SITUATIONAL ANALYSIS

Current State of Interprofessional Education (IPE) in Canada

April 28, 2008

learning to work together, working to learn together
apprendre à collaborer, collaborer pour apprendre
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Key Messages

» Interprofessional Education (IPE) is not a new concept in Canada. However, it has recently become more broadly recognized as one of the key strategies that may mitigate some of the health human resource challenges facing the Canadian healthcare system.

» In the past 40 years, many university institutions, educators, healthcare professionals and policymakers throughout Canada have been working together to move IPE forward.

» IPE is successful because champions are focusing on the following principles:
  1. One size does not fit all
  2. Resources are required
  3. Curricula changes are essential
  4. IPE must be introduced at the right time
  5. Collaborative learning environments must be created
  6. Structures must be modified to support collaboration
  7. IPE should be embedded in the system
  8. Evidence makes the best case for IPE
  9. Interprofessional players must engage the community

» The successes of Health Canada’s IECPCP projects assure us that health providers need not lack understanding of roles and responsibilities between health providers.

» The future of IPE in Canada depends on the ability of the Canadian movement to sustain itself and continue building the environment and resources necessary to embed it as part of the health education and health service cultures.

» Recommendations to further IPE in Canada include:
  1. Demonstrate and promote the benefits of interprofessional education
  2. Develop strategic plans for sustainability – promote resource allocation
  3. Learn from successes and mistakes
  4. Focus on programs and integration by developing and supporting leadership
  5. Implement policy change at government and organizational levels
  6. Facilitate collaboration through strategic and innovative partnerships
  7. Support knowledge exchange practices – translation and dissemination
  8. Fund interprofessional incentives and rewards in health and education
  9. Disseminate information that expands interest in IPE to a wider audience
  10. Articulate, advance, and advocate a comprehensive agenda for future research and evaluation
Executive Summary

Interprofessional Education (IPE) that leads to patient-centred, collaborative practice has long been recognized as a promising solution for some of the biggest health human resource challenges facing the Canadian healthcare system. For more than four decades a handful of educators, policymakers and health professionals have been working to gather evidence and develop a research pool that demonstrates how IPE can positively impact current health issues such as wait times, healthy workplaces, rural and remote accessibility and patient safety.

This document reviews the history and introduces the potential for IPE in Canada. For the purposes of this paper, interprofessional education has been defined as occurring “when two or more professions learn with, from and about each other to improve collaboration and the quality of care”.

Since the first notions of interprofessional thought in Canada were introduced at the University of British Columbia, enormous strides have been made to forward the interprofessional agenda. The 1969 article penned by Szasz and entitled Interprofessional Education in the Health Sciences: A project conducted at the University of British Columbia, set the stage for a number of experiments in the field, all achieving varying degrees of success. However, despite numerous attempts to develop IPE programs, building and sustaining even the most moderate has proven to be a challenge.

Nevertheless, recognizing the overall benefits to patients and healthcare providers, governments and academia have continued to work on the development of interprofessional education and collaborative care. The 2002 Romanow Report on the future of healthcare in Canada touched on interprofessional education and called for “new approaches to collaboration among health care providers in order to maximize the use of the health workforce.”

Following on the Report, First Ministers signed the 2003 Health Accord, marking a commitment to health human resource planning, recruitment and retention and interdisciplinary education. As a result, the National Expert Committee for Interprofessional Education for Collaborative Patient-Centred Practice (IECPCP) was formed.

The 2003 Pan-Canadian Health Human Resources Strategy included a component on IECPCP intended to facilitate and support the implementation of IPE across the healthcare system. Based on this strategy, Health Canada commissioned a 304-page literature review and environmental scan (led by Dr. Ivy Oandasan), developed a series of research papers exploring key IECPCP concepts, (synthesized by Dr. Vernon Curran) and held a number of stakeholder meetings. As part of the IECPCP initiative, twenty learning projects were chosen from 1 CAIPE 2002

Romanow Report (2002), page 87
across Canada to build the evidence base for IECPCP while promoting interprofessional education and collaborative practice. In addition to these learning projects, Health Canada funded a set of complementary projects under IECPCP that focus on system or meso/macro issues identified through the D’Amour & Oandasan IECPCP Framework.

Nationally and provincially, much has been accomplished to enhance IPE since the 2002 Romanow Report. The Canadian Interprofessional Health Collaborative (CIHC) has become the national hub for interprofessional education, collaboration in healthcare practice and patient-centred care, and continues to strengthen the network of stakeholders interested in furthering IPE. Nevertheless, many of the initial projects and initiatives are complete or are nearing the end of their Health Canada funding. In order to sustain the momentum and continue to move IPE forward in Canada, organizations across the country need to begin making decisions on how IPE can best be supported, promoted and sustained into the future.

This report looks at the principles that led to successful IPE initiatives in Canada. These include:

1. One size does not fit all
2. Resources are required
3. Curricula changes are essential
4. IPE must be introduced at the right time
5. Collaborative learning environments must be created
6. Structures must be modified to support collaboration
7. IPE should be embedded in the system
8. Evidence makes the best case for IPE
9. Interprofessional players must engage the community

Each of these nine principles is a step towards ensuring that the momentum around IPE continues to grow and move forward. The Health Canada funded IECPCP projects, the Canadian Interprofessional Health Collaborative, and a number of educators and institutions across the country are committed to working on each of these steps. Their combined efforts will propel multi-faceted change in health, education and the professions.

