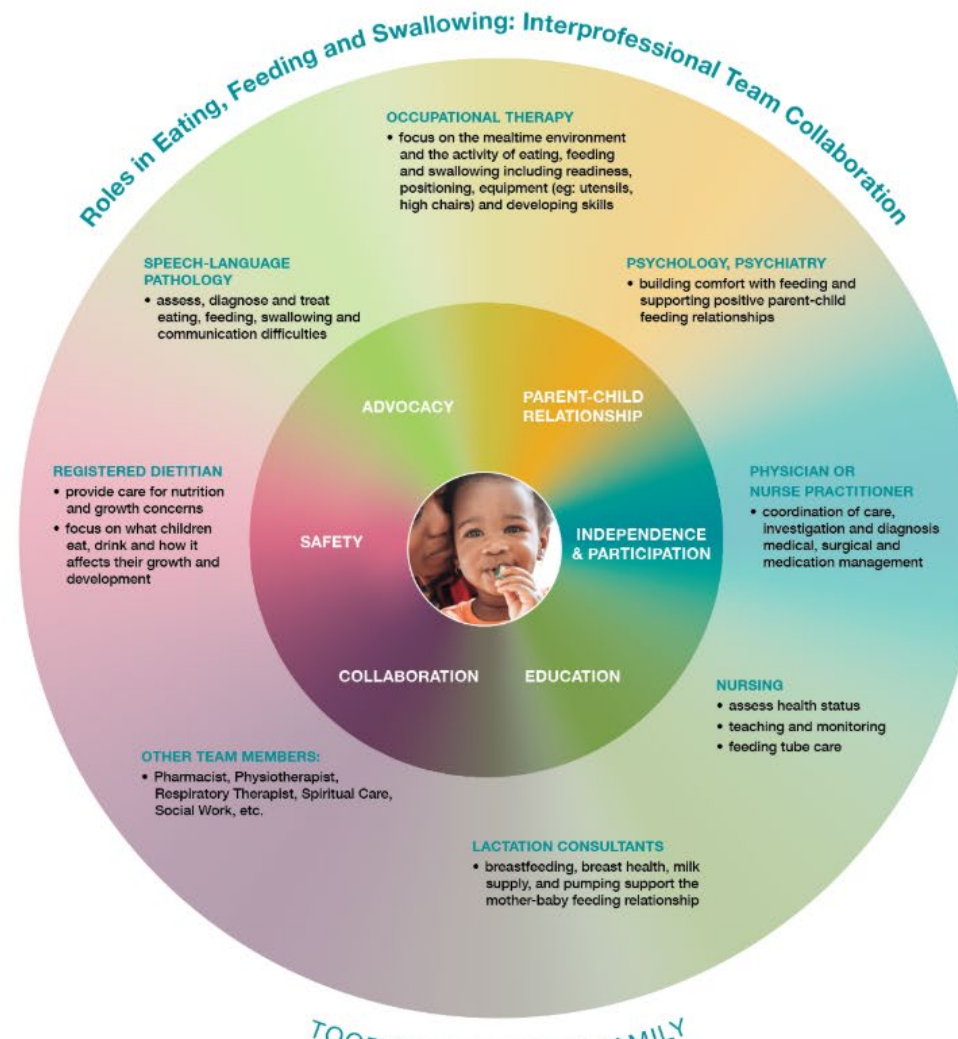
[FOR FAMILIES](#)[ORAL FEEDING](#)[TUBE FEEDING](#)[FAMILY LIFE & SELF-CARE](#)[YOUR CARE TEAM](#)[CARE COORDINATION](#)[TOOLS & TEMPLATES](#)

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[✓ IS FEEDING A STRUGGLE?](#)[✓ FIND SERVICES](#)[✓ VIRTUAL HEALTH](#)[✓ EQUIPMENT & SUPPLIES](#)[✓ FUNDING INFORMATION](#)[✓ FAQs](#)

Your Care Team

Every child's healthcare team is different, depending on your child's needs. Factors such as where you live and receive care also impacts who might be on your local team. If your child is accessing eating, feeding and swallowing services, members of your healthcare team will often help to coordinate care together with your child's Primary Care provider (eg: pediatrician, family doctor, or nurse practitioner) and other professionals in your community to improve care planning, communication, and your experience.



