AIPHE INTERPROFESSIONAL HEALTH EDUCATION
ACCREDITATION STANDARDS GUIDE

Phase 2 – Funded by Health Canada

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- Accreditation Canada
- Canadian Association of Occupational Therapists (CAOT)
- Canadian Association of Schools of Nursing (CASN)
- Canadian Association for Social Work Education (CASWE)
- Canadian Council for Accreditation of Pharmacy Programs (CCAPP)
- College of Family Physicians of Canada (CFPC)
- Committee on Accreditation of Canadian Medical Schools (CACMS)
- Physiotherapy Education Accreditation Canada (PEAC)
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INTRODUCTION

This guide to accreditation of interprofessional education in health and human service programs is intended to provide suggestions for accreditation agencies to consider when developing, implementing and evaluating interprofessional health education standards for accreditation purposes. It is not intended to be prescriptive. Each accreditation agency will want to adapt the language to suit its specific context, language and process. In addition, the list of examples is not exhaustive and is in no way meant to represent all examples of evidence. Nor is there any expectation that all criteria will be included or examples cited.

The hope is that the guide will provide useful options for accreditation programs to consider and adapt for their use and that accreditation documentation will include interprofessional education as integral to more than the academic program context.

It places accreditation of interprofessional education in the larger context of health education. It provides choices and alternatives that can help to shape accreditation standards within the much larger accreditation framework. While the document has been developed by the eight organizations representing six health and human service professions who have been part of the AIPHE initiative, the intent is for it to be used by any accreditation agency to help guide their inclusion of interprofessional education.

Ultimately we believe that accreditation of interprofessional health and human service education will positively influence interprofessional education and interprofessional practice, and, in the long term, improve quality of care and collaboration.

Glossary of Terms

A short glossary of terms and explanation of acronyms used throughout the document is provided here at the beginning of the document to help to orient the reader to the context.

Interprofessional education (IPE) is the process by which we train individuals and teams to practice collaboratively. The most commonly cited definition of IPE states that it “occurs when two or more professions learn with, from and about each other to improve collaboration and the quality of care” (CAIPE, 2002).1

Definitions of collaboration include:

“[Collaboration is] ...a process through which parties who see different aspects of a problem can constructively explore their differences and search for solutions that go well beyond their own vision of what is possible” (Gray, 1989).2

Collaborative patient-centered practice is designed to promote the active participation of each discipline in providing quality care. It respects goals and values for [patients] and their families, provides mechanisms for continuous communication among caregivers, optimizes caregiver participation in clinical decision making (within and across disciplines), and fosters respect for the contributions of all disciplines (Health Canada, 2004).3

Acronyms

AIPHE – Accreditation of Interprofessional Health Education
CIHC – Canadian Interprofessional Health Collaborative
IP – Interprofessional
IPC – Interprofessional Collaboration
IPE – Interprofessional Education
NaHSSA – National Health Sciences Students Association

INTRODUCTION

In the Canadian and international context of health and human services, evidence continues to emerge in support of collaborative patient-centred care. The concepts of interprofessional education (IPE) and interprofessional practice (IPC) have been increasingly studied as part of a growing imperative to embrace different models of health and social care. Changes are required in order to ameliorate the impact of global health care provider shortages and to improve the quality of care and reduce costs associated with poor patient safety records, duplication of services, and limited access to the right services at the right time.


The challenges and benefits of IPE have been well documented and increasing attention to IPE in pre-licensure programs is driven by reports such as the Future of Medical Education in Canada (AFMC, 2010) in which a separate recommendation relating to intra and interprofessional practice is highlighted. Other professions such as Physical Therapy and Occupational Therapy have revised their essential competency profiles to reflect roles including the collaborator role.

Modern health-care teams not only include a group of health professionals working closely together at one site, such as a unit team, but also extended teams with a variety of perspectives and skills, in multiple locations. It is therefore essential for health care providers to be able to collaborate effectively with patients, caregivers, colleagues and an interprofessional team of expert health professionals for the provision of optimal care, education and scholarship that facilitate and enhance patient/client-centred care. Accreditation of education programs is one way of assuring attention is paid during the pre-licensure professional programs to interprofessional education leading to collaborative patient-centred care.

In 2008 Health Canada funded Phase one of an initiative that brought together eight accreditation organizations for six professions: medicine, nursing, pharmacy, physical therapy, occupational therapy, and social work. This first phase of the Accreditation of Interprofessional Health Education (AIPHE) initiative developed guiding principles to inform the development of standards, criteria and evaluation/assessment methods as they relate to accreditation of interprofessional education in each profession that is part of AIPHE.

The guiding principles are included here for easy reference. The full document, Principles and practices for integrating interprofessional education into the accreditation standards for six health professions in Canada can be found on the AIPHE web site (www.aiphe.ca).