This report also highlights the potential for ‘mainstreaming’ IPE through national, regional, provincial and institutional strategies. It includes ten recommendations that can and should be taken at all levels of the system in order to build on the momentum underway and advance interprofessional education across the country.

Recommendations to further IPE in Canada include:

1. Demonstrate and promote the benefits of interprofessional education and collaborative care by continuing to build on the people, processes, structures, reports/research and funding already in place.
2. Develop long-term strategic plans that focus on funding and resources.
3. Learn from the successes and mistakes made by other countries in hoping for long-term system change with short-term investments.

4. Develop and support leadership in interprofessional education and collaborative care by focusing on programs and integration rather than short-term projects.

5. Implement policy change at the governmental, institutional and organizational level. For example, incorporate interprofessional competencies in professional regulatory scopes of practice.

6. Encourage collaboration between ‘system change silos’ by developing strategic and innovative partnerships that enable interprofessional collaboration in education, research and practice. Engage both IPE focused groups and groups with similar or overlapping mandates (i.e., patient safety, healthy workplaces, leadership).

7. Support knowledge exchange practices that help organize interprofessional functions at various levels of the system, coordinate ongoing work and minimize duplication.

8. Encourage incentives and rewards in both health and education sectors that are interprofessional-focused in addition to those that are discipline-specific.

9. Expand interest to a broader audience rather than focusing only on current interprofessional champions.

10. Articulate, advance, and advocate a research/evaluation agenda for interprofessional education and collaborative care.

In the past four decades, interprofessional education and collaborative practice have continued to expand across Canada, even as the healthcare system has become increasingly challenged to respond to a growing health human resource crisis. IPE is one of many solutions that should be employed to lessen the impact of these crises. If we continue to work towards a strong, sustainable healthcare system, with IPE principles embedded in the education and practice of all health professionals, we will positively impact some of the current concerns around access to healthcare, worklife quality for health care providers, recruitment and retention, and safe, patient-centred care.

Interprofessional education that leads to collaborative, patient-centred practice has a rich history in Canada and is currently seen as a pivotal and necessary focus for future health system sustainability. The future of IPE in Canada depends on the ability of the Canadian movement to sustain itself and continue building the environment and resources necessary to embed it as part of the health education and health service cultures.
SELECTED MILESTONES IN CANADA’S HISTORY WITH IPE

- First IPE course in Canada: University of Alberta
- UBC College of Health Disciplines
- First Ministers’ Accord on Health Care Renewal
- UBC Office of the Coordinator of Health Sciences
- Memorial University Centre for Collaborative Health Professional Education
- Szasz’s Milbank Quarterly paper
- Health Canada IECPCP National Expert Committee & Background reports
- Health Council of Canada Report
- Health Canada IECPCP Initiative – Cycle 1 & Complementary Projects Funded
- Health Canada IECPCP Initiative – Cycle 2 & Complementary Projects Funded
- Health Education Task Force
- NaHSSA
- Romanow Report
- BC Health Professions Regulatory Reform Act
- Ontario Blueprint for IPE; Provincial Funding
- Health Education Task Force
- Health Canada IECPCP Initiative – Cycle 2 & Complementary Projects Funded
- NaHSSA
- Health Council of Canada Report
- First IPE course in Canada: University of Alberta
- UBC College of Health Disciplines
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- UBC Office of the Coordinator of Health Sciences
- Memorial University Centre for Collaborative Health Professional Education
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- Health Canada IECPCP National Expert Committee & Background reports
- Health Council of Canada Report
- Health Canada IECPCP Initiative – Cycle 1 & Complementary Projects Funded
- Health Canada IECPCP Initiative – Cycle 2 & Complementary Projects Funded
- Health Education Task Force
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- BC Health Professions Regulatory Reform Act
- Ontario Blueprint for IPE; Provincial Funding
- Health Education Task Force
- Health Canada IECPCP Initiative – Cycle 2 & Complementary Projects Funded
- NaHSSA
- Health Council of Canada Report
PART ONE

The Past—
A History of IPE in Canada

In 1969, a paper entitled Interprofessional Education in the Health Sciences: A project conducted at the University of British Columbia, was published in the Milbank Quarterly (Szasz, 1969). In the ensuing 39 years, a great deal of progress has been made in realizing interprofessionalism in health sciences education. Nevertheless, many of the issues discussed by Szasz nearly four decades ago remain true to this day.

