



Tisser des liens interprofessionnels de divers réseaux

Rapport final du projet BRAID

Formation interprofessionnelle pour une pratique en collaboration centrée sur le patient

Août 2008

Remerciements

Le projet BRAID a été réalisé grâce à la contribution financière de Santé Canada et son initiative *Formation interprofessionnelle pour une pratique en collaboration centrée sur le patient*.

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Sommaire exécutif

En septembre 2006, l'Université du Nouveau-Brunswick – campus de Saint Jean (UNBSJ), en collaboration avec l'Université du Nouveau-Brunswick – campus de Fredericton (GRSE – Groupe de recherche en santé et en éducation), la Corporation des sciences de la santé de l'Atlantique (CSSA), le Collège communautaire du Nouveau-Brunswick (CCNB) et l'École de médecine de l'Université de Dalhousie a entrepris un projet BRAID¹ qui a été subventionné par Santé Canada. Ce projet vise la promotion et l'application des pratiques de formation interprofessionnelles dans les secteurs de l'éducation et cliniques. Tout au long du projet, la collecte d'information avait comme but premier de se prévaloir d'un cadre conceptuel qui serait par la suite mis en exécution tout en examinant les résultats attendus et les changements recommandés pour développer la capacité et la compétence des principaux intervenants y compris les enseignants, les étudiants et les responsables de la certification des intervenants en matière de la formation interprofessionnelle (FIP) et de la pratique interprofessionnelle (PIP). Les sections suivantes présentent les points principaux qui sont ressortis à partir des domaines touchés.

Le cadre conceptuel du projet et la cohérence des activités qui ont été réalisées

Les sources d'information proviennent d'une série d'entrevues menées auprès des étudiants, des enseignants et des intervenants en santé, des carnets d'activités des animateurs et des rapports d'étape trimestriels. Les informations recueillies démontrent l'ensemble des activités et de leurs résultats inhérents qui ont été menées par les animateurs, les membres de

¹ Le titre officiel du projet est la *Formation interprofessionnelle pour une pratique en collaboration centrée sur le patient*. À ces débuts, l'étiquette de BRAID lui a été attribuée et est maintenant reconnu aux niveaux local, provincial et national. (BRAID est une étiquette qui en anglais signifie Tisser des liens interprofessionnels de divers réseaux, *Bridging Relationships Across Interprofessionnal Domains*.)

l'équipe d'évaluation, ainsi que des divers projets réalisés par les groupes de travail et les comités qui ont été créés pour mener une composante du projet et qui tous répondaient aux objectifs du projet. Les résultats de ces efforts ont clairement démontré qu'il y avait suffisamment d'évidence pour appuyer les activités visées par le projet et les composantes du cadre conceptuel.

Toile de fond pour évaluer la motivation des intervenants à la FIP/PIP

Les résultats de l'évaluation effectuée à partir de l'échelle '*Readiness for Interprofessional Learning Scale*' révèlent qu'il existe une grande ouverture de la part des étudiants et des intervenants à adopter les principes évoqués de la FIP/PIP quant au travail d'équipe et de la collaboration, aux rôles et aux responsabilités et à l'identité professionnelle.

Ce que disent les participants suite aux initiatives de la FIP/PIP.

Les activités menées durant le projet comprenaient 31 ateliers de sensibilisation des FIP/PIP, et 19 sessions d'approfondissement des compétences. Un total approximatif de 90% de participants qui ont participé aux ateliers ont indiqué avoir approfondi leurs connaissances de la FIP/PIP avec des possibilités d'appliquer ces nouvelles connaissances dans leur pratique ou en formation continue.

L'engagement et la participation des enseignants

Les enseignants ont profité de plusieurs activités dans le cadre du projet BRAID. Ces activités comprenaient un sondage sur leurs besoins, un atelier sur le développement stratégique et le partage des stratégies concises du curriculum de la FIP. Les facteurs principaux qui ont été soulevés par les enseignants qui ont démontré un intérêt marqué pour la FIP touchaient le travail d'équipe des animateurs avec le personnel enseignant et le réseautage avec les membres de l'équipe du projet à la suite des ateliers. Les enseignants ont aussi rapporté que suite aux activités de la FIP, ils ont découvert des points d'entente avec des collègues de travail et ont

exprimé le besoin de renforcer le besoin de trouver des moyens favorisant le travail d'équipe. De plus, les enseignants ont indiqué avoir appliqué le cadre conceptuel BRAID et ont développé des stratégies d'apprentissage et de formation après avoir participé aux diverses activités du projet.

Les changements observés suite aux compétences acquises en FIP/PIP: Apprentissage des étudiants

Suite à l'atelier sur la communication interprofessionnelle dans le domaine de la santé, les étudiants ont rapporté un plus grande connaissance en FIP/PIP et une attitude professionnelle marquée. Après avoir complété le cours sur les stratégies possibles visant à enrayer les défis du travail d'équipe dans le domaine de la santé, les participants ont été témoins d'une plus grande intégration de la perspective professionnelle par les étudiants et ont réalisé l'importance de renforcer la collaboration interprofessionnelle des intervenants de diverses professions en santé. Les habiletés acquises suite aux activités de la FIP tels que témoignés par les participants comprenaient: des moyens de communication efficaces, des méthodes de prises décisionnelles en équipe, des approches de résolution des conflits et des compétences dans les domaines technologiques. À la suite du Sondage sur les compétences BRAID (BRAID Competency Survey (BCS)) et l'Échelle de l'efficacité personnelle (Self-Efficacy Scale (SES)), les étudiants ont indiqué qu'ils avaient maintenant une meilleure image de soi et qu'ils étaient en mesure de mettre en application leurs nouvelles connaissances, les outils et les méthodes reliés à la FIP/PIP.

Les changements observés suite aux compétences acquises en FIP/PIP: Développement professionnel des intervenants

Des membres de deux équipes d'intervenants en santé on participé à une série d'ateliers qui visaient à améliorer les connaissances et les compétences des intervenants en santé en matière de la PIP. Les intervenants en santé ont complété le Sondage sur les compétences de BRAID

avant et après avoir complété les modules de formation et de certification de la PIP. L'analyse qui en découle démontre une amélioration marquée de la compétence en PIP dans les domaines de la des communications efficaces, des approches de résolution des conflits et de la prise de conscience de la pratique réfléchie. Des entrevues ont été menées suite à l'atelier portant sur la certification et ont révélé de nombreux bienfaits soit une plus grande connaissance de la pratique interprofessionnelle, des nouvelles habiletés, une attitude positive et une appréciation accrue des différents types de personnalité qui existent à l'intérieur des réseaux et des équipes de soins de santé. En ce qui a trait aux possibilités de formation futures, les participants ont souligné le besoin d'évaluer les compétences des équipes de professionnels de la santé et d'adapter le contenu des ateliers pour rencontrer les besoins spécifiques des divers professionnels et groupes de travail.

Leçons tirées par les facilitateurs

La collaboration et les opérations du projet : Les caractéristiques principales des équipes collaboratives qui sont ressortis tout au long du projet touchaient le soutien mutuel, la reconnaissance des forces et la structure collaborative non hiérarchique.

La promotion de la FIP/PIP : Il faut avant miser sur la sensibilisation des bienfaits de la FIP/PIP si on veut bien préparer les intervenants et aborder le changement organisationnel.

La planification et l'application de la FIP/PIP : Le cadre conceptuel des compétences interprofessionnelles de BRAID est un modèle pratique de communication et de promotion fondés sur des compétences de base pour toutes les initiatives éducatives de BRAID. L'engagement des patients et la perspective des étudiants (L'Association des Étudiants des Sciences de la Santé du Nouveau-Brunswick) ont été des éléments importants à retenir lors de la planification des initiatives de formation et la pratique collaboratives centrées sur le patient.

La planification soutenue

En plus de la conceptualisation préliminaire du projet, un modèle logique a été conçu pour définir les objectifs, les intrants, les activités, les extrants, les résultats attendus avec une approche soutenue de la FIP/PIP même après la réalisation du projet initial. Bien qu'il existe un plan de travail soutenu pour tout projet BRAID, il faut prévoir des ajustements nécessaires afin de reconnaître les changements systémiques qui peuvent survenir dans les programmes de formation post secondaires et dans la structure des régions régionales de la santé. Qu'importe les changements possibles dans les domaines de l'éducation et de la santé, les principaux intervenants ont souligné l'importance de poursuivre les initiatives BRAID et de continuer d'agir en tant que "champions" en FIP/PIP touchant les diverses professions et les rôles organisationnels et ce, pour des années à venir.

Les messages clés et les retombées

- ◆ Les partenariats multi institutionnels contribuent aux bienfaits de la Formation Interprofessionnelle (FIP) et la Pratique Interprofessionnelle (PIP): l'évolution à partir de la formation offerte en silo à une pratique collaborative de diverses professions; l'interdépendance des divers intervenants; et la création des relations collaboratives et du réseautage avec et parmi diverses institutions.
- ◆ Pour arriver à une collaboration saine entre les domaines de la formation et de la pratique, il faut avant tout des champions, des chefs de file et des décideurs qui sont engagés fermement à l'approche collaborative interprofessionnelle et ont choisi d'y investir le temps et les ressources nécessaires.
- ◆ Si on veut augmenter la capacité de lier les domaines de la formation et de la pratique interprofessionnelle, il faudra prendre le temps nécessaire pour bien sensibiliser les principaux intervenants sur les principes et les mérites de la FIP/PIP.
- ◆ Il faut obligatoirement prévoir l'insertion de la FIP/PIP au curriculum des programmes reliés au domaine de la santé si on veut que les professionnels de la santé adoptent une approche collaborative centrée sur le patient.
- ◆ La perspective du patient est essentielle et doit s'intégrer à la planification des initiatives qui visent la formation et la pratique collaborative centrée sur le patient. L'utilisation des récits des patients (simulés ou réels) afficheront la valeur indiscutable de la FIP/PIP auprès des principaux intervenants.
- ◆ L'engagement des Ministères de la Santé et de l'Éducation postsecondaire, Formation et Travail est primordial afin d'assurer que le cadre conceptuel BRAID, basé sur les

compétences, les extraits et les résultats, ait l'ampleur nécessaire pour réaligner les directives permettant de former les équipes de professionnels de la santé existants et futurs au Nouveau-Brunswick.

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1.0 Le contexte

Le projet intitulé ‘Tisser des liens interprofessionnels de divers réseaux’, traduit de l’anglais *Bridging Relationships Across Interprofessional Domains*² (BRAID) est unique en son genre au Canada car il regroupe un ensemble de partenaires incluant une école de médecine, une université qui offre des programmes de formation en soins infirmiers et autres sciences de la santé, une régie régionale de la santé, un collège communautaire qui offre des diplômes d’infirmière auxiliaire autorisée et diverses autres disciplines en santé. En 2006, il existait très peu d’opportunité permettant d’examiner les rôles et les responsabilités, d’explorer de nouveaux cadres conceptuels ou de nouvelles philosophies ou encore de monter de nouveaux programmes de formation continue sur les compétences interprofessionnelles appliquées regroupant divers partenaires. Le projet BRAID visait à rallier ces objectifs en offrant une approche systémique et compréhensive à la formation et à la pratique interprofessionnelle pour les étudiants, les intervenants en santé et les enseignants.

La vision du projet reconnaît l’importance de préparer les prestataires de soins et services présents et futurs et de leurs fournir les connaissances, les habiletés et les compétences comportementales et attitudinales leur donnant ainsi les outils nécessaires pour former des équipes de travail interprofessionnelles et la capacité de s’adapter à un système de santé en plein essor. Le projet BRAID veut véhiculer cette vision en développant un modèle d’apprentissage en santé qui soit viable et qui donne les outils nécessaires aux divers professionnels de la santé leur permettant d’adopter une approche collaborative centrée sur le patient et de former des

² Le titre officiel du projet est la *Formation interprofessionnelle pour une pratique en collaboration centrée sur le patient*. À ces débuts, l’étiquette de BRAID lui a été attribuée et est maintenant reconnu aux niveaux local, provincial et national. (BRAID est une étiquette qui en anglais signifie Tisser des liens interprofessionnels de divers réseaux, *Bridging Relationships Across Interprofessional Domains*.)

équipes de travail interprofessionnelles. On retrouve certaines initiatives qui soutiennent les principes de la FIP/PIP dans certaines organisations qui forment le partenariat voulu; cependant, ces initiatives ne sont pas issues d'une approche collaborative. Ce projet a franchi de grands pas dans ses efforts de créer des partenariats collaborateurs. .

“Ce projet s'affiche dans une période très propice et offre une opportunité de créer des partenariats interprofessionnels qui permettront de développer de nouvelles approches dans les programmes de médecines offerts dans la province. Les étudiants pourront ainsi être exposés aux connaissances et à l'expérience de divers professionnels de la santé par le biais de plus petites sessions de groupes” (Dr. John Steeves, Membre du comité de pilotage).

Le projet BRAID vise quatre résultats spécifiques:

1. Offrir aux enseignants les connaissances nécessaires pour intégrer la formation interprofessionnelle collaborative à partir d'un modèle centré sur le patient dans leur programme d'enseignement.
2. Rehausser les compétences des étudiants et des professionnels de la santé de diverses disciplines leur permettant de participer activement aux équipes collaboratives.
3. Offrir aux étudiants et aux professionnels de la santé des nouvelles opportunités d'appliquer les compétences de la FIP à l'intérieur du travail d'équipe, et,

4. Identifier et favoriser les échanges sur les pratiques exemplaires selon les initiatives de la FIP.

Ce rapport présente un sommaire du projet BRAID. En premier, le rapport présente les composantes du projet suivit des méthodes utilisées et de la présentation des résultats de l'évaluation et de l'analyse des données suite aux diverses initiatives de cueillette d'information menées tout au long du projet. Par la suite, une synthèse des résultats est présentée avec un ensemble de recommandations pour assurer la continuité de la FIP/PIP au Nouveau-Brunswick. On retrouve à la fin du rapport une réflexion approfondie de l'ensemble du projet.

2.0 L'approche

2.1 Le but du projet et ses composantes

En septembre 2006, l'Université du Nouveau-Brunswick – campus de Saint Jean (UNBSJ), en collaboration avec l'Université du Nouveau-Brunswick – campus de Fredericton (GRSE – Groupe de recherche en santé et en éducation), la Corporation des sciences de la santé de l'Atlantique (CSSA), le Collège communautaire du Nouveau-Brunswick (CCNB) et l'École de médecine de l'Université de Dalhousie a entrepris un projet de deux ans subventionné par Santé Canada. Ce projet vise la promotion et l'application des pratiques de formation interprofessionnelles dans les secteurs de l'éducation et cliniques. Cette initiative s'intitule *BRAID - Bridging Relationships Across Interprofessional Domains* – et s'inspire du besoin de rehausser les compétences des partenaires cibles en matière de FIP/PIP afin de soutenir et de mûrir les approches collaboratrices centrées sur le patient.

Ce projet comprend sept composantes et les activités se sont déroulées à partir de septembre 2006 à août 2008. C'est lors des trois étapes préliminaires que se sont exécutés les activités de planification et la préparation de l'approche qui serait amorcée aux initiatives subséquentes d'exécution et d'évaluation. Les composantes IV, V et VI comprenaient l'ensemble des activités tandis qu'à la composante VII on retrouve la collecte, le codage et l'analyse des résultats. La dernière composante comprend la synthèse des résultats et la préparation du rapport final. La section suivante présente un précis de chacune des composantes.

Composante I: Les équipes de travail et les comités (Septembre-Octobre 2006)

Des équipes de travail et des comités ont été créées et confiées la responsabilité de diriger les initiatives principales du projet BRAID. L'Université du Nouveau-Brunswick – campus de Saint-Jean, le Collège communautaire du Nouveau-Brunswick et la Corporation des sciences de la santé de l'Atlantique ont prêté des personnes ressources, des enseignants et des intervenants en santé qui ensemble ont formé une équipe de facilitateurs et d'animateurs. Cette équipe s'est vu confiée la tâche de coordonner et d'assurer l'application des activités identifiées par le projet. Les services du Groupe de recherche en santé et en éducation ont été retenus afin de définir les modalités de l'évaluation pour mesurer les objectifs du projet. Le comité de pilotage a assuré la surveillance de l'ensemble des opérations du projet tandis que le comité des principaux intervenants a agit comme expert-conseil tout au long du projet. Chacun de ces comités était formé de représentants des organisations qui ont participé au projet soit des enseignants, des étudiants, des professionnels de la santé, des administrateurs et des anciens patients.

Composante II: Le Modèle Logique et le cadre conceptuel des compétences du projet (Novembre 2006/février 2007)

Les animateurs du projet et l'équipe d'évaluation se sont rencontrés sur une base mensuelle tout au long du projet. Leur première tâche a été de préparer un modèle logique qui servirait de cadre conceptuel et opérationnel pour le projet (Tableau 1; voir aussi l'Annexe I). Ce cadre conceptuel présente à la fois les activités prévues tout au long du projet et aussi les initiatives d'évaluation du projet.

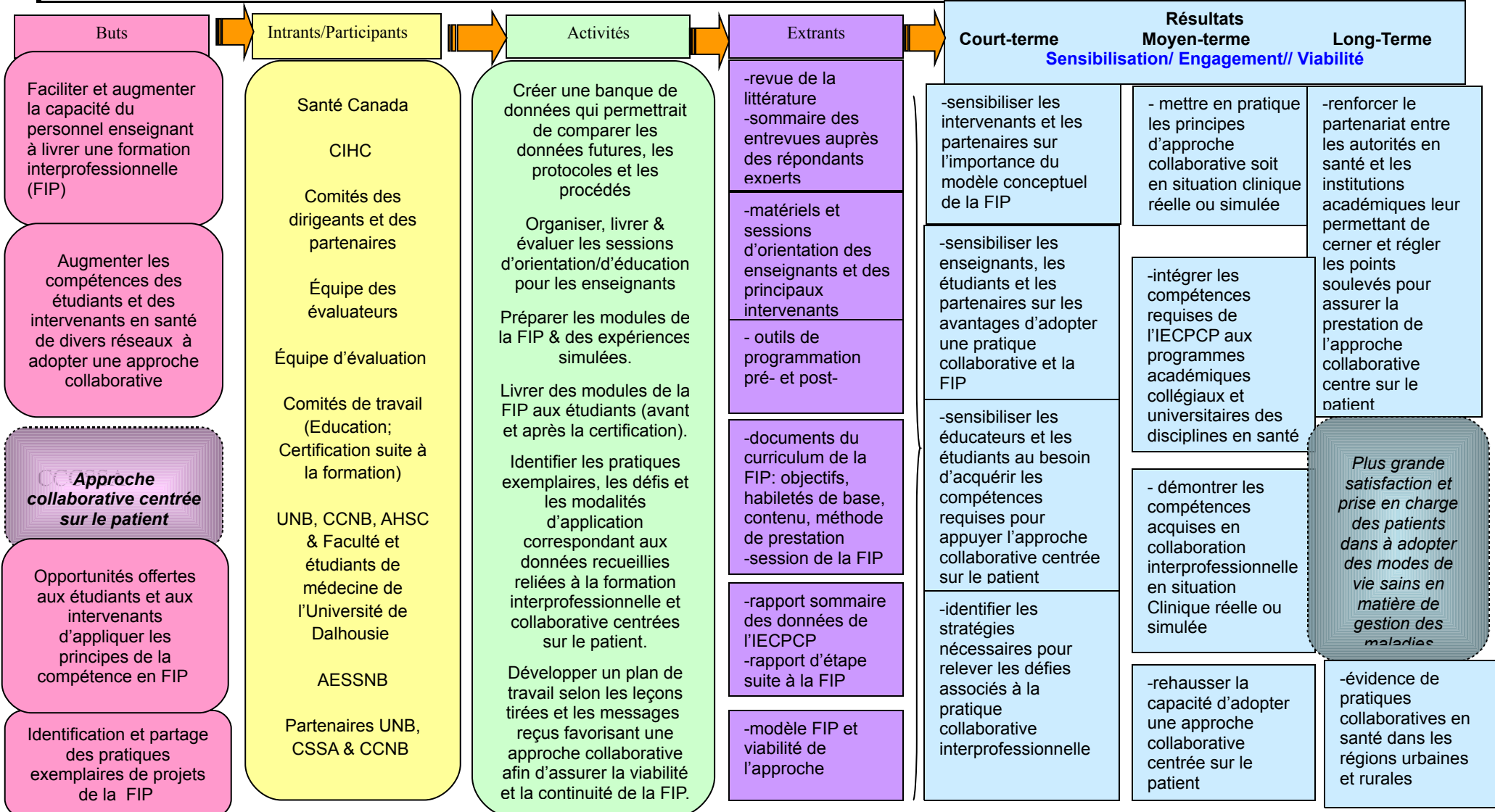
Pour appuyer le modèle logique, il a fallu créer ensuite un cadre conceptuel des compétences afin de dresser un curriculum de a FIP/PIP et définir les stratégies de formation pour les enseignants, les étudiants et les intervenants responsables de la certification. La revue

de la littérature et des pratiques exemplaires (Annexe IX) exécutée par l'équipe d'évaluation, et les commentaires et les observations reçus des principaux intervenants qui ont participé au sein des divers comités et groupes de travail ont permis de définir les hypothèses clés, les connaissances, les attitudes et les habiletés nécessaires précisés au cadre conceptuel des compétences (Annexe X).

