Implementing Interprofessional Care in Ontario

Final Report of the Interprofessional Care Strategic Implementation Committee

May 2010

HealthForceOntario

Ontario

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We are pleased to present *Implementing Interprofessional Care in Ontario: Final Report of the Interprofessional Care Strategic Implementation Committee*. This report showcases the extensive efforts that the Committee and its Working Groups have undertaken over the past two years to help lay the foundation of a culture of collaborative, patient-focused care in Ontario.

The Committee was formed after the release of *Interprofessional Care: A Blueprint for Action in Ontario* (July 2007). The *Blueprint* identified collaborative practice as the best way to improve patient outcomes and the quality of workplace experience for health professionals.

We brought together an outstanding group of individuals, including representatives from academic institutions and professional associations, as well as caregivers and regulators. Their invaluable knowledge and passion have helped to raise the profile of interprofessional care (IPC) and interprofessional education (IPE) efforts in Ontario.

Our goal was to work with the health care and education sectors to implement the carefully thought-out recommendations in the *Blueprint* at the system, organizational, education, practice, and policy levels. The *Blueprint* was designed to be a springboard for a wide cross-section of stakeholders—from individual organizations and health caregivers to educators, patients, and families—as they incorporate IPC/E into their workplaces and educational institutions.

When the *Blueprint* was released, we were overwhelmed by the amount of interest in IPC/E that was generated by the document. The collaboration, communication, and enthusiasm that made the *Blueprint* possible were in full force as the strategies and action items were carried out. Stakeholder consultation and information sharing continued to be a cornerstone of our efforts.

The Committee undertook many ambitious activities, such as championing IPC/E in a province-wide speakers' tour, encouraging participation in government IPC funding programs, and providing advice to government on implementing IPC through Local Health Integration Networks (LHINs). The Core Competency and Interprofessional Education Curriculum Working Groups also made great strides in implementing key facets of the *Blueprint*. Their efforts are detailed in these pages.

Along the way, we saw IPC being carried out at both the grassroots level and on a broader scale, through exciting and innovative government-funded initiatives. We also increasingly saw the instilling of IPE values in our educational institutions. Our hope is that this report will inspire and inform those who are committed to entrenching IPC in care delivery, and lead to nothing less than a transformation of our health care system.

We believe that this report will be used by a wide and varied audience. It contains key information about IPC/E—promoting best practices of IPC/E models and concepts—as well as tools to help with their implementation. We hope it will precipitate further discussion about IPC/E and prompt workplaces to engage in new ways of practice. A concerted and coordinated approach to IPC/E involving numerous stakeholders and caregivers will result in the systemic changes to the health care system that are needed to make interprofessional care the ideal standard of care.

We thank you for the opportunity to engage in this worthwhile and rewarding endeavour.

Yours truly,

Peeter Poldre
Jackie Schleifer Taylor
Co-Chairs, Interprofessional Care Strategic Implementation Committee

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The advice and recommendations contained in this report reflect the views of the Interprofessional Care Strategic Implementation Committee and not the organizations with whom individual members are associated.

Executive Summary

Interprofessional care (IPC) is a collaborative, team-based approach to providing optimal patient care. It benefits and empowers patients, and significantly improves health care provider satisfaction.

Studies have shown that IPC can lead to:

- increased access to health care
- improved outcomes for people with chronic diseases
- less tension and conflict among caregivers
- better use of clinical resources
- easier recruitment of caregivers
- lower rates of staff turnover

In Ontario, although IPC has gained a foothold at the grassroots level, a concerted, system-wide approach to its implementation is needed. Implementing IPC, and establishing a firm base for interprofessional education (IPE), requires the commitment of a range of stakeholders, including regulatory bodies, health care professional organizations, academic institutions, hospitals, insurers, community and support agencies, organized labour, researchers, patient/consumer groups, government, crown agencies, health caregivers, educators, administrators, patients, and families.