“It appears that, among other problems, the health professionals employ their talents inappropriately, and, as a consequence, scarce human resources are wasted. Evidence also indicates fragmentation and compartmentalization, both of scientific investigation and the approach to human problems, and of poor communication between those who provide different components of the health services.” (p. 449-450)

In response to the above challenges, Szasz identified a process to build and develop interprofessional education:

“Accordingly, a Committee on Interprofessional Education in the Health Sciences has been established to promote interprofessional education and to experiment with educational programs to arrive at recommendations concerning what the students should learn together with how they should learn it.” (p. 450)

Since 1969 there have been many attempts to introduce interprofessional concepts in educational programs and a number of “recommendations concerning what students should learn, together with how they should learn it”3. The movement towards interprofessional education and learning (IPE)4 for collaborative patient-centered practice5, has included many well intentioned and,

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3 See, for example, Colyer et al. (2005)
4 Interprofessional Education – Occasions when two or more professions learn with, from and about each other to improve collaboration and the quality of care. (CAIPE, 2002) This definition presents testable hypotheses which are not available with definitions such as interdisciplinary or multi-disciplinary.
5 Interprofessional Collaborative Practice. A process through which parties who see different aspects of a problem can constructively explore their differences and search for solutions that go significantly beyond their own professional vision of what is possible. Gray (1989)
in a few cases, highly successful experiments – funded by governments (i.e., National Health Service, UK), non-governmental organizations (i.e., World Health Organization), and foundations (i.e., Quentin N. Burdick Foundation, USA). However, despite the fact that there have been numerous attempts to develop IPE programs, building and sustaining even the most moderate program has proven to be difficult.

A number of additional forces have been enablers for collaborative practice and its precursor, interprofessional education. In the U.S.A. the publication of the Institute of Medicine’s *To Err is Human* (2000), the report of the Bristol Inquiry (2001) in the U.K., the publication of the Institute of Medicine’s *Health Professions Education – a Bridge to Quality* (2003), and finally *The Canadian Adverse Events Study* (2004) impressed health providers, health educators and governments with the need to re-evaluate their efforts.

In Canada, the publication of *Building on Values: The Future of Health Care in Canada* (2002), the Report of a Royal Commission under the direction of Roy J. Romanow, Q.C. was hugely important in directing Health Canada’s programs in many different areas, including IPE (p. 109). The subsequent First Ministers’ Accord on Health Care Renewal in February 2003, marked a budgetary commitment to health human resource planning, recruitment and retention and interdisciplinary education, with the subsequent establishment of the National Expert Committee for Interprofessional Education for Collaborative Patient-Centred Practice. The Accord also established the Health Council of Canada, whose inaugural report *Healthcare Renewal in Canada: Accelerating Change* carried a significant statement in support of IPE:

> “Health care delivery models of the future clearly envision teams of health care providers working together to meet patient needs.”

I. 1969–2008

**IPE DEVELOPMENT IN THE ACADEMIC CONTEXT**

Since 1969, organizations across Canada have been implementing IPE programs. However, implementation and decision-making around best practices and what a successful IPE program should look like have been largely inconsistent and primarily driven by and housed within the academic sector.

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The University of Alberta offered one of the first IPE courses in Canada. In January 1992, “IntD 410” was introduced on a pilot basis with 25 students from seven health science programs (dentistry, home economics, medicine, nursing, pharmacy, physical education and physiotherapy). The course focused on team building and learning about the various disciplines, patients/clients and their families.

For a detailed overview of the history of various approaches to IPE programs in Canada, see David A. Cook’s article entitled *Models of Interprofessional Learning in Canada*. The most frequent model of IPE employed in Canada involves a mandatory experience which is:

- Case-based
- Involves all students registered in Health Faculties
- Comprised of interprofessional student teams formed by students.

**The International Scene**

The emergence of interprofessional approaches to education and collaborative care began in the early 1970s in both the U.S.A and the U.K. Over the next 30 years, both countries tried many experimental approaches. In the U.S., the most notable were in the Department of Veterans Affairs and the Quentin Burdick rural initiatives of the Health Resources and Services Administration.

In the U.K. it was the growth and development of the Centre for the Advancement of Interprofessional Education (CAIPE), which continues to exist. CAIPE is credited with developing the accepted

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7 Journal of Interprofessional Care, Philippon, June 2005, pp 198
8 Journal of Interprofessional Care, Cook, May 2005, pp 107-115.
9 Ibid. pp 107
10 [http://bhpr.hrsa.gov/interdisciplinary/rural.html](http://bhpr.hrsa.gov/interdisciplinary/rural.html)
definition of IPE: “IPE occurs when two or more professions learn with, from and about each other to improve collaboration and the quality of care”. (CAIPE 2002)

Many of these experiments were original in design and successful in implementation. However, most were funded as one-time projects and did not include sustainability planning.

2. STUDENT LEADERSHIP

Students have played an increasingly important role in the development of IPE across Canada. From a relatively small beginning at UBC, the National Health Sciences Students’ Association (NaHSSA, incorporated as a society in 2005) is now a thriving organization that has held four annual meetings and is proving to be a highly effective voice in the promotion and support of IPE in Canada.

NaHSSA is the first and only national interprofessional student association in the world and seeks to involve Canada’s health and human service students in interprofessional education while promoting the attitudes, skills and behaviours necessary to provide collaborative patient-centred care.

The NaHSSA website (http://www.nahssa.ca/) is the best source of information about the work of this important student organization.


POLICY DEVELOPMENT

A. Health Canada’s IECPCP (2005)

The Federal Government’s 2003 Pan-Canadian Health Human Resources Strategy was intended to facilitate and support the implementation of the “Interprofessional Education for Collaborative Patient-Centred Practice” (IECPCP) Strategy across all health care sectors.\(^1\)

In the original agreement, changing the way health providers are educated was seen as key to achieving system change and to ensuring health providers have the necessary knowledge and training to work effectively on interprofessional collaborative teams within the evolving health care system.