Tableau 1

Un modèle logique

Notre Mission: Développer un modèle viable de formation en santé pour les étudiants et les professionnels de la santé qui leur donne les moyens nécessaires pour adopter une approche collaborative interprofessionnelle centrée sur le patient.



Un modèle des compétences interprofessionnelles (connaissances, attitudes/valeurs et habiletés) de la formation et guide d'utilisation des initiatives BRAID

Les théories du projet – Théorie de l'auto détermination et de Motivation au changement

Composante III: Les besoins de cueillette d'information (Novembre 2006-février 2007)

Au début du projet, les éléments clés d'information requises ont été identifiés en relation avec les objectifs du plan de travail BRAID et ils ont été redéfinis tout au long du projet et selon l'évolution des activités. L'information qui serait recueillie servirait à documenter la conceptualisation et la mise en pratique de toutes les activités durant le projet et ensuite d'examiner les résultats potentiels et les changements requis pour donner aux partenaires incluant les enseignants, les étudiants, les intervenants et les responsables de la certification en santé la capacité et les compétences requises. Plus spécifiquement, le projet BRAID visait à répondre aux questions suivantes:

- Quels aspects des principes du projet BRAID sont devenus des composantes clés du cadre conceptuel de l'initiative BRAID? Quels sont les éléments cohérents du cadre conceptuel et des activités menées tout au long du projet?
- Quelle était la motivation initiale des différents partenaires (les étudiants et les intervenants en santé) à s'engager aux initiatives initiales de la FIP/PIP et aux initiatives du projet BRAID?
- Quelles étaient les réponses et les résultats reliés qui ont été soulevés par les participants suite aux ateliers sur la sensibilisation et les compétences requises de la FIP/PIP?
- Est-ce que cette initiative a réussi à engager positivement les enseignants et les autres participants au projet?
- Quels sont les changements et les résultats qui ont été observés et documentés reliés à la compétence requise des étudiants en FIP/PIP?

- Quels sont les changements et les résultats qui ont été observés et documentés reliés à la compétence requise des personnes responsables de la certification en FIP/PIP?
- Quelles leçons peut-on tirer suite à l'initiative?
- Quels sont les éléments qu'il faut retenir pour assurer la viabilité et la continuité de l'approche de la FIP/PIP au-delà de l'initiative BRAID en cours?

Composante IV: Les ateliers de sensibilisation et des compétences requises en FIP/PIP (Octobre 2006-Juin 2008)

Tout au long de l'initiative, les facilitateurs du projet ont défini et mené les ateliers afin de promouvoir la FIP/PIP et ont aidé à développer les compétences dans ce domaine. C'est dans un esprit de partenariat qu'un grand nombre de personnes ont été invitées à participer aux divers ateliers. Ces participants comprenaient des étudiants, des enseignants, des intervenants en santé, des administrateurs et des représentants de la communauté et de la province. En plus des activités cibles du projet, soit les ateliers et les activités de sensibilisation et de perfectionnement en FIP/PIP, l'équipe de recherche a réalisé une production de deux montages vidéos BRAID³ qui peuvent être utilisés comme outils d'orientation professionnelle et de recrutement et ont servi à créer un site Internet BRAID (www.ipebraid.ca), et à monter des affiches et des présentations lors de conférences locales, nationales et internationales.

Composante V: Les activités des groupes cibles (Mars 2007-Juin 2008)

Trois groupes de travail ont été créés durant la première phase du projet : un groupe de travail sur le perfectionnement académique, un sur le curriculum ou le programme académique et un dernier sur la certification requise en FIP/PIP. À l'automne 2007, les groupes de travail du

³ Les montages vidéos BRAID sont: *BRAID: Bridging Relationships Across Interprofessional Domains* et *Collaborative Patient-Centred Care*. Les deux sont disponibles sur le site Internet www.ipebraid.ca (seulement en anglais)

perfectionnement académique et du curriculum ont été jumelés en un groupe de travail portant sur les besoins académiques. Chaque groupe de travail a désigné une personne en tant qu'animateur de projet qui serait chargé de coordonner les activités de chaque groupe de travail.

Les activités principales de divers groupes de travail étaient :

Groupe de travail sur le perfectionnement académique: Un questionnaire sur les besoins des enseignants; un atelier sur le développement de la stratégie en FIP; et, la distribution d'un abrégé des stratégies possibles du curriculum pour les programmes de formation en FIP au niveau du baccalauréat (Annexe XI).

Groupe de travail sur le curriculum: Un programme sur la communication de la FIP qui a été offert à un ensemble d'étudiants dans divers programmes de professions en santé offerts aux niveaux collégial et universitaire.

Groupe de travail sur la certification: Modules de formation continue sur la PIP offerts à un ensemble de professionnels en santé qui ont été offerts en deux sessions à des équipes de soins et services de santé.

Composante VI: Développement des plans viables (Janvier 2008-Juin 2008)

Durant les derniers six mois du projet, les animateurs du projet, les équipes d'évaluation et les membres des comités de pilotage se sont réunis pour discuter des éléments collaborateurs. Le but de ces rencontres était de développer un plan d'action pour assurer la continuité de l'approche de la FIP/PIP et le succès des initiatives futures BRAID. Un deuxième modèle logique (Annexe XIII) a été créé pour détailler les étapes d'un plan d'action pour assurer la viabilité de la FIP/PIP bien après la réalisation du projet en cours.

Composante VII: Cueillette d'information, codage et analyse des données (Novembre 2006-Juin 2008)

L'équipe de recherche a recueilli des données à chacune des activités de planification et de mise en œuvre du projet. Les informations recueillies comprenaient :

- Sondage pour mesurer la motivation à la FIP/PIP des étudiants, des enseignants et des professionnels de la santé (Annexe III),
- Documentation des activités des ateliers et des fiches d'évaluation des participants (Annexe II),
- Questionnaire d'évaluation des besoins des enseignants (Annexe IV)
- Sessions de groupe au mi-projet et dans le dernier quart du projet avec les animateurs de projet (Annexe VIII),
- Outil des mesures des compétences requises avant et après la certification des professionnels de la santé (chez les participants qui ont complété les sessions de formation continue menant à la certification en PIP) (Annexe VI et Annexe XII),
- Outil de mesures des compétences acquises des étudiants qui ont complété le module sur la communication en FIP (Annexe VII),
- Groupe cible organisé avec les étudiants lors du module de formation sur la FIP, et
- Entrevues téléphoniques avec certains intervenants en santé et participants (membres des comités de travail sur la formation académique, et la certification – Annexe V).

Toutes les données recueillies ont été codées et entrées dans la banque de données du projet. Des méthodes de recherche portant sur le contenu et la description des données ont été utilisées pour faire une analyse des tendances liées à la méthodologie utilisée et aux résultats de

l'initiative. Les rapports intérimaires se sont inspirés de l'analyse des données et de la synthèse des résultats. .

Composante VIII: Préparation du rapport final (Juillet 2008-Août 2008)

La huitième composante du projet serait la réalisation du rapport final. Dans cette étape, il a fallu faire une analyse synthèse de toutes les données recueillies. Des graphiques, des tableaux et des descriptions brèves sont des moyens qui ont été retenus pour présenter les thématiques principales dans le rapport final.

3.0 Les fait saillants

Les deux grandes composantes du projet étaient de recueillir de l'information pour chacune des activités du projet, documenter la conceptualisation et l'exécution de ces activités et examiner les retombées potentielles et les changements requis pour développer la capacité et les compétences en matière de FIP/PIP chez les principaux partenaires y compris, les enseignants, les étudiants et les responsables de la certification en formation continue. Les sections suivantes présentent un abrégé des principales thématiques qui sont ressortis suite aux activités du projet.

3.1 Le cadre conceptuel du projet et la cohérence avec les activités réalisées

Y avait-il une cohérence entre le cadre conceptuel et les activités de cette initiative ?

Les objectifs principaux du cadre conceptuel du projet BRAID étaient de faciliter la formation en FIP/PIP et de permettre aux enseignants de livrer les éléments de cette formation interprofessionnelle, d'augmenter les compétences des étudiants et des professionnels de la santé de diverses disciplines, de les encourager à travailler en équipe collaborative et de les encourager à adapter les principes de FIP/PIP et à échanger sur les pratiques exemplaires dans leur milieu de travail. Pour réaliser ces objectifs, les animateurs du projet, l'équipe d'évaluation et les membres des comités et des groupes de travail ont élaboré un plan de travail et une série d'activités.

C'est par le biais de rencontres de planification mensuelles, de consultations téléphoniques et de courriels que les animateurs et l'équipe d'évaluation ont assuré une communication soutenue tout au long du projet. Les membres du comité de pilotage et les divers partenaires se sont réunis à tous les trois mois ou plus souvent lorsque nécessaire. Les groupes de travail se sont réunis de façon régulière pour planifier et diriger les activités du projet. C'est

grâce à ces nombreuses rencontres et discussions qu'il a été possible de réaliser ensemble un cadre conceptuel du projet et à coordonner l'ensemble des activités selon des objectifs précis. Les résultats des entrevues auprès des participants y compris les étudiants, les enseignants et les intervenants en santé, les carnets des activités des évaluateurs et les rapports trimestriels ont témoigné les efforts déployés et les objectifs réalisés par les animateurs et les membres de l'équipe d'évaluation, des divers comités et des groupes de travail. Somme toute, la cohérence entre le cadre conceptuel et l'ensemble des activités du projet était évidente (hypothèses, objectifs des activités et extrants).

3.2 Toile de fond : évaluation de la motivation des intervenants à la FIP/PIP

En début du projet BRAID, quels étaient les éléments motivateurs permettant d'évaluer la capacité des étudiants et des intervenants en santé à s'engager aux activités de la FIP/PIP?

Un total de 154 étudiants et intervenants en santé ont participé à une grille ajustée intitulée *Readiness for Interprofessional Learning Scale (RIPLS)*. Ce sondage a été réalisé lors d'une activité préliminaire de sensibilisation qui a été organisée par l'équipe d'animateurs. Une description analytique a permis d'évaluer la motivation naturelle interprofessionnelle de l'ensemble des répondants. D'autre part, une analyse des variances a été faite pour évaluer les différences entre les étudiants et les intervenants en santé. Globalement, les résultats révèlent une ouverture aux concepts de la FIP/PIP en ce qui a trait au travail d'équipe, à la collaboration, aux rôles et responsabilités et à l'identité professionnelle. Parmi les énoncés des participants on retrouvait des témoignages de *travail d'équipe et de collaboration* chez les étudiants mais de façon plus marqué encore chez les intervenants en santé. On retrouve des différences entre ces deux groupes quant *au respect des rôles et des responsabilités*, les étudiants ayant des opinions plutôt neutres tandis que chez les intervenants en santé, il y avait une plus grande ouverture à brouiller les rôles.

3.3 Les opinions des participants face aux initiatives de la FIP/PIP

Suite à la participation aux ateliers de sensibilisation et de développement des compétences, quels sont les opinions exprimées de la part des participants et les résultats reliés à la FIP/PIP?

Au total, on compte 31 ateliers de sensibilisation à la FIP/PIP et 19 ateliers sur le développement des compétences. Les enseignants en santé, les étudiants et les intervenants en

santé ont participé à un tiers de ces ateliers respectivement. 90% des participants ont témoigné avoir amélioré leurs connaissances dans le domaine de la FIP/PIP et croyaient qu'ils seraient en mesure de mettre en pratique les concepts retenus.

Les données qualitatives révèlent un intérêt marqué des participants à se rencontrer et à échanger avec divers collègues et autres professionnels de la santé. De plus, les participants ont indiqué que les exercices simulés étaient un moyen efficace pour renforcer les concepts de la FIP/PIP lors des ateliers de sensibilisation et de développement des compétences. D'autres commentaires portaient sur l'auto réflexion, sur la pratique courante et les possibilités d'appliquer les principes de la FIP/PIP dans leur milieu de travail. Certains autres commentaires démontraient une intention marquée à utiliser les principes de la FIP/PIP surtout dans les domaines touchant la communication et le respect interprofessionnel.

Les animateurs ont indiqué qu'en plus des mérites des ateliers, que l'apport des montages vidéo a été un moyen très efficace pour communiquer et promouvoir les messages essentiels de la FIP/PIP à un plus grand auditoire. Aussi, le site Internet BRAID, s'est révélé comme ressource importante de promotion et de partage du matériel et d'information de la part des participants.

3.4 L'engagement et la participation de enseignants

Est-ce que l'ensemble des activités ont réussi à engager les participants au projet?

Les activités du projet BRAID destinées aux enseignants comprenaient un questionnaire d'évaluation des besoins, un atelier sur le développement d'une stratégie, des stratégies sur les possibilités de revoir et d'ajuster le curriculum académique en FIP. Les résultats des entrevues menées auprès de ce groupe de participants démontrent que les efforts déployés avaient effectivement engagé les enseignants lors des diverses activités (la moyenne étant 4.7 sur 5).

Parmi les facteurs qui ont contribué aux réponses favorables des enseignants, on retrouve, la relation de travail existante entre les enseignants et les animateurs et les suivis des membres du projet de recherche auprès des participants après avoir terminé les ateliers. La participation active de la part des enseignants est aussi un témoignage de l'appui et de la participation de diverses institutions et des autorités et dirigeants.

Les résultats ont aussi été soulignés par les enseignants en matière de FIP. Les enseignants ont affirmé qu'il était très important d'arriver à un point d'entente parmi les enseignants de divers programmes de formation et d'accroître la capacité de travailler en équipe. Suite aux activités avec les enseignants, ceux-ci ont soulevé l'importance d'identifier les extrants en utilisant un cadre conceptuel sur les compétences de la FIP BRAID comme ressource de planification pour revoir le curriculum académique individuellement et en comités. Aussi, les enseignants ont indiqué qu'ils s'étaient appropriés des exemples de stratégies discutées lors de l'atelier portant sur le développement des stratégies durant les semestres d'automne 2007 et d'hiver 2008.

Les activités du projet BRAID ont été efficaces comme première initiative pour amener les enseignants à travailler ensemble pour discuter des possibilités d'intégrer les principes de la FIP au curriculum académique. Les retombées possibles suite aux ateliers sur la promotion de la FIP comprennent; adapter et réaligner le curriculum, organiser un programme appliqué en clinique pour les étudiants, prioriser les besoins en matière de formation des équipes en FIP/PIP et favoriser le partage des connaissances et des pratiques exemplaires.

3.5 Les changements observés suite aux compétences acquises en FIP/PIP:

Apprentissage des étudiants

Quels sont les changements ou les résultats observables et documentés de l'apprentissage des étudiants en matière de la FIP/PIP?

Les étudiants ont rapportés avoir une meilleure connaissance des principes de la FIP/PIP après avoir participé aux groupes cibles sur la communication interprofessionnelle en santé qui ont eu lieu à la mi et fin semestre. Les domaines explorés qui ont le plus touché l'intérêt des étudiants durant ces sessions étaient les rôles des intervenants en santé de diverses disciplines, les méthodes efficaces de communication, les types de personnalité, les moyens de résoudre des conflits et la prise de décision éthique. Les participants ont aussi souligné l'importance des *attitudes professionnelles* qui comprenaient : le respect des opinions et des commentaires des autres disciplines, l'appréciation de la contribution des autres, la valorisation de la participation des patients, les attitudes positives et optimistes et l'ouverture à apprendre continuellement. Les étudiants ont aussi indiqué avoir développé de nouvelles habiletés sur lesquelles ils cherchaient à s'améliorer ou encore s'étaient nettement améliorés. Les habiletés soulignées sont étroitement alignées au cadre conceptuel de la FIP qui a été utilisé durant ce cours. Ces habiletés étaient : les moyens efficaces de communication, la prise décisionnelle en équipe, la gestion des conflits, et les moyens technologiques et autres compétences reliées.

Les étudiants ont complétés le sondage sur les compétences Braid (*BRAID Competency Survey (BCS)*) et la Grille Auto efficacité (*Self-Efficacy Scale (SES)*) lors de la dernière rencontre. Les résultats de ces deux sondages (BCS et SES) ont révélé de très haute performance dans les deux dimensions des compétences de la FIP et de l'auto efficacité. On retrouve aucune différence significative avant et après la certification dans les résultats des deux sondages (BCS et SES). En gros, ces résultats démontrent que les étudiants possèdent une image positive à

l'égard de leurs connaissances et leur confiance à pouvoir mettre en pratique les habiletés et les méthodes apprises sur la FIP/PIP dans le cours de communication.

Les résultats des groupes cibles accompagné de l'analyse des apprentissages exprimés par les étudiants ont permis de développer des stratégies efficaces d'enseignement des concepts et des compétences en FIP. Ces stratégies ou moyens d'apprentissage comprennent : le carnet de formation continue, la capacité de choisir ses lectures, les discussions en ligne, et la mise en pratique de la Stratégie du défi des équipes en santé. Cette dernière a été permis de constater ses bienfaits comme une meilleure intégration des perspectives des professionnels dans la planification des activités et l'importance de favoriser une approche collaboration avec les professionnels de diverses disciplines.

3.6 Les changements observés suite aux compétences acquises en FIP/PIP :

Développement professionnel des intervenants

Quels sont les changements ou les résultats observables et documentés de l'apprentissage des intervenants en santé responsables de la certification en FIP/PIP?

Des membres de deux équipes d'intervenants en santé ont participé à une série d'ateliers qui visaient à améliorer les connaissances et les compétences des intervenants en santé en matière de la PIP. Les principaux thèmes de ces ateliers étaient: *la prise de conscience de soi, la communication, la structure et le travail d'équipe, la prise décisionnelle et la pertinence du travail en petites équipes.* Les intervenants en santé ont complété le sondage sur les compétences BRAID (BCS) avant et après avoir complété les modules de formation et de certification de la PIP. Lorsqu'on compare les résultats des deux sondages, il est clair que les résultats sur les compétences sont plus élevés après avoir suivi la formation sur la FIP/PIP.

L'analyse qui en découle démontre une amélioration marquée de la compétence en PIP dans les domaines des communications efficaces, des approches de résolution des conflits et de la prise de conscience de la pratique réfléchie.

Des entrevues ont révélé de nombreux bienfaits suite à l'atelier portant sur la certification soit l'approfondissement des connaissances et les habiletés et les attitudes implicites au travail d'équipe mais très peu souvent enseignées. Les participants ont rapporté que les discussions entamées durant les ateliers se sont poursuivies lors des rencontres d'équipe et lors des échanges en petit groupe. Tout particulièrement, les étudiants ont apprécié les ateliers dont les sujets traités portaient sur la découverte de soi et les types de personnalité que l'on retrouve parmi les co-équipiers. En ce qui a trait aux possibilités de formation futures, les participants ont souligné le besoin d'évaluer les compétences des équipes de professionnels de la santé et d'adapter le contenu des ateliers pour rencontrer les besoins spécifiques des divers professionnels et groupes de travail. De plus, ils ont souligné l'importance dans le future, de prendre les moyens pour encourager davantage la participation et la collaboration de tous les membres des équipes lors des ateliers ou des programmes de formation en PIP.

3.7 Leçons tirées du projet

Quelles sont les leçons tirées suite aux activités du projet?

Suite aux activités du projet et des entrevues qui ont été menées lors des groupes cibles par les animateurs, on tire des leçons importantes du projet BRAID. Ces leçons permettent d'éclaircir certains thèmes qui touchent la collaboration, les opérations, la promotion de la FIP/PIP et la planification et la mise en œuvre de la FIP/PIP.

La collaboration durant le projet

Le développement des partenaires multisectoriels s'est avéré point critique pour se départir d'un apprentissage en 'silo' à un apprentissage collaborateur qui favorise le réseautage parmi diverses disciplines. Le soutien mutuel, la reconnaissance des forces et la structure collaborative non hiérarchique sont ressortis comme caractéristiques principales des équipes collaboratives. Sous le thème de la collaboration, l'initiative du New Brunswick Health Science Student Association (NBHSSA) a été soulignée comme un exemple type d'engagement des étudiants en partenariat avec divers organismes.