In the summer of 2007, *Interprofessional Care: A Blueprint for Action in Ontario* was submitted to the provincial government by the Interprofessional Care Steering Committee, which was struck following an IPC summit in 2006. The goal of the Committee was to create a blueprint to guide government, educators, health caregivers, organizational leaders, regulators, and patients in how to make the adoption of IPC a reality.

After a year-long process of reviewing the relevant research, and holding consultations and meetings, the Committee developed four key recommendations and identified associated activities. These provide an effective framework for implementing interprofessional care:

- **Building the foundation:** creating a firm foundation upon which key interprofessional care activities can be implemented and sustained.
- **Sharing the responsibility:** sharing the responsibility for ensuring that interprofessional care strategies are effectively implemented among interested parties.
- **Implementing systemic enablers:** providing systems, processes, and tools that will allow interprofessional care to be taught, practised, and organized in a systemic way.
- **Leading sustainable change:** leading sustainable cultural change that recognizes the collaborative nature of interprofessional care and embraces it at all levels of the health care and educational systems.

To put the principles of the *Blueprint* into action, the provincial Interprofessional Care Strategic Implementation Committee (IPCSIC) was formed. The Committee guided two working groups—the Interprofessional Education Curriculum Working Group and the Core Competency Working Group. These Groups were tasked with implementing two key recommendations out of the report: defining and agreeing on core IPC competencies, and developing IPE curriculum models.

From December 2007 to 2009, the Committee and its Working Groups engaged in extensive stakeholder consultation and information sharing. Members undertook a multitude of activities, from championing IPC/E in a speakers' tour around the province to generating tools to facilitate IPC implementation.

Literature scoping reviews were the first step in a systematic approach to data gathering, followed by visits to colleges and universities to explore the perceived benefits of IPE and ways to improve its implementation in the education sector. This fuelled the development of a conceptual framework to assist in the identification of interprofessional learning opportunities in pre-entry-to-practice, post-registration, and continuing education, as well as guides for developing curricula and tools for teaching and assessing interprofessional competencies.

Advancing Competence in Interprofessional Care: A Charter on Expectation and Commitments sets out a common language to describe IPC competencies and expectations for all audiences and users when IPC is practised. Competence in any area is a complex discussion and the Charter, based on the voices of patients and health caregivers, aims to transcend specific terminology and instead provide a descriptive model to talk about the behaviours and attitudes necessary to execute IPC. The Charter is complemented by a *Resource Guide*, which contains resource tools to support the Charter's use.

Finally, the Committee recommended an innovative approach to IPC implementation that capitalizes on Ontario's Local Health Integration Network (LHIN) structure. The model involves having one IPC lead/champion at each of the 14 LHINs, guided by a provincial IPC lead and a provincial body. Having a network of IPC leads/champions provides an organizational structure and function that enables the sharing of key initiatives and resources.

To further ensure sustainability, the Committee has recommended that the LHIN IPC leads/champions focus their initial efforts on the provincial diabetes strategy. By aligning IPC with diabetes, a pervasive chronic condition that involves multiple health caregivers, the LHIN IPC leads/champions will be able to both implement and shape their role in moving the IPC mandate forward and build an understanding and capacity that can be transferred to team-based collaborative care delivery models.

This report reflects the concerted efforts of a diverse group of individuals who, over the past two years, directed their considerable time and energy to furthering interprofessional care. The document contains key information about IPC/E—promoting best practices of IPC/E models and concepts—as well as tools to help with its implementation. It is hoped that this report will help lay the foundation for a culture of collaborative, patient-focused care in Ontario and prompt further discussion and initiatives designed to make interprofessional care the gold standard for care.

This report includes "Interprofessional Care in Action" boxes that provide brief overviews of some of the many innovative IPC projects underway in Ontario.

Throughout the report, members of the Interprofessional Care Strategic Implementation Committee also share their thoughts about what interprofessional care means to them.