The IECPCP initiative had a clear set of objectives that have served as the guide across the life of the funded projects. The specific objectives of the initiative are to:

\(^{11}\) http://www.hc-sc.gc.ca/hcs-sss/hhr-rhs/strateg/index_e.html
» Promote and demonstrate the benefits of interprofessional education for collaborative patient-centred practice
» Increase the number of educators prepared to teach from an interprofessional collaborative patient-centred perspective
» Increase the number of health professionals trained for collaborative patient-centred practice before, and after, entry-to-practice
» Stimulate networking and sharing of best educational approaches for collaborative patient-centred practice
» Facilitate interprofessional collaborative care in both the education and practice settings

The IECP CP initiative included extensive commissioned background work including:
» A literature review and environmental scan (by Oandasan et al\textsuperscript{12}), which resulted in the \textit{Interprofessional Education for Collaborative Patient-Centred Practice: An Evolving Framework} (referred to as the “D’Amour & Oandasan Framework”\textsuperscript{13})
» A series of research papers exploring key concepts (synthesis of these papers by Curran\textsuperscript{14})
» National Expert Committee (NEC) on Interprofessional Education for Collaborative Patient-Centred Practice, involving consultations with experts representing professional and national stakeholders

The IECP CP initiative funded 20 learning projects across Canada and one research meeting:
» May 2005 – Cycle 1, 11 projects funded
» May 2006 – Two-day meeting on research for IECP CP
» May 2006 – Cycle 2, 9 projects funded

In addition to learning projects, Health Canada funded a set of complementary projects focusing on system or meso/ macro issues identified through the D’Amour & Oandasan IECP CP framework. These projects include:
1. Legislation and Regulation Issues for Collaborative Patient-Centred Practice
2. Understanding Liability Issues for Interprofessional Education for Collaborative Patient-Centred Practice

\textsuperscript{13} \url{http://www.hc-sc.gc.ca/hcs-sss/alt_formats/hpb-dgps/pdf/hhr/ieccpcp_e.pdf} (accessed March 15, 2008)
4. Proposal to Advance Nursing Education within the Pan-Canadian Health Human Resource Strategy
5. Paradigm Shift in Interprofessional Education: The Unique Roles Academia Can Successfully Play in Effecting Lasting Change
6. Accreditation of Interprofessional Health Education\(^{15}\)
7. Canadian Interprofessional Health Collaborative (CIHC)\(^{16}\)

B. The Provinces – Policy Development

Wide variations in policy development are identified when comparing IPE province to province. While the Ontario and B.C. Governments have demonstrated their support of IPE with substantial funding, dedicated staff and increased policy activity, at the time of writing, other provinces have little IPE support aside from engagement in ad hoc committees.

ONTARIO:
A CASE STUDY OF IPE POLICY DEVELOPMENT

Policy development for IPE and related initiatives in the province of Ontario is the responsibility of the provincial Ministry of Health and Long-Term Care through HealthForceOntario. In August 2007, HealthForceOntario's IPC (Interprofessional Care) Project delivered the report, Interprofessional Care: A Blueprint for Action in Ontario (the Blueprint\(^1\)). The Blueprint details several actions the Province will take to ensure interprofessional care can be implemented across Ontario.

A number of IPE projects are funded by HealthForceOntario through the Interprofessional Care/Education Fund, which is a combination of two funding programs that were previously separately administered by the Ministry of Health and Long-Term Care and the Ministry of Training, Colleges and Universities.

The Ontario Government also funds the Ontario Collaborative, “a loose coalition of educators and practitioners in Ontario who are actively engaged in offering opportunities for interprofessional education and practice for learners and practitioners across health care.”\(^2\) The Ontario Collaborative operates as part of the CIHC.

PART TWO
The Present – IPE’s Current Status in Canada

The programs and structures supporting IPE that exist in Canada (for example, University of Toronto’s Office of IPE and Memorial University of Newfoundland’s Centre for Collaborative Health Professional Education) grew out of a deliberate collaborative process. Programs that existed before the publication of Romanow, and programs that have been developed since – have all benefited from the profile of interprofessional education presented in the Romanow report. The collaborative process leading to the establishment of IPE programs usually involves discussions between many faculty in health and human service programs (in universities, colleges and institutes), and community partners.

In 2007, Health Canada recognized that with the establishment of the Canadian Interprofessional Health Collaborative, the role of the National Expert Committee on Interprofessional Education had come to a close. A Health Education Task Force was stuck, reporting to the Advisory Committee on Health Delivery and Human Resources. The Health Education Task Force builds upon previous investments from the Pan Canadian Health Human Resource Strategy in interprofessional education and social accountability in medical school education.

Health Canada’s Interdisciplinary Education for Collaborative Patient-Centred Practice: Research Findings and Report published in February 2004, is a significant milestone in understanding the state of IPE in Canada\(^7\). This report remains a significant compendium of information.

\(^{17}\) Interdisciplinary Education for Collaborative, Patient-Centred Practice, Oandasan et al, 2004
Principles of IPE

A description of IPE’s current status in Canada is framed in terms of the critical success factors. When examining the kinds of academic programs that have been established through the IECPCP initiative it becomes clear that interprofessional education is successfully established when it adheres to clear principles.

