SUMMARY OF CIHC CENTRAL REGIONAL MEETING

The CIHC has organized three regional meetings in Canada in order to bring together those individuals and organizations that have an interest in interprofessional education for patient centred practice. At a meeting in the summer of 2007, the three regional meetings were determined to be the west [provinces west of Ontario], central [Ontario], and the east [Quebec to Newfoundland]. The central meeting was held on November 16th 2007 at 89 Chestnut Street in Toronto.

The planning committee for the meeting – Carole Orchard, Jennifer Medves, Brenda Sawatzky-Girling, and Susanna Gilbert selected a date when there was the best opportunity for maximum attendance. The end of the week was preferable for academics in Ontario due to teaching commitments. A one-day only meeting was planned because of fiscal considerations. The costs of the day were paid for by a grant the Ontario Collaborative received in early 2007 to develop a proposal for an Ontario section of the CIHC. As the interprofessional education leaders of the academic health sciences centres were to have met in the fall of 2007, this sub-group met the evening before to reduce travel costs. Key people were invited from the Ministry of Health and Long Term Care and the Ministry of Training, Colleges and Universities.

Each participant was provided with a binder of resources and information including two articles written by Lorie Shekter Wolfson on the perspectives of interprofessional education in the college sector. A number of other documents were available on a resource table from the various IECPCP projects, providing updates and information of innovations.

The agenda was designed to provide participants with one important success of each of the seven federally funded IECPCP grants. Each group was given 20 minutes to present including a few minutes for questions. The presentations of each group are available in the appendix and are posted on the web site. These presentations together with a presentation from John Gilbert were scheduled for the morning.

In the afternoon, there were two rounds of small group discussion. Participants could elect which group they wanted to join. Some choose to stay with the original group while others moved to another discussion topic. The notes from each of these small groups can be found following this summary.

At the end of the afternoon, each group provided three statements that emerged from the discussion. We did not provide a full summary at the time, instead elected to transmit the information electronically following the meeting.

To conclude, participants were asked what the next steps should be for the Ontario Collaborative. A further meeting was suggested when the IECPCP projects are completed and the provincial projects are close to completion. This will probably take the format of a peer reviewed conference held over two days. There are a number of activities related to IPE already underway in Ontario and there was general consensus that dissemination of the material will reduce the likelihood of duplication. The participants also agreed that we should petition for a different approach to a call for proposals that allows those interested in IPE and collaborative practice to collaborate and not to compete for grant money as this process is more likely to prevent true provincial wide collaboration.

The participants agreed that the presentations, notes and summary should be posted on the national CIHC website as this was a useful way to disseminate information.

Evaluation forms were received from about 20 people. Generally people were satisfied with the meeting and that the aims and objectives had been met. Several people who provided verbal feedback were satisfied and included those that had a real appreciation of the issues related to IPE and the enthusiasm and sharing of the people involved.

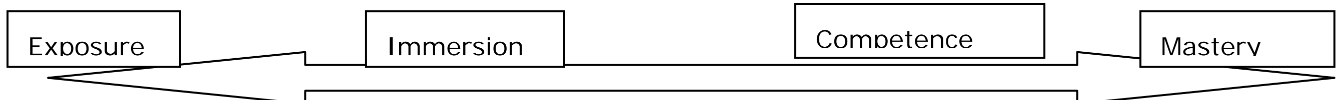
Working Group Notes

THEME #1
PREPARING FACULTY TO TEACH IECPCP

This topic was chosen to teach faculty because it is a small program with a lot of potential and more people are needed to facilitate ways to train facilitators.

The **content** includes the following categories:

1) Facilitation
2) Basic knowledge and skills
3) Attitudes
4) Organizational/curriculum
5) Building internal capacity
6) Infrastructure/rewards/incentives
7) Choosing IPE professional development
8) Short term faculty development leading to long term



In order to **expose** the faculty to IECPCP, attendance at conferences and meetings could provide needed information as well as an educational series with self identified interprofessional champions. Preceptors, students, clinical faculty and academic faculty all have a part within IECPCP and it must be remembered that this topic is very reciprocal in nature, where education leads to practice and practice leads to education.

