Action Strategy: Leading Organizational Approaches to Sustain IPE in the Post-secondary Education Sector

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for the

Canadian Interprofessional Health Collaborative

May 31, 2009

Key Messages

- IPE must transcend the classroom experience into the practice environment.
- Important to have credible champions/leaders at all levels of the learning experience.
- Necessary to have committees (curriculum, practice site, evaluation, research) to keep all stakeholders involved and informed.
- Relationships with governments are important as they provide philosophical and financial support.
- Showcase IPE success stories with stakeholders.
- Always speak the language of the stakeholder. Determine what is important to them and embed IPE into the conversation.
- Have a clear plan! Just do it! Be patient!

Recommendations

Structure
Embed IPE into existing health professional curricula for each year of the program.

By doing so, it removes barriers such as excessive student and faculty workload; ensures that students receive credit for work completed; and, assures that all graduates have had exposure to the philosophy of interprofessional collaboration. In addition, IPE must transcend the classroom experience into the practice environment and to do so scheduling impediments must be alleviated.

Mechanisms
Establish a central coordinating body for IPE outside of the Faculty of Health Professions.

An organizational structure as recommended above would allow the coordinator to report directly to the VP Academics. In doing so, the coordinator remains neutral to any single health professional program.

Faculties
Acknowledge faculty contributions to IPE as a valuable component and a necessary form of academic activity and as such are recognized for promotion and tenure.

By acknowledging this contribution, faculty become engaged in IPE as their involvement is not an add-on to an already existing faculty workload and is seen as being valued

Establish a core group of IP-trained faculty who are champions of IPE faculty as it is vital to the success of the IPE initiative.

Given the numerous challenges that exist in the literature if faculty are not prepared to facilitate an IPE course, it is essential to the success of IPE to assist faculty to develop skills in addressing curricular development, evaluation, and methods for being effective in IPE.

Funding
Provide equitable, adequate and ongoing funding mechanisms which are allocated over and above the normal operating budget.

IPE curriculum development is expensive and financial resources are required for faculty positions and development, research, teaching and learning methodologies, and evaluation.

Leadership
Create a culture of IP learning by threading an IPE philosophy through the mission, vision, values, and goals of the institution.

If IPE is to be sustained as the essential method of preparing health practitioners, then it must be entrenched into all facets of the institution.

Partnerships/relationships
Establish partnerships and recognized the significant role they play in IPE initiatives.

It is important to have credible champions/leaders at all levels of the learning experience to promote the necessity of IPE in relation to collaborative practice and quality of care. Partnerships and relationships are invaluable to providing clinical placements, opportunities for engagement, and collaborative research. This is a symbiotic relationship in that staff gain education required to mentor IP student placements, which in turn builds upon their collaborative practice.

Resources
Make available the resources required for a successful IPE initiative.

Resources that are necessary to a successful IPE program include, but are not limited to: staff, location, rooms, funding for research, timing, coordinator, and a repository for tools.

Policy Regulation
Encourage regulatory and accrediting standards that include IPE which will act as a catalyst for change.

Important to network with policy regulators, unions, health care leader associations, and health science Deans/Directors to advance the IPE initiative.

Introduction

Patients, families, government, and health care administrators are demanding an interprofessional collaborative patient-centred health care model that will address the complex needs of patients; improve patient safety and patient outcomes; promote job satisfaction; and, increase cost savings (Borduas et al., 2006). Interprofessional collaborative practice requires that health care providers from different disciplines develop collegial relationships and work together interdependently. Integral to this relationship is the notion that team members understand their own roles, responsibilities and scope of practice as well as those of their teammates; respect each other's perspectives; and, share in open and honest communication (Yeager, 2005; Hall & Weaver, 2001). However, collaboration is hampered in the practice setting by inadequate time for team building, professional turf protection, professional socialization, and power and status differentials (Gardner, 2005; Reeves & Lewin, 2004). To compound these factors, professionals from different disciplines have not been educated to understand the practices, expertise, responsibilities, skills, values and theoretical perspectives of professionals in other disciplines thus providing little chance for health providers from diverse professions to share ideas and knowledge or to work together (San Martin-Rodriguez, Beaulieu, D'Amour, & Ferrada-Videla, 2005). Academic institutions such as universities and professional colleges are responding to the need to change the way health care professionals are educated and are instrumental in preparing the future health work force to function collaboratively and safely (Borduas et al., 2006). A complex education approach such as interprofessional education is an effective way in which to ensure that health care providers have the necessary understanding, knowledge, training and tools to enable them to implement strategies designed to promote the active participation of each profession in patient care (Accreditation of Interprofessional Health Education (AIPHE) Steering Committee, 2009; Steinert, 2005).

While the need to create an interprofessional academic and clinical curriculum is evident, it may be a daunting endeavour due to the resources and expertise required to construct such a complex infrastructure (Borduas et al., 2006; Curran, n.d.). In an attempt to assist others in the journey towards creating an interprofessional program of study, data were collected in a case study format from selected Canadian post-secondary institutions. The case studies exemplify the opportunities, challenges and successes involved with the integration of interprofessional education (IPE) into health professional curriculum. Synthesis of the data reveals common critical factors regarding the implementation of IPE. Recommendations regarding leading organizational practices are made to support the implementation of IPE strategies.

Literature Review

Structure

The Centre for the Advancement of Interprofessional Education (CAIPE) has clearly defined what IPE is; a definition that is recognized worldwide. However, what must be made clear is what IPE is not: it is not an assembly of learners from different professions sitting in the same room listening to the same lecture, nor is it learners from one profession presenting information in a one-way discourse to other professions. It is the "active engagement of students from different professions in interactive learning – something must be exchanged among and between learners from different professions that changes how they perceive themselves and others" (AIPHE Steering Committee, 2009, p.6).

Oandasan et al. (2004) stress that interprofessional education is facilitated when an interface between the learner and the educator exists and where socialization issues (e.g., professional and cultural beliefs and attitudes) are shared in order to prevent stereotyping of the learner's own professional identity and that of others; a body of knowledge that describes the competencies (knowledge, skills and attitudes) required of health professionals to work collaboratively in the practice setting; a component where learners can be exposed to collaborative practice settings; faculty development regarding how to facilitate interprofessional education; faculty who are encouraged to reflect about their own professional beliefs and attitudes in relation to interprofessional collaboration; resources to establish and sustain interprofessional initiatives; and, support of IPE by those in leadership positions.

A major barrier of interprofessional education, as noted by Canadian health professional education senior administrators, was the scheduling of students from various professional schools into interprofessional education sessions (Curran, Deacon, & Fleet, 2005). Time-tabling difficulties may lead to the exclusion of some professional programs when IPE experiences are introduced (Curran, n.d). In addition to reported scheduling difficulties, there are a myriad of other complexities, such as: inconsistency of the numbers of students from each profession; differing learning styles; various evaluation styles; conflicting curricular periods; lack of buy-in; limited resources; lack of administrative support; turf battles; and, practical difficulties such as professional schools being located in different buildings (Anonson, Leischner, Manahan, Randal, & Weir, 2008; Curran, et al., 2005).