In summary, IPE initiatives have been successful to date because champions have incorporated the following principles:

1. One size does not fit all
2. Resources are required
3. Curricula changes are essential
4. IPE must be introduced at the right time
5. Collaborative learning environments must be created
6. Structures must be modified to support collaboration
7. IPE should be embedded in the system
8. Evidence makes the best case for IPE
9. Interprofessional players must engage the community

1. One size does not fit all

For IPE to be successfully implemented and sustained, it must be implemented in a flexible and changeable way that is tailored to the needs of the specific setting, organization or unit. For example, the characteristics of IPE implementation could vary between:

» A university as compared to a college or institute
» The acute care setting as compared to the community setting
» Rural as compared to urban settings
» From province to province

2. Resources are required

IPE programs and research require adequate and dedicated resourcing. This has been made clear in academic programs such as those established at UBC, Memorial University of Newfoundland, Queen’s University, University of Toronto, University of Western Ontario, Dalhousie University, Northern Ontario School of Medicine and George Brown College and in the practice settings such as Partners In Care at BC Children’s & Women’s Hospital and community health centres across the country.
3. CURRICULA CHANGES ARE ESSENTIAL

Learning from the work of curricular development across the IECPCP initiatives it is clear that curricular reform is essential in universities, colleges and the community. An academic unit offering programs in IPE must be viewed as a logical and integral part of disciplinary education, and forms an integral part of disciplinary curricula. IPE is about a new way of learning — not an add on to existing curricula but rather a way of shaping that curricula. Because changes to curricula require considerable agility, for such an academic unit to be successful it must be:

» Flexible
» Creative
» Persistent, and
» Committed to its vision and mission

Some patterns of curricular design are beginning to emerge. The University of Alberta requires health science students to complete one interprofessional course, and the University of Toronto will follow suit in 2009:

“Through IPE, students from nine health sciences-and social work-related programs and faculties will have the benefit of courses that bring them together and allow them to understand each other’s perspectives. By 2009, IPE courses will be mandatory in the curricula of all of them: pharmacy, dentistry, medicine, nursing, social work, speech-language pathology, occupational therapy, rehabilitation therapy and physical education & health.”

In addition, many universities and colleges are developing elective courses that provide opportunities for all students, at some time in their professional education, to meet and learn “with, from and about” students from other professional programs.

One of the key messages emerging from almost every experiment conducted with students is that they value the IPE experience. Many courses have demonstrated the viability of teaching and learning collaboratively, with many students providing positive anecdotal comments and desiring further studies.

From an evaluative review of the course-based approach to IPE as described in the literature it is clear that there are fundamental questions to be answered about how best to approach a curricular methodology and curricular reform, for example:

18 University of Toronto “News@UofT” Office of interprofessional education to enhance interdisciplinary learning: Lessons in co-operation”, Oct 6/06
19 Ibid.
1. Can disciplinary approaches to a topic (i.e. palliative care) be melded so that the curricula reflects interprofessional learning?
2. Can interprofessional theory be embedded in curricula so that students are required to learn with, from and about each other rather than separately?
3. Can faculty from distinct disciplines be prepared to teach interprofessionally, while still recognizing the scope of their own disciplines?
4. Can an IPE curricula be measured against traditional models?
5. Can preceptors (mentors/fieldwork or placement supervisors) in the field teach students from other disciplines and professions?

Recent research by the Canadian Interprofessional Health Collaborative on curricular development for IPE (publication pending) is encouraging and identifies the many different approaches that have been taken to address these and related questions. When introduced in 2008, the CIHC Library will house resources that will help teachers and learners develop programs based on the experiences of IPE curriculum development.

4. IPE MUST BE INTRODUCED AT THE RIGHT TIME

In parallel with questions about curricula changes and the organization of IPE are questions about the timing of IPE and whether the goal of IPE is best served by introducing learning early in disciplinary education. Opinions range from total immersion from the beginning of professional education, to working only at the post-licensure level. Evidence is still needed to determine the optimum time to introduce students to interprofessional education. Two options exist:

A. Early Exposure

Initially, it was reasoned that if students learned common subjects such as Chemistry, Anatomy and Physiology together they would automatically learn to be interprofessional. However, not all students require equal knowledge of Chemistry, Anatomy and Physiology. What seems to be apparent from the IECPCP initiatives, is that students who enter professional programs need, in their early years of preparation, to develop a clear sense of themselves in their profession. Expecting students to work collaboratively with other students in other

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20 See, for example, the work of the New Generation Project at the University of Southampton in Portsmouth in the U.K. URL: www.commonlearning.net
professional programs before they have gained that identity seems, in many cases, to be counterproductive. It has also become clear that until students have been exposed to their area of future professional practice, they have no idea about those matters on which they should collaborate.

B. Late Immersion

It is not yet clear from the IECPCP initiatives, whether the best time to immerse students in IPE is in the year prior to graduation from a professional program. By their year of graduation, students should have experienced a sufficient number of complex cases to understand the scope of their practice. This self-knowledge may make them willing to participate in interprofessional problem solving activities.

Opportunities for IPE initiatives also occur after graduation or licensure as offered by professional associations and employers. Ideally health professionals will have been exposed to IPE before such experiences in the practice setting.