- The patient/client/family is the central focus of effective interprofessional collaboration and, therefore, of effective interprofessional education.
- In order to educate collaborative practitioners, interprofessional education is an integral component of education for all health and human service professions.
- Interprofessional education is most effective when integrated explicitly into academic and practice or clinical contexts for learning.
- Core competencies for collaborative practice are used to inform health and human service interprofessional curricula in Canada.
- Interprofessional education embraces a relationship-centred approach as one of the key pillars of successful interprofessional collaboration.
- Interprofessional education requires active engagement of students across the professions in meaningful and relevant collaboration.
- Flexibility in the integration of IPE into health and human service curricula facilitates the development of accreditation standards that are consistent with each of the profession’s accreditation process and the diverse educational models across the country.
- Accreditation as one quality monitoring process for education, and regulation (licensing) as the quality control process for practice, must provide consistent messages about interprofessional education and collaboration.
- Emerging evidence is used to guide interprofessional education in all health and human service program curricula.

Required support structures for interprofessional education should be considered in all aspects of accreditation including institutional commitment, curriculum, resources, program evaluation, faculty and students.

Collaborative learning is integrated along the continuum of health professional education.

Specific knowledge, skills and attitudes are required for effective interprofessional collaboration and these are reflected in IPE curricula.

In 2010 Health Canada again provided funding for Phase 2 of AIPHE in order to develop examples of the language that may be used in standards and criteria for interprofessional education in each of the accreditation programs. In addition, Phase 2 was designed to develop an accreditation guide to ensure consistent evaluation of interprofessional education evidence in any health professional program. A Standards Development Working Group (SDWG) was created within AIPHE with representation from each of the accreditation organizations. The SDWG was charged with developing the standards’ language and examples of evidence that may be helpful to accreditation surveyors. This guide is the outcome of the SDWG work and provides recommendations for consideration by all health professions.

**Resources**

Partners in accreditation of health education programs, educators and surveyors may need to access resources that (a) help them to better understand the context of interprofessional collaboration for patient or family-centred care and (b) provide them with teaching strategies along the continuum of learning that engage students and residents in formal, informal and non-formal interprofessional learning.

The Canadian Interprofessional Health Collaborative (www.cihc.ca) is one source for a range of materials and resources that can be used to facilitate IPE and provides links to many resource sites. In addition, the AIPHE web site (www.aiphe.ca) provides access to other helpful resources and contacts. Together these resource sites can provide educators with ideas for teaching and assessing competence in collaborative practice and for accreditors, a broad range of resources to help them to evaluate the IPE approach in health professional programs.

**Interprofessional Competencies**

The National Competency Framework for Interprofessional Collaboration will inform the standards and criteria and will help to guide the development of the assessment and evaluation processes. The following section is reproduced with permission from the Canadian Interprofessional Health Collaborative February, 2011.

The CIHC Framework defines six domains for collaboration and provides three background foci to guide the application of the domains. The domains and background foci are provided here for reference and the full document can be found at www.cihc.ca.

**Role Clarification:** Learners/practitioners understand their own role and the roles of those in other professions, and use this knowledge appropriately to establish and achieve patient/client/family and community goals.

**Patient/Client/Family/Community-Centred Care:** Learners/practitioners seek out, integrate and value, as a partner, the input and the engagement of the patient/client/family/community in designing and implementing care/services.

**Team Functioning:** Learners/practitioners understand the principles of team work dynamics and group/team processes to enable effective interprofessional collaboration.

**Collaborative Leadership:** Learners/practitioners understand and can apply leadership principles that support a collaborative practice model.

**Interprofessional Communication:** Learners/practitioners understand principles that support a collaborative practice model.

**Interprofessional Conflict Resolution:** Learners/practitioners actively engage self and others, including the client/patient/family, in positively and constructively addressing disagreements as they arise.

Underpinning the framework are three background foci that influence the way in which the framework is applied.

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1. **Complexity**: Interprofessional collaboration approaches may differ along a continuum from simple to complex. For example, a recreational runner with a sprained ankle may only need to see one or two health care providers and the impact of the injury on the individual’s life is minor. However, a sprained ankle for a key member of the national soccer team can have a significant impact on the person’s life and will likely require a team of health care providers, including a sports psychologist before the player is ‘game ready’. A sprained ankle for a single mother with an infant and a toddler, who also has multiple health concerns and limited social support while living in a third floor apartment with no elevator, is considerably more complex. The team may need to become intersectoral in order to also address her transportation, income security and childcare concerns.