Les opérations durant le projet

Le point le plus important souligné au cours des premières phases du projet et appuyé par les participants tout au long du projet était la forte relation entre les animateurs du projet et l'équipe d'évaluation. Cette relation de travail exemplaire s'est manifestée lors de la création et la mise en application du modèle logique pour aider à clarifier les objectifs et les résultats anticipés du projet et aussi à diriger les activités prévues. En plus de la qualité exemplaire de cette relation de travail, l'appui soutenu des autorités et des leaders a aussi contribué au succès du projet car ils ont cru important de soutenir les concepts et la pratique de la FIP/PIP dans les programmes de formation et dans la prestation des soins et services de santé.

La promotion de la FIP/PIP

La sensibilisation des principaux intervenants sur les bienfaits de la FIP/PIP a été la pierre angulaire pour motiver les individus et assurer le changement organisationnel. Les différents extrants offrent des opportunités de promouvoir les concepts de la FIP/PIP. Ceux-ci comprennent la création du logo BRAID, du site Internet et des montages vidéo.

La planification et la mise en pratique de la FIP/PIP

Le cadre conceptuel sur les compétences requises pour la formation et la pratique BRAID nous a donné un modèle pratique de communication et de promotion des compétences de base requises pour toutes les initiatives de formation BRAID. L'utilisation des témoignages des patients (réels et simulés) ont permis de démontrer la valeur de la FIP et de la PIP aux principaux intervenants. Les perspectives des patients ont été un élément clé de la planification et de l'exécution des initiatives de formation de la collaboration centrée sur le patient. Cependant, cette dimension du projet a présenté des défis considérables.

4.0 Recommandations pour assurer la viabilité du projet

Quels sont les points à considérer pour étendre les activités de la FIP/PIP au delà du projet en cours?

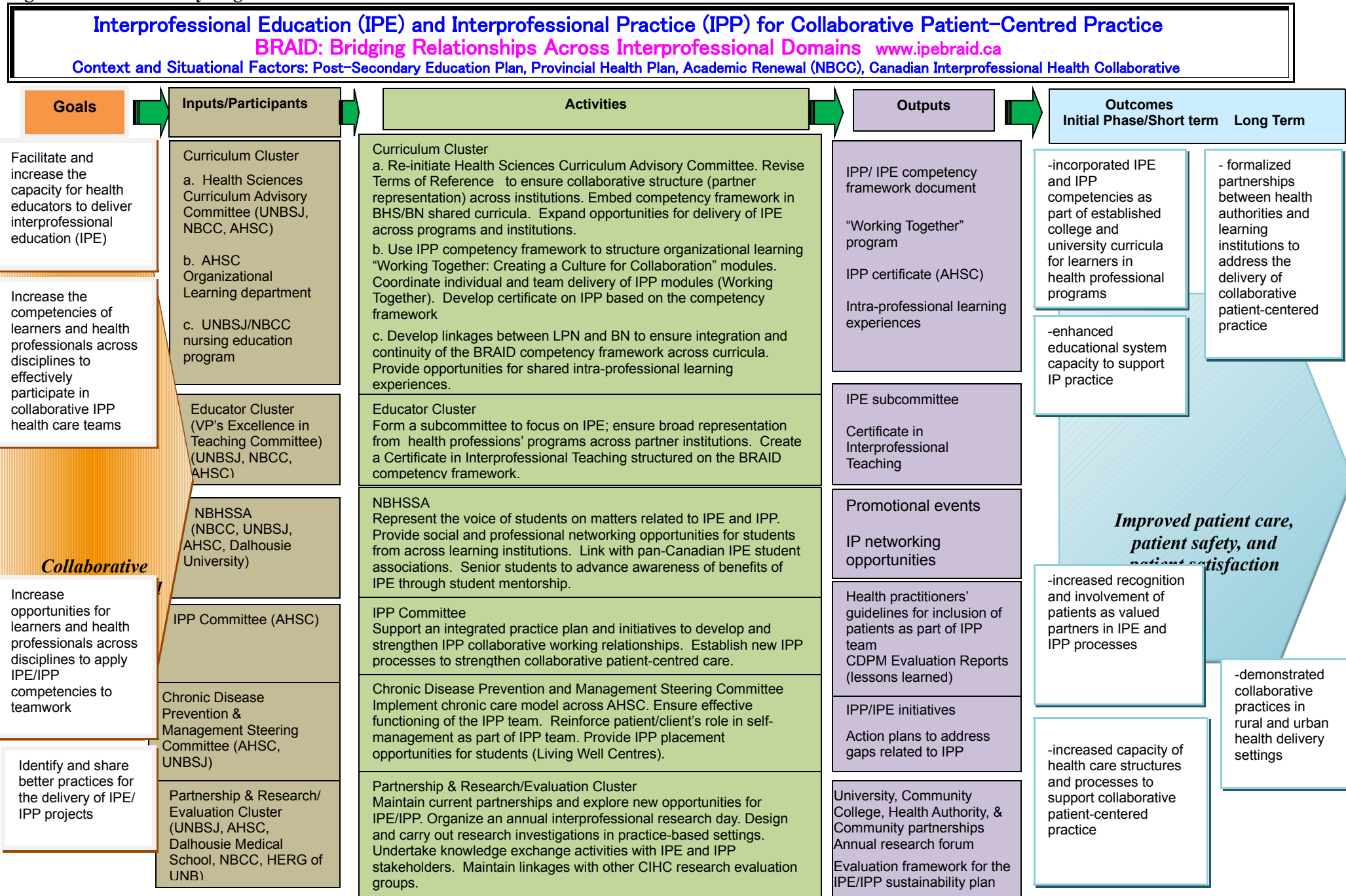
Durant les derniers six mois du projet, les animateurs du projet, les membres de l'équipe d'évaluation, les membres des comités de pilotage et de partenaires se réunis pour discuter et développer une approche soutenue pour l'ensemble du projet. Un deuxième modèle logique a été conçu pour présenter les buts, les intrants, les activités, les extrants et les résultats possibles associés à une démarche pour assurer la continuité de la FIP/PIP. Voici les points principaux de ce plan de travail :

- La réactivation du Comité consultatif du curriculum en sciences de la santé et la possibilité d'étendre la pratique dans diverses disciplines de la santé,
- L'utilisation du cadre conceptuel des compétences en FIP/PIP pour promouvoir et structurer des programmes de formation dans diverses institutions académiques,
- L'intégration et la continuité du cadre conceptuel des compétences BRAID en tissant des liens entre les programmes d'infirmière licenciée et d'infirmière auxiliaire autorisée,
- La création d'un programme certifié interprofessionnel basé sur le cadre conceptuel des compétences BRAID,
- Les efforts soutenus de la part de la NBHSSA à promouvoir la FIP/PIP pour l'ensemble de la province et ailleurs,

- Le soutien des initiatives de la FIP aux plans de soins des régions régionales de la santé (RRS),
- La reconnaissance du rôle important que doivent jouer les patients comme membre à part entière à l'équipe de la PIP et ainsi les aider à prendre une part active dans leur santé selon le modèle des soins chroniques, et
- Les activités de recherche et de partage des connaissances parmi les principaux intervenants de la FIP et de la PIP.

Bien qu'il existe un plan de travail soutenu pour l'ensemble du projet BRAID, il faut prévoir des ajustements nécessaires selon les changements systémiques qui pourraient survenir dans les domaines des régions régionales de la santé et de l'éducation post secondaire. Qu'importe les changements possibles dans les domaines de l'éducation et de la santé, les principaux intervenants ont souligné l'importance de poursuivre les initiatives BRAID et de continuer d'agir en tant que 'champions' en FIP/PIP touchant les diverses professions et les rôles organisationnels et ce, pour des années à venir.

Figure 2: Sustainability Logic Model



5.0 Conclusions et dernières observations

Les nombreux résultats observés n'auraient pas été possibles sans la planification et l'exécution du projet BRAID. En effet, l'évolution de la FIP et de la PIP aurait été beaucoup plus lente autrement. Les membres du comité de pilotage ont témoigné que sans avoir eu recours à ce projet, l'Université du Nouveau-Brunswick – campus de Saint-Jean (UNBSJ), la Corporation des sciences de la santé Atlantique (CSSA), le Collège communautaire du Nouveau-Brunswick (CCNB) continueraient de donner leurs programmes de formation indépendamment l'un de l'autre. Ils ont ajouté que l'évolution de l'intégration de programmes de formation interprofessionnelle et de la planification de nouveaux curricula aurait été beaucoup plus lente. La reconnaissance des étudiants en tant que champions est un élément primordial dans le mouvement de la FIP/PIP. À cet effet, l'Association des étudiants en sciences de la santé au Nouveau-Brunswick (AESSNB) n'existerait pas aujourd'hui et ne pourrait ni agir ni défendre ses droits dans la matière.

Les centres de santé communautaires auraient pu croire qu'ils adoptaient une pratique interprofessionnelle véritable. Aujourd'hui, il leur est maintenant possible d'explorer les principes de la formation et de la pratique interprofessionnelle comprenant le travail d'équipe, la clarification des rôles et la résolution des conflits en équipe. Cette approche permet aussi d'intégrer la capacité des patients de se prendre en mains en matière de maladies chroniques.

Il aurait été possible que le partenariat entre les quatre principaux intervenants incluant le CCNB, la CSSA, l'UNBSJ et la Faculté de Médecine de

“Tout comme la prévention et la gestion des maladies chroniques est le modèle de soins de choix, la formation et la pratique interprofessionnelle est le véhicule qui en assure sa prestation” (Barb McGill, Co-présidente du projet).

l'Université de Dalhousie n'ait pas été reconnu dans la région. Il est aussi possible que l'engagement envers la formation interprofessionnelle ne se serait pas étendu dans la région atlantique, ou à l'échelle nationale et internationale en si peu de temps.

Il a eu trois forces majeures qui ont positivement affecté le projet. Le CCNB était à s'interroger et faisait face à une réforme académique ce qui avait créé un climat incertain chez le personnel enseignant et les responsables des programmes de formation. Il en résulte, qu'il n'y avait pas d'étudiants de 2^e année au programme d'infirmière auxiliaire pouvant se jumeler au programme d'infirmière licenciée tel qu'envisagé. Le système post secondaire du Nouveau-Brunswick est sous la loupe présentement et toujours en attente des recommandations du rapport de la commission qui pourraient toucher la structure organisationnelle et les programmes de formation. Parallèlement, le système de santé vit aussi une réforme dans sa restructuration des huit régions régionales de la santé maintenant réduite à deux seulement. Par conséquent, il a fallu ajuster les initiatives afin que celles-ci répondent à cet environnement en mouvement. Même aujourd'hui, l'impact qu'auront tous ces changements sur la continuité et les retombées du projet demeure incertain. Cependant, le rapport de la commission soulèvera probablement l'importance de rehausser la collaboration et le partage des connaissances parmi les divers programmes de formation des diverses disciplines de la santé.

Les facteurs qui appuient le projet BRAID sont nombreux. Le point central du projet était de développer une structure collaborative qui soit de nature non hiérarchique. Cette approche a permis aux partenaires et aux principaux intervenants (les patients/consommateurs de soins et de services, les étudiants, les chercheurs, les professionnels de la santé, et les enseignants) de participer activement dans la conception des activités et des initiatives pour répondre aux objectifs fixés. La revue de la littérature sur la FIP et les besoins de formation

continue des professionnels de la santé tels les étudiants, les enseignants et les professionnels de la santé ont servi à créer *Les Compétences interprofessionnelles BRAID : un cadre conceptuel de la formation et de la pratique*. Ce cadre conceptuel et les hypothèses théoriques forment un modèle viable de la FIP/PIP. Un modèle logique a été développé pour représenter un schéma des composantes principales du projet comprenant: les hypothèses théoriques, les buts, les ressources, les participants, les extrants et les résultats (court terme, moyen terme et long terme). Ce modèle logique a aussi servi à structurer et planifier l'exécution du projet, l'évaluation des activités et a permis de créer un modèle soutenu du projet. Issu du projet BRAID a été la nouvelle Association des étudiants en sciences de la santé du Nouveau-Brunswick (AESSNB) afin de permettre aux étudiants de se rallier pour améliorer la pratique centrée sur le patient en faisant la promotion de cette approche et en inspirant nos futurs champions.

Les animateurs ont présenté des rapports mensuels aux membres des comités de pilotage et consultative et aux autorités qui ont participé au projet. Les leçons tirées touchant la communication et le partage des connaissances reconnaissent l'importance de l'engagement dès le départ des Ministères de la santé et de l'éducation postsecondaire, Formation et Travail. Cet engagement s'est manifesté seulement vers la fin du projet. Malgré ceci, le cadre conceptuel du projet BRAID a tout de même réussi à démontrer d'énormes avantages à adopter une approche interprofessionnelle collaborative des équipes de soins autant dans la pratique courante que dans le futur et à apporter les changements nécessaires aux divers programmes de formation, aux politiques et directives des régies régionales de la santé et ce dans toute la province et aussi à l'extérieur de la province.

Que nous réserve le futur? D'ici cinq ans, la faculté de médecine de l'Université de Dalhousie va offrir un nouveau programme de quatre ans et formera un partenariat de quatre

universités et ceci grâce au projet réalisé. Cette collaboration créera de nouvelles alliances à partir des projets respectifs des provinces de la Nouvelle-Écosse et du Nouveau-Brunswick. D'ici cinq ans, nous pouvons nous attendre à un programme de formation inter institutionnel avec la composante de la FIP/PIP intégrée au curriculum, à l'évaluation et à la recherche.

Appendices

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Appendix I: Project Framework

Introduction

The purpose of this aspect of this initiative was to create a project framework to guide the implementation and ongoing application of the BRAID project. Key insights and data for this effort were gleaned through monthly planning sessions and consultations between Project Facilitators and the Evaluation Team.

Methodology

Regular monthly meetings were held between Project Facilitators and the Evaluation Team over the course of the initiative. These meetings were also supplemented by multiple e-mail exchanges and phone contacts. The purpose of the preliminary meetings and interactions was to define a project framework that could guide the initial implementation and ongoing refinement of the BRAID project. A logic model method was adopted as a means for designing the overall framework for the project. The main components of the project logic model included:

- Theoretical assumptions - guiding principles and perspectives,
- Goals - project targets for positive change,
- Inputs - major project components and human resources,
- Activities - key actions implemented to meet project goals,
- Outputs - products that reflect implementation of project activities, and
- Outcomes - desired changes in key indicators that reflect that reflect attainment of project goals.

Upon completion, the logic model was submitted to the Steering and Advisory Committees for their consideration and review. Feedback from these working teams was the incorporated into the proposed framework and the preliminary draft of the logic model was finalized.

Results

Key insights and data gleaned from monthly planning and consultations between Project Facilitators and the Evaluation Team provided the basis for creation of the visual project logic model (Figure 1). This model provided a concise overview of the project framework including underlying assumptions, goals, inputs, activities, outputs and outcomes. With respect to key assumptions, emphasis was placed on creating readiness for IPE/IPP engaging, using evidence-informed methods for the development and the application of core IPE/IPP competencies; and development of effective interprofessional learning and practice teams through a Self Determination Theory needs-based model. The overarching intent of the initiative was to enhance *Collaborative Patient-Centered Practice*, with four supporting goals focused on facilitating and increasing the capacity of health educators to deliver interprofessional education (IPE); increasing the competencies of learners and health professionals across disciplines to effectively participate in collaborative health care teams; increasing opportunities for learners

and health professionals across disciplines to apply IPE/IPP competencies to teamwork; and identifying and sharing better practices for the delivery of IPE/IPP projects. To address these goals, key project inputs or human resources included: the Steering and Stakeholder Committees, the Project Facilitators, the Evaluation Team, the Working Committees (Education; Post-licensure) and the NBHSSA. Members of these committee and project teams were composed of students, educators, practitioners, patient representatives and other stakeholders from UNB, AHSC, NBCC and the Dalhousie Medical School. The identified activities of each project team and committee were linked with major objectives of the project plan.

The logic model also outlined specific project outputs which were intended to provide evidence of completed initiative activities including such project products as a literature scan of promising practices, quarterly progress reports, IPE/IPP awareness/competency-building materials, IPE/IPP curriculum materials, evaluation instruments and protocols, as well as sustainability plans. Finally, the project framework outlined particular project outcomes to be realized as a result of the implementation of the initiative. These outcomes mirrored the four major project objectives reflecting desired positive changes or developments associated with the IPE capacity of educators, the competencies of learners and health professionals, specific opportunities for learners and health professionals to apply IPE/IPP competencies; and the knowledge exchange of better practices and lessons learned regarding the project.

The resulting framework was subsequently used to structure and elaborate the planned implementation and evaluation activities of the project. It was also recognized that over the course of the project this model would conceivably be adapted or further refined as a result of implementation challenges, emerging instructional needs and lessons learned related to IPE/IPP, both during and beyond the time period established for the project. Figure 1 provides a visual representation of the logic model created for the BRAID initiative.

Appendix II: Facilitator Workshops

Introduction

The purpose of this aspect of the data collection was to document key information and feedback related to the delivery of IPE/IPP facilitator-led workshops during the BRAID initiative. These workshops included IPE/IPP Awareness Workshops carried out between October 2006 and June 2007, and Competency-building Workshops executed between July 2007 and December 2007.

Methods

Sources of data for this aspect of the evaluation included monthly activity logs completed by the Project Facilitators, as well as workshop feedback forms completed by participants who attended the various workshop sessions.

Activity Logs

Following each awareness and competency-building activity, facilitators completed a two-page activity log. This form assisted in making linkages between specific work tasks and the objectives, activities, outputs and outcomes outlined in the IPE logic model. Areas of inquiry included on the log form were beneficial for maintaining records of example IPE readiness and competency-building activities that could be applied in future IPE initiatives or events. In addition, the activity log highlighted facilitators' observations and reflections relevant to the implementation and outcomes of given work activities. From September 2006 to June 2008, 51 activity logs were completed and submitted to the evaluation team for analysis.

Workshop Feedback Forms

Participants who attended the various IPE awareness or competency-building sessions were invited to complete workshop feedback forms at the close of their respective sessions. The feedback forms were composed of a series of rating scale questions (strongly disagree to strongly agree) intended to elicit participants' perspectives regarding the relevance and applicability of workshop content. A total of 135 feedback forms were submitted for analysis.

Results

Activity Logs

Each log specified the particular working group that was the focus or theme for each workshop. In ten activity logs, specific working groups were not identified. When identified, 35% of sessions were focused on educators, 27% on students or curriculum development, and 29% on post-licensure professionals. Most sessions (61%) targeted awareness, while 37% also aimed to build competencies. As time progressed, there was a shift from awareness-only sessions to competency-building sessions.

Workshop feedback forms

Workshop participants were asked to complete rating scales indicating their agreement with various statements related to the relevance and applicability of IPE/IPP session content. Overall, approximately 90% of participants reported enhanced understanding regarding IPE/IPP concepts and potential areas of use within their own work contexts. A summary of key rating items for both the awareness and competency-building workshops is presented in Table 1.

Table 1. Workshop Feedback Forms: Percentage indicating “agree” or “strongly agree”

Statement:	Sessions: Awareness (Fall 2006-Spring 2007) (n=71)	Competency- building (Summer-Fall 2007) (n=64)
The session was well organized.	97%	100%
The information on IPE was applicable to my teaching/practice. I am able to apply the content of this workshop to my work.	92%	88%
My participation in the session has enhanced my knowledge with respect to IPE.	95%	89%
My participation in the session will influence my use of IPE principles in the future.	88%	85%
There was opportunity to interact with other participants. The workshop contributed to strengthening relationships.	88%	91%

Qualitative responses were also provided from participants on what aspects they found to be most beneficial, and what changes they might make as a result of the session/workshop. Awareness session respondents indicated that they appreciated the lectures/speakers, and the opportunities for interaction with colleagues and other professionals. In particular, simulation exercises conducted in both awareness and competency-building sessions were regarded as effective methods for presenting and reinforcing IPE/IPP concepts.

Many participants indicated that as a result of the session/workshop, they would be examining their current practices and principles with respect to IPE, and be considering ways to integrate IPE principles into their environment. Others noted that they intended to act as role models in actively promoting IPE principles, especially in areas related to enhancing communication and respect among professionals.

Appendix III: Baseline Readiness Profile

Introduction

The purpose of this aspect of the evaluation was to provide a baseline profile of readiness for IPE/IPP learning. Participants included students in the health sciences and post-licensure professionals.

Methodology

The *Readiness for Interprofessional Learning Scale (RIPLS)* (Parsell and Bligh, 1999) was adapted to provide a measure of readiness for IPP/IPE learning. This scale is composed of 19 items that request participants to rate their level of agreement with statements relating to interprofessional concepts. Four subscales are derived from the various rating items including: *Team Work and Collaboration*, *Professional Identity (Negative and Positive)*, and *Professional Roles and Responsibilities*.