As well, when IPE courses are not mandatory, students may have difficulty arranging time for course projects and also may not be committed to enrolling in such courses. Lumague et al. (2006) reported that students participating in an IPE initiative observed that busy school schedules brought challenges to find common time to work on IPE projects, such as group presentations. Furthermore, because many IPE initiatives are considered to be extracurricular and do not count towards mandatory clinical hours, students may feel apathetic about having to spend additional time participating in IPE projects.

Curricular organization, student assessment, and instructional responsibilities are within the separate domains of each university department (i.e., faculties or schools). Due in part to budgetary implications, it is therefore a challenge to navigate departmental boundaries and foster greater collaboration in relation to curricula (Curran, n.d.). Gilbert (2005b) suggests that "a major barrier to implementing interprofessional education is that faculty structures in the health and human services are modeled on the organization and management of traditional faculties of Arts and Sciences, which do not have to contend with patient-centred learning" (p. 96). As well, departments and schools base faculty reward systems on intraprofessional, rather than interprofessional, scholarship and teaching. This type of a reward system can be a deterrent to interprofessional education (Gilbert, 2005b).

Mechanisms

In addition to the requirement of faculty advocates for interprofessional learning, champions at various levels both within and outside the educational organization are key drivers of change. These champions consist of formal leaders who strategically implement change, allocate adequate human and financial resources and inspire commitment from various stakeholders (Borduas et al., 2006). Within the educational setting, formal leaders can institute the following

supports: flexibility in funding structures; reward mechanisms for faculty engaged in IPE; time, space and equipment dedicated for IPE experiences; joint IPE curricular development which includes evaluation and assessment of students within each discipline's curriculum; shared responsibility for management; and, a governance structure that promotes a collaborative environment among the disciplines (Gilbert, 2005a). Champions who lobby for government policies, accreditation standards and regulatory standards that demand interprofessional collaboration positively impact the reality of interprofessional education (Gilbert, 2005b; Oandasan & Reeves, 2005).

Faculties

Facilitating a heterogeneous group of students from different professions offers a rich learning environment but requires faculty to be expert program planners and competent interprofessional facilitators (Freeth & Reeves, 2004). A sound knowledge of group dynamics, an ability to value diversity within the group, and the skill to use professional differences creativity within the group are critical interprofessional facilitation behaviours (Freeth, Hammick, Reeves, Koppel, & Barr, 2005). Interprofessional facilitation demands that faculty can apply educational principles such as adult learning theory, reflective practice, problem-based learning, experiential learning, critical appraisal and questioning techniques (Hall & Weaver, 2001; Oandasan & Reeves, 2005). Faculty who are enthusiastically committed to collaboration and who act as interprofessional role models for students in the classroom and in the practice setting are valuable assets to collaborative endeavours (Freeth & Reeves, 2004).

Negotiation across faculties is required to advance IPE within the school (Borduas et al., 2006). Currently there is often a single subject approach to teaching; however, if we are to ensure that the right provider is at the right place at the right time there is a need for new forms of teaching and learning and training teachers for different roles (Parsell & Bligh, 1999). Faculty may not have the skill sets, self-assurance, social networks or political resources to undertake an IPE initiative (Borduas et al., 2006). As well, IPE is often an add-on to an already heavy teaching load. Faculty development in relation to interprofessional education is necessary for both theoretical and clinical teaching (Baldwin & Baldwin, 2007; Freeth & Reeves, 2004; Steinert, 2005). Teaching interprofessional courses should be seen as a valuable and necessary addition to the curriculum (Gilbert, 2005a) and incentives should be provided to encourage universities to develop and implement interprofessional education initiatives (Curran, n.d.).

Funding

Gilbert (2005b) suggests that a major barrier to developing interprofessional education initiatives is a reluctance to contribute money to curricula shared with other faculties. University funding is typically based on the number of students in each faculty; as such there is a lack of re-allocation of monies for interprofessional initiatives (Borduas et al., 2006). Funding to support the development, implementation and evaluation of interprofessional education programs is therefore a major catalyst for change.

Leadership

Support from senior administrators is critical to the implementation of IPE (Borduas et al., 2006; Curran, 2005). Organizational changes which help achieve improvement in interprofessional

learning include: a fundamental shift in perspectives by having health professional educators from different disciplines work together in the design and implementation of a new innovative curriculum; systemic change with activities supported by top leadership; faculty open to learning new roles and working collaboratively across colleges and disciplines; conscious and consistent leadership; and, systematic methods to measure progress and guide improvement (Gelmon, White, Carlson, & Norman, 2000).

Partnerships/relationships

Creating a provincial program that respects traditional professional and post-secondary territories is challenging (Charles, Bainbridge, Copeman-Stewart, Art, & Kassam, 2006). The hierarchy of professions and traditional boundaries such as exists between medicine and nursing, need to be managed and discussed by faculty when designing IP curriculum (Borduas et al., 2006). Barriers of creating partnerships as noted by Newell-Jones (2008) include the use of acronyms and jargon; attitudes between professionals; hierarchical structures; and, power differentials. Other barriers as noted in the literature include: differing professional cultures, value systems and philosophical approaches to patient care; stereotypical perceptions of other professions resulting from uniprofessional socialization experienced during the educational process; curricular and scheduling difficulties; perceived loss of professional status; negative attitudes of IPE from health care workers, students, faculty and senior academic administrators; lack of resources and a commitment for IPE; gender and social class differences; silo-effect of health care as each profession has defined its own identity, values, sphere of practice and role in patient care; legislative regulation of health professions enacted province by province resulting in competition rather than collaboration; and, salary differentials which establish a class structure (Gilbert, 2005b; Hall, 2005; Oandasan & Reeves, 2005; Smith, Meyer, & Wylie, 2006).

Resources

Hammick (2005) notes that resource, organizational and administrative challenges can arise when embarking on the creation of IPE curriculum. Key points that she advises one to monitor include: deciding and documenting the model of IPE that is to be used; planning early for the development, approval and delivery process; staff team development; and, having awareness of encroaching conflict when IP curricula is developed. Resource issues may arise in the following categories: teaching staff and external examiner availability and staff training and development. Organizational challenges to be considered include: location of teaching, size and number of teaching rooms, coincidental teaching appointments and external examiners. Finally, resources regarding support staff, timetabling, exam boards and student recruitment must be well thought-out.

