International Perspectives on Interprofessional Learning and Care: The Toronto Story

Advancing a Cultural Shift Towards High Quality, Patient-Partnered Healthcare

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For today...

- Share a bit about our context
- Reflections from our journey
- Looking ahead...what's next for leading and sustaining interprofessional learning and collaboration



Our Toronto Journey

Success has been built on an explicit focus and partnership between academia and practice







"If health care providers are expected to work together and share expertise in a team environment, it makes sense that their education and training should prepare them for this type of working arrangement." (Romanow, 2002)













Interprofessional Education

"occurs when two or more professions learn about, from & with each other to enable effective collaboration & improve health outcomes."





Framework for Action on Interprofessional Education & Collaborative Practice WHO, 2010

Interprofessional Collaboration

Occurs when <u>multiple health workers</u> from different professional backgrounds provide comprehensive health services by <u>working with patients</u>, their families, carers and communities to deliver the <u>highest quality of care across settings</u>.





(Definition of Collaborative Practice: Framework for Action on Interprofessional Education & Collaborative Practice WHO, 2010

The International Context







Shortage of **4.3 million health workers** world-wide

(Framework for Action on Interprofessional Education & Collaborative Practice WHO, 2010)





Quality and Collaboration

Crossing the Quality Chasm envisions a future where clinicians "understand the advantage of high levels of cooperation, coordination and standardization to guarantee excellence, continuity, and reliability. Cooperation in patient care is more important than professional prerogatives and roles. There is a focus on good communication among members of a team, using all the expertise and knowledge of team members"

Institute of Medicine, 2001





Harvard Business Review 2002

What percentage of issues between professionals are due to the lack of interpersonal communication skills and not the competencies of the parties?





Val Ulstad, MD, MPH, MPA

Harvard Business Review 2002

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MEASURING THE IMPACT OF INTERPROFESSIONAL EDUCATION ON COLLABORATIVE PRACTICE AND PATIENT OUTCOMES

INSTITUTE OF MEDICINE OF THE NATIONAL ACADEMIES





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Teamwork in Healthcare is being proposed as **one of the solutions** to help stabilize and sustain the health care system



Teamwork Positively Impacts Outcomes

- Improved <u>Outcomes</u> in specific populations
 Neonatal ICU, geriatrics, fractured hips (Zwarenstein et al., 2005)
 Stroke Functional Outcome (Strasser et al., 2008)
- Improved <u>Safety</u>

SBAR Communication Tool (Velji et al., 2008) Fewer deaths when in 'true' team (West, 2006)

- Improved <u>Cost Efficiency</u> (D'Amour, 2005)
- Improved <u>Professional Satisfaction</u> (Cohen & Bailey, 1997)
- Leads to a <u>Healthy Workplace</u>
 - (Shamian & El-Jaradali, 2007)

UNIVERSITY OF TORONTO



Framework for Action on Interprofessional Education & Collaborative Practice

IPC can decrease:

- total client complications
- length of hospital stay
- tension and conflict in caregivers
- staff turnover
- hospital admissions
- clinical error rates
- mortality rates









Why the Centre for IPE?

Interprofessional Education



Collaborative Practice



Health Care Context

- Interprofessional learning as an enabler of health care priorities
 - Quality and safety
 - Patient-centered care
 - Value of care
- Recruitment and retention



University of Toronto Context

- 11 health sciences programs
- 1600 first year students
- 12 fully-affiliated teaching hospitals
- "Full curriculum"



Health Sciences Programs

- Dentistry
- Kinesiology
- Medical Radiation
 Sciences *Michener Institute*
- Medicine
- Nursing

- Occupational Therapy
- Pharmacy
- Physical Therapy
- Physician Assistants
- Social Work
- Speech-Language Pathology





INTRODUCING AN IPE CURRICULUM





Centre for INTERPROFESSIONAL EDUCATION

Centre for INTERPROPESSIONAL EDUCATION

A Framework for the Development of Interprofessional Education Values and Core Competencies Health Professional Programs, University of Toronto