The **Core Competencies** involved are the following:

1) Roles
2) Communication
3) Team effectiveness
4) Self reflection
5) To see and experience
6) Facilitation

There are a few **types of teaching** that can be used in order to facilitate the faculty in teaching IECPCP including; co-teaching, using a "guest" participant, supervisors of team placement (both uniprofessional and interprofessional, SW, OT, and Psychology), observation and shadowing, role modeling, and structured discussion.

Faculty and clinicians and other health professionals need an immense amount of information in order to effectively teach IECPCP beginning with the attitudes, skills, and knowledge. It needs to be shown that facilitation is very different than regular teaching and learning and it is not just what is happening in the classroom.

In order to get the entire faculty on board we need to build capacity and could do this with the support from administration and promote with incentives, rewards, infrastructure, and development.

Continuum exposure to mastery (facilitation):

- How to expose faculty?
- How to immerse faculty?
- How to develop competency?
- How to gain mastery?

The question of **who is responsible for educating the clinical faculty** is still unanswered; however a link between education and practice needs to be made to make this less challenging. The faculty needs to know what is in it for them and if the school provides education it gives them buy in and they become a role model for the students.

Some plausible **solutions** to many of the challenges that have or will present themselves are having faculty who can teach the IPE aspect who are not also in the program as well as having a shadowing experience where a student goes to a clinician of a different profession and work one on one with them. It would also be beneficial to see how family health teams who do not currently have an OT or PT in their office have students from those professions go and work with them and on the same note, have a PT enter the ER, where there is usually no PT available.

Some of the **challenges** that may occur could include that the faculty developer needs mastery, however it is not available within house, the need of buy in from the faculty development department, the need of a consultant, and the lack of funding.

In order for the faculty to be successful in becoming facilitators of IECPCP they will need good facilitators, to know the organizational and curricular components. However, none of this is possible without the bodies to do so, therefore a way of recruiting the faculty would be to advertise and ask for individuals with experience in IPE.

The **faculty that would be most valuable** in this role are those who are self-identifiers, they have a background in education, psychology, social work, or conflict resolution, they are willing to and succeed in collaborating on anything, that are excellent communicators, are energized and enthusiastic, and have the ability to ask questions that will reframe the questions.

There are a few choices that faculty have in order to **share their material between organizations, including:**

- Course to prepare faculty (U of T immersion course)
- Michener ("camp" course)
- CEDC
- OHA conferences
- OHA educational
- Professional organizations
- Educational organizations

Three Key Points

1) Faculty development competencies
    - Exposure
    - Immersion
    - Competent
    - mastery
2) Need mastery team in province to educate faculty.
3) Need to get message out to province.

THEME #2: HOW TO CREATE A COMMMON SET OF IPE COMPETENCIES

Most importantly, it needs to be decided **"What are competencies?"** What do we mean when we speak of competencies? Definitions need to be clarified on similar words because for example, cooperate, coordinate, and collaboration do not all mean the same thing, for instance, collaborative care has its own set of specific competencies. There also needs to be clarity on the definitions of IPE, competencies, and IPC and whether these competencies are based on skills or behaviours. In order to achieve this, there needs to be an exhausted literature search completed.

In addition to the clarification needed about competencies, there also needs to be a working definition of competency; IPE vs. IPC. Right now the best work on competency based evaluation is coming out of Belgium and is more of a "know how" with behavioural indications and is continuously dynamic and changing.