[FOR FAMILIES](#)[ORAL FEEDING](#)[TUBE FEEDING](#)[FAMILY LIFE & SELF-CARE](#)[YOUR CARE TEAM](#)[CARE COORDINATION](#)[TOOLS & TEMPLATES](#)

QUICK LINKS

[✓ IS FEEDING A STRUGGLE?](#)[✓ FIND SERVICES](#)[✓ VIRTUAL HEALTH](#)[✓ EQUIPMENT & SUPPLIES](#)[✓ FUNDING INFORMATION](#)[✓ FAQs](#)

Care Coordination

The following are some common answers to questions that you may have regarding coordination of care for your child and family.

[What is my role as a Parent or Family Member? +](#)[Who might be involved in our care? +](#)[How can we prepare for going home from the hospital? +](#)[Who do I talk to about...? +](#)[With whom and when will follow-up occur? +](#)[How do I find or know who our Care Coordinator is? +](#)[How do I talk to our healthcare team about our goals? +](#)[What if different clinicians give me different information? +](#)[How do we prepare for transitioning from pediatric to adult care? +](#)

Collaborative Goal Setting



Practice Director, Provincial
Occupational Therapy

Carmen Lazorek

What is Collaborative Goal Setting (CGS)?

An intentional, shared decision-making process....

Parent = expert on their child, knowledgeable about what is important to the family; their values, preferences, motivations

Provider = expert on health condition, rehabilitation process

Why Collaborative Goal Setting?

- ✓ Improved client outcomes
- ✓ Improved engagement, satisfaction, motivation
- ✓ Improved clinical outcomes, self-management, attendance/commitment
- ✓ Patient-centered care
- ✓ Patient First strategy
- ✓ What matters to you

GOALS

What motivates, and what matters

Not pre-configured

Principles of Collaborative Goal Setting

PROCESS

Shared
Decision
Making

GOAL

- Client Centered
- Drives intervention
- Documented

Documentation of Collaborative Goals

Collaborative Goals and Treatment Plan Flowsheet (Inpatient)

The screenshot shows a table titled "Collaborative Goals and Treatment Plan" with a sub-header "Patient Care Plan". Below this is a section for "Select Discipline for Patient Care Tracking". The table has five columns: "Goal #", "Goal Statement", "Goal Progression", "Goal Notes", and a blank column for tracking. The rows are labeled "Task #1", "Task #2", "Task #3", and "Task #4", each with a corresponding "Progression" row.

Treatment Planning Activity (Outpatient)

The screenshot shows a software interface for "Treatment Planning". It has a top navigation bar with "Snapshot", "Chart...", "Synopsis", "Episode", and "Treatment Pl...". Below this is a "Care Planning" section with a "Collaborative Goals/Treatment Plan" header. There are tabs for "Care Plan" and "Problem". The main area contains a "Problem" field, a "Goal" field, and a list of "Task" items, each with a checkbox. A "Close" button is at the bottom.





FOR PROVIDERS

CLINICAL PRACTICE GUIDE

CLINICAL TOOLS & FORMS

- Screening Tool
- Assessment Tools & Questions
- Food Record
- Collaborative Goal Wheel** 
- Feeding Care Plan