	EXPOSURE: Introduction	IMMERSION: Development	COMPETENCE: Entry-to-Practice
Collaboration Interprofessional (P) theory Contract and cutures of the health case system Contract and cutures of the health case system Contract and an an effective team member Contract and an an effective team Contract an an effecti	Knowledge - Describe even sole, responsibilities, values and scope of practice effectively to clients/ advertistantiles and other professionals. - Describe the context and outputs of the interprofessional (P) environment that behind teamwork. - Identify instances where IP care will improve client/patient/family outcomes.	 Skill / Behaviour Accurately describes the tales, responsibilities and scopes of practice of other professions. Contribute its: Contribute its: Contribute its: Effective decision-making in P teamwork with king judgment and catical thinking. Team effectivenes through effection on P even function. the establishment and maintenance of effective P working selationships/ partnerships. 	 Skil / behaviour Work collaboratively with other, as appropriate, to assess, plan, provide car/ intervention and make decisions to optimize class / patient/smil/ heilth extremess and improve quilty of case. Sensonsale lackship is advancing effective? If sears function theory is availing intervention classifier is advancing effective? Team function theory is availing intervention of effective decision-making. Sensonsale lackship is advancing effective? Team function theory is availing intervention of effective decision-making. Sensonsale advance advance is also infraint? If group and support others in their to say, to chable and adaptability. Sensons of demonstration effective? Evolving electronic patients/pawith classify patienti/lam/law and other team members, teams analytic cognitizations to approx the advance of common goals. Dial / behaviour Communicates effectively including giving and necessing leadback. Schweise Figure functioning through effectively addessing P conflict. Schweise Figure F
	communication and/or in remeint.	Skill@ehavtour • Constitutes to effective P communication, including: • Onling and near Wing feedback, • Addmaining coefficient of there near of opinions, • Self-self-self-self-self-self-self-self-s	Skil / Behaviour • Communicate effectively, inducing giving and nearing feedback. • Advance IP group functioning through effectively addressing IP conflict. • Variant and infective IP team member by: • Shating information, • Listening attentively, • Listening feedback to others, • Providing feedback from others. Attitude • Osvelop assertees of and contribute to continual improvement of IP team dynamics and group processes through effective IP communication.
Value r and Chico • Salational-centred • Diversity sensitive • Interdependence • Creativity/Innovation	Knowledge Coescribe IF team dynamics as they relate to individual team members' values and the impact on team functioning in etitical diammas. Coescribe the mature of iP etitical reasoning and justification. Skill / Behaviour Identify IF etitical issues within a team context. Uklise the basic skills of reasoning and justification as it relates to identified etical issues within an IF team. Attitude Reflect on eem values, personal and professional, and tespect those of other IF team members/ values including accountibility, respect, confidentiality, tout, integrity, honestand and behaviour, quity as it relates to IF team functioning to matinice quality, unip prient care.	E Knowledge • Detective frameworks for ethical decision-making within an IP team. Skill / Behaviour • Guided by an othics framework, contribute to IP othical reasoning and decision-making. Attitude • Advances values including account billity, respect, confidentiality, struit, integrity, honesity and ethical behaviour, equity as it relates to IP team functioning to maximize quality, safe patient care.	Skill / Behaviour • Perform effectively to develop thand team values. • Tractice ethics lyin an IP environment. • Able to use a formework for ethical diction-making to guide ethical reasoning within an IP team. Attitude • Accept through respect and value, others and their contributions in relational-centred care.
	REFLI	ECTION, LEARNING AND FORMATIVE ASSESSMENT	o linkersity of Tooris, Certie for Interprotessional Education
		LEARNING CONTINUUM	

National Interprofessional Competency Framework



U.S. - IPE Competency Domains

- Values/ethics for IP Practice
- Roles/Responsibilities
- Interprofessional Communication
- Teams and teamwork



American Interprofessional Education Collaborative Expert Panel, 2011



Curtin IP Capability Framework Western Australia





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Integrating an IPE Curriculum

- Core competencies
- Development phase
- Scaling successes
- Embedding and strengthening intraprofessional curriculum
- Making it requisite



What Students Say

Greatest value placed on clinical experiences with other students and real patients/clients; practice-based experiences





Student-Led Curriculum

- IHI and Quality Improvement

 Observerships and practicums
- IMAGINE (student-run clinic)



Developing our Educators

- Key strategy to build capacity in practice
- Educational resources
 - DVD series
 - IPE placement handbook & coaching
- Development programs
 - *− ehpic*[™]
 - Collaborative Change Leadership
 - Customized training



Successes to Date

- Stability after the funding ends
- Enhanced curriculum capacity
- Strong practice partnerships
- Evidence of student impact
- Organizational impact
- Global reach Institute of Medicine



LOOKING AHEAD...







IMPACT



- Improved Patient Outcomes
 - Access and Quality
 - Care Experience
- Cost Efficiency
- Health Professional Satisfaction




Quality and safety: Are tools the answer?





Surgical Patient Safety Checklist Haynes, Weiser et al. NEJM (2009): 360;5: 490-499

Table 1. Elements of the Surgical Safety Checklist.*

Sign in

Before induction of anesthesia, members of the team (at least the nurse and an anesthesia professional) orally confirm that:

The patient has verified his or her identity, the surgical site and procedure, and consent

The surgical site is marked or site marking is not applicable

The pulse oximeter is on the patient and functioning

All members of the team are aware of whether the patient has a known allergy

The patient's airway and risk of aspiration have been evaluated and appropriate equipment and assistance are available

If there is a risk of blood loss of at least 500 ml (or 7 ml/kg of body weight, in children), appropriate access and fluids are available

Time out

Before skin incision, the entire team (nurses, surgeons, anesthesia professionals, and any others participating in the care of the patient) orally:

Confirms that all team members have been introduced by name and role

Confirms the patient's identity, surgical site, and procedure

Reviews the anticipated critical events

Surgeon reviews critical and unexpected steps, operative duration, and anticipated blood loss Anesthesia staff review concerns specific to the patient