Policy Regulation

Accreditation

"Without inclusion of IPE in accreditation standards, there is no reason for academic programs to engage in IPE" (Gilbert, 2005b, p 97). Health Canada has funded a project for six Health and Human Service professions to develop shared principles and draft standards for the accreditation of IPE in Canadian Health and Human Service education programs. These six

professions have role-modelled interprofessional collaboration in that they have reached agreement on a common glossary of terms, capitalized on similarities inherent in IPE, and created adaptability in the standards and evidence that will establish IPE into curricula (AIPHE Steering Committee, 2009). Creating standards to bring interprofessional education and interprofessional care into the accreditation and certification criteria for the various professional education programs may be one way of ensuring interaction between professional schools and faculty (Allison, 2007).

Regulatory Bodies

In Canada, provincial and territorial governments grant health professions the privilege of self-regulation. Each health professional self-regulatory body defines its scope of practice. Competition between health professionals results if "regulators have a tendency to place their own professional interest in control of a scope of occupational turf ahead of their obligation to serve the broader public interest" (Lahey & Currie, 2005, p.201). Since health professional education programs are influenced by their regulatory bodies, educational programs often reflect these territorial perspectives rather than promoting interprofessional collaboration (Gilbert, 2005b). Roberts, Martin, Carlisle, and Alderson (2007) argue that government policy should support collaboration and encourage various health professionals and their regulators to work together. These authors advocate that "the development of regulatory standards requiring an educational course in collaboration would ensure that students receive this type of training and education" (p.41).

Description of Work

The case study approach was used as it helps to examine changes over time, provide insight for future endeavours and analyze the relationship between experiences. The data gleaned, though not generalizable, can contribute to knowledge transfer in the form of a commonality experienced by a group of individuals (Reinharz, 1992). Case studies can be useful in examining past and current experiences of the participants, and thus relate to a broader audience.

The selection criteria used to choose the sites for these case study interviews included:

- Availability of selected schools to participate in the interview within the given timeline
- Location at a Canadian post-secondary education institution (university, college, or institute)
- Demonstration of leadership in IPE in Canada (e.g., date IPE initiative established, number of learners enrolled, number of IP programs/credits, published reports documented on school website)
- Link on the Canadian Interprofessional Health Collaborative (CIHC) website
- Mechanism to coordinate IPE at the school (e.g., Office of IPE)
- Academic accreditation approval
- Health Canada IECPCP grant recipients

For ease in decision-making for selecting the sites, all post-secondary schools were grouped according to geographic region as follows:

- Western: British Columbia, Alberta, Saskatchewan
- Central: Manitoba, Ontario, Quebec
- Eastern: New Brunswick, Nova Scotia, Prince Edward Island, Newfoundland & Labrador

Six schools (1-2 per geographic location) were selected based on the above criteria; however, the final decision for inclusion resided with the CIHC. The following post-secondary institutions participated in the interview process:

- Western: University of British Columbia, College of Health Disciplines (UBC-CHD), University of Saskatchewan (U of S)
- Central: George Brown College of Applied Arts and Technology (GBC), University of Toronto (U of T), University of Western Ontario (UWO)
- Eastern: Memorial University of Newfoundland (MUN)

Recruitment began when the consultants reviewed each school's website to determine who acted as the IPE lead. CIHC also provided to the consultants information regarding contact leads at each site. These persons were then contacted via email with an introductory letter explaining the project. Individuals were asked to contact either of the two consultants within a given time frame. Interviewees were informed that their willingness to participate in the case study interview implied consent to share the information provided with a wider audience. From the six selected schools, eight individuals participated in the interview process. More than one individual at a site was interviewed when the initial interviewee felt they could offer no further data. The following individuals represented each interviewed site:

UBC-CHD: Leslie Bainbridge (aka LB), Associate Principle, College of Health Disciplines
John Gilbert (aka JG), Principle & Professor Emeritus, College of Health Disciplines
U of S: Peggy Proctor (aka PP), Assistant Academic Coordinator Clinical Education, College of Medicine
Peter Krebs (aka PK), Administrative Officer, Interprofessional Health Science Office
GBC: Gary Kapelus (aka GK), Coordinator, Interprofessional Centre for Health Sciences
U of T: Ivy Oandasan (aka IO), Clinical Studies Resource Centre member, Toronto Western Research Institute (former Director, Office of Interprofessional Education U of T)
UWO: Carole Orchard (aka CO), Coordinator, Office of Interprofessional Health Education & Research
MUN: Anne Kearney (aka AK), Assistant Professor, School of Nursing and Faculty of Medicine (Division of Community Health & Humanities)

Data were gathered through a semi-structured interview guide (Appendix B). The interview guide was created following a literature review that revealed the nuances involved with creating an interprofessional curriculum. Each telephone interview lasted between 1 to 1 ½ hours and was tape-recorded, transcribed verbatim and returned to each participant to ensure that their story was accurately captured. Five of eight interviewees reviewed and edited the transcripts. Data were compiled and synthesized according to the interview structure, highlighting the similarities and differences.

The anticipated target audience for the findings of the report are two-fold: first, for decision-makers in the post-secondary education sector, such as faculty and university/college health science deans and administrative leaders. Secondly, for Federal/Provincial/Territorial government policymakers responsible for higher education and health services funding; health care employers; and, professional associations.

Synopses of Sites

The following synopses provide a brief history of each site.

Western sites:

University of British Columbia

When John Gilbert became Coordinator of Health Sciences in 1995, he was charged with looking at the organization of Health and Human Services programs at the University of British Columbia. There was much discussion about creating a Faculty of Health Sciences; however, "Health Sciences are not like a Faculty of Sciences or a Faculty of Arts where there's a centrality. The problem with Faculties of Health Sciences is that there is no cross cutting programs, they were just doing their thing" (JG). As a result, the College of Health Disciplines was created. In 1997, John went to the 1st All Together Better Health conference in England and came back from that meeting, charged up to really begin to think seriously about what could be done at UBC. That's how IPE at UBC got started!

Lesley Bainbridge, the current Associate Principal of the College of Health Disciplines explains that the College's role is to work with 15 Health and Human Service programs to embed IP learning into their curriculum and seek opportunities for students to learn together.

University of Saskatchewan

IPE has evolved since 1999 when Peggy Proctor first approached another faculty member to determine if physical therapy students could join a First Nations healing class being offered to medical students. The rest is history, as Peggy and her colleague went on to teach these classes and worked together to make them more interprofessional.

In 2003-2004, interprofessional PBL began with physical therapy and medical students. These cases evolved and became known as Interprofessional Multi Problem Based Learning modules (IMPBL). IMPBL modules are threaded throughout the existing courses and are offered to medicine, physical therapy, nutrition, social work, clinical psychology, and pharmacy students with the vision to have all the various health professions engage in these IPE experiences.

In 2005, the University of Saskatchewan secured funding from a Health Canada IECPCP grant. From 2005-2008, it was like "heaven in IPE because there was grant money available which encouraged individuals to research, present, publish, and evaluate the outcomes of the IPL" (PP).