Team Work and Collaboration items represent a willingness to share knowledge, as well as the views that shared learning is generally beneficial, and that positive relationships with other professionals are necessary. The second construct, *Professional Identity* includes two subscales. These reflect the importance attached to professional identity, and allows for both *negative and positive* aspects. The *Roles and Responsibilities* subscale reflects the importance of role boundaries and divisions between professions.

The RIPLS was administered to a total of 154 students and health practitioners. Administration of this survey was completed as part of the preliminary activity at a series of awareness-building workshops organized by the Facilitator Team. These workshops were executed between November 2006 and January 2008.

Following each workshop, completed protocols were forwarded to the Evaluation Team. Participants' responses from the completed surveys were coded and subsequently entered into a project database. Analysis of variance was applied to investigate RIPLS subscale mean outcomes for student and health practitioner participants.

Results

Full Sample Baseline Readiness Profile

Descriptive analysis was undertaken to examine the interprofessional readiness of the full sample. Overall, the percentage distribution of participants' ratings across subscale items indicated openness to IPE/IPP readiness concepts related to team work and collaboration, roles and responsibilities and professional identity. Table 2 provides a summary of these outcomes.

Table 2. Full Sample Results of Baseline Readiness for IPE/IPP Learning

N= 154	Mean Rating	Strongly Disagree					Strongly Agree	
		1	2	3	4	5		
<i>Team Work and Collaboration</i>		4.5						
Learning with others from diverse health professions will help students become more effective members of health care teams	4.6		1%	1%	38%	59%		
Patients/clients will ultimately benefit if health care students work together	4.6		1%	2%	30%	67%		
Shared learning among health care students will increase their ability to understand clinical problems	4.5		1%	5%	39%	55%		
Learning with health care students before licensure will improve health professionals' relationships after licensure	4.3		2%	11%	43%	44%		
Professional communication skills should be learned with health care students from diverse disciplines	4.5		1%	8%	36%	55%		
Shared learning will help students to think positively about other health care professionals	4.4		1%	10%	33%	55%		
For small group learning to work, students need to trust and respect each other	4.7			2%	25%	73%		
Team-building skills are essential for all health care students to learn	4.7			4%	26%	70%		
Shared learning will help students to understand their own limitations	4.1		1%	17%	48%	34%		
<i>Professional Identity</i>		Strongly Disagree						
<i>Negative Professional Identity</i>		2.0						
Students will not want to waste time learning with other health care students	2.2	32%	40%	11%	10%	6%		
It is not necessary for pre-licensure health care students to learn together	2.0	32%	43%	17%	4%	4%		
Clinical problem-solving skills can only be learned with students from their own discipline	1.9	43%	40%	7%	5%	5%		
<i>Positive Professional Identity</i>		4.2						

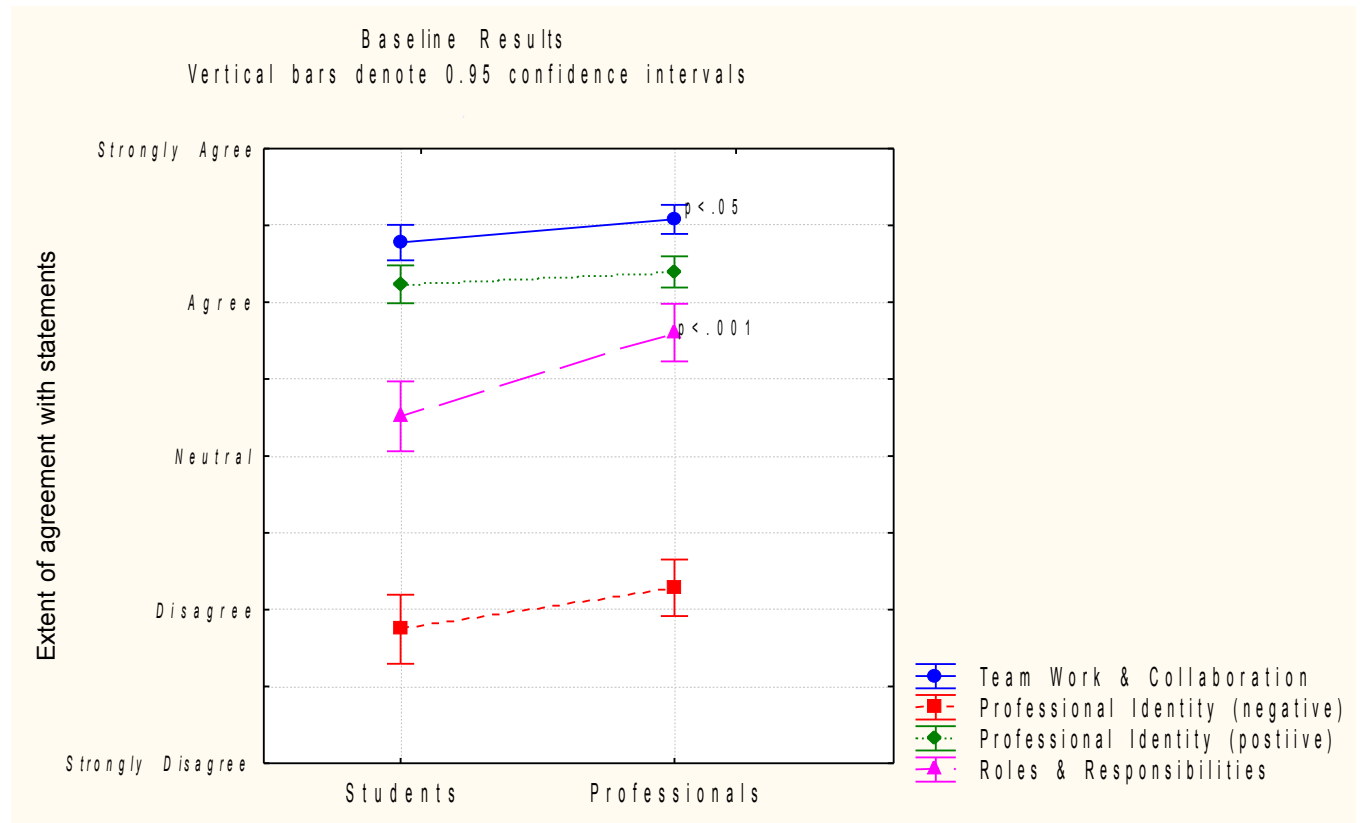
Shared learning with other health care students will help them to communicate better with patients/clients	4.3		2%	14%	41%	43%
Shared learning with other health care students will help them to communicate better with other professionals	4.4		1%	4%	45%	50%
Students will welcome the opportunity to work on small-group projects with other health care students	3.7	1%	5%	33%	45%	16%
Shared learning will help to clarify the nature of patient/client problems	4.2		1%	11%	52%	36%
Shared learning before licensure will help students become better team members	4.4		1%	7%	41%	51%

<i>Roles and Responsibilities</i>	3.6	Strongly Disagree Strongly Agree				
		1	2	3	4	5
Students are often unsure of their professional role and its implications for collaborative practice	4.1		4%	18%	42%	36%
Students from my discipline have to acquire much more knowledge and skills related to collaborative practice than do other health care students	2.5	32%	21%	24%	11%	11%

Comparison of Student and Practitioner Readiness

Analyses of variance (ANOVAs) were also applied to explore mean rating outcomes related to practitioner and student outcomes. Mean responses across scales for both students and practitioners supported a direction indicating a readiness to engage in interprofessional learning with others. Statements emphasizing *team work and collaboration* were agreed with by both students and practitioners, though significantly more so by practitioners than students. Differences between groups also emerged with respect to *roles and responsibilities*, with students indicating a trend towards neutral opinions, whereas professionals reported a greater degree of willingness to blur and overlap role boundaries. Both groups endorsed items reflective of the positive impact of IPE on *professional identity*, and both disagreed with statements indicating that IPE might have a negative impact on professional identity. Figure 3 provides a summary of these results.

Figure 3: Baseline Readiness among Students and Practising Professionals



Appendix IV: Educators' Needs Assessment Questionnaire

Introduction

For this data collection effort a Needs Assessment Questionnaire (NAQ) was administered to educators from eight health profession programs. The purpose of this effort was to explore meaningful ways in which to introduce health professional educators to IPE and to facilitate increased use of such concepts in their work with students. The outcomes of the NAQ were subsequently used to structure an IPE workshop for educators who had been participants in this aspect of the initiative.

Methodology

The NAQ was comprised of a series of open-ended questions intended to elicit educators' perspectives regarding IPE and effective professional development as a means for promoting awareness of such concepts among their colleagues across various professional health programs. Areas of inquiry included: *existing professional development opportunities for educators, preferences for professional development, and IPE topics that would be helpful for educators.*

A total of 45 educators completed the NAQ at the outset of an IPE awareness session facilitated by the Facilitator Team in the spring of 2007. Eighty percent of participants held full-time employment status, whereas 20% were part-time instructors. Content analysis was applied to analyze themes emerging for the various areas of inquiry.

Results

Professional Growth Opportunities

Participants reported a range of professional development opportunities in which they engage as part of their role as educator. Some of these included formal or structured training events sponsored by their institution or other professional groups. These examples included: faculty-sponsored workshops and sessions, in-house professional development programs, and academic conferences or professional events. Other examples reflected more self-initiated learning opportunities; such as, self-study through journals or professional publications, attendance at lunchtime sessions ("Lunch 'n' Learn"), or participation in organized discussions with colleagues, and the completion of online course or workshop programs.

Educators also recognized key challenges associated with pursuing professional development, especially in an interprofessional context. These obstacles involved having sufficient time given course loads, service and research expectations, as well as obtaining the necessary resources to cover associated costs related to attending specific educational or professional events. In spite of these identified challenges, educators affirmed the value of modelling ongoing professional learning for students as well as for practitioners.

Preferences for Educator Professional Development

Participants also highlighted key preferences associated with the delivery of professional development activities for educators. Aggregate responses emphasized the importance of providing interprofessional opportunities for educator in-services, reinforcing the need for basing workshop and training content on better practice evidence, and ensuring that the content and delivery of professional development activities be applicable for a wide range of educators. Specifically, the noted preferences for educator professional development included:

- *Collaboration/Team Work*: Opportunities to work with their peers from varied health disciplines - shared objectives, mutual understanding of roles, coordinated efforts
- *Knowledge Updates and Exchanges*: Literature-informed practices, successful teaching examples, exposure to new ideas, site visits among educators on lessons learned/innovative approaches, and
- *Practical Instructional Applications*: Effective learning and teaching methods, preparation for and use of educational technology.

Potential Actions for Promoting IPE Among Educators as Learners Together

In addition to exploring the characteristics associated with meaningful professional development, participants also provided insight on key activities that would increase collaboration among educators with regard to IPE. Four theme categories of action emerged for this area of inquiry, including:

- *Adapting and Aligning Curriculum* (Common framework/theory; consistent mission, objectives and content; shared skill development, common course strategies and activities),
- *Integrating Applied/Clinical Activities* (Grand rounds, case studies, shadowing other professionals, IPE courses strategies),
- *Prioritizing Content on Team Functioning* (Critical thinking, conflict resolution, communication, self-reflection, role clarification),
- *Learning About and Applying Better Practices*: (Understanding how others have implemented interprofessional education) and
- *Getting Started* (Identifying champions, holding a joint workshop).

Strategy Development Workshop

The final theme related to promoting IPE entailed “Getting started”. Based on the educator perspectives gleaned from the NAQ, the project facilitators planned and executed a strategy development workshop for educators from the three partner institutions involved in the project. The workshop was held in October 2007 and involved approximately 35 educators. The intent was to bring together educators for a preliminary event to share their current course strategies for promoting IPE concepts. The BRAID competency framework was used as a guide for strategy sharing and development. The majority of the workshop time was devoted to small group work with the final hour providing opportunity to share the specific strategies related to each of the BRAID IPE competencies. The outcomes of this workshop resulted in the compendium of 13 varied strategies for promoting IPE competencies with students within the health profession programs. These included:

- *A Term Case Study Approach for Comprehensive Patient Care Planning,*
- *A Health Profession Fair,*
- *A Series of Learning Activities to Increase Role Clarification,*
- *Observing Intact Interprofessional Teams,*
- *Applied Theory and Skill Development,*
- *Identification of Challenges to Interprofessional Practices and Potential Solutions,*
- *Interprofessional Planning and Decision-Making to Address a Health Care Crisis,*
- *Rotating Leadership Roles in Interprofessional Planning and Decision Making,*
- *Analysing Interprofessional Planning and Decision Making Approaches,*
- *Recognising and Affirming Interprofessional Contributions to Planning/Decision Making*
- *Educator Exchanges,*
- *Researching and Sharing Evidence-Informed Interprofessional Practices, and*
- *Interdisciplinary Clinical Rounds and Interprofessional Team Participation*

Following the workshop, the written strategies were disseminated to all participants as a resource for promoting IPE within their respective course options. A copy of this document is included as Appendix XI.

Appendix V: Participant Interviews: Educators, Students and Post-licensure Practitioners

Introduction

The purpose of this aspect of the evaluation was to examine the key planning and implementation activities from the perspective of participants who were directly involved in organizing or who had attended IPE/IPP initiative activities organized by the three key working groups of the BRAID initiative. These working groups included the Curriculum Working Group, the Educator Working Group (merged in the fall of 2007 with the Curriculum Working Group to form the Education Working Group), and the Post-licensure Working Group.

Methodology

Participant interviews were completed at the midpoint and towards the close of the initiative. Individual and focus group interview approaches were used to facilitate this data collection component of the evaluation. A semi-structured interview format was employed to examine participants' perspectives on a range of open-ended questions related to the activities and accomplishment of the BRAID initiative. Rating scale questions were also included in conjunction with various qualitative items for one set of participant interviews. Interviews ranged approximately from 30 minutes to one hour in length.

For this aspect of the evaluation three specific data collection endeavours were undertaken, each on focusing on the efforts of a specific BRAID working group. A summary of these is as follows:

Educator Interviews: Phone interviews were completed with health educators and/or practitioners (n=6) who had been involved in planning or who had attended educator-focused IPE activities. Areas of inquiry included: *IPE Educator Activities: Intent, Type and Engagement, Enabling Processes and Accomplishments, Challenges and Next Steps*. For each interview, a written summary was completed, highlighting the key participant responses to each area of inquiry.

Student Focus Group Interviews: Mid- and end of term focus groups were held with students (n=35) who completed the IPE course hosted by UNBSJ in February 2008. Areas of inquiry included: *conceptualizations of IPE/IPP, benefits and challenges associated with competencies, learned or applied IPE/IPP competencies (knowledge, skills, and attitudes), and effective IPE instructional strategies*. Following each focus group discussion, students completed a summary sheet outlining their groups' responses to each of the areas of inquiry. In conjunction with the focus group interviews, students were also invited to submit excerpts of their learning journals to further elaborate key themes rendered from the focus group interviews.

Practitioner Interviews: Phone interviews were completed with participants who had attended various IPP competency workshops for post-licensure health professionals. Areas of inquiry included: *organization and delivery of workshops, most useful content presented, challenges and impact of associated practitioner workshops, and next steps*. Consistent with the educator interviews, a written summary was completed, highlighting the key participant responses to each area of inquiry.

For the previous data collection activities, interview or session summaries were merged to provide a unified data set for each respective interview or focus group endeavour. Content analysis was subsequently applied to identify key themes arising from each area of inquiry.

Results

€ducator Interviews

IPE Educator Activities: Intent, Type and Engagement

Participants were asked to initially describe the overall purpose or intent of the IPE activities undertaken with them. These activities included IPE awareness sessions, administration of the Needs Assessment Questionnaire and the execution of the Educator Strategy Development Workshop. Participants highlighted five main objectives associated with these initiative efforts including to:

- Increase awareness of IPE among educators,
- Promote development of IPE BRAID competencies,
- Enhance communication and mutual understanding among educators,
- Find ways to collaborate with other educators, and
- Develop strategies for teaching.

There was general consensus among participants that the various completed activities with educators had contributed to the preliminary steps necessary to begin addressing these objectives. Responses to the various IPE activities were described in positive terms, with participants indicating that these efforts had *effectively engaged* educators who were in attendance at the various events (**Mean rating = 4.7** on a 5-point scale where, 1=not at all, 3=somewhat, 5=very much).

Enabling Processes and Accomplishments

Participants also identified a range of initiative processes and interactions that had contributed to an initial positive response among educators to IPE-related content and activities. These included:

- Strong acceptance of the project by participating institutions,
- Administrative support, flexibility and endorsement from senior policy and organizational leadership,
- Widespread willingness among educators to share and collaborate,
- Relationship linkages and follow up conversations with stakeholders by Project Facilitators.

Several outcomes were also highlighted related to IPE activities undertaken for educators. These included finding common ground with educators from different program and increased recognition of the need to work together. In addition, application of initiative outputs was reported as a result of IPE educator activities. For example, the IPE BRAID Competency Framework for curriculum planning was applied by both individual instructors and committees across the various participating institutions. In addition, educators reported that example strategies from the Educator Workshop had been appropriated by instructors during the fall and winter terms.

Challenges and Next Steps

With respect to challenges, time constraints for educators and lack of a common meeting place were identified as potential barriers for continuing dialogue and collaboration among on IPE. In addition, the level of uncertainty related to provincial post-secondary planning was cited as an existing challenge to making concrete plans for next steps; however, the importance of identifying and engaging new IPE champions across educational intuitions at all levels was viewed as a critical consideration for sustaining the initial momentum and accomplishments of the overall BRAID initiative.

Student focus Group Interviews

Conceptualizations of IPE/IPP

Student participants were initially asked to describe their conceptualization of IPE/IPP as a result of their course work to this midpoint in the term. Students' responses underscored the value of and need for participation of individuals with diverse knowledge, expertise and background experiences within health care teams in both inpatient and outpatient service delivery systems. They also acknowledged the importance of demonstrating an understanding and appreciation for the individual strengths of all members of the health care team, no matter what their professional designation. Overall, IPE/IPP was conceptualized as:

- Working together with other health professionals, possessing differing attitudes, beliefs, backgrounds and experiences, to solve issues and promote better patient outcomes,
- Learning with and from different professions (scope, knowledge and skills) in either a classroom and/or a clinical setting,
- Working with other professions in a respectful and professional manner, and
- Learning to communicate effectively with professionals in other disciplines in general or in defining specific patient care plans.

Benefits and Challenges Associated with IPP/IPE

Student participants reported a range of key benefits associated with IPE/IPP. These reported benefits focused on potential positive impacts for both health care teams, as well as for patients and their families. Specifically, cited advantages included:

- *Role Clarification and Functionality:* Increased role awareness, increased professionalism and respect,
- *Enhanced Relationships:* Improved communication, decreased conflict and positive work atmosphere,

- *Effective Team Processes*: Within and between groups, effective problem-solving, coordinated care planning for the patient, better patient care,
- *Increased Knowledge about the Patient*: Expanded perspectives, and
- *Improved Patient Outcomes*: Enhanced patients health, happier patients.

Student participants also highlighted existing challenges or concerns they had experienced or observed in their clinical placements or within their respective programs of study related to IPE/IPP. Some of these included lack of personal knowledge regarding the health professions, observed authoritarian attitudes between health care professionals, as well as the recognition for the need for increased patient involvement and “voice” in IPE/IPP activities. In terms of potential solutions, students stressed the importance of providing increased cross-program opportunities for working on IPE/IPP-related concepts and skills. In particular, they underscored the value of increased collaboration among health professionals and student interns from diverse disciplines during clinical placements.

Learned or Applied IPE/IPP Competencies

Students were also asked to identify vital knowledge they had gleaned from course-related readings, lectures and activities. Areas of reported *knowledge* included acquired content about health professions and their roles on teams, methods for effective communication with others, personality and conflict styles, and ethical decision-making. Participants also highlighted a range of noted *professional attitudes* that had been reinforced throughout the course. These included:

- Respecting input and ideas from other professions,
- Appreciating contributions from others,
- Valuing the patient’s voice,
- Demonstrating positive and optimistic attitudes, and
- Exhibiting openness to learning.

In discussion of specific professional attitudes, participants also identified certain skills on which they had worked or increased their proficiency over the course of the term. The cited skills aligned closely with the IPE competency framework used for the course. Areas of noted skill development included: Effective communication skills, team decision-making methods, conflict management approaches, as well as technological and online discussion related competencies.