2. **Contextual Issues**: In specific areas of practice such as rehabilitation, residential care, and paediatric care, the competency framework is used in support of a comprehensive and consistent team. However, in an Emergency Unit or a high turnover acute medical unit, health care providers may work together only for a short period of time before shifts change and patients are discharged. In a community setting where a family has a disabled child there is a need to integrate beyond traditional providers to teachers in education settings and community health. In addition, the capacity of an individual to demonstrate the integration of these competencies in different contexts is a reflection of their comfort level and skill set within the practice setting.

3. **Quality Improvement**: By working together across professions and across institutional roles, improvement activities carried out by interprofessional teams, rather than individuals or uniprofessional teams, more effectively address quality issues, especially in complex systems. By working together across professions and across institutional roles, improvement activities can effectively address issues in any context of practice at any point along the continuum of simple to complex.

**Standards and Criteria**

The accreditation organizations that were part of the AIPHE initiative agreed to include common domains for consideration in the accreditation of the interprofessional components of health education programs. These include organizational commitment, faculty, students, educational program (curriculum), and resources. These five domains will be used to frame the suggested language that each program can use to embed Interprofessional education (IPE) standards and criteria. The document suggests options for standards language as well as potential criteria and examples of evidence which may be used as a starting point.

- **CONTEXT** is used to describe the focus of the standard. For example the organizational context has a specific focus on integration of IPE in the university’s mission and endorses it in its documentation.
- **LANGUAGE** is used to provide examples of language that may be used to describe a specific standard in one or more accreditation documents.
- **CRITERIA** signal examples of the types of evidence an accreditation surveyor would be looking for to determine whether or how well the program meets the standards.
- **EXAMPLES** suggest ways of finding and/or assessing the quality of the evidence.

While the global measures of evidence are relatively easy to articulate, the actual evaluation of the overall IPE/IPC approach in any health and human service education program and the level to which each program meets a pre-determined standard is not as easy. Each accreditation agency will need to determine, using their usual practices, how much evidence is adequate for their programs to have met the standards for IPE.
ORGANIZATIONAL COMMITMENT

The main focus of the organizational commitment section of standards relates to the support that the university or college leaders and administration provide for IPE activities. Links between the academic institution and the community organizations are very important however the main focus of the education accreditation process is to address those issues within the mandate of the university or college. Policies, resources, documentation, strategic directions and positioning of interprofessional education leading to collaborative patient-centred care are all key responsibilities of the institution.

CONTEXT:

- Organizational commitment means that the organization has integrated and endorsed the concept of interprofessional education (IPE) for interprofessional collaboration (IPC) in practice.
- Organizational support may be realized at any level of the organization but preferably at the level of the Vice President’s Office. It may also come from the deanship/program/director level.
- Organizational commitment may also be expressed through support for social accountability/responsibility that supports and promotes IPE.
- Organizational support may also be recognized in the provision of resources that support IPE/IPC and recognition of the value of IPE.

SUGGESTIONS FOR STANDARDS LANGUAGE:

- IPE must be recognized as a valued teaching strategy for inter-program collaboration.
- The organization must demonstrate an awareness and understanding of IPE for IPC.
- Organizational structures and processes must be in place to support IPE.

SUGGESTIONS FOR CRITERIA:

- Evidence of language in the organization’s mission statement and/or strategic plan exists related to interprofessional education for collaborative practice and person/family-centred care.
- All health programs offer mandatory interprofessional learning opportunities.
- Communications strategies are in place to facilitate awareness and understanding of IPE for IPC.
- Evidence is present of an institutional structure to support strategic planning and delivery of IPE.
- Evidence of communication and collaboration between post-secondary and regional health organizations exists.
- Evidence of resources allocated to support IP aspects of education is available.
- Budget lines are committed to IP activity.
- Dedicated time, space and funding are available for IPE through, for example, an office or faculty member dedicated to IPE.
- Interprofessional language is reflected in organizational policies.
EXAMPLES OF EVIDENCE:

■ Language can be found in the mission that signals that the organization aims to graduate collaborative practitioners by embedding IPE experiences in the curriculum.
■ Language in the mandate signals that the organization supports the IPE Office’s or dedicated faculty member’s mission and mandate.
■ The organization’s strategic plan contains a goal for interdisciplinary teaching and learning.
■ Faculty workload for teaching interprofessionally is accepted and valued by the administration.
■ The organization allocates budgeted funds to support IPE activities.
■ Senate or similar body has approved IPE courses or credit for inclusion in students’ transcripts.
■ Health and human service program requirements for graduation specify the explicit IPE requirement to be met.
■ Health and human service program schedules embed IPE learning activities into timetables.
■ Website, brochures, factsheets, newsletters regularly contain references to IPE and/or IPC.
■ IPE Steering and Advisory committees exist to facilitate program implementation.
■ An IPE office or faculty member is assigned as a coordinator for IPE with teaching workload release time.
■ An interprofessional IPE faculty group works to develop and implement IPE learning across disciplines.
■ An IPE student group, possibly as a chapter of the National Health Sciences Students Association (NaHSSA) is supported and encouraged.
■ Topic-specific student committees or societies (e.g. Philosophy of Health Club; Indigenous Students in Health Association) that are interprofessional are supported and encouraged.
■ Funding is provided to support student participation in IPE provincial and national conferences.
■ IPE committees encourage cross representation between and among institutions.
■ A provincial oversight committee exists to facilitate and support IPE and IPC implementation.
FACULTY/ACADEMIC UNIT