5. COLLABORATIVE LEARNING ENVIRONMENTS MUST BE CREATED

Health Canada funded IECPCP projects across the country have struggled with questions around collaborative learning and the environments in which it is best stimulated. Questions such as “how do we encourage health and human service programs to collectively understand each others’ academic and professional missions?” have been driven by the need to build a collaborative, civic, academic-community relationship, which would take social responsibility for health achieving a global status in the broadest sense envisioned by the World Health Organization:

“...there is a health baseline below which no individuals in any country should find themselves: all people in all countries should have a level of health that will permit them to work productively and to participate actively in the social life of the community in which they live.” (WHO)21

Questions posed in various ways and locations across Canada have been articulated in a way that might help frame a new and consistent approach to IPE. For example:

21 WHO, Global Strategy for Health for All by the Year 2000 (Geneva, 1981), 59
1. How might Canada educate students in health and human service programs to apply an interprofessional understanding to:
   - *universal public health programs*, which target the entire population e.g. clean water?
   - *targeted programs* which focus on specific populations e.g. rural and remote regions?
   - *clinical programs* that are concerned with a broad range of health issues but within a specific domain e.g. chronic disease management?
2. In pre-licensure education, how might Canada replace some discipline-specific learning with interprofessional learning that prepares new entrants to the healthcare system to work in a collaborative environment?
3. In building IPE, can we use evidence to inform policy decisions that support interprofessional practice?
4. How might Canada integrate interprofessional education with the population health and wellness goals identified by various governments?

6. **Structures must be modified to support collaboration**

Institutional structures do not necessarily support collaboration in either the education or the health sectors. Over the years, significant discussion has taken place about barriers to effective IPE programs, and how to address these barriers. There is a broad consensus on the difficulties of scheduling courses, meeting professional requirements, recognizing faculty involved in IPE for promotion and tenure, and cost implications. Gilbert (2005) has examined these and other barriers that have prevented (and continue to prevent) the emergence of a culture of interprofessionalism within both the post-secondary education sector and the healthcare industry. Identified barriers include:

- Factor #1: Health care providers receive minimal interprofessional and team learning to address issues such as:
  - Interpersonal differences
  - Fear of change
  - Stereotypes

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22 In Canada these included, amongst many at the time: *Closer to Home* (Seaton et al 1991), *Toward a Healthy Future* (Health Canada 1997), and *Inaugural Health Plan* (Vancouver/Richmond Health Board 1999), all of which have their origins in the *Royal Commission on Health Services* (Hall 1964), *A New Perspective on the Health of Canadians* (Lalonde 1974), and *Achieving Health for All* (Epp 1986).
Factor #2: Systems don’t necessarily support collaboration, for example:
- Models of practice
- Discipline-specific departments
- Management structures and priorities
- Institutional structures and priorities
- Policy

While efforts have been made to remove barriers on the surface of the system, the deeper systemic roots have not been well articulated or resolved. As a result, barriers frequently remain in place, even after a successful experiment in IPE is completed. For example, a small and dedicated group of faculty may agree – for the purposes of a grant funded IPE project, to devote time to the goals of that project, with little or no institutional recognition for their contribution. Individuals and institutions working to implement IPE, whether in academia or practice, face a number of structural challenges such as:
- Reward structure for faculty who are often not compensated for teaching interprofessional courses (i.e., tenure track excludes IPE)
- University/college/institute funding is generally allocated by faculty or department, and excludes interdisciplinary or co-lead programs
- Health professionals have limited opportunities and time to focus on interprofessional activities within their organization (i.e., hospital, health authority, private practice)
- Many managers and administrators are faced with lack of support when attempting to introduce IPE as a new concept within their organization
- The healthcare system is driven by ‘issue of the day’ with education receiving less attention than clinical areas in terms of budget, human resources allocation, etc.
- IPE is often seen as an add-on or “non-essential” program, as a result it is frequently a lower priority.
7. **IPE SHOULD BE EMBEDDED IN THE SYSTEM**

The changing world of health service delivery may push the post-secondary sector to recognize interprofessional education as an essential part of disciplinary education, rather than an add-on. It has become clear from the many innovative IPE projects throughout Canada that there are significant opportunities for greater cooperation, coordination and collaboration among and between health provider education programs and the health and human service delivery sector.

For example:

The Interprofessional Rural Program of British Columbia (IRPbc) places teams of students representing a range of health and human services into remote/rural B.C. communities. The student teams experience the challenges and rewards of rural practice while developing interprofessional and discipline-specific skills across the continuum of care. The goals of the program are to foster rural recruitment, advance interprofessional collaboration, provide new practice sites for students and ultimately improve the health of people living in rural communities.23

The Interprofessional Disaster/Emergency Action Studies (IDEAS) Network is committed to building an infrastructure for collaboration in the development and testing of emergency preparedness strategies. IDEAS is facilitating collaborative associations between institutions; creating interprofessional training materials; using technology to deliver curriculum and exchange ideas; conducting interprofessional drills and
exercises; developing tools for measuring human performance and outcomes under disaster conditions; and integrating students into a community disaster plan.24

Statistics Canada designates more than 65 health occupations as “Health Professions and Related Clinical Sciences”25. Instructional programs prepare individuals to practice as licensed professionals and assistants in these identified health care professions, many of which are regulated and controlled by a variety of mechanisms, such as:

» Government legislation
» Professional associations
» Facility and educational program accreditation, and
» Union influence

When considering the reality of how patients receive health services, the complexity is further increased by the large number of health and human service occupations that are not regulated (e.g. home care aids). To reduce the possibility of disconnects, it is imperative that IPE be embedded in our health and education systems in a manner that helps students and providers to understand each others’ competencies and roles.