Effective IPE Instructional Strategies

The *process of taking time to reflect and write* was viewed as particularly helpful for connecting course content to applied clinical experiences and case examples. Other cited benefits associated with journaling included development of critical thinking skills, enhanced written competencies, improved communication skills with other health professionals, and structured opportunities to explore IPE themes in greater depth from a personal perspective. Post-licensure students also highlighted various examples when their written reflections had been helpful for processing specific team dynamics and exploring approaches for working collaboratively from an IPE perspective.

Students expressed appreciation with the opportunity to choose reading materials that were relevant to their respective professions and areas of study. Assigned readings contributed key

content for completion of reflective passages for journal entries, as well as conversational themes for collaborative exchanges in small group work and among health team members in the clinical context.

Online discussion forums and postings were also viewed as positively contributing to collaborative interactions outside of traditional classroom exchanges. The web environment was described as providing adequate time for analyzing the perspectives of other students prior to formulating personal conclusions. For some participants the online course activities were regarded as more comfortable than in-class discussion groups. For these students, the online aspect of the course reflected their personal learning preferences and created increased ease for them to express their thoughts and feelings.

The Healthcare Team Challenge was highlighted by many participants as the most beneficial IPE instructional strategy undertaken during the course. This learning activity involved a development of a team-based response to an assigned patient case. The Healthcare Team Challenge was also described as the most “stressful” component of the course; however, it was the aspect from which students reported learning the most about IPE/IPP. As a result of this instructional strategy, students experienced and shared views within the classroom context from a range of health care disciplines. In their respective small groups, students reported being challenged to think beyond their own professions in conceptualizing case information and designing care plans for patients. Students’ comments also described the development of closer team relationships through the Healthcare Team Challenge, with some participants attributing greater learning value to the process of collaboration than the final group product.

In terms of overall comments, participants indicated that they had learned valuable lessons from the course on self awareness, communication with others, and the diversity of roles of various health science professionals. Students asserted the importance of having the IPE communication course as a requirement across all professional health programs within the province. In addition, they highlighted the need to continue their personal professional development of IPP as they move to full time positions within a range of clinical and health care settings.

“I enjoyed being given the opportunity to select a communication article to analyze which was relevant to my particular profession.”

*Through this style of learning I was able to develop effective ways **to implement what I had learned to my actual performance** during my clinical rotations ...”*

“It provided a means for me to go out of my comfort level and be a ‘leader’. I had never done this type of leadership role.”

“The Healthcare Team Challenge was probably the most stressful component of the course, however it is where I learned and contributed the most.”

“We were forced to think outside the realm of our professions. During this time you could say we bonded to become a multidisciplinary force.”

Practitioner Interviews

Organization and Delivery

Participants asserted that in general, individual workshop modules had been well-executed and that the applied delivery format had been conducive to active involvement of practitioners from the two health care teams. Facilitators were described as “knowledgeable” and “effective” in terms of their presentation styles and interactions with workshop attendees. Overall, comments from participants were consistent with aggregate feedback resulting from the post-workshop surveys. With respect to specific feedback regarding the workshop venue, participants asserted that it was advantageous to be off site and inaccessible to interruptions or requests from others.

Most Useful Aspects of IPP Training

In discussing the most useful aspects of IPP training, participants emphasized the value of receiving training in the context of an existing team. In this regard, implications or suggestions regarding specific IPP content, skills or methods could ideally be appropriated in a timely manner and serve to enhance existing health care team functioning. Other noted beneficial aspects included the placement of the initial “self-exploration” workshop at the outset of the training sessions and its potential to support individualized and team learning throughout other IPP workshops. This workshop was viewed as “foundational” in that it placed emphasis on understanding and appreciating both personal and diverse approaches for learning, interacting with others, and problem-solving.

Workshop Outcomes and Recommendations

Participants highlighted that the various workshops had reinforced knowledge, skills and attitudes that were often implicit in existing team functioning; however, participants highlighted that many of the professional conversations that had been initiated during the workshops continued as themes of professional deliberations in team meetings or smaller collaborative exchanges following the training. In particular, workshop content related to “self-exploration” and “personality styles” was viewed as helpful for enhancing participants’ understanding and appreciation of the range of “personality types” that they encounter in day-to-day interactions on their respective health care teams.

A few participants also spoke of “being champions” for their team with respect to promoting continued work on IPP. With respect to future workshops, participants highlighted the benefits of assessing the professional IPP competencies of given health care teams and adapting the workshop content and delivery format to meet the varied professional needs of specific groups. In addition, it was asserted that future workshop training should take steps to further encourage the collaborative participation of all team members during IPP workshops or in-service training programs.

Appendix VI: IPP Post-Licensure Training Modules

Introduction

The intent of this aspect of the evaluation was to measure potential changes in IPE/IPP competencies based on administration of the *BRAID Competency Survey (BCS)* to health practitioners, both before and after completion the IPP Post-Licensure Training Modules. The major themes of these workshops included: *self-awareness, communication, team structure/process, decision making and small group facilitation*. These were generally well received by participants. A summary of participant feedback for each the various workshops is presented in Appendix XII.

Methodology

The BCS was administered to the members of two health care teams (n=38) who completed a series of five professional development workshops intended to enhance IPP competencies. The BCS was designed to be used with professional development or training programs applying the BRAID Competencies Framework (Appendix X). This measure is composed of 12 rating scale items that comprise 4 competency subscales. They are as follows:

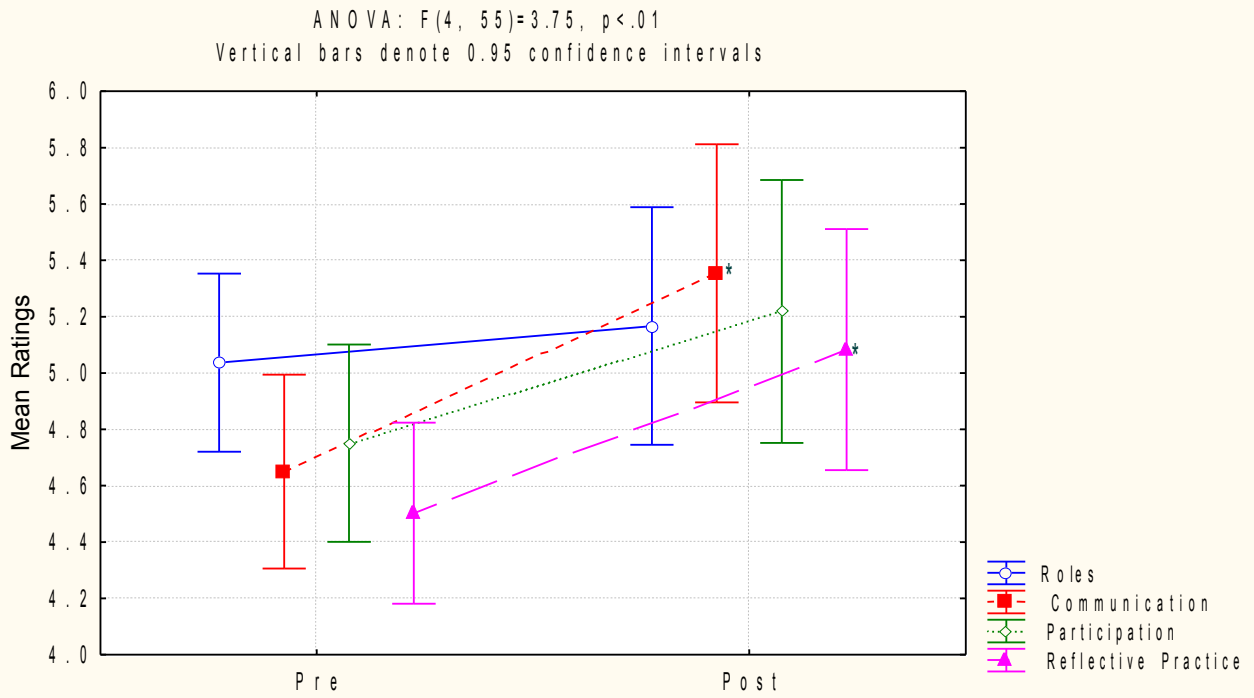
- Role Clarification and Affirmation,
- Effective Communication and Conflict Management,
- Participatory Planning, Decision-Making and Problem-Solving, and
- Self-Awareness and Reflective Practices.

A pre-post evaluation design was used to measure possible changes in IPE/IPP competencies among workshop participants. Analysis of variance and associated post hoc tests were used to analyze pre- and post-module mean subscale outcomes resulting from the administration of the BCS.

Results

Statements were generally rated higher following completion of the IPE/IPP training modules. When statements were grouped according to their respective subscales, significant results were observed for indicators of Effective Communication and Conflict Management, as well as for Self-awareness and Reflective Practice. Figure 4 provides a summary of these results.

Figure 4



Appendix VII: IPE Post-Course Outcomes

Introduction

The purpose of this data collection activity was to provide insight into post-IPE course participant outcomes related to IPE competencies and perceptions of self-efficacy. The instruments used for this aspect of the evaluation were the *BRAID Competency Survey (BCS)* and the *Self-Efficacy Scale (SES)*.

Methodology

The BCS and SES were administered to students who were enrolled in an IPE communication course offered by UNBSJ. A description of the BCS was included in the Methodology section for the IPP Post-Licensure Training Module (section 7.2). The SES is an instrument intended to provide estimates of self-confidence (10-point scale rating items denoting low “1” to high “10” confidence) in four specific areas related to IPE/IPP. These core areas form the basis for the major subscales of this measure:

- **Participation** – Working with other students from different professions to resolve problems in the team, developing a realistic appropriate patient care plan, understanding respective roles in an interprofessional team, and understanding patient benefits of team care.
- **Goals and Objectives** – Recognizing and expressing the objectives of IP learning and the extent of progress towards achieving those objectives.
- **Feedback** – Providing feedback to team members and others regarding team roles and team functioning.
- **Communication** – Learning and effectively communicating with others from different professions.

Participants (n=26) were composed of pre-licensure students enrolled in varied bachelor-level health professional programs, as well as post-licensure students who had returned to complete their undergraduate programs. The BCS and the SES were administered to student participants during the final class of the IPE course.

Results

Outcomes of the BCS and SES revealed high mean ratings across all subscales related to the IPE competencies and areas of self-efficacy. There were no significant differences noted between pre- and post-licensure students on either the BSC and SES. Overall, these outcomes suggest positive self-perceptions among students regarding knowledge and confidence to apply skills and methods related to IPE/IPP following participation in the undergraduate communication course. A summary of these results is presented in Figures 5 and 6.

Figure 5

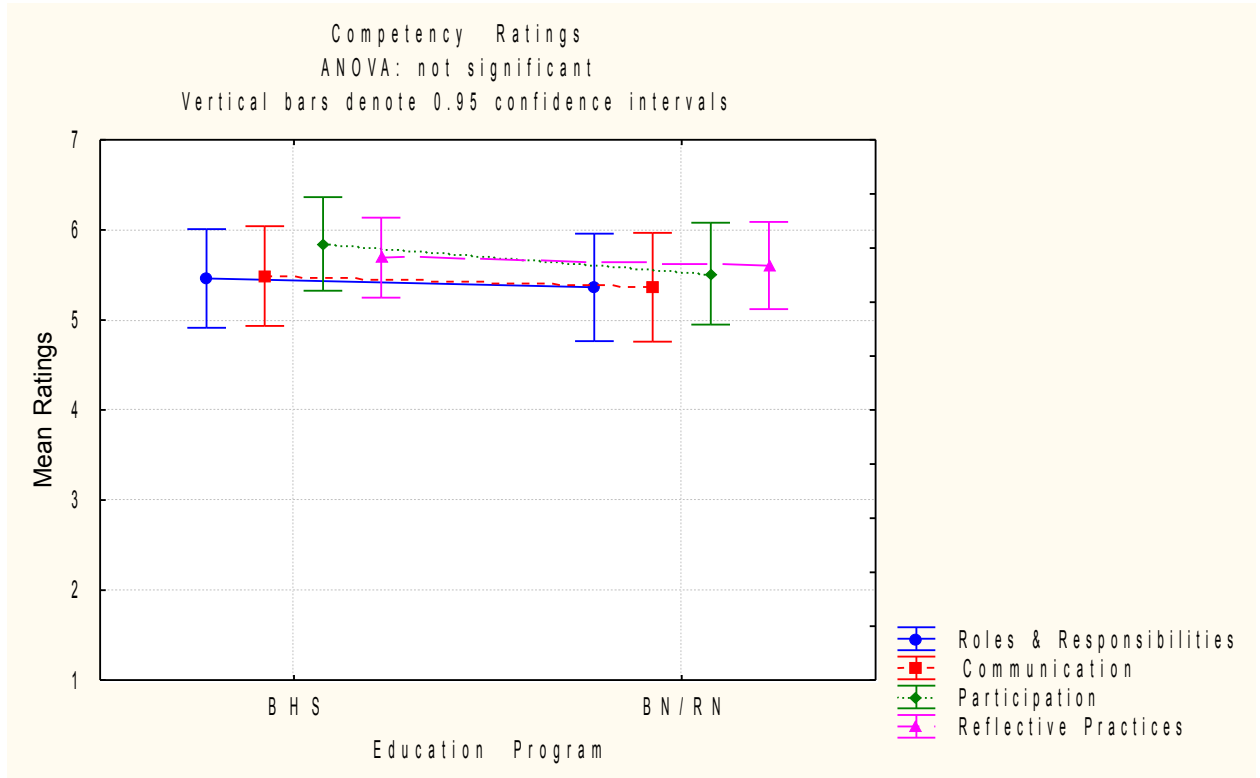
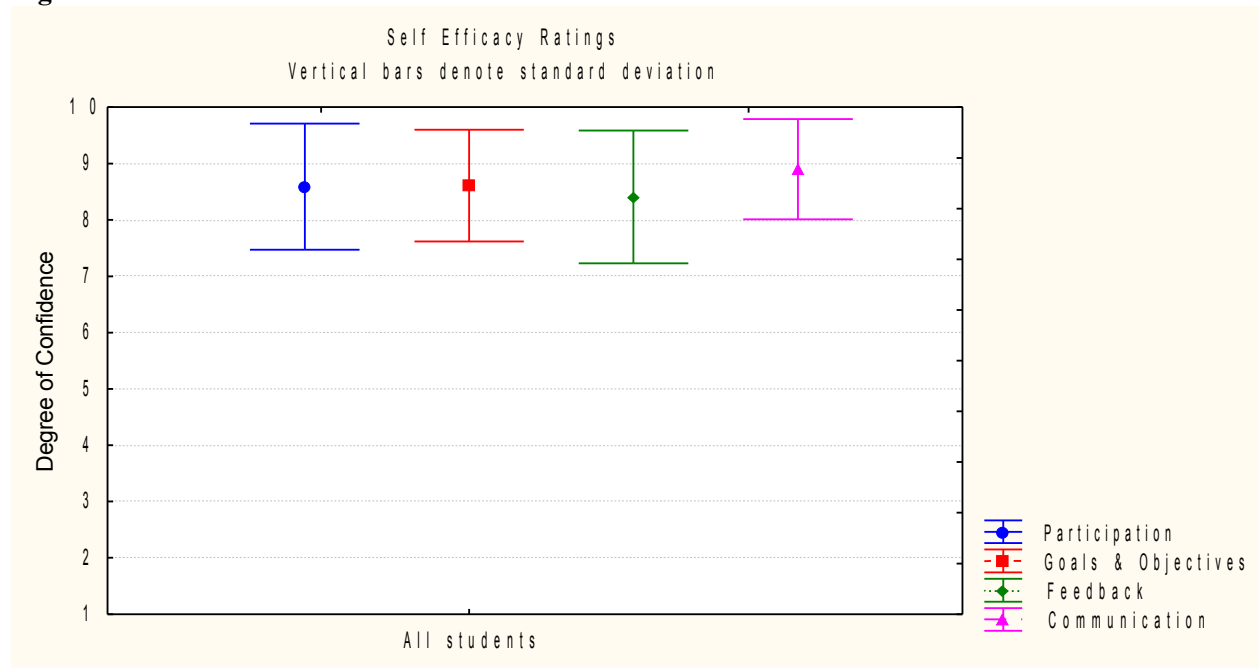


Figure 6



Appendix VIII: Facilitators' Lessons Learned

Introduction

The intent of this aspect of the project was to document key lessons learned related to the implementation of the project. Focus group interviews with Project Facilitators were carried out in April 2007 (midterm) and May 2008 (final quarter).

Methodology

A semi-structured interview was used to facilitate these data collection sessions. These sessions were led by two members of the Evaluation Team. Summary notes were kept and subsequently compared at the close of each session to identify key themes related to lessons learned that could be applied to similar IPE projects in other jurisdictions. The identified lessons learned were subsequently organized according to major theme categories.

Results

The following provides an overview of key lessons learned related to the BRAID initiative. Key lessons learned are presented according to the following headings: Project Collaboration, Project Operations, IPE/IPP Promotion and IPE/IPP Planning and Implementation.

Project Collaboration

- Multi-institutional partnerships contributed to key benefits for IPE including: the move from silos of learning to collaborative professional practice; the development of interdependence among stakeholders, and the creation of collaborative relationships and networks within and between institutions.
- Bridging relationships across educational and practice institutions required champions, decision-makers, dedicated time and resources, and commitment to collaborative processes.
- Mutual support and recognition of strengths assisted in the development of functional leadership teams.
- A collaborative non-hierarchical structure was a central driving force supporting the development and implementation of the project.
- Collaboration with NBHSSA provided a vehicle to engage students across partner organizations.

Project Operations

- The development and application of a project logic model assisted in clarifying initiative goals and anticipated outcomes, as well as guiding the implementation of key actions.

- A strong working alliance between the facilitator and evaluator teams was recognized as mutually beneficial for both teams and was viewed as particularly important during early developmental phases and in the application of lessons learned.
- Securing support from senior organization leaders was recognized as a critical step for sustaining initiative activities and for embedding IPE/IPP related concepts and practices as part of educational and service delivery systems.

IPE/IPP Promotion

- The creation of the BRAID logo served as a key IPE/IPP promotional tool in all phases of the project.
- Investing time in building stakeholder awareness and understanding of the principles and benefits of IPE/IPP was essential to building capacity for interprofessional learning and practice to occur.
- The BRAID website provided an easily accessible portal for dissemination of project materials and information for project stakeholders/participants.
- Using professional associations' publications provided an effective means of communicating with nursing practitioners.
- The BRAID videos appealed to a broad audience of participants and provided a powerful marketing approach for promoting and communicating key messages related to IPE/IPP.

IPE/IPP Planning and Implementation

- The BRAID Interprofessional Competency Framework for Education and Practice provided a practical model for communicating and promoting consistent use of the core competencies and provided structure and principles for all BRAID educational initiatives.
- Using patient narratives (simulated or real) provided a meaningful demonstration of the value of IPE and IPP for all stakeholders.
- Engaging the patient's perspective was central when planning for collaborative patient-centred education or practice initiatives; however, securing this input was challenging.
- The contribution of professionals from diverse health disciplines was identified as a critical component of IPE course development and delivery.

Appendix IX: Literature Scan – IPE

Introduction

What follows is a summary report of a literature and web search on interprofessional education conducted in the summer of 2006. It examines literature that discusses the design, implementation and evaluation of interprofessional health education programs.

Definitions and Terms

Interprofessionality and interprofessional education are emerging concepts. In general terms, they refer to occasions when two or more professions learn *with, from and about* each other in order to improve collaboration and enhance the quality of health care (Oandasan & Reeves, 2005a). Writers in the literature have differentiated the term interprofessional from other terms that have been used as synonyms, for example, multi-disciplinary teams. Emphasis is placed on the prefix *inter* referring to between partners, rather than to *multi* (more than one, but may still be working independently) or *trans* (across, unidirectional). In addition, *profession* is used to differentiate a field requiring specialized knowledge, as opposed to *discipline* referring to a field of study (Oandasan & Reeves, 2005a). An agreed upon definition of interprofessional education is “health professional students learning *with and about each other* in the educational and practice setting” (Barr, 2003; Gilbert, 2005b, p.89)

History and Context

Increasing emphasis upon collaboration between health care professions has been developing since the 1970s, and interprofessional education has been introduced in various forms as a means to facilitate this way of working (Barr, Hammick, Koppel & Reeves, 1999). This movement began as a response to the shift from institutional to community-based health care and reemphasis on population health needs (Schmitt, 2001) and to the pressing needs to reduce duplication of effort, to better use scarce resources, and to meet more effectively the complex medical and social needs of health care patients (Camsooksai, 2002; Irvine et al., 2002; Reeves, 2000). There was also a recognition that no one profession, especially with greater specialization of health professionals, could master all the knowledge and skills required to provide holistic care for patients (Carpenter, Erickson, Purves, & Hill, 2004; Freeth, 2001; Gilbert et al., 2000; Irvine et al., 2002; Tunstall-Pedoe, Rink & Hilton, 2003; Wood, 2001).