Central sites:

George Brown College of Applied Arts and Technology

The desire to bring IPE to George Brown College of Applied Arts and Technology began in 2004 when Lorie Shekter-Wolfson, Dean of Health Sciences and Community Services, wanted to integrate Health Sciences programs, which were located at four different campuses, into a single new building. The Dean's vision was that there would be an IPE curriculum in which the

students across Health Sciences would learn together. In 2004, the Centre for Health Sciences hired an outside consultant, Gary Kapelus, to work with faculty representatives to facilitate the development of an IPE framework and document IPE learning outcomes.

Over the next couple of years the College supported various IPE activities, in the form of pilot projects, to encourage faculty to become engaged in IPE. As well, the College provided formal support for the development and evaluation of permanent IPE curricular activities. As the early roll-out strategy was to link the importance of a new IPE curriculum to the future health sciences building, many faculty were hesitant to engage in this process until they saw signs that the new building would become a reality. Despite this, a number of faculty across the Centre for Health Sciences became seriously engaged, on their own initiative, in IPE development.

There are two examples of the many successes achieved in delivering new IPE curriculum. "*Collaboration: The future of health care in Canada*" is a full credit IPE theory course with a practical application component which has been offered each semester since 2007. The second experience, *"The Health Promotions Hub"*, offered since 2007, provides an opportunity for students to complete an interprofessional field placement in health promotion. The goal of the Health Promotions initiative is to have learners become accustomed to interprofessional teamwork and health promotion by designing and conducting health promotion activities.

University of Toronto

In June 2005, the Council of Health Science Deans at the University of Toronto asked the University Provost for funding through the "Academic Incentive Fund" to create an Office of Interprofessional Education. At approximately the same time, Ivy Oandasan was completing her work for Health Canada in the area of developing the *Interprofessional Education for Collaborative Patient-Centred Practice* model. She accepted the position of Director, Office of Interprofessional Education with the hope that it would give her the opportunity to test this framework. Having been successful in securing grants which enabled her to develop a strategic plan to advance both IPE and IPC, Ivy's background created a perfect fit for the role.

Ivy believed that practice settings needed to understand the necessity of practicing in an interprofessional collaborative approach and how this approach is interdependent with IPE. Numerous projects were conducted within the practice setting to establish IPC leaders who continue to advance IPE and IPC in the hospitals to this day. In 2006, the Dean made an announcement that by fall 2009 all health professional students at the university will participate in an IPE curriculum. After receiving permission from the Deans, an Interfaculty Curriculum Committee (ICC) was formed in June 2007 as the means to advance IPE as they would have the structure to make decisions for an interprofessional curriculum and could then communicate this to each of their respective Curriculum Committees. Ivy worked with her team to create a core IP competency framework. An education summit was held in February 2008 to further engage educators and leaders regarding the framework. In the past year, the team has been working diligently to further advance the curriculum.

University of Western Ontario

In November 2004, Carole Orchard was approached by the Dean, Faculty of Health Sciences to ask if she would be willing to lead the IPE initiative at the University of Western Ontario, when

she stepped down as the Director, School of Nursing. A vision was created to move IPE and collaborative practice into the mainstream teaching and practice of all health programs.

In January 2007, the Office of Interprofessional Health Education and Research (IPHER) opened, with Carole named as the Coordinator. The Office is a "hub" of resources, as it is the "one stop place for IPE in the region" (CO) and serves the entire London area and beyond. Energy at IPHER focuses on 4 target groups: students, faculty, health and patients.

An innovative method of incorporating IPE into existing programs is known as "Enrichment Components", where students are placed into an IP clinical experience. Students have to apply and be accepted into the Enrichment Component. It is mandatory to complete a team development module set and attend a one day workshop before entering the clinical placement. Students' performance is evaluated and this evaluation goes back to the faculty member in their discipline to be included in their overall course evaluation.

Eastern sites:

Memorial University of Newfoundland

Anne Kearney explains that IPE first began at Memorial University in Newfoundland in 1999 when the Faculty of Medicine took the lead in developing an intensive, comprehensive curriculum in relation to HIV/AIDS. The Collaborative Center for Health Professional Education at Memorial University was established through funding from the Faculty of Medicine to assist in the development of these interprofessional programs.

In 2005, the comprehensive curriculum became a reality with a Health Canada IECPCP funding grant. Four professional groups were included in the IECPCP research: medicine, nursing, social work and pharmacy. During this project, 11 interprofessional modules/blocks were implemented. The Dean/Directors of these Schools of Health Professions decided which courses would house each specific module. In addition, faculty teams were created and were to decide on the process necessary to integrate the modules into their course and to determine how evaluation would occur. All of the modules/blocks were evaluated as part of the course so it would be included in the course syllabus. In the fall of 2008, Human Kinetics and Recreation and Social Work became involved in IPE.

Synthesis of Data

Structure

Community served.

Five of the six sites interviewed serve both urban and rural communities; the sixth attends to a predominantly urban core. The **UBC-CHD** branched into the rural experience when an Executive Director in the Ministry asked John Gilbert for assistance because there were not enough Pharmacists in Northern British Columbia. John asked him to think about putting teams of students in rural areas because "it's not about getting a pharmacist there, it's about getting a nucleus of people who work together professionally so that you don't lose them". The Interprofessional Rural Program of BC (IRPBC) emerged with $250,000 funding from the Ministry.

While a majority of the IP learning occurs onsite at each institution, there may be a mixture of onsite and distance learning opportunities, dependant on site. At many sites there are either existing online IP learning opportunities or they are being considered for development. For example, **UBC-CHD** has an online IP elective while the **UWO** Sensitization workshops are being transferred into a Web CT course because there will not be ongoing funding to offer at the current level.

Number of health professional programs.

Each university has various and numerous health professional programs, with numbers ranging from five to 18. The most often cited programs represented included nursing, medicine, pharmacy, physiotherapy, human kinetics and recreation, social work, and clinical psychology. **GBC** offers 17 different heath science programs such as dental hygienist, dental assistant, fitness and lifestyle management, personal support worker, and nursing.

Pre or post-licensure IPE.

Although the main educational focus for IP learning relates to pre-licensure learners, some sites have developed, or are in the process of developing, initiatives for post licensure IP education. For instance, the **U of T** offers a 4-day team coaching workshop to healthcare professionals. At **MUN** the Rural Mental Health Project's focus is to improve mental health in rural areas and includes teams of professionals in the community (teachers, police, clergy, as well as the traditional heath care team).

Number of staff.

Numerous variations existed in the staff hired to conduct IPE activities as outlined below. These positions have changed or are currently changing since the inception of the IPE initiative at each school due to available funding. Unless otherwise noted, all positions were full-time equivalencies (FTE):

MUN – 2 co-dDirectors, two faculty leads , one project manager, one research coordinator, one administrative support.