The faculty/academic unit is essential to ensure that IPE principles are integrated into each program. Partnerships across the professional programs are critical to the success of IPE initiatives and can best be fostered by faculty members who are willing and prepared to seek out ways to embed IPC into their areas of teaching and learning. Creating value and respect for IP teaching and scholarship is important to foster faculty engagement in IPE.

CONTEXT:

- Faculty members within the academic program and practice education environments must understand, promote and support the implementation of IPE for IPC.
- Training in IPE strategies, IP group facilitation, and IP assessment/evaluation acknowledges the unique knowledge and skill set required.
- Interprofessional planning for IPE will positively influence curricular design that embeds IPE/IPC. Time, structures and processes specific to IPE planning need to be in place.

SUGGESTIONS FOR STANDARDS LANGUAGE:

- Support for interprofessional education and practice must be embedded in both faculty and health delivery organizations’ documentation such as policies, strategic directions etc.
- IPE must be recognized as a valued teaching strategy that contributes to teaching dossiers and promotion and tenure considerations.
- IPE must be recognized as a valued and credible context for educational scholarship.
- The academic program actively promotes the engagement of tutors and instructors from different professions in teaching IPE/IPC knowledge and skills.
- Members of diverse academic and/or administrative units are appointed to steering, advisory and planning committees that involve IPE/IPC.
- Faculty engaged in IPE must be appropriately trained, supported and recognized.
- IP continuing professional development is supported for all preceptors/supervisors/mentors in practice in the clinical community.

SUGGESTIONS FOR CRITERIA:

- Faculty development is required and provided for all faculty members engaged in IPE.
- New faculty hires are required to complete an IPE teaching program as part of their orientation.
- All relevant courses have an embedded component of IPE learning for students.
- Ongoing opportunities exist for IP faculty development related specifically to teaching/facilitating learning in an IP environment.
- Participation in IPE faculty development is mandatory for all faculty members and external instructors.
- Evidence exists of a professional mix of instructors/mentors/tutors/preceptors and interactive learning in courses and supervised practice education opportunities.
- Faculty have opportunities to develop skills in seeking out interprofessional learning opportunities for students within agency-based interprofessional teams.
Evidence exists that faculty involvement in IPE activities (planning, coordinating, facilitating) is part of assigned faculty/clinician (preceptor) workload.

Evidence exists for recognition of interprofessional planning and teaching in tenure and promotion and other routes faculty members take.

Evidence of faculty recognition for excellence in IPE and research exists.

Academic and practice sites present a single continuum of IPE from classroom to IPC in the practice setting.

Faculty and clinical faculty members have opportunities to socialize across professions.

All faculty members and clinical teachers are provided with feedback about the interprofessional learning opportunities they provide to students.

Interprofessional meetings and decisions are facilitated among practice sites, educators and regulators.

EXAMPLES OF EVIDENCE:

Financial support is provided for faculty to participate in IPE faculty development programs either in-house or offered through external agencies.

Faculty activities that bring members from different disciplines together to explore development of IPE learning activities with cross-program groups of students are encouraged.

Interview processes for new hires includes an exploration of their philosophy around interprofessional learning.

Tracking of participation in IPE faculty development is regularly conducted.

Tracking of number of IPE learning opportunities offered by academic unit is regularly conducted.

Explicit criteria to evaluate the quality of IPE offerings are available and accessible.

Course outlines clearly articulate interprofessional learning activities focusing on at least one IP collaborator competency (refer to National Competency Framework for Interprofessional Collaboration, page 6) and involving students from more than one profession.

Faculty review processes contain an area for interprofessional teaching activities.

Academic and clinical faculty members are provided with opportunities to participate in clinical teaching programs to assist in developing strategies to help their students gain IP learning within practice teams.

Annual performance reviews of faculty are required to contain evidence of interprofessional teaching with faculty in other programs for cross-disciplinary groups of students.

Annual performance reviews rewards scholarly achievements related to participation in IPE teaching, learning, and practice activities.

Faculty members are identified and recognized as IPE champions through awards, certifications, official titles, and/or website recognition.