In 1978, the World Health Organization (WHO) urged health professions to adopt a more holistic approach to health care (Mandy, Milton & Mandy, 2004). Since then, in Canada, the 2003 First Ministers’ Health Accord on Health Care Renewal has identified that changing the way health professionals are educated is a key component of health system renewal (Oandasan et al, 2003).

Regarding post-graduate education, both the College of Family Physicians of Canada and the Royal College of Physicians and Surgeons of Canada have specified expected competencies and objectives for interprofessional education and for collaborative practice. Training in other health

professions is usually less well defined (Cook, 2005). Researchers have noted, however, that requiring interprofessional and collaborative activities does not equate to either instruction in or assessment of competencies.

In Canada, a number of universities have active interprofessional education programs:

- University of British Columbia's College of Health Disciplines,
- University of Alberta,
- University of Saskatchewan,
- University of Toronto,
- University of Ottawa,
- McMaster University's Division of Rehabilitation Studies,
- Memorial University of Newfoundland
- Dalhousie University (Cook, 2005; Watson & Wong, 2005).

Models

Barr (1996) has categorized some of the many existing interprofessional education models into five types:

- Sharing and exchange
- Action-based and goal driven
- Observation; and shadowing with debriefing and reflection
- Simulation based; skill building
- Interprofessional practice placements

Cook (2005) described five potential models for interprofessional learning.

1. *No specific education on interprofessional health care.* This model assumes that because health professionals are well educated in their own profession, and required by that profession to interact with other professions, that a successful collaborative relationship will develop spontaneously. Cook noted that this model appears to be pervasive in Canada, although less so at major universities.
2. *Some generic team building exercises only.* Team building is a useful skill for which several successful workshops have been developed. Research from studies on collaborative learning in non-health areas indicated that team building is most effective when carried out in context.
3. *Shared instruction in core content area only.* Shared instruction often occurs in relation to areas common to all health professions or areas that transcend professional boundaries, such as ethics and communication skills. In such courses, interprofessional learning may or may not occur.
4. *Shared content but with a deliberate interprofessional focus.* An example of this model might be having students from multiple professions take classes together over an intense short-term period. Learning objectives would include interprofessional approaches to shared case problems.
5. *Specific instruction on interprofessional education.* In Canada, this has been implemented in a variety of ways, including
 - As an elective program (University of BC and for a time, University of Alberta);

- Intermittent discussions throughout the undergraduate education (Dalhousie University);
- A separate course at a particular point in the undergraduate program (Memorial University and University of Alberta)
- Individual clinical placement, where interprofessional practice is a requirement.

Framework

An evolving framework, as described by D'Amour and Oandasan (2005), outlines two interdependent domains: interprofessional education and collaborative practice. Collaborative patient-centred practice is an approach or practice orientation, a means for health care professionals to cooperate with each other and with their patients (Herbert, 2005). Such an approach represents a paradigm shift, in particular in the values, codes of conduct, and ways of working together among professionals (Herbert, 2005). Interprofessional education and collaborative patient-centred practice are considered interdependent because the education process requires settings for learners to practice and experience collaboration (D'Amour & Oandasan, 2005). In order to ensure that these potential benefits of this model of health care are realized, it is necessary to ensure that the education model and practice model reflect each other.

Interprofessional education is considered to have micro level factors centred around teaching, meso level factors relevant to institutions, and macro level factors that concern systemic aspects of both the educational and the professional systems (D'Amour & Oandasan, 2005).

An overview of the education model is as follows:

Systemic Factors (macro)

- Affect both the learning and the practice settings. vision for health, social and educational systems that fits with interprofessionality (D'Amour & Oandasan, 2005).

Institutional Factors and Organizational Structure (meso)

- Leadership / resources
- Administrative processes (D'Amour & Oandasan, 2005).

Teaching Factors and Human Relationships (micro)

- Learning context: how to teach, who is involved, what to cover, when exposure or immersion to collaborative practices should occur
- Faculty development: how to facilitate interprofessional education, recognizing ones own professional beliefs and attitudes regarding interprofessionality and collaboration (D'Amour & Oandasan, 2005).

Systemic Factors (Macro)

Structural and financial separations of training programs may serve to segregate professionals and fail to provide opportunities to teach or practice collaboration (D'Amour & Oandasan, 2005). Faculties define their own curricula, and set rules for examination of students and

assignment of teaching responsibilities. Reward systems of promotion, tenure, and merit are based on single disciplines or departments, not on interprofessional activities (Gilbert, 2005b).

Regulatory bodies act to define scopes of practice, and may implement policies that impact on adoption of collaborative practices (D'Amour & Oandasan, 2005). Professional associations often seek to maximize autonomy and respect for their members and in the process may not duly acknowledge the roles and competencies of others in the health care system. Such professional bodies exert control over whether interprofessional education may progress, as they establish ethical boundaries, guidelines for curriculum, and the amount of contact students have with patients before graduation. Between 1995 and 2005, several professional associations in Canada have made provision for the inclusion of interprofessional experiences in education (Gilbert, 2005).

Institutional accreditation processes can act as powerful forces for collaborative efforts, especially if they include monitoring measures of collaboration and interprofessional education (D'Amour & Oandasan, 2005). Without inclusion of interprofessional education in accreditation standards, there is no extrinsic motivation for academic institutions to engage in such activities (Gilbert, 2005). Gilbert also emphasizes that interprofessional education itself should not be accredited by any external agency, but should instead become an integral part of disciplinary accreditation.

Institutional Factors and Organizational Structure (Meso)

Collaboration must occur not only within teams, but also within and between organizational settings, for example as part of a health care network. Leadership individuals assume governance roles. At this level, the structure of clinical care is formalized, and might include the development of shared information protocols and procedures (D'Amour & Oandasan, 2005).

Leadership / Resources

Factors related to leadership include the development of a vision of interprofessionality. The success of any initiative implementing interprofessional education is dependent on institutional and political leaders (Oandasan & Reeves, 2005b). In addition, interprofessional education requires administrators with capacity and authority to provide resources, decide on educational policies, and promote champions of the vision (D'Amour & Oandasan, 2005; Oandasan & Reeves, 2005b).

Administrative Processes

Administrative processes refer to methods of organizing and implementing interprofessional education, including financial incentives and logistical decisions (D'Amour & Oandasan, 2005). Challenges to interprofessional education may be encountered in the form of inequalities in the number of students (and money tied to student counts), differences in assessment methods, and timetable clashes because of curricula differences (Horsburgh, Perkins, Coyle & Degeling, 2006; Oandasan & Reeves, 2005b). Other potential difficulties arise when attempting to secure joint validation and accreditation, or to negotiate financial arrangements (Oandasan & Reeves, 2005b).

One important question is whether interprofessional courses and experiences are mandatory or elective for students. Researchers argued that mandatory requirements convey the message that

such learning is an essential part of education, and will compel completion by those who are potentially less interested in participating (Freeth & Reeves, 2004; Oandasan & Reeves, 2005a).

Teaching Factors and Human Relationships (Micro)

Content and Participants

In interprofessional education, learners must gain an understanding of not only their own role and potential contribution to the team, but also that of other professionals (D'Amour & Oandasan, 2005). Key issues include teambuilding or collaborative working (Gilbert et al., 2000; Horsburgh, Lamdin & Williamson, 2001; Parsell & Bligh, 1998; Tunstall-Pedoe et al., 2003). At early stages, education should focus on content and exercises that develop group skills, communication skills, conflict resolution skills, and encourage interpretation of a given situation from a new perspective (Barr, 1998; Barr, 2005; Freeth & Reeves, 2004; Gardner, Champerlin, Heestand, & Stowe, 2002; Hall & Weaver, 2001; Horsburgh et al., 2001; Tunstall-Pedoe et al., 2003).

Learners of interprofessional education include students, health educators, and post-licensure practitioners. Interprofessional education may occur pre-licensure when students are still in formal training, or post-licensure once they become an independent practitioner (Oandasan & Reeves, 2005a). Post-licensure learning is more familiar to some people as “professional development” or participation in “joint training” or “shared learning” (D'Amour & Oandasan, 2005; Oandasan & Reeves, 2005a).

Learning Context

In most post-secondary educational institutions, individuals in one health profession are trained separately from those of another profession. They are typically housed in separate buildings, and have minimal interaction with students of other professions (Oandasan & Reeves, 2005b). Such isolationist tendencies may spill into social interactions, and researchers have cautioned that occasions which are meant to advance interprofessional education must facilitate and structure exchanges between pre-existing groups (Carlisle, Cooper & Watkins, 2004).

Interactions and interfacing between different professionals are necessary components of socialization processes, i.e., the transfer of attitudes, beliefs and behaviours from established community members to new entrants (Oandasan & Reeves, 2005b). Professional and cultural beliefs and attitudes that develop among health professionals can affect their willingness to collaborate with other health professionals (D'Amour and Oandasan (2005). Several differences among professions that have been emphasized, including:

- Types of professional knowledge, and the value placed on social or natural sciences
- Perceived academic status, prestige of the profession
- Expectations of how others will perceive them and behave towards them (Oandasan & Reeves, 2005b).
- Views regarding clinical work organization, responsibility, and accountability (individual vs

collective) (Horsburgh, Perkins, Coyle & Degeling, 2006).

Different professions will each bring their own “aims, objectives, priorities, and philosophical position which result in different approaches and perspectives on what is judged as quality care” (Gilbert, 2005b, p. 89) Learners enter disciplines and programs with already-formed stereotypes of their own profession and that of others. Stereotypes often reflect pay scale and funding differentials and contribute to perception of class structures and hierarchies of status or prestige. Strong identification with one discipline is thought to contribute to perceptions of exclusive professional turf and to practices of operating in service delivery silos. Interprofessional education aims to emphasize perceptions of common territories, and to shape the process of identifying with a discipline by providing role models of educators and professionals who practice collaboration (D’Amour & Oandasan, 2005; Gilbert, 2005b).

Issues of socialization and stereotypes pervade discussions around when is the best time to expose learners to concepts of interprofessional learning, and whether that exposure should take an immersion format. Some researchers are proponents of offering interprofessional education in the initial phases of student programs, with the rationale that it will prevent stereotyping attitudes from developing. In contrast, it has been argued that if interprofessional education it is introduced at the initial phase of training, the student will not have had time to acquire experience necessary for knowing how or what they can contribute to a team. In addition, students in early years may perceive the aim of collaborative practice as only remotely relevant to them, and may be pre-occupied with learning their profession-specific knowledge and skills. At the other extreme, when interprofessional education is introduced to post-licensure practitioners, it is often regarded with suspicion because its apparent purpose is to change and enhance the current practices (Carlisle et al., 2004; Oandasan & Reeves, 2005a).

Facilitating Factors

Studies of interprofessional education processes have concluded that it needs to be ongoing throughout the educational experience, built on a model of student development, case/scenario-based, interactive, patient/client focused, and developed with the prerequisites for teamwork in mind (Barrett, Greenwood & Ross, 2003). Interprofessional education often uses a progression, moving from “paper” cases to simulated patients to real cases with real people (D’eon, 2005; Hall & Weaver, 2001).

Environment and settings

Non-threatening learning environments are essential for interprofessional education (Oandasan & Reeves, 2005a; Parsell & Bligh, 1998). Essential conditions in such learning environments include: equal status of participants, a sense of optimism, understanding of professional differences and similarities, and the perception that other group members are typical representatives of their profession (Barnes, Carpenter & Dickenson, 2000; Oandasan & Reeves, 2005a;).

Community placements provide exposure to professional practice, help to build cultural competency, and have an influence on learners’ attitudes and social responsiveness (Reeves, 2000; Ross & Southgate, 2000). Student placement settings provide opportunities to observe,

shadow, and practice. To ensure positive experiences, it is essential that health professionals being observed or shadowed also be engaged in the interprofessional education process and welcome the learners into their environment (Carlisle et al., 2004).

The role of preceptor provides a link between practice and education, as it facilitates the application of theoretical knowledge in practice settings (Pickens & Fargotstein, 2006). Preceptors assist recent graduates and new employees in adapting to their clinical roles, and are recognized as promoting recruitment and retention. Preceptors may benefit from educational programs designed specifically for them (Pickens & Fargotstein, 2006).

Methods

Themes that emerge on effective interprofessional education methods include emphases on interaction, on adult learning principles, and exercising critical thought and reflective processes (Barr, 2005). Interactions should be guided to facilitate participants in jointly negotiating solutions to cases and problems (Reeves, 2000).

Researchers have investigated pedagogic approaches that best accommodate interprofessional learning (Adams et al., 2005; Barr, 2005; Barr, Freeth, Hammick, Koppel & Reeves, 2006; Cooper, Carlisle, Gibbs & Watkins, 2001; Edward & Preece, 1999; Freeth, Hammick, Koppel, Reeves & Barr, 2002; Freeth & Reeves, 2004; Guest, Smith, Bradshaw & Hardcastle, 2002; Hall & Weaver, 2001; Ker, Mole & Bradley, 2003; Mires et al., 1999; Parsell & Bligh, 1998; Reeves, 2001; Wahlstrom & Sanden, 1998). The following teaching methods were found to have been the most commonly used:

- Problem-based learning with a focus on shared case problems
- Small group and seminar discussions
- Role play and simulated ward experiences
- Workshops with problem-based multidisciplinary case studies
- Team building sessions
- Student placement settings

Some researchers have emphasized the value of role play and simulation-based approaches. They noted that such methods allow for interactive “learning through doing” and experiencing a team from different perspectives. Morison and Stewart (2005) provide sample checklists to assess role play and simulation-based sessions, including behavioural indicators to be rated on quality of information conveyed, effectiveness of communication, and professional roles and team-working.

Opportunities for reflection are key components of strategies to teach interprofessional education. As part of case problem-solving exercises, learners must contend with complex issues, for example, those related to hierarchy, role blurring, decision-making, and leadership. Researchers noted that engagement in self and group reflection enhances understanding of one another’s roles, backgrounds, and perspectives on clinical decisions (D’Amour & Oandasan, 2005; Parsell, Spalding & Bligh, 1998; Pirrie, Wilson, Harden & Elsegood, 1998; Wood, 2001).

Faculty Development

Faculty development refers to activities that institutions might use to renew or support faculty in their multiple roles. The activities may be designed to prepare individuals or institutions, or to improve their knowledge and skills with respect to teaching, conducting research, and administrating (Steinert, 2005).

Faculty may play roles related to establishing an environment that supports the goals and objectives of interprofessional education, and also act as role models. As teachers they facilitate team formation and functioning. Literature on facilitation strategies emphasizes skills relevant to managing small groups and working in a collaborative manner (Steinert, 2005).

As researchers have observed, most teachers are not at ease with material and processes outside of their discipline, and have not themselves undergone training in collaborative environments (Steinert, 2005). An essential aspect of faculty development is having teachers of different health professions learn together about teaching and about interprofessional education (Steinert, 2005). Teacher training programs were identified as a means of providing teachers, both in classroom and in practice settings, with the knowledge, skills and attitudes necessary to foster interprofessional education (Steinert, 2005).

Resistance to interprofessional education is sometimes based on the perception that it aims to inappropriately simplify knowledge from various disciplines, or that it is about ensuring that learners are multiply-skilled (Gilbert, 2005a). Faculty attitudes identified as barriers to interprofessional education included “condescension and defensiveness” and an air of “academic elitism” (Steinert, 2005). Suggestions put forth for fostering interprofessional education through faculty development included:

- Have faculty development sessions attended by members of diverse health professions
- Create of neutral and safe spaces for dialogue and interaction
- Discuss of the overlap of different roles, recognition of the friction due to overlap
- Focus on generic skills of teaching
- Educate faculty members in teams that aim to change the work environment (Steinert, 2005).

Outcomes

Learner Competencies

Researchers have begun to outline specific competencies to be obtained by learners of interprofessional education in the areas of knowledge, skills, and attitudes. Knowledge includes content related to group facilitation and functioning, roles and contributions of one’s own and other professions, as well as familiarity with conceptual models of health care. Skills to be developed lie in the areas of communication, conflict resolution, problem solving, coping with uncertainty or ambiguity, leadership, and group reflection practices. Attitudes to be fostered in interprofessional education include a willingness to work together, mutual respect, and an openness to trust in the competencies of self and others (D’Amour & Oandasan, 2005; Freeth & Reeves, 2004; Oandasan & Reeves, 2005b).

Competence, or excellent performance in a specific work context, is a useful concept in defining standards and expectations. As part of interprofessional education, competencies help to ensure consistent and equitable performance assessments, and to link education programs with evidence-based criteria (Oandasan & Reeves, 2005a; Verma, Paterson & Medves, 2006).

Organizational Practice and Collaboration

Interprofessional education and teams are believed to offer benefits for the health care system and the professionals in that system. With respect to the system, interprofessional teams yield a more efficient service provision, with reduction in service duplication and minimizing of unnecessary intervention (Freeth & Nicol, 1998; Hall & Weaver, 2001; Ker et al., 2003). In addition, there is a potential decrease in the burden placed on acute facilities as a result of increased prevention and patient education interventions (Grant et al., 1995).

In terms of interprofessional education's impact on health care delivery professionals, the following benefits may be realized:

- Higher levels of professional satisfaction and personal confidence (Barr, 2005; D'Amour & Oandasan, 2004; Freeth & Nicol, 1998; Glen, 1999; Hall & Weaver, 2001; Pirrie et al., 1998; Wood, 2001)
- Enhanced understanding of teamwork with students prepared to share experiences (Atkins & Walsh, 1997; Barr, 2005; Forman & Nyatanga, 1999; Harden, 1998; Horsburgh et al., 2001; Parsell & Bligh, 1998)
- Increased mutual knowledge and understanding of the roles of other professions (D'Amour & Oandasan, 2005; Freeth & Chaput De Saintonge, 2000; Freeth & Reeves, 2004; Gilbert et al., 2000; Horsburgh et al., 2001; Morison, Boohan, Jenkins & Moutray, 2003; Parsell & Bligh, 1998; Pirrie et al., 1998)
- Improved intra- and inter- professional communication with the development of common concepts, values, perspectives, and language (D'Amour & Oandasan, 2005; Edwards & Smith, 1998; Lough et al., 1996; Mandy et al., 2004; Pirrie et al., 1998).

In order to ensure that these potential benefits of this model of health care are realized it is necessary to ensure that the education and practice models reflect each other. Evidence of positive outcomes related to interprofessional education and collaborative practice would include an increased number of settings where collaborative practice is modelled. Another favourable outcome would be more visible role models of health professional who transcend turf barriers, and demonstrate respect for and knowledge of the different skills brought by different professions (Herbert, 2005).

Patient Involvement

The use of interprofessional teams in patient-centred practice may include benefits for patients, as manifested through increased coordination of services, integration of health care for a wide range of health needs, and empowerment as an active partner in care (Grant et al., 1995). The framework of D'Amour and Oandasan (2005) indicates that learning among professionals impacts patient outcomes, and patient perspectives inform the learners. In particular, the model

emphasizes that to be effective as an education programme for patient-centred care, the interprofessional education must be informed by the patients' views of illness and wellness trajectories. Patients may inform programme development, and may be involved in the steering committee.

Evaluations

Few studies have examined pre-licensure or pre-registration interprofessional education (D'Amour & Oandasan, 2004; Reeves, 2000) and most evaluation studies are American, but findings are similar to those in the U.K. (Reeves, 2000). The limited evaluation of interprofessional education that has been done has primarily identified outcome effects related to changes in attitude, skills, and beliefs; has not been able to discern effects on professional practice; and has rarely used educational and psychological theories to guide the development of interprofessional education (Cooper et al., 2001). Freeth et al. (2002) report that over half (51%) of the outcomes reported in studies are related to the learners' views on the learning experience and its interprofessional nature. The acquisition of knowledge and skills, and changes in organizational practice were the next common, followed by attitudinal changes, patient benefit, or changes in practitioner behaviour.

In the few studies that included a control group, it was not always shown that reciprocal perceptions were improved or sustained or that patients received direct benefit (Barr et al. (1999). A review of UK evaluations was commissioned by the British Educational Research Association in cooperation with CAIPE (Hammick, 2000). This review confirmed the findings of Cooper and her colleagues (Cooper et al., 2001) that outcomes of interprofessional education were primarily related to changes in knowledge, skills, attitudes, and beliefs, and that effects on professional practice were not able to be discerned (Barr, 2005).