Chapter 1:

Introduction and Background

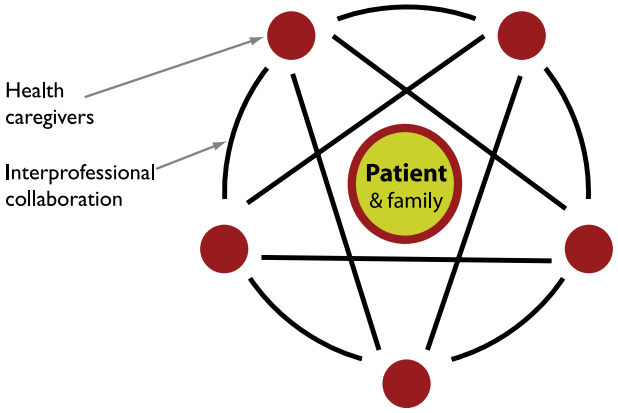
What is Interprofessional Care?

Interprofessional Care: A Blueprint for Action in Ontario defines interprofessional care (IPC) as follows:

> **the provision of comprehensive health services to patients by multiple health caregivers, who work collaboratively to deliver quality care within and across settings.**

It is a collaborative, team-based approach to providing optimal patient care, given the systemic demands and unprecedented challenges in health care (see Figure 1).

Figure 1: Interprofessional Care Defined[1]



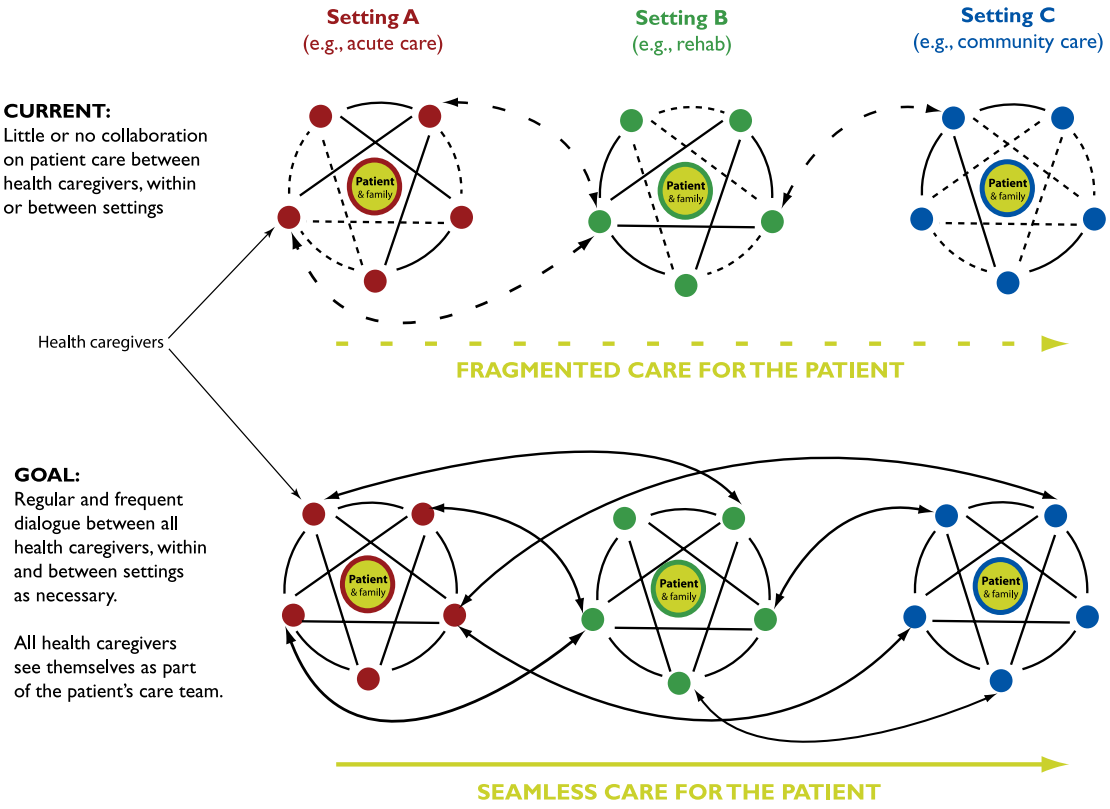
Working collaboratively to place patients and families at the centre of the health care system enhances care delivery for the patient and contributes to improved job satisfaction for the health care provider. The education system must prepare current and future health care providers to work in interprofessional, collaborative, team-based models so that Ontarians have access to the right number and mix of qualified care providers.