Evaluators from Belgium are measuring the competencies through behavioural indicators within the competencies. In order to measure these competencies, you need to use the accepted set of steps to create competencies because they are not all equal, there are differences within the value and importance within them. There are two ideas that could help with evaluating these competencies more efficiently, and those are the use of a common language and the possibility of focusing on IPC as the end product. The practice arena will likely be looking at three key aspects of the competencies; knowledge, skill, and judgment and due to the current work that is being done and is to be done in the next round of projects, it would be important to let these follow through and work on developing a common set of language.

There are many ways in which we can evaluate the competency development thus far, such as systematic reviews, a colloquium, and an iterative process. The systematic review would be one way to see what all has been done around competency development in this area including, literature searches, IECPCP projects, Health Force Ontario work, CIHC and more. However one concern with doing a systematic review is with spending too much time on it, as we don't want to hinder the process. A colloquium of experts coming together in the field working on competencies vs. inventory would be another way of evaluation, however this process needs to be critical of the information that is out there, because not all of the information presented may be correct. Lastly, an iterative process could be another thought where all stakeholders needs to be included in the process.

The reason for doing all of this competency development is to inform curriculum development as well as to inform practice and portability. The question then becomes how to incorporate competencies within non-competency based curriculum and practice. The developed competencies need to be applicable to the practicing professions and we need to be able to move some of the Regulatory Bodies forward on this topic as an expectation of practice.

The process for all of this to take place has many remaining questions such as, do you get one person to develop a working document and then send out for a broad based consultation to get a Pan Canadian perspective? Also, who do you include in terms of practice arena, how broad of an area do you want to cover? How do you relate it back to continuing health education and what do we do to facilitate knowledge uptake?

In order for this process to work it needs to be simple and flexible and each group will define their own uptake of it. A group of behaviours, such as the KISS principle with perhaps only 4 or 5 competencies with levels within allowing for growth. The depth and application with vary based on the profession or group using the model, as will the level of attainment.

For those who do not have competency based models, these can inform them how to use them within their existing curriculum and then work at creating a common understanding. There needs to be an assessment of development or achievement or another level, either way it needs to be decided on what is measured. While these competency models can be used within many professions, it needs to be respected that there are different curricula approaches and different skill levels.

Three Key Points

1) Few and Flexible – continuum in depth of attainment
2) Implications on evaluation – Is a competency measurable? Objectives vs. Competencies
3) Need to honor different curricula approaches and different skills and educators; to be relevant to students and clinician (to be reinforces)

THEME #3
WHAT SHOULD AN IPE CURRICULUM LOOK LIKE?

GOAL: We don't expect mastery of the IPE competencies, but knowledge that can be applied to the clinical setting and ability to identify issues in the clinical setting. Mastery will come with practice if IPE competencies over time. (National core competencies)

There are many parts to developing an IPE curriculum. First and foremost there needs to be a **definition** decided upon for IP collaboration. The next phase is to actually move ahead and develop the curriculum. In order to do so there needs to be key **people involved**. Student learners; pre and post licensure as well as clients and patients should all be involved in curriculum planning. Program advisory committees should also be involved, as well as members of the public in order to include as many of the stakeholders as possible.

The curriculum should be diverse in nature and there must be a role for regulators at the beginning of development to ensure that the curriculum is consistent with college guidelines. The IPE curriculum should **target** those disciplines that are accessible and involve the public in order to promote education on IPC.

An important decision to be made is at what **level of study** do you introduce IPE curriculum to the learners? It needs to be decided whether it is more effective to introduce IP into the curriculum early on in their learning career, or later as well as whether it should be available for graduated students. However, it would be very beneficial to have an IPE curriculum included in every year of study within every program. There is a possibility to follow the continuum for practitioners who were unable to have this opportunity when they were students, to be able to access this material and information. In order to aid in the recruitment process, the local high schools could be visited as well as including an "introduction to health professions" course during the first year of study.

There are a few **challenges** that can be foreseen such as the implications for unionized environments, including unions too early on, and creating entrenched practice settings.

