Interprofessional Education and Care: The Time is Now

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Presentation Outline

- Define IPP, IPE, CIPE
- Brief historical context for “Why Now”?
- Focus of IPE learning and basic elements
- IPE learning principles
- IPE curricular strategies
- IPE learning methods
- IPE Basic curriculum elements
- IPE curricular examples
- Practice Models
- Key challenges: Evaluating IPE Outcomes, Faculty Development, IPE research
Definitions

- IPP → “two or more professions working together as a team with a common purpose, commitment and mutual respect” (Freeth et al. 2005)
- IPE → “when two or more professions learn with, from and about each other to improve collaboration and the quality of care” (CAIPE 2002)
- CIPE → intentional IP learning for practitioners
IPE -
Important Historical Points

- IPP has preceded IPE i.e., IPE is practice-driven
- CIPE (informal) preceded other forms of IPE
- Undergraduate IPE first introduced in US in mid-late 1960’s
- First IOM report on “Educating for Health Teams” - 1972
- IPE never “mainstreamed” - although IPE supported by various foundations, HRSA, Veterans Administration
- In past, IPE almost always “elective”, for small numbers
Cycles of interest in IPP emerged over time from specific specialty sectors—rehabilitation, mental health, comprehensive care in chronic ills, primary care, rural care, geriatrics [vulnerable population], intensive care, hospice and palliative care. Blips in IPE might follow…

IPE in graduate medical education absent

Most practice settings were not aligned to receive graduates ready to practice interprofessionally

Payment systems did not reward IPP

Health professions education remained in “silos”
Why IPE now: What has changed

- Awareness of quality, but, especially SAFETY issues in health care, primarily in hospital settings
- Incorporation of models from group dynamics, aviation, business, human factors, and organizational change
- Awareness that poor communication and teamwork contribute to safety and quality issues
- IOM 2003 report on health professions education
- Safety [as well as cost and quality] is a general concern that has brought everyone “to the table” raising the possibility for mainstreaming IPE
What else has changed in the intervening decades?

- Health care fields other than medicine have continued development as autonomous professions.
- IPE pedagogies are much more developed; systematic reviews give glimpses into best practices based on current evidence.
- Evidence base for IPP and outcomes is growing.
- Awareness that IPE is not only a national, but international concern.
Definition:
IPE→ "occurs when two or more professions learn with, from and about each other to improve collaboration and the quality of care" (CAIPE 2002)

What is the focus of the IP learning?

The safety issues have made clear that knowledge and skills in the processes of care delivery are as important as clinical knowledge and skills.
Differences in “Teams” vs “Teamwork” language

- “Team” language prevails, as in the IOM (2003) competence: “work in interdisciplinary teams”; and in the overall vision: “deliver patient-centered care as members of an interdisciplinary team”

- Teamwork language is embedded in the details with words like: cooperate, collaborate, communicate and integrate [care in teams]; coordinate continuous care
Differences in “Teams” vs “Teamwork” language

- A “team” is a small group of people who share the care of a population of patients; it is one way to organize care delivery, requires specific knowledge about small group dynamics.

- Patient safety, with its focus in large institutions, should challenge “team” language as limited in the context of complex institutional processes.

- Teamwork language names the general processes of care that are the focus of learning together.
Teamwork Competencies--a Hierarchy: Three “C’s” Plus One

Effective Communication processes underlie each “C”, as does the idea of professional and patient relationships.
Jody Gittell on “Relational Coordination” in High Performance Health Care (McGraw-Hill, 2009)

- Shared knowledge
- Shared goals
- Mutual respect
- Across functional roles

“The quality of relationships may also determine the effectiveness of the communication. Even timely, accurate information may not be heard or acted on if the recipient does not respect the source.” (p. 16)
“Learning as participation [is] not simply a way of acquiring skills, but also of developing an identity and sense of belonging in a community”. (Barr, 2005)
Pedagogy of IPE: Educational and Adult Educational Principles

- Leveling, timing and sequencing of IPE training
- Combining didactic and experiential learning
- Both classroom-based and work-based
Curricular Strategies

- Curricular vs extra or co-curricular
- Required vs elective
- Courses vs “threads”
Learning Methods