There is strong empirical evidence[1,2,3] that IPC's collaborative, team-based approach will ultimately result in many service improvements to patient care delivery (see Figure 2), including:

- increased access to health care
- improved outcomes for people with chronic diseases
- less tension and conflict among caregivers
- better use of clinical resources
- easier recruitment of caregivers
- lower rates of staff turnover

The successful development and implementation of IPC are dependent on, but not restricted to, regulatory bodies, health care professional organizations, academic institutions, hospitals, insurers, community and support agencies, organized labour, researchers, patient/consumer groups, government, crown agencies, health caregivers, educators, administrators, patients, and families.

Figure 2: IPC—Spectrum of Patient Care[1]



Interprofessional Care and Education: The Environment

Interprofessional Care

Interprofessional care is not a new idea, but one that has become a more formally recognized approach to care delivery.

In Ontario, several significant initiatives—including Family Health Teams (FHTs) and Anaesthesia Care Teams (ACTs)—highlight the growing interest in, and implementation of, IPC. FHTs typically comprise physicians, nurses, nurse practitioners, and other health care professionals who work collaboratively to deliver quality, timely, and accessible primary care. FHTs are designed to help reduce the number of unattached patients and improve health care outcomes by focusing on disease prevention, chronic disease management, and health care promotion.

ACTs are a collaboration between anaesthesiologists and two innovative, new health care roles: anaesthesia assistants and nurse practitioners-anaesthesia. ACTs are designed to increase access and decrease wait times for surgical procedures by increasing the number of trained anaesthesia professionals.

In May 2006, the Ministry of Health and Long-Term Care (MOHLTC) announced the creation of HealthForceOntario (HFO), a multi-year strategy to ensure that Ontarians have access to the right number and mix of qualified health caregivers, now and in the future. The strategy is a joint initiative of the MOHLTC and the Ministry of Training, Colleges and Universities (MTCU).

The strategy focuses on:

- identifying and addressing Ontario's health human resource needs,
- engaging partners in education and health care to develop skilled, knowledgeable caregivers and create health care delivery teams that will make the most of their abilities,
- introducing new and expanded provider roles to increase the number of caregivers working in health care and build on the skills of those already in the system, and
- making Ontario the employer of choice for all health caregivers.

A cornerstone of HealthForceOntario is a greater emphasis on interprofessional collaborative care. The HealthForceOntario Marketing and Recruitment Agency, created under the HFO strategy, has administered interprofessional care/education funding programs since October 2008. Projects funded under the Interprofessional Care/Education Fund help to build interprofessional health care teams by linking interprofessional education and practice. This fund supports projects at the intersection of health and education.

The Optimizing Use of Health Providers' Competencies Fund works to optimize the existing potential in health care delivery teams. Applicants were asked to explore the best ways to use the skills and abilities of the caregivers on their team. This program is the first of its kind in Canada.

On June 28, 2007, the Minister of Health and Long-Term Care approached the Health Professions Regulatory Advisory Council (HPRAC) for advice on a number of matters affecting the regulation of health professions in Ontario. (HPRAC is an independent agency of the government created under the *Regulated Health Professions Act, 1991* [RHPA], to provide advice to the Minister on matters related to the regulation of health professions in Ontario.)

The Minister's letter asked HPRAC to:

> *recommend mechanisms to facilitate and support interprofessional collaboration between health Colleges beginning with the development of standards of practice and professional practice guidelines where regulated health professions share the same or similar controlled acts, acknowledging that individual health Colleges independently govern their professions and establish the competencies for their profession.*

The Health Professions Regulatory Advisory Council recommended changes to the scope of practice for various professions, as well as changes to legislation, regulation, structures, and processes to enable enhanced, patient-centred care delivery by health professionals working to their full ability. Conclusions and recommendations to encourage interprofessional collaboration among health professionals were also presented.