UBC-CHD – one of each: Principal, Associate Principal (0.5 FTE), research project manager/coordinator, and curriculum coordinator. There are also three IT positions. "All of us have faculty positions [outside of the College] – we don't have people with faculty positions *within* the College – we all come from somewhere else. Those of us within the College are not the only ones doing the work on IP. We tried to integrate it into how the programs do their education" (LB).

GBC - one coordinator, two course faculty, and other faculty as needed. There is also one Health Promotions Specialist (part- time FTE) to help with IPE.

UWO - a Coordinator, administrative assistant, research coordinator, project coordinator to support funded projects and part-time faculty as necessary.

U of T – a Director (0.6 FTE), one faculty with expertise in curriculum and IP content development (0.7 FTE), one faculty with assessment expertise (0.4 FTE), two faculty that advance the development of IPE structured learning and placements (present status unknown), and two faculty that focus on the evaluation framework (present status unknown).

U of S – With IECPCP funding there were two Coordinators (0.5 FTE) for two separate initiatives for a two to three year period. Currently, graduate students are hired (0.2 FTE) to fill these positions, thus support is more transient. "The project is complicated and by the time these individuals have learned the role they leave to pursue their careers. The faculty team is becoming fatigued from dealing with this issue because IPE coordinating activities are added on top of regular duties" (PP).

Description of IPE.

Most of the institutions have some elective interprofessional courses. More commonly the practice is to strategically embed interprofessional learning into the existing curriculum as described in the examples that follow. As John Gilbert explains, "It is difficult to provide a "course" in IP that all students can take. The literature shows failures because one size does not fit all".

UBC-CHD - Faculty question themselves as to what makes a good IPE experience. "What is enough of an IPE experience and how do we capture the parameters for that? If you say you've had an IP experience we [need to] know that this experience embodies all the characteristics that we would see being necessary to being a valued, important and credible IP experience" (LB). The College faculty liaises with health professional program faculty to embed IP learning into their existing curriculum so that learners receive credit as part of their regular program of study. Some of the IP learning opportunities offer a combination of theory and clinical while others do not. "The path of course preparation is tortuous, negotiation intensive and still has some problems around funding" (JG).

MUN - IPE credit is incorporated as part of the course to which it is attached and commonly constitutes 5% of a course mark. The clinical component is just being developed at MUN.

U of S - there are three compulsory Interprofessional Multi Problem Based Learning (IMPBL) modules threaded though existing courses. "The learning is not after hours; it is not optional and is part of the course. IPE is a core competency and the ability to work in teams is not optional - not a nice to have and every student should have to practice it in their pre-licensure training" (PP). Although there is no formalized clinical aspect of the curriculum associated with these modules, there have been independent clinical IPE initiatives.

GBC - offers a formal full credit IPE theory course that is a requirement for a significant number of health science students at one campus. Another learning opportunity is the interprofessional field placement (read: clinical) in health promotion. In this experience, learners receive credit for their participation in this placement in different ways, depending on the requirements of their program.

U of T - learners complete core IP activities and some electives. Clinical sites have established numerous IP placement opportunities and the plan is that while the students from various

disciplines are in IP clinical placements there is an individual available to them who is experienced in facilitating IP content.

UWO - No IPE program per se; more about weaving the philosophy through areas that have the need. Sensitization workshops, for students from all disciplines, practitioners and faculty, use standardized patients as the anchor point. Practice placements are part of the Enrichment Component and may be credited toward students' regular program clinical practice requirements. Outcomes of the clinical are then forwarded to the respective programs so that students can get credit on their transcripts. The UWO is currently trying to expand into acute care and are developing agreements with St. Joseph's and London Health Science Centre to pilot two clinical placements within each facility for IP groups of students.

Mechanisms

All interviewees discussed the crucial role of Deans/Directors, community partners (i.e.: Health Authorities, healthcare institutions, community colleges), students and core faculty in the IPE initiative albeit in different ways. Regarding the necessity of IPE champions, all sites recommended that there should be faculty champions who have "credibility, can walk the walk, teaches, role models and has 'war stories' that other faculty can connect with" (GK). Champions will enable the creation of a culture of IP collaboration.

In relation to a designated "office" of IPE, five of the six sites had an IPE organizational structure, which they referred to either as an Office, Centre, or College. There were many variations of composition of staff, roles, and reporting mechanisms within each of these "offices". For instance, at **U of S** an Administrative Officer supports the Council of Health Sciences Deans as well as various formal sub committees that develop strategies for the embedding IPE in the curricula. However, there is not a single person identified as an academic coordinator who can respond to the internal subcommittees and raise the profile of IPE internally, locally and nationally. Whereas, the **UBC-CHD** is unique in that the College was established outside of the Faculties allowing the Principle of the College to report directly to the VP Academics; a similar reporting structure of the other Deans. It is suggested that having an independent leader of the "office" allows for autonomy in that they are not beholding to any of the Deans of the various health professions; the advantage being that "there are a lot of different agendas to deal with and you can't do that if you're aligned with a particular faculty" (JG).

Faculties and faculty preparation

The faculties involved in IPE initiatives are dependent on the available Schools of Health Professions in each institution. As a result, there was much dissimilarity. For example, at **UBC-CHD** all programs that have a health or human services focus are involved in College activities "there is nothing stopping us from including others except resources and time - the capacity" (LB). **GBC's** experience differs in that, it has been mainly nursing and dental hygiene, with limited involvement from other programs. At **MUN**, all health professional programs are involved in the IP initiative; however "There are other schools in the province (e.g., radiation technology programs, laboratory technical programs) [that] do not come under MUN's mandate. Partnering would be difficult due to logistics such as course scheduling and finding common times to meet face to face to discuss IP" (AK).

Faculty Preparation

"What does the CAIPE definition really mean – for pedagogic purposes, for practice? What does learning with, from and about really mean? Maybe you can't really teach an IP course until you've been through all of those matters that have to be understood in order to work interprofessionally such as the determinants of health; stereotypic rivalry; power; class; language; and, gender" (JG).

All interviewees stressed the importance of faculty preparation when embarking on an IP learning initiative; nevertheless, not all sites currently have a faculty development course. Overall, some of their faculty have engaged in IPE certificate courses, some have attended IPE conferences, and some have been involved with in-house workshops offered to the faculty who will be involved with IPE. Both **MUN** and **UWO** provide examples in that one offers a ½ day workshop twice a year and the other developed a 2 ½ day faculty teaching certificate program, respectively.