There are many arenas that could benefit from and IPE curriculum, however the main **focus** should be to infuse IPE and IPC into areas like palliative care as well as to include a tie into research and add an evaluative component throughout. In order for the IPE curriculum to be complete, there must include a practice piece that will aid in application and awareness of the curriculum.

The **process** stage of development should move from the awareness stage into the engagement stage with many social opportunities involved as well as opportunities for simulation practice. The process should also include a link to evaluation and research and should be focused on the process and not the product.

In order to **measure** our findings, it needs to be decided whether we define it as "competencies" or "learning objectives" because there are many different learning objectives included. From the beginning of development there needs to be integration of outcomes measures and during this stage the focus should be on the end product rather than on the process.

There are many **components** involved when developing a new curriculum, especially an IPE curriculum where it is an inclusive vision with shared perspectives. There is a need for an identification of a common language, terminology and taxonomy to be developed as well as a high need for social interaction. It needs to be made sure that the scope of practice and standards are considered as well as the depth of all health care roles as well as their own are understood by all learners. There are socialization skills that are needed to have effective IPE learning, which include positive and effective communication, conflict resolution (core competencies), reflection and collaboration tools, as well as team building proficiency needs to be learnt within the team environment.

Learning strategies need to be included in the discussion of creating an IPE curriculum and one of the main learning strategies that need to be included is the simulation opportunities. In addition to the simulation, bringing case studies into the mix, both with a regionalized and local feel but also including a Northern and Aboriginal focus would be highly beneficial.

The way that a new curriculum is **delivered** is very important and one of the ways this could be done successfully is by using a blended delivery model. This could include synchronous and asynchronous (but with face to face contact included) as well as an online session and practice. An online session could be very useful (even though there is minimal face to face contact) because online learning increases support and time allowance for reflection that may not be so easily offered in any other method. Small group facilitated sessions as well as the cafeteria style choices are two other ways in which delivery of the IPE curriculum can be achieved. As can be seen from the vast array of delivery methods to choose from, leaving a smorgasbord approach for the learners to choose from is just one other way in which delivery of the curriculum can be accomplished.

The **timing** in which to introduce the curriculum is yet another question that must be answered; however there are some very important details that must be incorporated. The curriculum should be required in each profession rather than optional as well as it being a part of both pre and post licensure levels. It is also possible and an effective way of extending the IPE reach to include the curriculum into continuing education as well as to practicing professionals who would be interested in learning about collaboration and IPE.

In order for this curriculum to be widespread and to involve as many different schools and faculties as possible, there needs to be a **sharing of resources**. This then means that there is a need for a repository of IP resources available as well as a way in which these resources and content can be shared. As a result of the sharing of individual's intellectual property the legal issues or sharing need to communicated throughout all participants.

Three Key Points

1) Collaborative and inclusive
2) Diversity in delivery models
3) Agreement on core competencies and terminology

THEME #4
HOW SHOULD WE MEASURE PATIENT OUTCOMES RELATED TO ICP?

The **structure** of such a task as measuring patient outcomes includes many different tools and people. First and foremost, family health teams should be involved in this process. Different tools that would be beneficial in measurement would be the use of electronic patient charts as well as the use of an IP tool for assessing and care planning. It would also be useful to keep a chart in the patient's home so that all health care professionals can update and access it equally. A crucial element to remember is that this is Patient-Centred and that the patient is a true member of the team and has a voice to be heard.

There are many different **processes** that can be measured in relation to patient outcomes; including looking at the impact of wait times; whether they are positive or negative, assessing the reduction in ER visits, identifying that teamwork is being accomplished among all members including the patient as well as producing more appropriate care, assessing reductions in complications; both pre and post, identifying the perceived quality of care, and assessing the patient's control over their own care.

There are many outcomes that could be measured when addressing patient outcomes and therefore they have been grouped into three categories.