Talking interprofessional care

"Quality is the dominant theme in health care today, and interprofessional care is the foundation. Developing implementation strategies for this transformational agenda has been a remarkable experience."

William Shragge
IPCSIC member

In response to HPRAC's advice, the government introduced Bill 179, the *Regulated Health Professions Statute Law Amendment Act, 2009*, which seeks to improve access to health care in the province, again supporting the HealthForceOntario strategy.

The *Regulated Health Professions Statute Law Amendment Act, 2009*, aims to improve the health care system by, among other things:

- expanding scopes of practice to 12 professions;
- requiring the health colleges to work together to develop common standards of knowledge, skill, and judgment in areas where their professions may provide the same or similar services; and
- making team-based care a key component of health college quality-assurance programs to ensure the ongoing competence of registered health professionals.

Interprofessional care in action

The Humber Institute of Technology and Advanced Learning is developing a virtual learning community (VLC) that focuses on geriatric, pediatric, mental health, chronic disease management, and emergency care through case simulation. The team comprises physicians, nurses, paramedics, and nurse practitioners:

Students from entry to practice and continuing education, paramedic and nursing programs, will work with faculty and physicians to learn how these cases may be handled optimally using interprofessional skills. Students will demonstrate they are better able to understand the perspectives of other members of the interprofessional team as they engage in problem solving together. Physicians, nurses and paramedics will report increased understanding of IPC through working together on case development. Faculty will engage in new educational opportunities that better allow the capture of clinical complexities of the real world.

The Bill, which was introduced on May 11, 2009, received Royal Assent on December 15, 2009. This Bill amended 25 Acts administered by the MOHLTC and one administered by the Ministry of Community and Social Services. These changes can be viewed by visiting e-Laws, which is a database of Ontario's statutes and regulations, at www.e-laws.gov.on.ca.

Interprofessional Education

To put an effective interprofessional approach in place, there must be seamless integration between the education system preparing the workforce and the health care system that employs/deploys it. To assist in the development of interprofessional education, MTCU and MOHLTC committed to providing annual financial support, starting in 2006–07, to the six Ontario Academic Health Science Centres (AHSCs): University of Western Ontario, University of Toronto, University of Ottawa, McMaster University, Queens University, and the Northern Ontario School of Medicine. The Centres also contributed one-quarter of the funding each year.

This funding helped facilitate the establishment, in each AHSC, of dedicated resources with a mandate to promote the development, implementation, and ongoing evaluation of a core interprofessional curriculum for health professional students. The funding also supported liaison activities to create common strategies and increased resources for interprofessional content development and clinical teaching and learning in interprofessional settings. The AHSCs were also asked to include other universities and local colleges with health sciences programs in their initiative, in order to ensure that the benefits of interprofessional education and care are integrated throughout the province.

Some of the current AHSC initiatives include the following:

- Through the Program for Interprofessional Practice, Education and Research (PIPER) at McMaster University, in five of six programs, achievement of IPE competencies is now mandatory. As well, ongoing faculty-development initiatives have seen more clinical and academic faculty trained in how to facilitate IPE. Seed funding was also provided to over 12 projects to develop educational offerings to support PIPER's educational model, in which students pick from a menu of educational activities in order to achieve their IPE competencies.
- The Office of Interprofessional Education and Practice at Queen's University has developed resources to support interprofessional education and practice. They include a Patient Perspective Module and a Collaborative Practice Module, developed in conjunction with the South Eastern Interprofessional Collaborative Clinical Learning Environment project, as well as a Collaborative Practice Assessment Tool, developed through the university's Inter-Professional Patient-Centred Education Direction.
- An IPE task force is working to integrate IPE objectives through all undergraduate medical school courses at the University of Western Ontario's Schulich School of Medicine & Dentistry. The School of Nursing and its collaborative partner Fanshawe College are in the process of revising the BScN curriculum. One curricular thread around IPE and a further one related to IP Collaborative practice are being introduced into the curriculum. IPE efforts also extend to the occupational therapy and physical therapy programs.