Funding

The question of yearly funding varies from site to site, and like the **U of S** they consist of a combination of funding opportunities that are accessed in an entrepreneurial manner. Examples include using unexpended monies from the operating budget; annual strategic funds; one-time financial supports; or monies from other academic units. At **UBC-CHD**, the university provides a baseline operating fund; however, this money alone would not provide for their operating costs therefore additional funding is secured through many avenues (e.g., the Ministry of Advanced Education, indirectly from the Ministry of Health, tuition fees, research grants, endowments and educational grants). The **UWO** also describes funding from outside sources in the form of infrastructure grants given to academic health science centers by the Ministry of Ontario to establish an Office of IPE. The initial funding ended last year at the UWO but they were successful in being granted additional funding for another year through Health Force Ontario. **GBC** received three-year curriculum funding from the Ontario Ministry of Training, Colleges and Universities specifically to develop permanent IPE curriculum. Conversely, with the exception of the IECPCP funding, IPE at **MUN** has been primarily funded by the Faculty of Medicine. They have been engaged in discussions with government to establish a College within MUN to advance IPE and research.

Other than financial support, in-kind contributions were noted to be extremely important. John Gilbert suggests that, "you have to be supported by a first-rate administrative assistant and at least two ½ time faculty positions because you will need people to work on curriculum and the relationship with the community. So, you're talking a ½ million to start and up to a million to do it properly. I'm not suggesting that all this money is put into the Office – think about the ½ million outside of the normal operations as the way in which the various programs will support IPE…add up the in-kind support from the various departments. If the IP teaching is truly part of the role of the instructor then this is an in-kind commitment (around $12,000 per person). So, not looking at a million to fund the organization but looking at what are the contributions that the various programs will make to do this?"

For all sites, however the question remains - how we will fund IPE in the future, in a more sustainable manner? The **UWO** is exploring a long-term funding model where funding would be shared by all stakeholders (colleges and practice settings that use their services). They are also trying to build a revenue stream, for example, charging for consultation, workshop services, and materials. **GBC** suggests that it will be necessary to reallocate the existing operational budget in a different way as there is no money directly budgeted for IPE. It is hoped that each program will be able to contribute money to the endeavour.

Leadership

Interviewees emphasize the necessity of leadership at all levels. "[IPE] needs leadership behind it – organizational level, team level, individual level and cultural level. There needs to be a focused attention to it. I am not sure that I agree that one person needs to be in charge because one person in charge models a hierarchical behaviour that we did not want in the first place. I think there are ways of facilitating activity and having collaborative leadership around the development of IP practice" (LB, **UBC-CHD**).

A philosophy of IPE was either endorsed verbally by institutional leaders or through a documented mission or vision statement. For example, "the Dean consistently speaks of the importance of IPE but this is not formally documented in a mission statement or in constitution" (GK, **GBC**). While at **UBC-CHD**, there is a strategic plan for the College with mission, vision and values. A review of the health programs was conducted to determine if "there is a consistent message and that everyone is saying something about IPE in their mission, mandate or operational goals" (LB). As well, the programs are committed to requiring that all students have IPE experiences before they graduate.

Many of the schools have IPE committees who provide varying degrees of leadership. To illustrate, at **UWO,** there are several established committees which include faculty, practitioners and students that make recommendations to the Coordinator as well as report to the Council. At **U of S,** the Health Science Dean Committee formed a subcommittee called the Interprofessional Health Education Committee which does not have funding or formal power but is an advocacy and capacity building group. The official power lies with a new Curriculum Chairs group and discussions are unfolding as to how these two committees will collaborate in regards to curriculum changes.

Finally, faculty from all institutions demonstrated IP leadership by engaging in either IPE research and/or the dissemination of IPE knowledge through presentations and publications.

Partnerships/relationships

In order for IPE to flourish in the educational institution, partnerships and relationships were established with other post-secondary educational institutions, Health Authorities and government ministries. **GBC** has a range of partnerships. One example is with St Michael's Hospital Fitzgerald Academy (University of Toronto) where two second year medical students can experience an IP clinical placement. "These partnerships are excellent examples of being able to provide unique IPE field experiences for a broad range of students and learners including those from outside GBC. This has also created innovative opportunities for staff-faculty engagement and collaboration across institutions and collaborative research opportunities" (GK). Faculty at **UBC-CHD** stress the invaluable role of the health authorities

who now "realize that the students of today are the practitioners of tomorrow and with the health and human resource shortage they are looking very much at student placements and recruitment opportunities" (LB). It has become evident that hospitals require staff education regarding IP collaboration, want to offer IP clinical placements to students and be known as leaders in IP collaborative practice. CEOs of Health Authorities/institutions need to "understand that not only do they provide service they are also learning organizations. Forty percent of student's time is spent in the facility!" (JG).
Relationships with government were identified as being important as they provide financial and philosophical support. John Gilbert advises that it is important for discussions to occur with the Ministry of Health to identify their concerns and with the Ministry of Advanced Education so that there is an understanding that the students occupying the seats are the practitioners who will care for others.

Although many interviewees did not identify factors that could hinder the relationship with partners, Lesley Bainbridge describes two possible issues that may influence these relationships. She explains that some partners want more quantifiable evidence for IPE and that people are reluctant to change thus making knowledge translation or knowledge dissemination vital to the change management process.

Policy Regulation

At **GBC** it was noted that regulatory issues could sometimes impede IPE, therefore support is required to circumvent these barriers. Carole Orchard, **UWO**, acknowledges "that it is not that people do not want to incorporate IPE into their curriculum; it's that they do not know how it will fit because they are concerned about accreditation". So, when the "Office" collaborates with faculty she recommends being respectful of their perceptions and concerns of what the controls are by regulators and accreditors.

Anne Kearney (**MUN)** notes that in her experience regulating bodies such as those for medicine and nursing are asking for IPE in relation to entry-level competencies. She purports that having IPE ncluded in educational and hospital accreditation requirements does increase support for hese institutions to move in this direction. Leslie Bainbridge explains that the National Accreditation Project, funded by Health Canada, may be instrumental in having interprofessional accreditation standards built into the regular accreditation program for the health professions education programs. In British Columbia, health professions legislation has included IP practice as part of the regulatory process. **UBC-CHD** faculty are now planning workshops to "help the regulators to think about what that means in a regulatory context and how they support it for their members who are licensed practitioners" (LB).

Other groups that were viewed as having an impact on policy and regulation were unions, health care leader associations, health science Deans and Directors, and the Canadian Association of Allied Health Programs.

Summary

What has worked?

Similar interprofessional education enablers were identified by the participants and included: faculty engagement; having a clear plan; using resources differently across divisions; reward models for students and faculty; leadership support; IP curriculum committees; and, sustainable funding.

It was the passion, hard work, dedication, and preparation of faculty that was instrumental in establishing IPE at **U of S** (PP). Faculty had creative ideas for IPE initiatives so when IECPCP grant funding was awarded to the university; it was disbursed to faculty by a "mini-granting process", which provided faculty with the assistance needed to conduct numerous IPE projects. This process was a "key to success as good ideas got funded. It was a bottom up approach which rewarded people for what they wanted to do" (PP). Anne Kearney (**MUN**) relates similar enablers such as IECPCP grant funding, faculty commitment, champions and "the university culture saying that IPE is important".