Awards for curriculum development, practice education and professional development in interprofessional areas are offered annually.

Faculty workloads explicitly contain annual objectives related to involvement in IPE activities.

Faculty teaching interprofessionally are recognized for this work in their allocated workloads.

Staff/faculty members are provided with release time to actively participate in IPE planning, implementation and evaluation.

IP preceptors are provided with training to support their ability to assist students in seeking out and gaining IP practice experience within interprofessional teams.

Student reflections on practice experiences include their interprofessional learning opportunities.
STUDENTS

Students often enter educational programs with an overall understanding of teamwork and collaboration and wish to see this fostered in their health professional programs. However, challenges arise in busy curricula when trying to balance discipline-specific and interprofessional curriculum elements. Students need encouragement to see IPE as important in their program of study and educational initiatives must examine ways to provide IPE with a sense of importance and to encourage student-led initiatives that include a broad range of students with different backgrounds and which focus on issues that students find relevant and engaging.

CONTEXT:

■ IP practice and non-practice learning opportunities will have a positive influence on students’ knowledge, skills, and attitudes related to interprofessional collaboration.
■ Involvement in student-initiated IP opportunities demonstrate support for and commitment to IPE and foster IP collaborative and leadership attributes.
■ Role models in the academy and the community exert a strong influence on student attitudes and must be recognized as integral to the overall IPE experience.

SUGGESTIONS FOR STANDARDS LANGUAGE:

■ Students are actively engaged in interprofessional learning activities.
■ Students take responsibility for creating a learning environment that supports collaborative person/family-centred learning and practice.
■ Students can identify practices that foster or impair the learner’s ability to learn how to collaborate with other disciplines in health and social care in both academic and community settings.

SUGGESTIONS FOR CRITERIA:

■ Evidence that the admissions process for students makes reference to capabilities that would be conducive to being a collaborative health professional (e.g., communication, shared decision making, conflict management).
■ Early exposure to interprofessional concepts is provided in all health programs.
■ Students from at least two disciplines/professions interact in an interprofessional learning situation once in each semester of their health professional programs.
■ Students develop the ability to critically assess interprofessional client-centred collaborative practice with functioning teams.
■ Evidence of assessment of students’ thinking related to interprofessional learning or practice.
■ Evidence that messaging in the learning environment; in particular the practice education environment is supportive of interprofessional, patient/family-centred collaboration.
EXAMPLES OF EVIDENCE:

- Program documentation refers to collaborative practice and team skills as required competencies for graduates of the professional program.
- Students’ level of participation in interprofessional practice education opportunities is tracked.
- Student advice on interprofessional learning plans and opportunities is evident based on their membership on curriculum committees.
- A student advisory committee for IPE exists across programs.
- Students are formally recognized for their involvement in student initiated IP activities through awards or notations on transcripts.
- Patient/family as educator sessions with at least partial focus on team-based care are offered to IP groups of students.
- Exit competencies or, program outcomes or, ends in view for the program include collaborative practice competencies.
- Student orientation programming includes specific IP activities/lectures.
- Students are exposed to well-functioning interprofessional patient-centred collaborative teams in the clinical setting.
- Students participate in team meetings/rounds as regular parts of the clinical experience.
- Student reflective journals discuss the ability of the teams in which they participated or which they observed to work collaboratively and how well they included the patient and family in discussions.
- Students submit abstracts related to interprofessional learning or practice to conferences for presentations.
- Students write papers on interprofessional learning or practice topics.
- Students conduct research studies with a focus on interprofessional education or practice.
- Students are required to include documentation related to interprofessional collaborative practice in their course/program portfolio.
- The Institution provides student credit for interprofessional learning.
EDUCATIONAL PROGRAM

The educational program or curriculum is the anchor for interprofessional education along the continuum from classroom-based learning through to practice education in community environments. Focusing on outcomes that relate to the collaborative practitioner leaves room for creative and innovative learning strategies that are grounded in evidence and theory and that can be assessed.

CONTEXT:

- A common understanding of IPE and IPC within and across academic units facilitates the development, implementation, and evaluation of various IP learning opportunities.
- The educational program addresses three key areas that are important to IPE: learning and exit outcomes, learning strategies, and assessment of student abilities.
- IPE enables IPC and should be embedded throughout the learning continuum for all learners.
- The interprofessional educational outcomes of the academic program embrace attitudes, skills, knowledge, behaviours and values.
- Exit competencies are an important component of the academic program context.
- IPE offerings should involve an iterative process of quality improvement.