COLLABORATIVE PRACTICE

PROFESSIONAL DEVELOPMENT

COMMUNITY OF PRACTICE

FAMILY RESOURCES

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✓ FIND SERVICES

✓ VIRTUAL HEALTH

✓ EQUIPMENT & SUPPLIES

✓ FUNDING INFORMATION

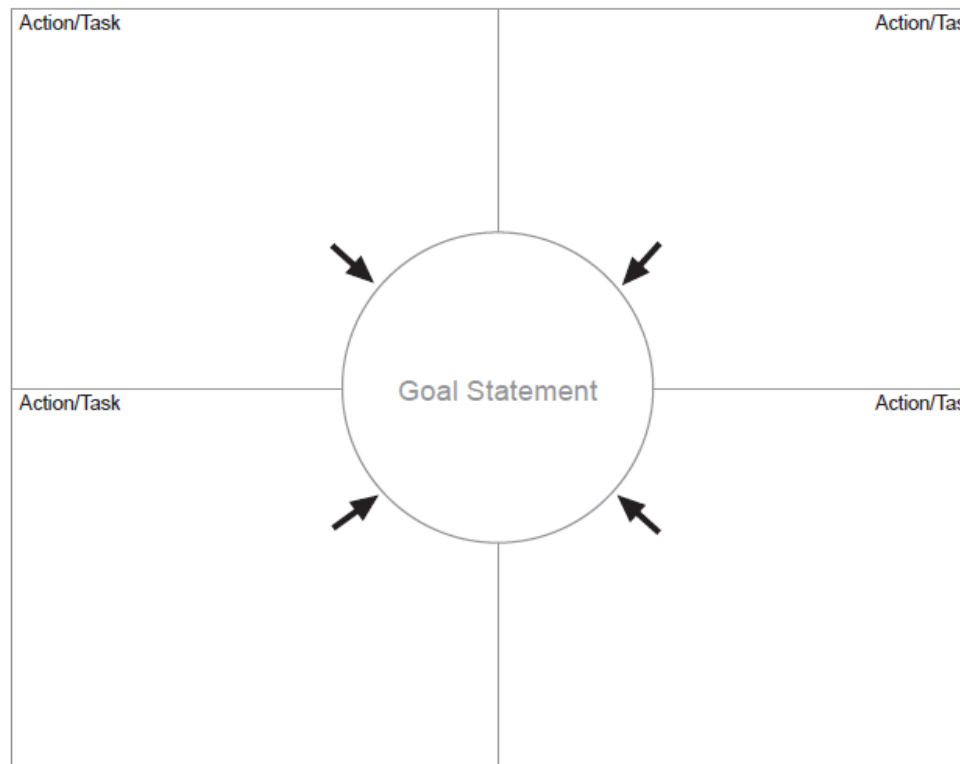


Goal Wheel

Collaborative Goals and Treatment Plan

Last Name <i>(Legal)</i>		First Name <i>(Legal)</i>	
Preferred Name <input type="checkbox"/> Last <input type="checkbox"/> First		DOB <i>(dd-Mon-yyyy)</i>	
PHN	ULI <input type="checkbox"/> Same as PHN	MRN	
Administrative Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Non-binary/Prefer not to disclose (X)			

Developed and Shared with *(Name of family member)* _____ Date *(dd-Mon-yyyy)* _____



Goal Notes/Considerations:

Follow Up

Healthcare Provider <i>(Last name, first name)</i>	Designation
Signature	Contact Information