Involving students and community partners in the development of IPE are cited by as the real hallmark of the work accomplished at **UBC-CHD** (LB). When the students believe in IPE, it motivates the faculty members to engage in IPE. The students have a Health Science Student Association and are provided with some funding which they use to bring students from different professions together to share in events such as conferences, educational discussions, and barbecues (LB).

It was noted at **GBC** that, "Our scholarly work in developing and evaluating IPE has grown and we are a significant presence at every IPE conference. This is a strong foundation for expanding existing initiatives, engaging more faculty and building the future IPE curriculum for the new facility" (GK).

The approach to building IPE at **UWO** included the coordinator meeting with everyone who was a head of a program to open the dialogue…"tell me what you know about IPE; how can I help; what do you do already?" This helped to shape the Office Interprofessional Health Education and Research.

At **U of T**, the creation of a flourishing community of practice has allowed IP collaboration to infiltrate the system at the teaching hospitals. "This was one of the most successful components of my term. One thing that has brought the hospitals and universities together has been IPE" (IO).

What isn't working?

IPE barriers consisted of scheduling issues; inadequate funding; the amount of time needed to integrate IPE into the existing curriculum; lack of understanding regarding how to integrate IPE; IPE clinical not seen as important as discipline-specific clinical; securing IPE clinical placements; policies and systems that remain disciplinary focused; lack of available space; extra work and lack of rewards for faculty; and, dealing with saboteurs and skeptics. Interviewees provided further insight about some of these barriers and the strategies used to overcome them.

<u>Scheduling</u>

At **GBC,** "IPE courses reach 12% of the total health sciences student body (n=2500) in a year. In order to reach a bigger proportion of the student body, significant scheduling changes are

required" (GK). Complexities of arranging schedules that enable learners to complete interprofessional clinical experiences were identified at all sites. At **U of S** and **MUN** the size of some programs makes it difficult to include all students in IPE. Peggy Proctor (**U of S**) notes that if there was a mandate to have all nursing in IPE it would still be very difficult because of the large numbers of students.

Strategies include:

- Securing a time and place in the curriculum for IPE
- Having a central coordinating body (i.e.: " an administrative hub")
- Focusing IPE activities on programs where it makes sense - encouraging natural partnerships
- Encouraging openness on the part of the programs to collaborate for common IPE time

Resources

At **U of S** IPE is not seen as a course and therefore not given priority for room booking (PP). Anne Kearney (**MUN**) concurs, describing having to meet in the evenings because that was the only time that space was available to accommodate their needs. "We needed breakout rooms and at times might need as many as 25 rooms so the logistics of that required that we have our face to face activities at night…" Other resources that were mentioned include more funding and the involvement of more people. **MUN**, **U of T**, and **U of S** all remarked that the end of IECPCP grant funding significantly impacts on the continuation of IPE initiatives.

Strategies:

- Securing permanent meeting rooms
- Obtaining strategic funding from the university/college to support IPE development
- Obtaining continuing government funding
- Examining an equitable funding mechanism that would commit each School of Health Professions to commit a percentage to an IPE operating budget
- University Provost to match funds proffered by each School

Discipline-focus

At **UWO** it was observed that it takes time for some disciplines to move away from discipline-specific thinking. "We are trying to move through systems that are disciplinary anchored and therefore cannot think outside their boxes… takes a lot of time to shift their thinking and fit IP into their 'box'" (CO). Another example of discipline-focus was experienced at **GBC as** some disciplines have policies that indicate that a student must be preceptored in clinical by a member of the same profession.

Strategies:

- Creating a vision which moves IPE and collaborative practice into the mainstream teaching and practice of health programs
- Advancing IP knowledge, skills and attitudes in faculty, students, patients and health practitioners
- Discussing the philosophy of IPE with faculty at every available opportunity
- Showcasing the successes of IPE with all stakeholders
- Seeking commitment from programs to have their students involved in small IPE initiatives so that they are able to determine whether they want to make a more formal commitment to IPE

Faculty engagement, recognition and workload

All interviewees stress the importance of addressing recognition and workload as a means of engaging faculty. Anne Kearney (**MUN**) suggests that IPE must be designed so that it is included in the assignment of faculty workload and does not threaten promotion and tenure. "No matter how much faculty believes in it, it is not a sustainable option to have it added to their regular workload". In many institutions, discipline-specific teaching is valued as a consideration for promotion and tenure. Anne Kearney has created a "Statement on the Value of IP Teaching", which describes how IPE does not resemble regular teaching and elaborates on its value. This Statement will be shared with governing Deans and Directors, the Vice President-Academic, Faculty Relations, as well as unions. At **GBC** "no one has the time to integrate IPE into the curriculum...there is a lack of understanding on how to integrate IPE. It is viewed as an add-on to programs that are already seen as having a full course load" (GK).

Strategies:

- Making it attractive for faculty to engage in IPE
- Offering faculty formal time through their workload assignments to work on IPE-related activities
- Lobbying to make IPE accepted as a valuable and credible part of a faculty member's dossier

Other broad strategies for change in relation to incorporating IPE into the university/college culture include:

- Having a full time IPE coordinator in a recognized position
- Providing a repository of IPE tools for health educators
- Providing faculty development opportunities related to IPE
- Having administration endorse a formal mandate to integrate IPE into curriculum
- Realizing that as an IPE champion you have no formal authority and that the role is advisory in nature – "cannot issue ultimatums" (CO, **UWO**)
- Encouraging faculty to conduct IP research

What has changed as a result of an IP initiative?

Similar findings among the sites suggest that despite the logistical challenges, there are faculty champions who really believe in IPE. Anne Kearney (**MUN**) has witnessed increased interprofessional faculty networking and sharing of opinions. As the reputation of IPE success and its necessity is disseminated at **GBC** and **UBC-CHD**, other programs are now asking to have their students involved as it results in powerful and effective learning.

Further, **GBC**, **U of T** and **UBC-CHD** propose that IP clinical placements have spawned a close working relationship with outside facilities who have then challenged the communities to change their service delivery model to that of an interprofessional nature. Peggy proctor (U **of S**) suggests that by providing an early, middle and late IP experience, the continuum of learning from student to practitioner is enhanced.

Pearls of Wisdom

MUN
Anne Kearney advises having a core group who will lead IPE is essential "not for money or glory, because it is hard work and individuals must believe in IPE and be committed to it; it is vitally important to have a program manager". As well, when IPE is introduced one must be cognizant of learner fatigue due to repetition of modality and format which can occur if faculty does not alter the curriculum when incorporating IPE into existing courses.