1) *Access to Care*: Patient and relative perception regarding access and action and results.
2) *Efficiency of Care*: Speed, continuity, progress, cost benefit analysis, enhanced data collection and evaluations through EPR, electronic patient records, and benchmarking role change of all members of the team.
3) *Quality of Care*: Patient satisfaction, anecdotes from patients and families and professionals with collaboration, improved and appropriate communication, fewer adverse events, connections between patient expectation and received care, continuity of care across the system (information, management, relationships), shared decisions making, greater patient compliance, more effective use of professionals' knowledge and skills, specific outcomes related to settings, and improved care and prevention of health problems.

Three Key Points

1) Continuity of care (information, management, and relationships need to be measured)
2) Structure, process and outcomes should be measured.
3) Measures need to collect data from providers and recipients of IPCP

THEME #5
HOW CAN WE DEVELOP AN EFFECTIVE NETWORK OF EDUCATORS, RESEARCHERS, PRACTITIONERS AND DECISION-MAKERS ACROSS ONTARIO?

Group 1

The first question regarding this is whether or not the network is necessary and if so, what do we want to accomplish from it and how do we make it effective. One of the major benefits of having a network is to fan out the information so that everyone receives that same knowledge base. It could be useful to use the first wave of students and ambassadors as a feedback loop to inform the continuing development process.

There may be different ways that networking could be established instead of the traditional committees and conferences, such as an Ontario page on the CIHC and focused meetings; such as "IP and the family health team". Leveraging the use of technology could also be an innovative approach, such as teleconferencing, the use of an E-library, as well as a tool similar to "facebook" for sharing of ideas, for example Vince Chen (St. Mike's).

The individuals that should be present within the network are those that are in place and accountable to continue to support. From this, they can then organize the provincial activity and create a provincial dialogue with the decision maker and/or policy maker. In order for the network to be beneficial, it needs to be workable and not burdensome and open for participants beyond academic, cooperative non-competitive. Within the network there will be a funding element, however with the network together it can seek support beyond the government.

The next step would be to name leaders from each centre that can participate and create forums, make changes and access and organize data to influence policy makers. It would also be a good representation to include the leverage of the Family Health Teams under the umbrella of the CIHC.

Group 2

The first question of the sessions was that of the necessity of a network and whether we need one or not. If a network is chosen, what kind of a network will be in use, what kind of a forum will be created and how do we partner to share information? There is some redundancy, however some is necessary, for example E-cases, need some parallel, some customization and some standardization.

There is a need for a repository as has been previously suggested as well as national lessons and professional lessons in order to share at all levels. A blueprint has been released demonstrating appropriate knowledge sharing and could be used to model collaboration. The network could be a link for provincial and national government liaison and Ontario could be used as the region in a national structure (current regional meetings). There needs to be more support for NaHSSA chapters as well as the new addition of the CHSRF who could be aligned as a partner of common interests.

List of Attendees

Andrea Burton
Ann Russell
Brenda Sawatzky-Girling
Carole Orchard
Cassandra Thompson
Cheryl Forchuk
Cori Schroder
Cory Ross
Cynthia Whitehead
Debbie Sargent
Denyse Richardson
Donna Cunningham
Elizabeth Steggles
Frank Schmidt
Gail Beagan
Gwen Gignac
Helen Taylor
Ian Newhouse
Gary Kapelus
Jennifer Medves
Jill Shaver
John Gilbert
Kathryn Parker
Kelly Manian
Kevin Barclay
Kelly Reilly
Kirsten Pavelich
Lewis Tomalty
Louise Philippe
Lynda Weaver
Lynn Casimiro
Lynne Sinclair
Marlene Raasok
Mary Preece
Patty Solomon
Paula Burns
Scott Reeves
Stephanie Janveaux
Sue Beardall
Susan Brajtman
Trish Dryden
Wayne Bruce

In total 72 people were invited. One or two people could not travel due to bad weather and problems with Air Canada on the day.