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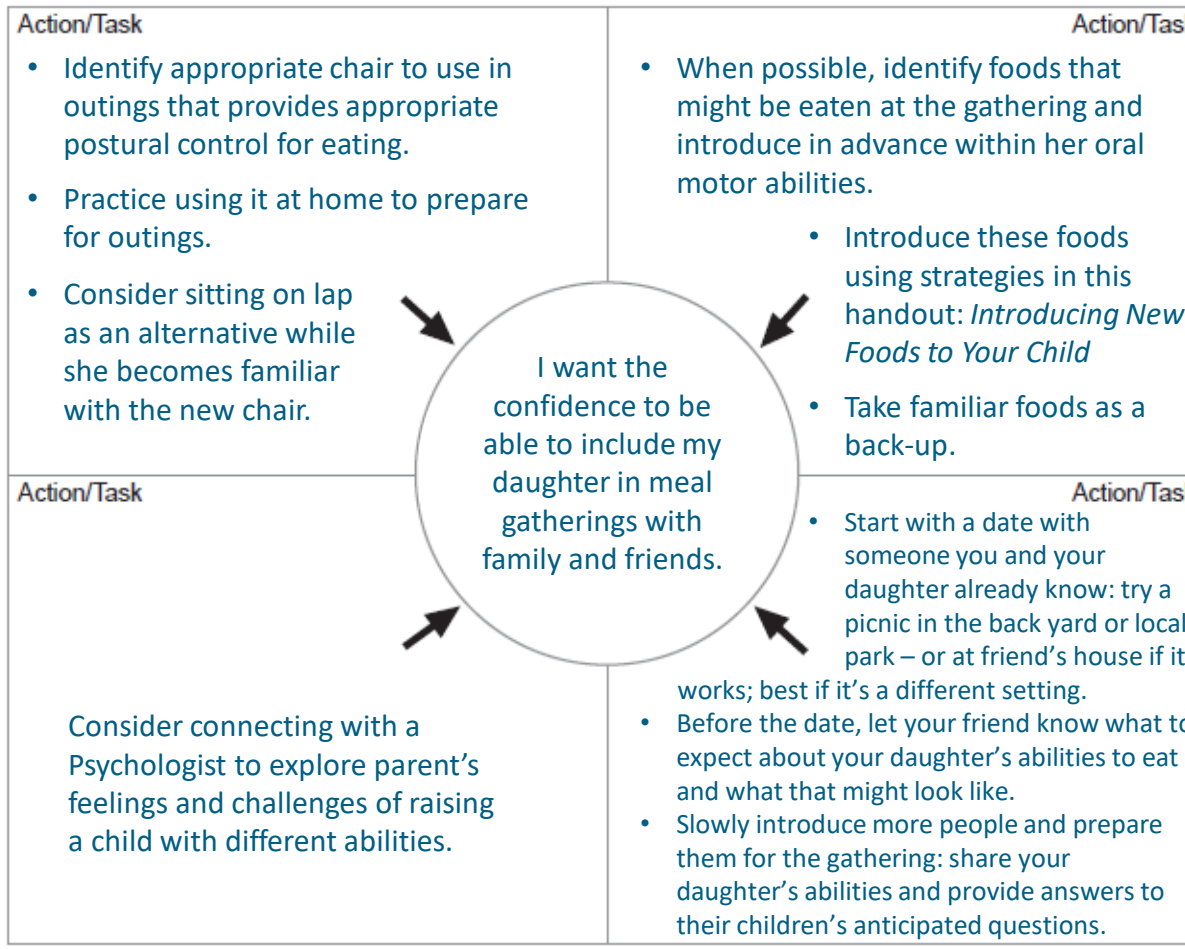
ting (AHS Staff

Last Name (Legal)		First Name (Legal)	
Preferred Name <input type="checkbox"/> Last <input type="checkbox"/> First		DOB (dd-Mon-yyyy)	
PHN	ULI <input type="checkbox"/> Same as PHN	MRN	
Administrative Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Non-binary/Prefer not to disclose (X)			

Goal Wheel

Collaborative Goals and Treatment Plan

Developed and Shared with (Name of family member) _____ Date (dd-Mon-yyyy) _____



Goal Notes/Considerations:

Follow Up OT appointment to look at seating and demonstrate food introduction strategies.

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Collaborative Goal Wheel

Collaborative goal setting provides a means by which to plan ahead, provide direction and establish a clear, mutually understood trajectory of the child's management or treatment plan between the healthcare professional and parent or caregiver, and across the interdisciplinary team. Parent, and if possible child, participation in the development of the child's own meaningful goals and treatment plan, provides:

- confidence that their treatment team is working in a coordinated way to help them work towards goals that are important to them
- consistency, e.g. commitment to one plan, across the EFS team, and parent or caregivers
- improved patient outcomes.

Steps of Goal Setting

Step 1: Collaboratively choose a goal that is important to the child and family.

Step 2: Explore ideas to break down the goal into smaller more manageable steps. Smaller steps enhance self-efficacy and goal attainment. Tools such as SMART (Specific, Measurable, Attainable, Rewarding, Timely) can be used.

Step 3: Explore potential barriers that may impact goal achievement; manage expectations by discussing the amount of change desired, the speed of which the change may be accomplished, and the ease of accomplishing the change and effects this change with have on other aspects of the infant, child, or family's life.