SUGGESTIONS FOR STANDARDS LANGUAGE:

- A common collaborative competency framework must be adopted by the institution, academic units and practice education environments.
- Interprofessional learning opportunities are clearly described in the academic program.
- Interprofessional learning opportunities outline explicitly stated IP learning objectives.
- Student/learner participation in interprofessional, patient/family-centred learning opportunities is mandatory.
- Students are regularly assessed (knowledge, skills, attitudes, behaviours) on their collaborative competencies.
- IP learning opportunities are continually evaluated for their effectiveness.

SUGGESTIONS FOR CRITERIA:

- Evidence exists to show that students/learners are provided with IP learning opportunities that address all collaborative competencies.
- Evidence exists to show that students have ‘mastered’ the range of collaborative competencies.
- IP learning takes place in practice and non-practice environments.
- Evidence-based or informed IPE strategies are integrated into the IPE curriculum.
- Other health care professionals are involved actively in the training of students.
- Student assessment strategies that measure collaboration are evident.
- Ongoing evaluation of IP learning opportunities occurs.
Language in the curriculum reflects the engagement of students in learning about patient/family-centred collaboration.
Teaching of IPE/IPC concepts/competencies is explicitly integrated into the program materials such as student handbooks, orientation manuals and graduate attributes.
Student groups are supported that either provide advice and feedback to curriculum and/or offer interprofessional student activities and learning opportunities.

EXAMPLES OF EVIDENCE:
- Documentation (e.g. curriculum blueprint, ‘session’ or ‘module’ learning objectives) outlining collaborative competencies addressed.
- Documentation (e.g. student portfolio or passport) outlining collaborative competencies ‘mastered’ by student.
- A variety of IP practice education offerings including IP community projects, observation and critical reflection of IP team rounds, patients/families as educators, shared case discussions, IP collaborative care planning, IP shadowing.
- IP student projects that engage communities.
- A variety of IP non-practice or classroom based education offerings including interprofessional problem based learning (IP-PBL), IP cases, IP simulation, IP or Team Objective Structures Clinical Examinations (OSCEs), online learning.
- Practice and non-practice education opportunities involving IP groups of facilitators and learners across the program.
- Students can describe interactions with instructors in other professions as part of program.
- Standardized patient encounters to teach listening and patient-centred skills based on an interprofessional case with formal feedback on the collaborative practice elements are incorporated in program courses.
- Psychometrically sound tools are regularly used to assess student team collaboration.
- Student focus groups are used to gain insight into their interprofessional competency development across the program.
- Student group assignments, presentations, scholarly papers, research studies, reflective journals, and portfolios show evidence of development of IP collaboration competencies.
- Courses use case-based learning that allows students from more than one discipline to interact with ‘patients’ in learning situations.
- Course syllabi identify interprofessional learning in at least one component of each relevant course.
- Curriculum committee members seek input from students in the institution’s interprofessional student group around student development of interprofessional collaboration competencies.
- Program evaluation includes IPE.
RESOURCES

The resource base for IPE needs to be articulated so that initiatives can be developed, tested and implemented. Some IPE resources do require funds to purchase and some require additional human resources. Dedicated resources can facilitate IPE functionally and philosophically.

CONTEXT:

- Resources for IPE can mean staff, space, funds, equipment and other costs that support IPE.
- Policies and funding associated with the practice settings will affect the ability of any IPE program to become embedded in practice sites.

SUGGESTIONS FOR STANDARDS LANGUAGE:

- Funding models support sufficient faculty identified as IP champions/leaders that understand, promote and support IPE and IPC.
- There is dedicated space, support, and staff time devoted to IPE.
- Faculty/staff/equipment/facility resources are available to facilitate interprofessional learning.
- IPE and IPC research/scholarly work is funded and valued.
- Practice sites must be able to provide collaborative learning environments.

SUGGESTIONS FOR CRITERIA:

- IP champions/leaders must be present in each participating academic unit.
- Trained IP facilitators are funded to provide time and are given workload flexibility to teach in other programs and to facilitate IPE in their home program.
- Mixed/different methods of teaching for IPE in both practice and non-practice learning environments are supported.
- Evidence exists of resource allocation to develop, implement and evaluate IPE.
- Funded faculty research initiatives include IPE related issues.
- Resourced collaborative practice environments can provide IPE learning opportunities.
- Learning spaces must be present for shared learning.
- Institutional IPE faculty teaching and clinical teaching development programs are available.
- Support must be provided for an IPE student NaHSSA chapter.
EXAMPLES OF EVIDENCE:

- Formal identification of IPE responsibilities on faculty member web sites and other institutions/unit communications.
- Staff release time in the clinical setting to engage students in IPE.
- IP communications strategy in place (e.g. newsblast, website, fact sheet, brochure).
- IPE Office has a budget to support such items as office and research assistant, office supplies, travel.
- Evidence of faculty obtaining grants to study issues related to IPE or IPC.
- IP teams are funded to provide supervision for individual or teams of students.
- Preceptors are provided with professional development to enable and facilitate IPE in the practice setting.
- Health programs have a budget line for interprofessional teaching/learning activities.
ACCREDITATION AND KEY PARTNERSHIPS