8. EVIDENCE MAKES THE BEST CASE FOR IPE

Research in Canada along with scholarly contributions from the international community, has established a strong foundation on which future activity can be based. At present, the research on IPE in Canada has been driven by the evaluation metrics established by Health Canada. The following series of systematic reviews covering the international literature on IPE has been conducted over the past eight years:

» Barr et al, 2000 Evaluating Interprofessional Education: A UK Review for Health and Social Care

24 http://www.ideasnetwork.ca/

BRITISH COLUMBIA: A CASE STUDY ON USING REGULATORY REFORM TO EMBED IPE

On April 10, 2008, the BC Minister of Health introduced the Health Professions Regulatory Reform Act. Section 10 (f) introduces a change to the bylaws of all Regulatory Colleges in B.C. that will require each College “to promote and enhance the interprofessional collaborative practice between its registrants and persons practising another health profession.”

This type of legislation, which has been similarly introduced in Ontario, will embed IPE in the bylaws of each College, and push the post-secondary institutions to ensure health and human science students are appropriately educated to meet the requirements of their professional regulatory body’s governance.

1 http://www.leg.bc.ca/38th4th/1st_read/gov25-1.htm (accessed April 28, 2008)
While these reviews have demonstrated some benefits of IPE, there remains a need to develop a body of quantitative and qualitative scientific evidence linking interprofessional education with more collaborative practice and ultimately better patient care.

9. **INTERPROFESSIONAL PLAYERS MUST ENGAGE THE COMMUNITY**

From the work of IECPCP to date it is possible to identify at least four groups with vested interests in IPE. For a complete list of stakeholders, see the CIHC Dissemination Strategy. For the purposes of this report, specific groups which must be organized in order to further IPE in Canada include:

1. Health and Human Service Providers
2. Faculty Members in Educational Institutions
3. Clients/Patients/Citizens
4. Various Levels of Government

Canada’s health and human service programs have a long history of rich clinical/fieldwork relationships with a wide range of community agencies – hospitals, health regions, private and non-governmental organizations. Following on this historical success, a number of IPE projects are assuming a role in supporting cross-faculty, collaborative health and human service activities with community partners locally and nationally (i.e., Saskatchewan’s Autism IP Training Program and SWITCH – Student Wellness Initiative Toward Community Health).

Evidence also suggests that developers of IPE programs will need to work with government ministries to initiate and/or support activities and develop policies that foster interprofessional practice, both within educational and community institutions.

http://www.cihc.ca/resources-files/CIHC_DS-May07.pdf
The Canadian Interprofessional Health Collaborative has a unique and important role in bringing existing and new stakeholders together at one table. As the hub of interprofessional collaboration in Canada, the CIHC brings together individuals from the 20 IECPCP projects, as well as others interested in IPE, to share information, exchange best practices, and discuss lessons learned.
PART THREE

The Future: Enhancing & Sustaining IPE

Since the 1960s, many new health professions have evolved and the rush to ensure professional stature has been great. In some cases professions have overlooked the fact that all professions contribute to serving the needs of the population. The initial responses to the IECPCP projects and resulting policy and system changes, suggest that further embedding IPE in the health and education sectors is an evolving trend. The goal is to ensure that patients and clients reap the benefits of a more collaborative approach to healthcare.

Health Canada is currently evaluating whether the IECPCP initiative has met its stated goals (as described on page 13–14). In order to facilitate evaluation and implementation of IPE on a national level, Health Canada launched the Canadian Interprofessional Health Collaborative to act as the hub for interprofessional activity in Canada.

The CIHC has facilitated critical connections between a number of important stakeholders, including:

» Those involved in the first and second cycle (IECPCP) learning projects
» The “complementary projects” focusing on system or meso/macro issues
» Other groups and individuals in education, practice and research at the local, provincial, regional and national levels across Canada
» International groups

The CIHC is moving ahead with an agenda that focuses on research and evaluation, curricula, partnerships and knowledge exchange and student leadership (See the appendix for an outline of CIHC’s sub-committees and their activities).

**Recommendations**

In order for the momentum around IPE to continue in Canada, individuals as well as public/private organizations need to buy into the concept and importance of IPE. Three key elements that will drive progress are:

» Personal responsibility (individuals taking the initiative to practice/demonstrate IPE)
» Organizational change (organizations putting the infrastructure in place to facilitate IPE)
» Policy development (governments working to embed IPE in the fabric of the health and education systems).

This report also highlights the potential for 'mainstreaming' IPE through national, regional, provincial and institutional strategies. Building on the principles outlined above, the report includes ten recommendations that can and should be taken at all levels of the system, in order to build on the momentum underway and advance interprofessional education across the country.