UWO
Carole Orchard emphasizes, "Live, eat, breathe IPE! You must have an in-depth understanding of the field to be credible. It cannot be a surface knowledge; you must have the research knowledge about IPE. There is no innovative idea that is not worth pursuing".

U of T
Ivy Oandasan recommends that individuals must "Understand the level of engagement that those making decisions need to have" and consider the skills sets of the team of individuals that are needed to make the IPE initiative successful. Ivy shares that, "I worked with the two sectors working hand in hand. I had the system aspect which is why I think it has worked… I had the province, the regulatory bodies, the culture is shifting in those systems and then I got the hospital and educational sector trying to create those organizational frames. I can say that this framework is useful in trying to come up with guideposts of what you need to do".

UBC-CHD
Leslie Bainbridge challenges that "… we need to be present at conferences where we get asked awkward questions that we need to be able to answer. We don't want to become a silo in and of itself". Also, involving students and community partners is crucial to IPE initiatives. John Gilbert counsels, "Always talk the language of the industry – safety, chronic disease management, or primary care and place the concept of IP in those types of discussions".

U of S
Peter Kreb states, "we need to take IPE out of the classroom and into the practice setting" (the university is currently working with the Academic Health Sciences Network to formalize clinical IPE placements) and when embarking on the road to IPE Peggy Proctor echoes these words, "Just do it, like the Nike slogan … there would be a lot of people would say you need a structure, a framework, you need to plan it and have a 5 year goal… and I think you need both."

GBC
Gary Kapelus recommends developing a clear strategy; creating IP courses that bring together students of disciplines that would be more likely to encounter each other in the workplace; having supportive administration; and, "take a lot of time and be patient".

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Appendix A

Dear Colleague,

Re: IPE Project

Hello, we are writing regarding a project that we are conducting on behalf of the Canadian Interprofessional Health Collaborative (CIHC). This project will use a case study approach to describe and examine leading organizational practices of Canadian post-secondary institutions that have integrated interprofessional programs into their curriculum. The following selection criteria were used to determine the sites to be invited to take part in the project:

- Located at a Canadian post-secondary education institution (university, college, institute)
- Demonstrated leadership in IPE in Canada
- Mechanism to coordinate IPE at the school
- Academic accreditation approval
- Link on CIHC website
- Representative of: Geographic location and size of school

The final criterion will be the availability of the 'site' to participate in the interview within the given timeline.

As a faculty or administrator from one of the six selected sites we invite you to share your IPE experiences in a telephone interview. The interviews will be conducted between **April 17 and April 24, 2009** at a time convenient to you and should take approximately one (1) hour to complete. Attached you will find the interview questions for you to review prior to the interview. You may wish to submit a written response to the questions in addition to the interview.

It is anticipated that the information gleaned from the case study interviews will provide data concerning the critical factors of implementation of interprofessional education, such as the success factors; strategies to overcome identified challenges and barriers; key relationships/partnerships; resource requirements; faculty education; program benefits; program structure; recommendations; and, policy development. Findings will be published in a report authored by CIHC; therefore, your willingness to participate in the case study interview implies consent to share the information provided with a wider audience. Your name will be withheld from any publication upon request.

Please contact Kelly Lackie at (902) 473-1457 or Kelly.lackie@cdha.nshealth.ca or Valerie Banfield at (902) 473-7651 or Valerie.banfield@cdha.nshealth.ca **by April 16/2008** to confirm

your interest and availability in participating in an interview. At that time we will provide you with a more detailed explanation of the project. In addition, please feel free to contact Brenda Sawatzky-Girling, Managing Director of CIHC, at brendasg@telus.net, if you have any questions or concerns.

Sincerely,

Kelly Lackie and Valerie Banfield

Appendix B

CIHC IPE Project
April 2009

Case Studies

Site:____

Contact:____

Date: ____

Would you tell me your story about how IPE came be at your institution?
- Prompt: who or what was the impetus for integrating IPE into the curriculum at your institution?

Demographic data:

Structure

- Urban vs. rural – community served; location; clinical practicum sites
- Number of health professional programs - number of health science students and faculty
- How many staff have you hired to conduct IPE activities? What are their current roles and FTE equivalents?
- Pre or post-licensure IPE sessions provided
- Are there people who volunteer their time from other faculty/organizations to assist with the IPE course?
- Length of time of IPE initiative – half or full credit
- Type of IPE course (credit vs. certificate)
- Onsite vs. distance
- Relationship between theory & practice – is there a clinical component of the course; Practice sites available – type & number
- Curricula involved in IP session – are the courses electives? Mandatory?

Mechanisms

- Who must be involved & how?
- Office or champion of IPE in the school?

Faculties

- Which faculties are included in the IPE initiative?
- Is there anyone that you would like included but are not? Is there anything that would help in making this work?
- Describe how faculty are prepared to lead &/or facilitate IPE.

Funding

- How is funding structured for IPE specific components?

- What resources are required?
- Sustainability – ongoing funding available?
- In-kind vs. externally funded
    - → Does your university/community college provide support to your IPE administrative structure? If yes - would you be willing to provide the range of the amount of support (per year) that is being (or planned to be) provided?
        - ____<$50,000
        - ____$50-$100K
        - ____ $100 - 200K
        - ___$200K-300K
        - ___>300K
    - → Resourced by the school - Budget $; In-kind contributions
    - → Resourced by partners- Budget $, In-kind contributions

Leadership
- Development – what is the IP philosophy of program or school?
- What year did IPE begin in your school? Provide a bit of a history of the evolution.
- Leadership initiative – publication, presentations
- role of leadership, administration, faculty, students
- who is involved & how
    - → What is the governance structure at your university/community college?
    - → What enables IPE?
    - → What hinders IPE?
    - → What is the title of your IPE lead?
    - → Who is he/she accountable to?
    - → What committee structure has been developed?

Partnerships/relationships
- Do students complete practical IPE exercises, rotations?
- What partnerships have been established?
- What are the working relationships & partnerships where students complete practice education/practicum?

- What enables this relationship?
- What hinders this relationship?
- Are there other relationships that are integral to the IPE activities at your school?

Resources - Who, what, where, when & how???
- start-up vs. long-term
- faculty preparation
- location of IPE sessions

Policy Regulation:
- What is your relationship with the health system?
- Are there any national/provincial/local policies and regulations that facilitate/impede your progress in implementing the IPE session? i.e.:
    - o Deans of Faculties of Health Sciences
    - o The Canadian Association of Allied Health Programs

- Accrediting bodies (provincial, federal)

Summary/Wrap up

- What has worked?
- What isn't working?
- What barriers and challenges have you encountered? Outline the strategies that were employed to overcome these.
- What has changed as a result of an IP initiative?
- What recommendation would you provide for others who are establishing IPE initiatives in their schools? E.g. Pearl of wisdom