It is clear that educational organizations cannot meet accreditation standards alone. Partners in the practice setting, government, regulatory colleges, and professional associations are keenly interested in, and critical to, successful accreditation of health and human service programs. In addition, a key role in the AIPHE projects was held by a representative from Accreditation Canada which provides “…national and international health care organizations with an external peer review process to assess and improve the services they provide to their patients and clients based on standards of excellence.” Connecting educational and service delivery accreditation standards helps to ensure that students and practitioners are informed about and skilled in interprofessional collaboration. For more information about the Accreditation Canada process and standards related to assessment of service delivery in Canada see www.accreditation.ca.

To explore partnerships more fully, AIPHE held a national web based “gathering” in November 2010 that involved five key stakeholder groups (educators, regulators, practice sites, government, and professional associations) which allowed the importance of partnerships and a sense of ownership of IPE and IPC to emerge. The key messages found in Appendix 1 help to describe the many partners that are essential in the education of collaborative practitioners. Appendix 2 lists the names of the organizations who participated in the gathering. For more details please see the AIPHE Summary Report on the Key Stakeholder Gathering, which can be found on the AIPHE web site (www.aiphe.ca).

For accreditation programs, consideration of these key partnerships in the context of interprofessional education and practice, can strengthen the relevant accreditation standards and engage a broader range of stakeholders in meeting them.

APPENDIX 1
SUMMARY OF PARTNERSHIP MESSAGES

Practice sites:
The continuum of interprofessional education from the academic setting to the practice setting is one of the anchors of training for collaborative practice. Practice sites suggested that a common language and mechanisms to foster a common understanding would assist in creating and maintain a seamless interprofessional education continuum. Continuing professional development (CPD) for preceptors and all health care providers who engage with students is one of the ways in which practice sites can contribute actively to the accreditation evidence for IPE. Positive role modeling for students through effective teams in practice and through team training and interprofessional preceptor development can significantly influence the learning experience. As 40 to 50% of a health professional student’s time is spent in the practice setting, this engagement of practice sites in developing the practice end of the learning continuum is essential. Strong leadership and champions within the practice setting can contribute to practice education interprofessional learning opportunities, resource allocation to team-based care, CPD priorities that enhance interprofessional practice and partnerships at senior levels of administration that support interprofessional education. Finally, partnerships between academic and practice sites that support interprofessional learning can ultimately improve quality of care and collaboration in the workplace.

Government:
Government links to accreditation are not often articulated but government participants in the “Gathering” saw a role for government in providing leadership and sustainable funding in support of IPE development and innovation. Government ministries also have a critical role in establishing health and human service priorities provincially and can influence service provider organizations at the system level to develop, implement and evaluate interprofessional practice and, de facto, interprofessional education in practice sites. Co-operation between ministries focused on health and those focused on post secondary education can also strengthen the continuum of interprofessional learning from classroom-based settings to practice sites.

Regulators:
Regulators in the health and human service professions are responsible for standards of practice provincially and for continuing competence of service providers who are regulated under provincial legislation. While the extent to which regulators influence curriculum directly varies from profession to profession, the regulatory context can significantly promote interprofessional education and practice. Essential competencies across the health and human service professions guide entrance exam blueprints, quality improvement programs in regulatory colleges, as well as continuing competency approaches. Interprofessional practice, if integrated into these regulatory mandates, can significantly influence interprofessional education especially in practice sites. Legislated scopes of practice are a key element of achieving consensus on shared competencies and full scope as part of negotiated team roles and responsibilities. If regulators across professions can work together to define practice standards using a common language and understanding of interprofessional collaboration, their role as a key partner in interprofessional education can be more fully realized.

Professional associations:
Professional associations promote their professions and advocate on their behalf. Many professional associations provide significant continuing professional development opportunities and offer focused areas of interest for members. If professional associations promote concepts of collaborative practice and interprofessional learning to their members, linking them to interprofessional resources and activities, it signals a level of importance to the concepts of interprofessional education and practice that can help to raise awareness of current and future trends in health service delivery and the role of collaboration.