Step 4: Make one change at a time and record data to accurately track progress.


Step 5: Regularly review success as each goal is achieved (or steps within a goal) and before progressing to the next.

Step 6: Reassess goals on a regular basis to evaluate criteria for discharge.

Template:

[🔗 Goal Wheel: Collaborative Goals and Treatment Plan](#)

Refer to:

-  [Pediatric Collaborative Goal Setting Practice Support](#)
- [🔗 Rehabilitation Model of Care Sharepoint Site](#) (AHS Staff Login required)
- [🔗 Connect Care Document Library for information on Collaborative Care Planning and Goal Setting](#) (AHS Staff Login required – search for "Goal")
- [🔗 HealthChange](#)

Contact Us

Email: PEAS.Project@ahs.ca



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Contact Us

We welcome you to contact us to learn more about the PEAS project or to provide your feedback about this website. Please do **not** include any personal health information. If you have a health concern, contact [Health Link at 811](#) or see our other [contact options](#).



Close this note from the top right corner.

First Name

Last Name

Email

Subject

Message

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About PEAS

Pediatric Eating And Swallowing (PEAS) is a quality improvement initiative to standardize services and improve care for children with an eating, feeding and swallowing disorder in Alberta.

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News

Now Available: PEAS Virtual Training sessions for providers

6/26/2020

We are pleased to announce that we will be offering the PEAS Virtual Training for healthcare providers this summer and fall. Please see the attached newsletter for registration information!



[PEAS Healthcare Provider Training Invitation](#)

PEAS EventBrite page: <http://peas-ahs.eventbrite.com/>

PEAS update during COVID-19 crisis

3/26/2020

Dear Pediatric Eating And Swallowing (PEAS) community,

To ensure that Albertans are provided with the best care possible, we are pausing PEAS project plans that affect operations management and staff involved with COVID-19. In particular, we are **postponing** the following for 2 months or longer as needed:

- [Virtual Training sessions](#) (originally planned for April and May)
- Innovation Learning Collaborative (originally planned for June 3)
- Family survey data collection

About PEAS

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QUICK LINKS

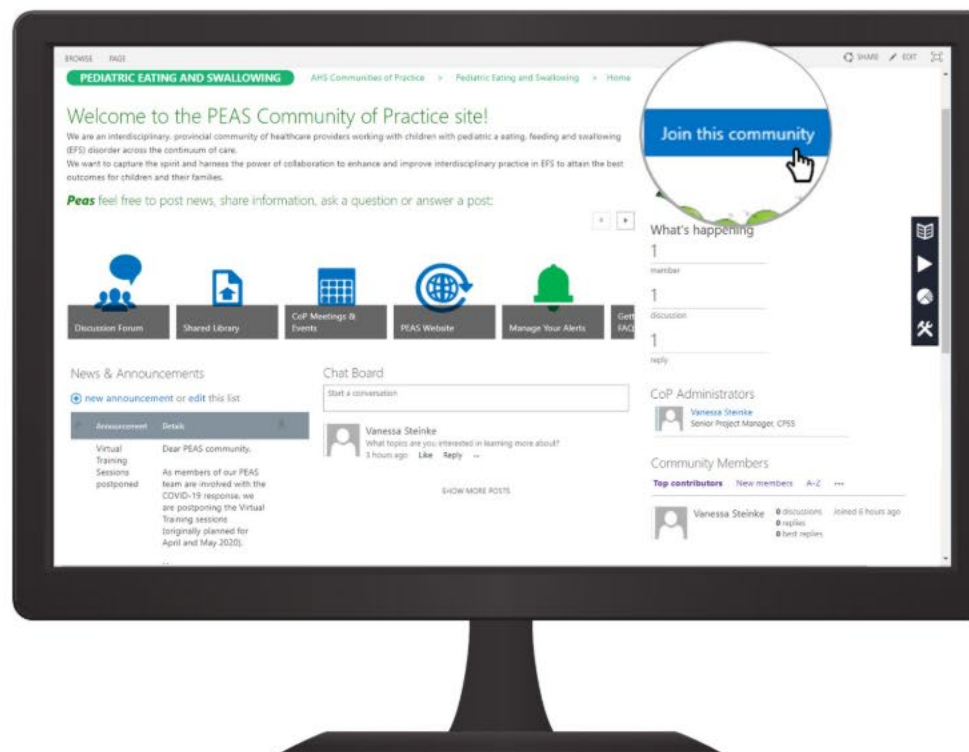
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Community of Practice