In a systematic review of evaluations of interprofessional education that were subject to criteria set by the Cochrane Collaboration (where evaluations randomized and clinical controlled trials, before-and-after studies, or Interrupted Time Series Studies) initial searches of CINAHL and MEDLINE databases produced 1062 abstracts from which 99 potentially met the criteria. An analysis of these showed a lack of methodological rigour, with none fulfilling the strict criteria (Barr et al., 1999; Zwarenstein, et al., 2001). As Zwarenstein et al. (1999) pointed out, however, "it is important to stress that our finding of no evidence of effectiveness does not imply that there is evidence of ineffectiveness of interprofessional education, simply that no such evidence currently exists" (p. 422).

Another Cochrane review with similar criteria was conducted in November 2003. Of the 26 relevant articles, there were no studies of pre-licensure interventions, all were reports on post-licensure collaborative efforts (Zwarenstein, Reeves & Perrier, 2005). Post-licensure collaboration has proven easier to assess with methods of quantitative rigour. Results of the 2003 Cochrane Collaboration review indicated that there was reliable evidence of collaborative interventions having a positive impact on patient and health care processes and outcomes (Zwarenstein et al., 2005).

Reviewers using Cochrane Collaboration criteria noted the difficulties inherent in conducting controlled trials of pre-licensure interprofessional education, as schools would need to be the unit of randomization (Zwarenstein et al., 2005). Groups of intervention schools in the health sciences would be facilitated in undertaking interprofessional education, and other randomly assigned health science schools would need to be prevented from initiating interprofessional and collaborative activities. The researchers also stressed the need for qualitative research designs to explain effects of pre-licensure interprofessional education (Zwarenstein et al., 2005).

Other researchers have extended cautionary advice against reliance on limited methodology, that is, quantitative controlled trial or before-and-after measures that do not capture processes of student interaction (Reeves, 2000). Other researchers have questioned the wisdom of applying evidence-based criteria in evaluating the complexities of education research (Carpenter et al., 2004). Researchers have stressed that randomization of learners and blinding of assessors may be impossible, inappropriate and artificially contrived, and have advocated for qualitative criteria of learning that can inform formative as well as summative evaluations (Stone, 2006). With this perspective, a parallel review was conducted using the same sources as the Cochrane Collaboration systematic review, but taking into account a wider range of research methodologies and a continuum of outcomes. Preliminary findings were that when interprofessional education altered practices or benefited patients, it usually took the form of in-service sessions where the learners were qualified practitioners. In such contexts, learners might have daily contact with patients and be apt to form stronger links than those forged between pre-registration learners and patients (Hammick, 2000).

Several studies have been conducted recently into the student perspective on interprofessional education and collaborative practice. Interprofessional education programs were described by students as important in improving patient care, fostering critical and lateral thinking, and in providing opportunities to develop their own roles as well as their function as team members (Kilminster et al., 2004; Koffman & Higginson, 2005; Lumague, et al., 2006; Pozner et al., 2004). Students at their second module level were asked to provide feedback on their interprofessional education experiences. They emphasised that it was essential for students involved to feel they had a relevant contribution to make as a team member. Other critical areas for success included opportunities to transfer classroom skills to clinical settings, and to minimize episodes of negative group dynamics. Students indicated they had come to appreciate the approach to learning, which was guided by a facilitator instead of a teacher. They also noted that the interprofessional education program had increased their knowledge of others' role as well as their own confidence to participate in collaborative interactions (Johnson, 2005).

Researchers have identified the need for more work on “defining outcomes and long-term benefits for patient care and agreement on core interprofessional competencies and educational method” (Ross & Southgate, 2000, p. 742). They have also called for a “greater number of studies based in the interpretive and critical paradigms, more emphasis on process, and more examples of qualitative data collection” (Freeth et al., 2002, p. 44).

Cook (2005) noted that in making evidence available with respect to interprofessional and collaborative activities, research challenges would need to be overcome. As the professionals involved in such initiatives are involved in many time-consuming tasks, they may not make time

for writing publications. Further, because individuals from multiple professions should author the publication, writing itself will take more time and make demands on more people. Faculty would benefit from tenure and promotion committees who would “give due weight” to interprofessional publications.

Future of Interprofessional Education

The importance of leadership and the commitment to the organizational change necessary to implement and sustain pre-registration interprofessional education in the curriculum cannot be overemphasized (Ross & Southgate, 2000). Without resources, time, and organizational capacity, the barriers to interprofessional education will simply remain insurmountable.

As mentioned earlier, the First Ministers’ Accord in 2003 included a health human resources strategy to promote interprofessional education and to thereby advance collaborative care. In addition, in 2004 the First Ministers renewed their commitment to initiatives to support interprofessional education with the development of a Canadian Health Human Resources Strategy (Watson & Wong, 2005). One component is the Interprofessional Education for Collaborative Patient-Centred Practice strategy with the ultimate goal of the multi-year initiative being the development and implementation of various facets of interprofessional education for collaborative patient-centred practice in all health sectors in Canada. Interprofessional education is still in its infancy in Canada, but “with the commitment of governments, post-secondary institutions, and the different health professions, interdisciplinary education and subsequent inter-professional collaborative practice may become a more predominant characteristic in primary health care” (p. 23).

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Appendix X: Competencies Framework

Interprofessional Competencies: A Framework for Education & Practice

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Acknowledgements:

This report was made possible through a financial contribution from Health Canada. The views expressed in this report do not necessarily represent the views of Health Canada. The authors would like to acknowledge the support and contributions made by members of the BRAID Curriculum Advisory, Educator Development and Post-Licensure Working Committees.

BRAID - Bridging Relationships Across Interprofessional Domains

BRAID is funded by Health Canada under the Interprofessional Education for Collaborative Patient-Centred Practice (IECPCP) initiative. This New Brunswick project represents a collaborative partnership between the University of New Brunswick (UNB), New Brunswick Community College (NBCC), Atlantic Health Sciences Corporation (AHSC) and Dalhousie University Medical School.

During the first year of the IECPCP initiative, project facilitators, in collaboration the evaluation team, undertook a range of key development activities intended to operationalize an interprofessional education (IPE) model that would address the needs of the interprofessional health community of practice in the greater Saint John area. These efforts entailed delivery of IPE awareness-building sessions, administration of IPE readiness surveys and need assessment activities with health educators, post-licensure health practitioners and students enrolled in various university and college health programs. These preliminary developmental tasks resulted in the creation of several major program outputs designed to guide the implementation of an evidence-informed application of IPE. These program outputs include a competency framework and a theoretical model of change.

The adopted competency framework outlines the knowledge, attitudes/values and skills essential for the effective implementation of IPE processes across educational and practice-based settings. The elements of this framework are consistent with the current IPE literature. They also reflect the professional need areas/competencies endorsed by health students, educators and practitioners in the greater Saint John area.

The theoretic assumptions outlined in this foundational program document highlight the intrapersonal process of change and professional identity development that support the acquisition of essential IPE competencies. This model also considers the key relationship needs that should be met to ensure the actualization of IPE processes in the context of relationships and interactions with others.

Openness to Collaborate

The BRAID framework of interprofessional competencies supports the values inherent in patient-centred collaborative care. The four competencies emerge from the overarching theme of *Openness to Collaborate* and are described in terms of three key facets: knowledge, attitudes/values and skills.

Key insights from a literature scan IPE publications (HERG, 2007) and the outcomes from a baseline IPE readiness survey provided the means by which to identify core competencies to be targeted as part of this initiative. As a result of this preliminary analytical effort, four major competency areas were delineated including: *role clarification and affirmation; effective communication and conflict management; participatory decision-making and problem-solving, and self-awareness and reflective practices*. Core competency areas were subsequently described in terms of three key facets: *knowledge, attitudes/values and skills*.

Knowledge refers to content related to the functioning, roles, and contributions of one's own profession, as well as those of other healthcare providers. It also includes awareness of the benefits and challenges associated with collaborative patient-centred practice (D'Amour & Oandasan, 2005; Freeth & Reeves, 2004; Oandasan & Reeves, 2005b).

Attitudes/Values denote the degree of openness and level of commitment to working collaboratively with other healthcare professionals. Attitudes to be fostered in IPE include mutual respect, an appreciation of individual differences and a willingness to trust in the professional competencies of self and others (D'Amour & Oandasan, 2005; Freeth & Reeves, 2004; Oandasan & Reeves, 2005b).

Skills refer to demonstrated capacities that visibly contribute to the effective delivery of collaborative patient-centred practices. The actualization of essential skills are supported by sufficient knowledge of roles and team functioning, as well as demonstration of attitudes that convey a willingness to collaborate with other health professionals and that value the contribution of all team members (D'Amour & Oandasan, 2005; Freeth & Reeves, 2004; Oandasan & Reeves, 2005b).

The identification of core competency areas is beneficial for ensuring consistent practices and equitable performance assessments in both learning and work-related settings. Similarly, clearly operationalized competencies are also necessary for effectively evaluating IPE models and subsequently linking evidence-based criteria to IPE instructional approaches (Oandasan & Reeves, 2005a; Verma, Paterson & Medves, 2006).

“Interprofessional Education (IPE) is those occasions when members (or students) of two or more professions learn with, from and about each other to improve collaboration and the quality of care” (CAIPE, 1997/2007).

BRAID Competency Framework

Role Clarification and Affirmation:

We understand the roles, responsibilities, competencies and scope of practice of our profession and of other professions in respect to our own. *Knowledge*

We respect and value the roles, responsibilities, competencies and scope of practice of other health professions. *Attitudes/Values*

We can describe patient-centred issues and make decisions based on our professional role, responsibilities, competencies and scope of practice in simulated and/or collaborative teams with other health professions. *Skills*

Effective Communication and Conflict Management:

We understand the principles of effective group process including group reflection practices.
Knowledge

We value open and honest interactions that contribute to the development of trust among interprofessional or intraprofessional teams. *Attitudes/Values*

We routinely use effective interpersonal communication techniques and established processes for addressing interprofessional or intraprofessional group conflict. *Skills*

Participatory Planning, Decision-Making and Problem-Solving:

We understand the processes that facilitate discussion, problem-solving, mutual understanding and information sharing. *Knowledge*

We value and support the participation of all professions in discussion and decision-making.
Attitudes/Values

We use agreed upon participatory processes to plan, make decisions and problem-solve. *Skills*

Self-Awareness and Reflective Practices

We are aware of our personal values and perceptions; and, the ethics and scope of practice of our profession and those of other health professions. *Knowledge*

We value the role that self-knowledge and critical self-reflection play in enhancing interprofessional collaboration. *Attitudes/Values*

We apply self-knowledge and use self-reflection as a means to ensure personal accountability and commitment to the success of collaborative teams. *Skills*

Theoretical Assumptions

The BRAID interprofessional education initiative is based on three major theoretical components: a model of essential competencies for collaborative patient-centred practice, a process of change that demonstrates the move from awareness and knowledge of IPE concepts to the acquisition and actualization of attitudes and skills related to IPE competencies, and the facilitative conditions prerequisite for fostering the creation of effective professional healthcare teams within learning and post-licensure contexts.

Process of Change and Professional Identity Development

D'Amour and Oandasan (2005) describe interprofessional education and collaborative practice as two interdependent domains that have contributed to a new and emerging framework for healthcare delivery in the Canadian context. Herbert (2005) asserts that the preparation,

implementation and sustaining of such patient-centred delivery models requires a paradigm shift, in particular in the professional values, codes of conduct, and ways of working together among healthcare providers, as well as among those being trained as future healthcare professionals. Embracing a new perspective on how health professionals work and interact together involves a process of change for health practitioners and managers, as well as for health educators and students.

A widely used model for understanding the process of change was developed by Prochaska and DiClemente (1983, 1986) and was further elaborated by Prochaska and Norcross (2001). They conceptualized a sequence of stages of change through which individuals progress in adopting attitudes and behaviours that contribute to positive personal growth and development in the context of their relationships and activities with others. With respect to IPE, the process of change could be defined as a series of professional development stages through which pre- and post-licensure healthcare providers not only become aware of the benefits associated with collaborative patient-centred practice, but also become self-determined professionals in the application of IPE competencies within collaborative practice settings. Based on the stages of change model, such a professional development process might be conceptualized in five distinct phases:

Pre-contemplation: Lack of recognition regarding the value of collaborative patient-centred practice, inadequate knowledge of core IPE competencies;

Contemplation: Attendance at IPE awareness or promotional events, exploration of the potential benefits and challenges associated with collaborative healthcare approaches, increased awareness regarding potential reasons or rationales for participation in IPE learning opportunities, and cursory knowledge of IPE core competencies;

Preparation: Participation in IPE core competency-building and practice activities, increased understanding and appreciation of a variety of health professional roles and their contribution to collaborative practice processes, identification of professional strengths and areas for growth related to IPE core competencies;

Action: Application of IPE core competencies in simulated and collaborative practice healthcare settings, participation in a wide range of team-based problem-solving and decision-making processes, use of self-reflection to evaluate and refine execution of core competencies;

Maintenance: Implementation of policy and system supports that assist in extending and sustaining IPE learning and professional development opportunities, evaluation, review and refinement of implemented IPE and collaborative practice models.

Conditions for Change and Learning

The process of change is actualized within the context of relationships or interactions with others. This may include a wide range of IPE professional relationship experiences within classroom settings, collaborative practice team sites or planning meetings among university and college educators. Ideally, the qualities of relationships that are fostered as a result of these interactions will contribute to the development of self-determined healthcare professionals who effectively apply IPE competencies within collaborative practice settings. In this regard, self-determination refers to the capacity to think about, plan, and act on decisions that contribute to one's professional growth and that of other healthcare providers in the context of patient-centred care. The modeling of such professionalism should also characterize the kind of collaborative processes to be fostered within the patient-provider relationship.

The process of change and professional identity development is supported when key relationship needs are sufficiently met within the existing learning or practice context. The fulfillment of these individual needs provides the sources of motivation that create readiness for personal change and learning. According to Deci and Ryan (2000), these individual needs include:

Autonomy, which refers to the need for personal freedom to make choices or decisions that affect our daily work and activities. When this need is satisfied in conjunction with other need areas, freedom and choice are expressed in ways in which respect is demonstrated for self and others.

Relatedness, which refers to the need for connection to and positive working alliances with other significant individuals. Fulfillment of this need is met through interaction with others, membership in groups or collaborative teams, and support and encouragement received from others.

Competency, which refers to the need for recognizing and using personal gifts and strengths in achieving personal or collaborative goals with others. Fulfillment of this need provides individuals with a sense of personal achievement and accomplishment.

Learning or practice-based settings can contribute to the satisfaction of these needs by empowering health professionals and students to collaborate with their peers in the development of their own solutions to specific challenges or issues related to the delivery of patient-centred care. These collaborative efforts ensure opportunities for inclusion and active participation of all health professional groups. As a result of such efforts, collaborative core IPE competencies are not only applied among health professionals in their daily work interactions, but also extended to and modeled within patient-provider interactions. In this regard, patients are introduced to autonomy-supportive health care contexts in which they become active participants and collaborators in the management of their own health and wellness (Williams, Frankel, Campbell & Deci 2000).

An Example: Interprofessional Competencies for BN Students

The following demonstrates an application of the BRAID Interprofessional Competency Framework in relation to a health discipline learner while demonstrating the process of change and professional identity development.

Openness to Collaborate broad general abilities essential to interprofessional education.

1. Role Clarification and Affirmation
2. Effective Communication and Conflict Management
3. Participatory Decision-Making and Problem-Solving
4. Self-Awareness and Reflective Practices

Contemplation – Preparation Beginning Level (Knowledge) - Learners:

1. (a) Describe the roles, competencies, ethics and scope of practice of the nursing profession.
(b) Describe the roles, competencies, and scopes of practice of other professions in respect to nursing.

2. Define the principles of effective group task and maintenance functions including group reflection.
3. Recognize the processes that facilitate group discussion, problem-solving mutual understanding and information sharing.
4. Identify personal values and perceptions. **Autonomy**

Preparation – Action Intermediate Level (Attitudes/Values) – Learners:

1. (a) Identify the roles, competencies, ethical codes and scopes of practice of intraprofessional and interprofessional co-learners.
(b) Demonstrate respect and value for the roles, competencies, ethical codes and scopes of practice of other health professions learners.
2. Demonstrate open and honest interactions that contribute to the development of trust among interprofessional or intraprofessional co-learners.
3. Integrate and support the participation of interprofessional or intraprofessional co-learners in discussion and decision-making.
4. Evaluate the role that self-knowledge and critical self-reflection plays in enhancing intraprofessional and/or interprofessional collaboration. **Relatedness**

Action Advanced level (Skills) – Learners:

1. Evaluate patient-centred issues and make decisions based on nursings’ roles, competencies, ethical code and scope of practice in practice-based or simulated collaborative teams.
2. Routinely use effective interpersonal communication techniques and established processes for addressing interprofessional or intraprofessional group conflict.
3. Use agreed upon participatory processes to plan, problem-solve and make decisions in practice-based or simulated collaborative teams.
4. Apply self-knowledge and use self-reflection as a means to ensure personal accountability and commitment to the success of collaborative teams in practice-based or simulated situations. **Competency**

Post-licensure goal is the ongoing maintenance and continuing development of competencies.

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Appendix XI: Educator Strategies

1. A Term Case Study Approach for Comprehensive Patient Care Planning

Targeted Core Competency:

√ *Role affirmation and clarification*

Objective/Goal:

To increase students' understanding of the roles, responsibilities and scope of practice of other health care providers, with a focus on those health care team members trained in programs offered at NBCC and UNB.

Description/Instructional Methods:

This problem-based/experiential learning approach is designed to be undertaken as a term project across disciplines, in the second term of both 1-year and 2-year programs. This learning activity includes the participation of both educators/instructors and students. During a half-day workshop session small groups of students representing different disciplines will be presented with a case study from which they are to create a comprehensive patient care plan. These term projects are to be student-directed and similar to a term research report or thesis. Each group will be assigned an instructional supervisor with whom they can consult.

Evaluation/Follow-up Processes:

At the close of the term students will present their comprehensive patient care plan to a panel that will be composed of instructors and health care professionals from the local health authority. Feedback will be elicited from the panel, as well as from other student small groups regarding the presented care plans.

2. A Health Profession Fair

Targeted Core Competency:

√ *Role affirmation and clarification*

Objective/Goal:

To introduce to students the wide range of roles, responsibilities, competencies and scopes of practice within a variety of health care professions

Description/Instructional Methods:

The purpose of this activity is to explain to new students entering various health care fields the roles of individual health professionals. This would be an ideal activity to conduct during the first few weeks of classes at the start of the term.

This learning activity involves the preparation of a health employment fair in which instructors and senior students organize and coordinate a series of health profession exhibits for beginning students. Exhibits would feature equipment or tools, types of data gathered, and small demonstrations of activities for each discipline. At each exhibit, students would have the opportunity to observe or participate in hands-on learning activities. Seniors students and instructors would be available to answer questions posed by new students.

Evaluation/Follow-up Processes:

For completion of this activity, student participants would be paired with a peer from an alternate health discipline. Together these students would complete a checklist or questionnaire intended to facilitate a review of the information gleaned from the various exhibits visited (e.g., scavenger hunt type activity).

3. A Series of Learning Activities to Increase Role Clarification

Targeted Core Competency:

√ Role affirmation and clarification

Objective/Goal:

To assist students in understanding the role and activities of varied health professions

Description/ Instructional Methods:

The following provides a range of possible activities that could be undertaken with students from various health professions to increase role affirmation and clarification:

- Organize a multi-disciplinary health panel and have professionals describe their roles to students
- Model IP activities being undertaken by diverse health professionals in problem-solving a case study
- Have students interview health professionals regarding their role and relationship to other health service providers
- Include students in rotations with other health professionals
- Have students analyze the ethical codes of varied health professions noting areas of convergence and difference

The preceding activities could be undertaken individually or as part of an IPE workshop or information session.

Evaluation / Follow-up Processes:

Follow-up activities could include administration of on-line evaluations, completion of reflection papers or journals or required participation in on-line discussion forums with students from varied health disciplines.

4. Observing Intact Interprofessional Teams

Targeted Core Competency:

√ Role affirmation and clarification

Objective/Goal:

To provide students with an orientation to the roles and responsibilities of different health care professionals who serve on interprofessional teams

Description/Instructional Methods:

This learning activity provides students with insight into individual health professions, as well as the nature of their roles and interactions within the same interprofessional team. The use of intact teams to demonstrate effective implementation of IP concepts could be undertaken in a variety of ways including:

- Panel discussions with interprofessional teams members
 - Video presentations of actual interprofessional team meetings
 - Role playing team situations that address realistic case study examples
 - Job shadowing opportunities to observe interprofessional teams in practice in health care settings
-

Evaluation/Follow-up Processes:

Reflection papers or activity responses to identify core IP competencies and the nature of their implementation,

5. Applied Theory and Skill Development

Targeted Core Competency:

√ *Effective communication and conflict management (Role affirmation and clarification is assumed for this learning activity).*

Objective/Goal:

- to identify principles of effective group processes (communication, conflict management)
 - to demonstrate knowledge of effective communication and conflict management techniques
 - to engage in reflective practices
-

Description/ Instructional Methods:

Students will be provided with a series of mini-lessons and reading assignments designed to increase their knowledge of basic group theory and interpersonal skill development (e.g. effective listening, conflict management skills). Through case study discussions (video/written) and role play situations students will apply their theoretical knowledge and practice effective use of basic interpersonal and helping skills. Guided reflection exercises will provide students with the opportunity to evaluate their own professional growth with respect to basic theoretical concepts and acquired skills.