Educators:
From an educator’s perspective, interprofessional education is important yet challenging. One area that clearly presents important interprofessional learning opportunities is the practice setting and so close partnerships between academia and the health service provider sector are imperative. Simultaneous planning and implementation of interprofessional education that involves educators and preceptors/practitioners is essential in building a seamless continuum of learning for both students and practitioners. Scholarship / research is another key partnership area. There is a need for more evidence to support the impact of interprofessional education and interprofessional practice and it is important that such research involve both sectors. Educators must consider embedding IPE as part of their curriculum and not implementing IPE as an add-on, disconnected from clinical, health, or system processes that are relevant to the student or learner. Leadership and funding within the education sector are also important issues that may benefit from partnerships, especially with government and practice sites.
Listing of organizations that participated in the AIPHE Key Stakeholder Gathering, November 8, 2010

Alberta Advanced Education and Technology
Alberta Health Services
Algonquin College
Aylee Consulting
Baycrest
BC Academic Health Council
BC Ministry of Advanced Education and Labour Market Development
BC Ministry of Health Services
Canadian Council on Continuing Education in Pharmacy
Canadian Medical Protective Association
Canadian Physiotherapy Association
Canadian Society of Hospital Pharmacists
Centennial College
Centre de formation médicale du Nouveau-Brunswick
Centre de pédagogie appliquée aux sciences de la santé, Faculté de médecine, Université de Montréal
Centre for Interprofessional Education, University of Toronto
Centre for Nursing Studies
Centre hospitalier de L’Université de Montréal
College and Association of Registered Nurses of Alberta
College of Family Physicians of Canada
College of Nurses of Ontario
College of Nursing, University of Saskatchewan
College of Pharmacy and Nutrition, University of Saskatchewan
College of Pharmacy, Dalhousie University
College of Physicians and Surgeons of Ontario
College of Physiotherapists of Manitoba
College of Registered Nurses of British Columbia
College of Registered Nurses of Manitoba
Council of Ministers of Education
Dalhousie University
Dalhousie University College of Pharmacy
Dalhousie University Medicine & Dentistry
Département de Pédiatrie, CHUS – Fleurimont
Department of Health, Government of New Brunswick
Department of Occupational Therapy, University of Manitoba
Faculté de médecine et des sciences de la santé, Université de Sherbrooke
Faculté de pharmacie, Université de Montréal
Faculty of Health Professions, Dalhousie University
Faculty of Medicine, Dalhousie University
Faculty of Medicine, Memorial University
Faculty of Medicine, University of Ottawa
Faculty of Pharmaceutical Sciences, University of British Columbia
Faculty of Pharmacy, University of Manitoba
Family Practice Health Centre
Federation of Medical Regulatory Authorities of Canada
First Nations and Inuit Health Branch, Health Canada
Health Canada
Health Canada, Office of Nursing Policy
Health Workforce Division, Alberta Health and Wellness
Hospital for Sick Children
Interprofessional University Clinic at the University of Ottawa
La Cité collégiale
Lawrence S. Bloomberg Faculty of Nursing, University of Toronto
Manitoba Health
Manitoba Pharmaceutical Association
McGill University
McMaster University
McMaster University, School of Nursing
Medical/Health Informatics Program, Faculty of Medicine, Dalhousie University
Memorial University
Michael G. DeGroote School of Medicine
Ministry of Training, Colleges and Universities
Mount Royal University
National Health Sciences Students’ Association
New Brunswick Association of Occupational Therapists
New Brunswick Pharmaceutical Society
New Brunswick Physiotherapy Association
Northern Ontario School of Medicine
Nursing Education Program of Saskatchewan
Nursing, Dalhousie University
Ontario College of Pharmacists
Ontario Medical Association
Ontario Physiotherapy Association
Ontario Society of Occupational Therapists
Ordre des pharmaciens du Québec
Ottawa Hospital
Pharmacy Examining Board of Canada
Physical Therapy, University of British Columbia
Physical Therapy, University of Manitoba
Professional Association of Interns and Residents of Ontario
Provincial Health Services Authority
Public Health Agency of Canada
Queen’s University
Registered Nurses Association of Ontario
Réseau de santé Vitalité Health Network – zone 1B
Hôpital régional – Dr. Georges L. Dumont
Royal Ottawa Health Care Group
Saskatchewan Academic Health Sciences Network
Saskatchewan Institute of Applied Science and Technology
Saskatchewan Ministry of Health
Saskatchewan Society of Occupational Therapists
Saskatoon District Health
School of Dental Hygiene, Faculty of Dentistry, University of Manitoba
School of Occupational Therapy, Dalhousie University
Schulich School of Medicine, University of Western Ontario
National Health Sciences Students’ Association
Toronto Rehabilitation Institute

Université de Sherbrooke
Université Laval
University of Alberta
University of Calgary
University of Manitoba
University of Montréal
University of New Brunswick
University of Ottawa
University of Saskatchewan
University of Victoria
University of Waterloo School of Pharmacy
Vancouver Coastal Health Authority
Vancouver Island Health Authority
Veterans Affairs Canada
Victorian Order of Nurses Canada
Vitalité Health Network
Winnipeg Regional Health Authority