We have just launched the Pediatric Eating And Swallowing Community of Practice (CoP) for healthcare providers who work with children with a pediatric eating, feeding and swallowing (EFS) disorder. This virtual CoP is an interdisciplinary community of healthcare providers across the continuum of care in Alberta. The goal of this CoP is to capture the spirit and harness the power of collaboration to enhance and improve interdisciplinary practice in EFS to attain the best outcomes for children and their families.

To join the PEAS Community of Practice:

1. You must be a healthcare provider with an AHS account.
*See below for information on how to obtain an AHS account.
2. Go to the PEAS CoP website here: <https://extranet.ahsnet.ca/teams/CoP/PEAS/SitePages/Home.aspx>
If prompted, enter your AHS account name and password.
3. Click "Join this community" as shown below. That's it!



Questions & Comments?



Big PEAS & Thank YOU!

- Working Group co-chairs & members
- Steering Committee
- Leadership Team
- Family Advisors

Survey: <https://survey.albertahealthservices.ca/peas.webinar3>



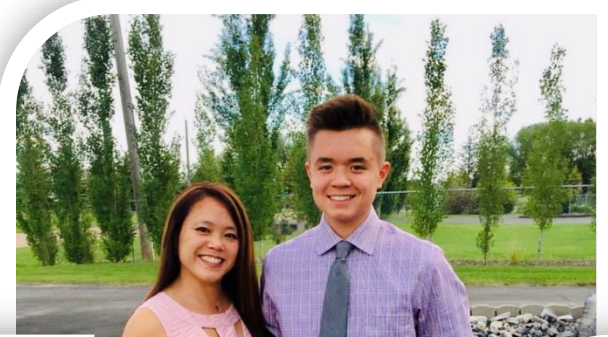
Thank You

PEAS Roles & Implementation Working Group!

- Bob Brown, KM Consultant
- Carla Lummerding, Family Advisor
- Cheryl Brown, RCSD Manager
- Heather Moore, OT Calgary
- Jacinda Sartison, Pediatric Home Care Manager
- Jamie Canonaco, Family Advisor
- Jody Brudler, RD Manager
- Julia Giesen, SLP Royal Alexandra Hospital
- Laura Benard, Senior Practice Consultant, HPSP Physiotherapy
- Lily Ragan, ACH Manager
- Lisa Gordey, Senior Practice Consultant, CoACT-HPSP
- Lorelea Morin, OT ACH
- Lynn Millard, Psychologist Calgary
- Maxine Scringer-Wilkes, RN, Lactation Consultant ACH
- Melanie Matiisen-Dewar, Manager ACH (PEAS Co-Chair)
- Melissa Lachapelle, RD Provincial Practice Lead
- Mini Kurian, SLP Stollery
- Moonira Rampuri, OT ACH
- Shannon Armstrong, OT Grande Prairie
- Shobha Magoon, OT, Edmonton Home Care
- Siju John, Care Manager, Pediatric Community Rehabilitation
- Terra Ward, SLP, GRH
- Tina Nelson, SLP, ACH
- Tricia Miller, Manager, South Zone (PEAS Co-Chair)
- Vanessa Steinke, Project Manager, Provincial (PEAS Co-Chair)
- Wendy Johannsen, SLP, Stollery
- Winnifred Cull-Power, Manager, ACH, Home Care
- Yolán Parrott, OT Clinical Practice Lead, Glenrose



Tribute to Wendy Johannsen



Thank you!



PEAS.Project@ahs.ca

Survey: <https://survey.albertahealthservices.ca/peas.webinar3>