1. Demonstrate and promote the benefits of interprofessional education and collaborative care by continuing to build on the people, processes, structures, reports/research and funding already in place.
2. Develop long-term strategic plans that focus on funding and resources.
3. Learn from the successes and mistakes made by other countries in hoping for long-term system change with short-term investments.
4. Develop and support leadership in interprofessional education and collaborative care by focusing on programs and integration rather than short-term projects.
5. Implement policy change at the governmental, institutional and organizational level. For example, incorporate interprofessional competencies in professional regulatory scopes of practice.
6. Encourage collaboration between 'system change silos' by developing strategic and innovative partnerships that enable interprofessional collaboration in education, research and practice. Engage both IPE focused groups and groups with similar or overlapping mandates (i.e., patient safety, healthy workplaces, leadership).
7. Support knowledge exchange practices that help organize interprofessional functions at various levels of the system, coordinate ongoing work and minimize duplication.
8. Encourage incentives and rewards in both health and education sectors that are interprofessional-focused in addition to those that are discipline-specific.

9. Expand interest to a broader audience rather than focusing on current interprofessional champions.

10. Articulate, advance, and advocate a research/evaluation agenda for interprofessional education and collaborative care.
Conclusion

Interprofessional education is an essential precursor to a collaborative patient-centred practice environment. Although it may have taken more than 40 years for Canada to develop its concept of IPE, in the past four years Canada has demonstrated its role as the international leader in this field. This progress has been largely made possible by the federal IECPCP initiative, funded and supported through Health Canada. Many of the IECPCP activities across the country were able to leverage this funding in imaginative ways. Encouragingly, some provinces have supplemented IPE with their own funding programs. The system-issue complementary projects supported through the IECPCP initiative have the potential to be constructive in understanding and resolving some of the aligned complexities, such as legislation, regulation and academic barriers.

The future of IPE now depends on the ability of the Canadian “movement” to both sustain itself and to continue building the environment and resources necessary to embed it as part of the health education and health service cultures. It is hoped that as the CIHC develops, it will continue to facilitate the achievement of these goals.
APPENDIX
The Canadian Interprofessional Health Collaborative

CIHC’s Mission: The Canadian Interprofessional Health Collaborative advances interprofessional education and research to promote collaborative patient-centred care.

CIHC’s Vision: Canada’s healthcare providers are well prepared for teamwork and collaboration with patient/clients and communities to achieve high quality care. They learn and work in an integrated health and education system that enables and supports them.

The CIHC believes that when different health care providers learn with, from and about each other, they are more capable of working together to provide better patient care. CIHC discovers and shares promising practices to promote interprofessional collaboration.

The CIHC Steering Committee advises and guides the efforts of the CIHC. Membership includes representation from the interprofessional learning projects, NaHSSA and Health Canada.

Many of CIHC’s core activities build on D’Amour and Oandasan’s Interprofessional Education for Collaborative Patient-Centred Practice: An Evolving Framework (2004). For more information on CIHC sub-committees, see http://www.cihc.ca/about/core_activities.html.

Partnerships & Knowledge Exchange Sub-Committee

“Creating relationships with the health, academic and policy sectors; identifying and sharing best practices in interprofessional collaboration through communications, knowledge translation, dissemination and technology.”

CIHC’s Partnerships and Knowledge Exchange Committee “PKEC” works with the CIHC Secretariat to develop strategic relationships that will further the work of the CIHC and ensure the Collaborative remains sustainable in the future. The PKEC is looking for effective ways to share promising information and practices about interprofessional education and collaborative care. The PKEC informs stakeholders and policymakers as they make decisions that impact the delivery of patient-centred care.

An electronic library is one of the knowledge exchange keystones of the CIHC toolkit, specifically designed to aid those

searching for information on IECPCP. The goal is to create a CIHC Library targeted to educators, students and practitioners with an interest in interprofessional education (IPE), and accessible to all CIHC members. Such a repository will have the advantage of making materials created under the Health Canada IECPCP umbrella more widely available for health sciences educators across Canada, past the life-cycle of the current funding envelopes.

Research & Evaluation Sub-Committee

“Looking at how interprofessional collaboration works, or would work, based on testable theories and models. Studying, learning and planning effective strategies to evaluate and improve interprofessional collaboration.”

The Research & Evaluation Committee seeks to understand the processes involved in IPE, how these processes link to the outcomes and experiences of the patient/family/community, the health care team and the organization, and evaluation strategies to improve IECPCP.

The Research & Evaluation Committee also acts as a platform for connecting researchers and evaluators and developing research collaborations across Canada for future IECPCP activities. The Committee identifies knowledge gaps and strategizes how to close those gaps. As work progresses, the Research & Evaluation Committee will engage educators, program managers, researchers and policy makers to provide their expertise and knowledge on how to direct future IECPCP research and evaluation.

Curricula Sub-Committee

“Studying curricula related to interprofessional collaboration and identifying changes needed in health profession curricula.”

As the CIHC identifies the best approaches to achieving IECPCP Canada-wide, subsequent changes to health professions curricula (pre and post-licensure) are necessary. The work of the CIHC Curricula Committee centers around studying and learning how current curricula relates to various groups impacted by IECPCP. The IECPCP funded initiatives have given considerable thought to the development of innovative IPE curricula and competencies.

Many of the learning materials and other tools developed via the IECPCP initiative will soon be readily accessible via the CIHC Library.

For more information, see: www.cihc.ca
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