Nursing staff review confirmation of sterility, equipment availability, and other concerns

Confirms that prophylactic antibiotics have been administered ≤60 min before incision is made or that antibiotics are not indicated

Confirms that all essential imaging results for the correct patient are displayed in the operating room

Sign out

Before the patient leaves the operating room:

Nurse reviews items aloud with the team

Name of the procedure as recorded

That the needle, sponge, and instrument counts are complete (or not applicable)

That the specimen (if any) is correctly labeled, including with the patient's name

Whether there are any issues with equipment to be addressed

The surgeon, nurse, and anesthesia professional review aloud the key concerns for the recovery and care of the patient

* The checklist is based on the first edition of the WHO Guidelines for Safe Surgery.¹⁵ For the complete checklist, see the Supplementary Appendix.





Abstract Findings:

- Results The rate of death was 1.5% before the checklist was introduced and declined to 0.8% afterward (P=0.003). Inpatient complications occurred in 11.0% of patients at baseline and in 7.0% after introduction of the checklist (P<0.001).
- Conclusions Implementation of the checklist was associated with concomitant reductions in the rates of death and complications among patients at least 16 years of age who were undergoing non-cardiac surgery in a diverse group of hospitals.

WHAT MUST BE CORE FOR ALL PROESSIONS?



- Admission/recruitment attributes
- Orientation in practice settings
- Curricular content





ACCREDITATION OF INTERPROFESSIONAL HEALTH EDUCATION (AIPHE)

Principles and practices for integrating interprofessional education into the accreditation standards for six health professions in Canada.



Overarching direction for the development of accreditation standards that incorporate IPE provides links to resources that will assist education programs to make curricular changes in support of the

IPE standards.

Accreditation Principles for IPE

afmc.ca/aiphe-afiss

Assessment of Competence





Reflections on Leading and Sustaining Change





Our Toronto Journey

Success has been built on an explicit focus and partnership academia and practice





Partnerships & Engagement

- Partnerships between academia and practice are critical for success
- Identify champions at the universities/colleges and in the practice settings
- Develop vision, goals and build curriculum opportunities together
- Build on what is already working



Patient Engagement

- Where we've been intentional
 - Curriculum design and delivery (e.g. health mentors)
 - Professional development
 - Strategic planning
- What we need to do more of
 - Governance committees



Structures that connect







Structures that connect

- Executive Committee (Deans & CEOs)
- IPE/C Leaders in practice
- Academic Coordinators of Clinical Education
- Inter-faculty Curriculum Committee
- 250+ Community of Practice
- Annual Curriculum Planning Day



TRANSFORMING PRACTICE





Organizational Culture

- Definition, vision and principles for IPC
- IPC integrated into strategic plans
 - Aligned with quality/safety
 - Visible metrics
- Evidence of language and symbols that promote interprofessionalism
 - Jargon, space, roles
- Accreditation opportunity to influence how we define teamwork





Leadership

- Recruit for transformational capacity at all levels, not profession
- Role-modeling of leaders critical given the 'hidden curriculum'
 - Especially true for clinical managers
 - Negotiating role overlap
- Structure of quality committees



Human Resource Practices

• Recruitment

- Hire for collaboration
- Interprofessional panels & questions
- Orientation
 - Beyond general orientation for all staff
 - Focus on key clinical competencies
 - Structured shadowing with debriefing



Human Resource Practices

- Performance Enhancement
 - Requisite and regular feedback
 - Team-oriented (IP peer feedback, category for IP teamwork)
- Job descriptions
 - Accountability for team functioning "It's everyone's business"
- Recognition build on current practices with intentional focus on *IP* teamwork





Technology-Enabled Practices

- Electronic Health Record
 - Seen as an enabling or inhibiting
 - Interprofessional development
 - Requisite use for all providers
 - Educational development plan needed
 - Space for questions between team members (e.g. discussion board, flags)



Education Practices

- Shared educational space
- IPL strategy in place
 - Learning opportunities for students and staff
 - Specific IPL capacity building
- Professional development
 - Opening up current uni-professional offerings as the standard



IP Model of Care

- Mutual respect
- Role understanding
- Shared leadership
- Interprofessional staffing mix
- Common goals & integrated care plan
- Some co-location
- Specialized roles for care co-ordination (e. navigator, service co-ordinator)







IP Model of Care

- Team "meetings"
 - Blend of face-to-face and technology
 - Case reviews for complex patients
 - Rounds/huddles
 - Reflection, reflection, reflection
 - Debriefing
 - Socialization
- Patient care needs assessment





Critical Enablers

- Interprofessional roles
 - Expanded VP Education mandate
 - Facilitators from both academia and practice
- Engaged leaders
- Patient and student voices
- Scaling successes
- Creating a community



Key Learnings from Our Journey

- Explicit focus and partnership between education and practice
- Not waiting for everything to be just right
- Sharing stories
- "Fan the fires" strengths-based
- The real work is about culture change





Additional Resources



http://www.cornellpress.cornell.edu/book/?GCOI=80140100065220





www.ipe.utoronto.ca



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