- Active learning
- Problem-based learning
- Reflective learning
- Situated learning
- Self-directed learning
Basic elements of IPE

- Ethical framework
- Knowledge, attitudes, and skills
- Teamwork training- WHO’s “collaboration readiness”
- Systems’ context
Interprofessional Ethical Framework

- Basic values uniting all who work in [a particular sphere of] health care
- Mutual obligations
- The common good
- Expression in societal values, professional codes of ethics, organizational and educational mission statements, and personal values
IP Knowledge - Process Oriented and Relationship Focused

- Own role
- Other health team members’ role, training and capabilities
- Principles of communication and teamwork
- Conflict resolution approaches
- IP process improvement approaches
Knowledge

- Own role
- Other health team members’ role, training and capabilities
- Larger context of collaborative care
Learning strategies
Learner outcomes-Knowledge

Didactic- e.g.,
Studying codes of ethics, standards of practice, examining personal stereotypes (reflection),
Looking at socio-political, professional and organizational context

Experiential e.g.,
Talking to young people as a group of health professions’ students about different roles
Interviewing persons from other “professions’
Shadowing/ engaging in the work of “other” professional
Knowledge and Skills

Principles of communication and teamwork
Conflict resolution approaches
IP Process improvement approaches
Learning strategies
Learner outcomes-Knowledge and Skills

**Didactic e.g.,**
- Reading about basic theories/principles of teamwork; observing role models in practice;
- Use of Team STEPPS and other electronic educational resources
- Process improvement in teamwork

**Experiential e.g.,**
- Teamwork exercises/games*
- Problem-based team competitions, e.g., Clarion
- Second Life family Simulation exercises
  *communication distortion, cooperation, hand-offs/coordination, time-limited exercises
Knowledge, skills, and context of care

Incorporating knowledge and skills into systems of care
Learning strategies

Learner Outcomes: Knowledge and Skills and
Patient & Community Improvement Outcomes

- Training wards and student-run clinics
- Organizational and community needs assessment and health improvement projects
- Service learning projects
- International clinical experiences
Applying Process of Care Competencies

- Knowledge of Systems-small and large
  [diverse health delivery models]
  e.g. - prevention and primary care like the Alaska rural team model or health care home model
  - hospital-based microsystem like ICU
  - specialty-based model, small team in a large hospital, like a palliative care consultation team
Key Question?

- What are the appropriate outcomes of IPE across the continuum of undergraduate to CE?
- Knowledge?
- Attitudes?
- Skills?
- Behaviors?
- Patient and family outcomes?
Alternative Assessment Frameworks

- Skill-based
- Capability-based
- Competency-based
- Integrative approach

Good resource: A National Interprofessional Competency Framework, CIHC, 2010 (built on the integrative approach) Appendix 1, and Appendix 2: one page summary
Key challenges: Competency assessment

- Defining interprofessional competencies
- Linking IPE learning principles, methods, and strategies to competencies
- Measuring levels of competence [“collaboration-readiness”] along the learning continuum
- Linking competent performance to appropriate health care outcomes
Institutional tailoring

- One size will not fit all
- Overall competencies, learning principles and methods may be similar
- Basic principles of organizational change will apply BUT
- IPE learning strategies will need to be tailored to the specific institutional educational and clinical learning contexts, opportunities and needs
CAB II, May, 2009: Dr Carol Aschenbrener’s presentation on organizational change principles

The Need for Faculty Development

- Learning to teach together across the professions
- Theoretical frameworks for content being taught (relationships and processes)
  
  e.g. Sargeant, J (2009)- Theories to aid understanding and implementation of IPE. J Cont Ed Health Prof, 29, 178-184.
- Applying learning principles, methods, and strategies to IPE
- Evaluation of IP learning
The Importance of Evidence: Educational Research

- The rationale for IPE is “to improve collaboration and the quality of care”
- If we prepare health professions students to be competent collaborators

IPE $\rightarrow$ collaborative competence

Collaborative competence $\rightarrow$ improved outcomes
Evidence for Positive Outcomes of IPE

- UK Joint Evaluation Team (JET) team—8-year effort; worldwide reviews of the outcomes of IPE
- Cochrane systematic reviews