Evaluation /Follow-up Processes:

Learning/reflective journals
Self-assessments

6. Identification of Challenges to Interprofessional Practices and Potential Solutions

Targeted Core Competency:

√ *Effective communication and conflict management*

Objective/Goal:

To identify challenges and solutions associated with IP communication and conflict management

Description/Instructional Methods:

Students are presented with a digital recording or role play of a team-based case situation. In this scenario interprofessional competencies related to effective communication and conflict management are not demonstrated. Students are invited to analyze the given situation and identify challenges or obstacles that impede interprofessional team work. They are also asked to consider what team actions could assist in enhancing patient-centred care.

Evaluation/Follow-up Processes:

Small group discussions followed by submission of an individual reflection paper

7. Interprofessional Planning and Decision-Making to Address a Health Care Crisis

Targeted Core Competency:

√ Participatory planning, decision making and problem solving

Objective/Goal:

To assist students in evaluating how various professions respond to a health care crisis.

Description/Instructional Methods:

Students are presented with a mock health care crisis situation (e.g. Airplane crash, SARS, or a disaster identified by an Emergency Medical Organization- EMO). Through library and on-line research and interviews with health professionals, students in small groups from varied health disciplines are invited to formulate an interprofessional team response to the given scenario. Group responses would subsequently be presented and peer feedback would be elicited to consider the IP process and consequences of each suggested approach for addressing the health care crisis situation.

Evaluation/Follow-up Processes:

Small group presentations, peer feedback and instructor observations

8. Rotating Leadership Roles in Interprofessional Planning and Decision Making

Targeted Core Competency:

√ Participatory planning, decision making and problem solving

Objective/Goal:

To provide students with direct experiences in leading or facilitating an IP planning and decision making process

Description/Instructional Methods:

Small groups of students from varied health disciplines will be presented with a patient chart and/or a case situation. To address the specific challenges or areas of concern related to the given case, students will be required to meet as a planning and decision making team on several occasions. For each team meeting, students will rotate team leadership or facilitator roles.

Evaluation/Follow-up Processes:

Team member checklists will be used to examine participatory methods. Individual reflections will be completed to investigate students' perspectives regarding their role as a facilitator.

9. Analysing IP Planning and Decision Making Approaches

Targeted Core Competency:

√ Participatory planning, decision making and problem solving

Objective/Goal:

To evaluate specific IP planning and decision making models and their effectiveness in facilitating shared understanding, participatory methods, information sharing and patient plan development

Description/Instructional Methods:

Provide students with specific team meeting approaches or structured models for implementation of participatory IP planning and decision making processes. Once the given models have been introduced, invite students to apply the given IP team approaches to specific case plan situations. As a follow up to this exercise, invite students to consider the challenges and benefits associated with the given IP models.

Evaluation/Follow-up Processes:

Hold a class debate to analyze the advantages and disadvantages of specific IP meeting or problem solving formats.

10. Recognising and Affirming IP Contributions to Planning/Decision Making Processes

Targeted Core Competency:

√ Participatory planning, decision making and problem solving

Objective/Goal:

To assist students in identifying and affirming the contribution of various health professions to IP planning/decision making processes

Description/Instructional Methods:

Present students with a digital recording or in-class dramatization of IP team meeting in the process of making plans or making decisions about a given case situation. In small groups invite students to identify the roles and contributions of each health professional team member. In addition, ask small groups to identify any concerns or strengths associated with the depicted team processes.

Evaluation and Follow-up Processes:

Following completion of the small group discussions, hold a debriefing session with the full class. Students may also be given the option of rewriting the given drama incorporating class feedback to enhance the original IP process.

11. Educator Exchanges

Targeted Core Competency:

√ Self awareness and reflective practices

Objective/Goal:

To provide continuing education and to rekindle educational enthusiasm of instructors

Description/ Instructional Methods:

Invite instructors to observe or participate in two or three classes from alternate health disciplines of their choice. As part of this professional experience, instructors could be invited to lead or coordinate an IPE student activity in collaboration with educators from the given class site.

Evaluation/Follow-up Processes:

Recognition of this site visit and its outcomes could be documented in instructors' professional development folder or portfolio.

12. Researching and Sharing Evidence-informed Interprofessional Practices

Targeted Core Competency:

√ Self awareness and reflective practices

Objective/goal:

To foster collaboration and knowledge of evidence-informed IP practices among students from varied health disciplines

Description/Instructional Methods:

As part of class requirements, organize students into small group literature or journal club teams. Ask students to consult the literature databases from their respective disciplines to identify evidence-informed practices related to IP health care team approaches. Upon completion of their research, students would subsequently share their findings with other team members.

Evaluation/Follow-up Processes:

Have each literature group prepare a poster of their key findings related to IP practices and present them at in-class conference day.

13. Interdisciplinary Clinical Rounds and Interprofessional Team Participation

Information on the part of competency framework this group is working on:

- √ Role affirmation and clarification
 - √ Effective communication and conflict management
 - √ Participatory planning, decision making and problem solving
 - √ Self awareness and reflective practices
-

Objective/Goal:

To acquaint students with the full range of interprofessional practices through participation in clinical rounds and interprofessional team meetings

Description/Instructional Methods:

As part of on-site clinical educational programming students will be invited to observe and participate in a wide range of interprofessional processes in various health care settings. Small group debriefing sessions, reflective journaling, as well as interactions with post-licensure professionals will provide the basis for gaining direct experience with and opportunities for enhancing core IP competencies.

Evaluation/Follow-up Processes:

Instructor feedback and observations, clinical supervisory feedback, reflection journals

Appendix XII: Post-licensure Training Module Feedback

Module 1

	Mean Rating	Strongly Disagree		Neutral		Strongly Agree	
		1	2	3	4	5	
Know Thyself							
1. This workshop addressed my learning needs in this area.	4.5			6%	34%	59%	
2. The information that was provided was applicable to my practice/work.	4.3			9%	48%	42%	
3. My participation in this workshop has enhanced my knowledge and skills in this area.	4.4			3%	52%	45%	
4. My participation in this workshop will influence my practice/work in this area.	4.2			6%	64%	30%	
5. The trainer was knowledgeable of the subject matter being presented.	4.9				6%	94%	
6. The trainer presented the information in a clear and concise manner.	4.9				9%	91%	
7. The trainer was enthusiastic and responsive to participants' learning needs.	4.8				21%	79%	
8. There was opportunity to interact with other participants.	4.3			3%	61%	36%	
9. There was opportunity to interact with the trainer.	4.4					55%	45%
10. The facilities were comfortable and conducive for learning.	4.5					48%	52%
11. The module was well organized.	4.7					30%	70%
12. I would recommend this workshop to others.	4.7					33%	67%

Modules 2-4

Only one facilitator was present for each of Modules 2, 3, and 4. Ratings for this facilitator are reported. Participants were asked to rate the extent to which the facilitator was well prepared, knowledgeable, and approachable, as well as how good the presentation was.

Module:

Effective Interpersonal Communication: overall 3.5 (range of ratings: 2 – 5)

Structuring Your Team: overall mean = 4.7 (range of ratings: 2 – 5)

Collaborative Decisions: overall mean = 4.8 (range of ratings: 3 – 5)

Respondents were asked their opinion regarding the small group activities, specifically the extent to which they found them stimulating.

Module

Effective Interpersonal Communication: mean = 3.4 (range of ratings: 1 – 5)

Structuring Your Team: mean = 4.2 (range of ratings: 3 – 5)

Collaborative Decisions: mean = 4.7 (range of ratings: 3 – 5)

Participants rated the usefulness of the module as a blended learning experience (e-learning and classroom). On a scale of 1 (not useful) to 5 (useful)

Module

Effective Interpersonal Communication: mean = 3.3 (range of ratings: 2 – 5)

Structuring Your Team: mean = 4.0 (range of ratings: 3 – 5)

Collaborative Decisions: mean = 4.3 (range of ratings: 3 – 5)

Respondents indicated the extent to which they found the materials provided for the classroom module to be useful. On a scale of 1 (not useful) to 5 (useful)

Module

Effective Interpersonal Communication: mean = 3.5 (range of ratings: 1 – 5)

Structuring Your Team: mean = 4.1 (range of ratings: 3 – 5)

Collaborative Decisions: mean = 4.3 (range of ratings: 3 – 5)

Participants were asked how often they expected to use the newly learned concepts and practices in their job.

Module

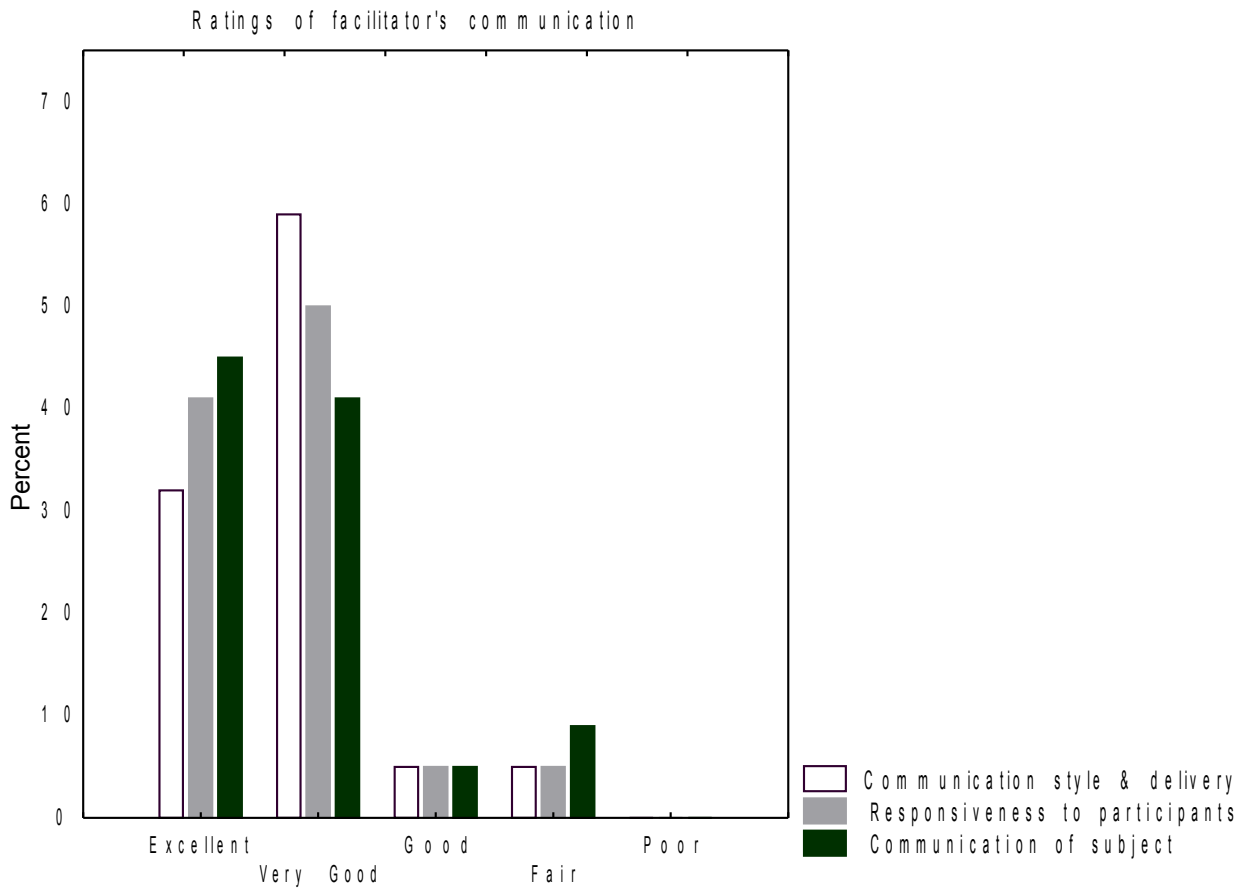
Effective Interpersonal Communication: 100% reported “daily”

Structuring Your Team: 77% reported “daily;” 18% reported “once a week.”

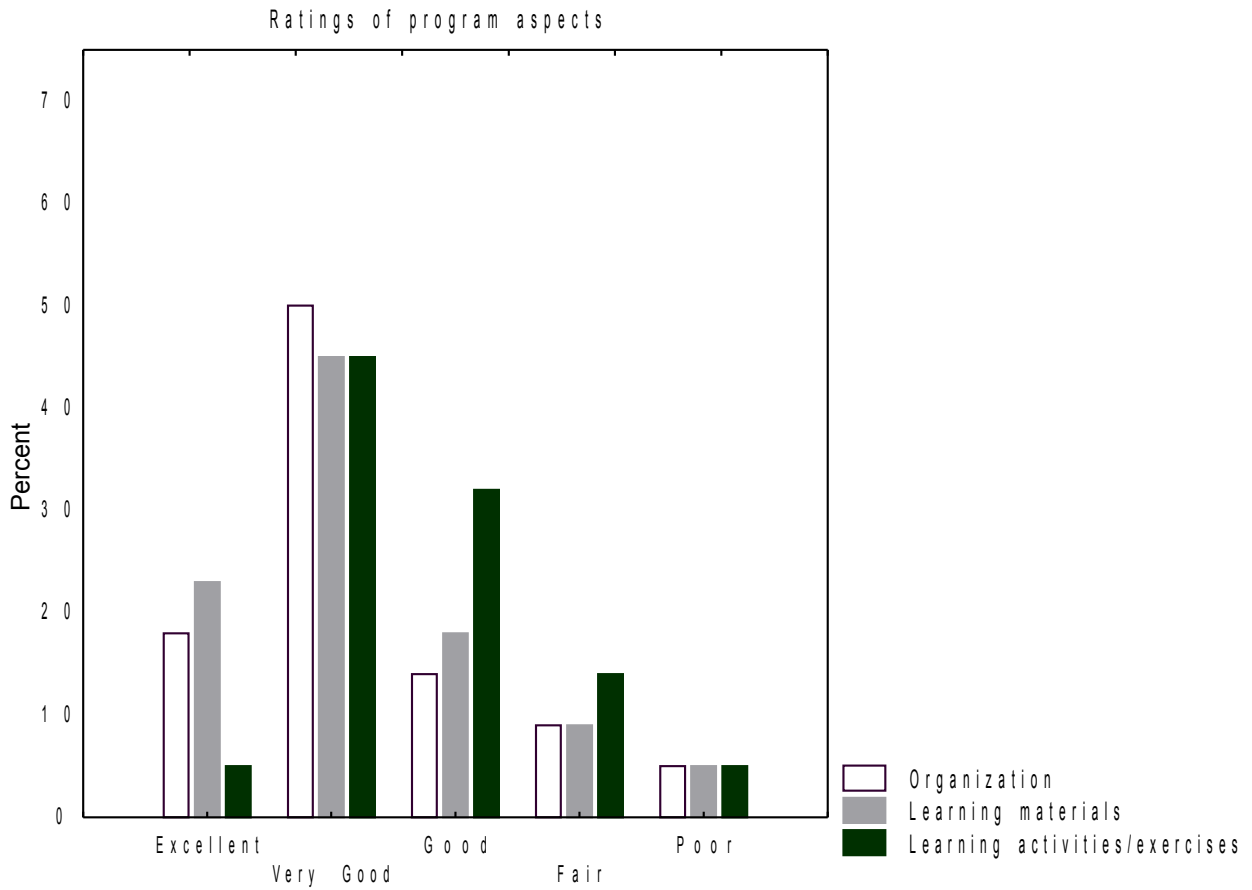
Collaborative Decisions: 73% reported “daily;” 7% reported “once a week;” 20% reported “once a month.”

Module 5

1. Please rate the facilitator's communication during the program	Excellent	Very Good	Good	Fair	Poor
a) Style and delivery	7	13	1	1	
b) Responsiveness to participants	9	11	1	1	
c) Communication of subject	10	9	1	2	

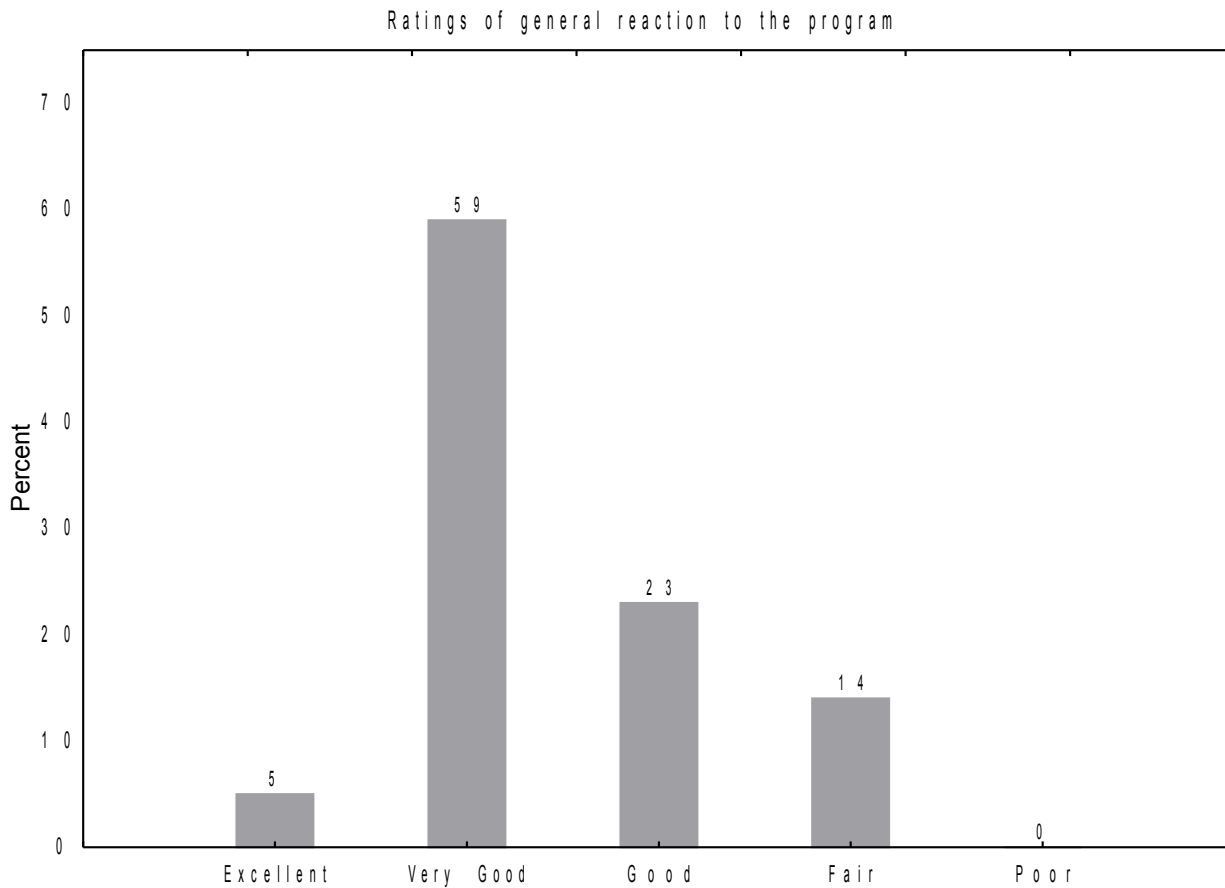


2. Rate the program for the following:	Excellent	Very Good	Good	Fair	Poor
a) Organization	4	11	3	2	1
b) Learning materials	5	10	4	2	1
c) Learning activities/exercises	1	10	7	3	1



3. What is your general reaction to the program?

Excellent	Very Good	Good	Fair	Poor
1	13	5	3	0



4. As a result of attending the course, I feel I will be able to facilitate a small group discussion so that it is effective, efficient manner and builds unity and respect amongst the participants.

Yes 82%

Appendix XIII: Sustainability Logic Model

Interprofessional Education (IPE) and Interprofessional Practice (IPP) for Collaborative Patient-Centred Practice
BRAID: Bridging Relationships Across Interprofessional Domains www.ipebraid.ca
 Context and Situational Factors: Post-Secondary Education Plan, Provincial Health Plan, Academic Renewal (NBCC), Canadian Interprofessional Health Collaborative