In 2008–09, the ministries increased the number of post-secondary institutions that would receive financial support. They include three additional universities (Ryerson University, the University of Windsor, and York University) and six colleges (Algonquin College, Centennial College, Conestoga College, La Cité collégiale, George Brown College, and Humber College).

A number of innovative ventures are underway at these institutions, including the following:

- Algonquin College has a steering committee and a plan to integrate interprofessional education across the curriculum in all health and health-related programs. As well, the funding helps support an Academic Health Council at the regional level.
- George Brown College has added two new courses to its Health Sciences curriculum: Collaboration: The Future of Health Care in Canada, and Health: Living the Connections. It also instituted an Interprofessional Grand Round Program, and its new Health Promotion Hub—an onsite applied learning lab—brings students from various health programs together to learn from each other through the design and implementation of outreach projects.
- Centennial College's School of Health and Community Studies has established an Academic Chair, Interprofessional Education, and a permanent IPE subcommittee of the School's Curriculum Advisory Committee. In addition to budgeting for participation on provincial and national IPE committees and integrating IPE education into undergraduate and post-graduate programs, the school holds interprofessional mock-disaster exercises.

- The infrastructure funds were essential for the integration of interprofessional education in La Cité collégiale's health sciences and community services programs. The funds were also used to organize teams working on IPE activities and tools during 2009–10 (e.g., the Francophone health games, IPE simulation, interprofessionnal health promotion activity, IPE on-line modules, etc.). La Cité collégiale also participated in the development and operations of the Academic Health Council, which created a structure for more efficient regional IPE development.

At a national level, efforts to support health professions in working more collaboratively with each other and with patients are guided by the Canadian Interprofessional Health Collaborative (CIHC), which is funded by Health Canada. This group, which communicates and collaborates with Ontario, is a national hub for interprofessional education, collaboration in health care practice, and patient-centred care. Members strive to strengthen interprofessional education for a collaborative, patient-centred practice (IECPCP) knowledge base and to share this information with policy-makers, planners in the health and education systems, health professionals, and educators.

In 2009, CIHC turned its attention to the practice setting: its Mainstream strategy focuses on initiatives to recruit and engage a wider array of health caregivers in meaningful and innovative ways, drive interprofessional collaboration beyond academic institutions, revitalize the working lives of practising health caregivers, and directly affect patient care.

Finally, the Centre for the Advancement of Interprofessional Education (CAIPE), which is internationally recognized for the advancement of IPC/E, has been promoting and developing IPE through its members in the United Kingdom and overseas since 1987. The Centre provides information and advice through its website, bulletins, papers, and outlets provided by others, and has a close association with the *Journal of Interprofessional Care*. CAIPE also delivers workshops that facilitate development in IPE and foster exchange and mutual support between members and others.

Interprofessional Care: A Blueprint for Action in Ontario

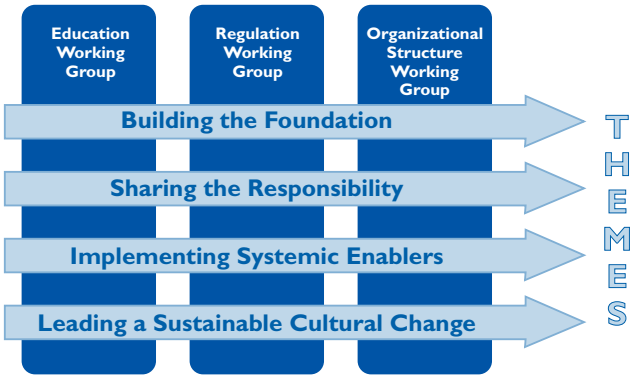
The initiative behind *Interprofessional Care: A Blueprint for Action in Ontario* arose following an invitational IPC summit that took place in June 2006. The Interprofessional Care Steering Committee was struck to undertake the work of creating a blueprint that would provide guidance to government, educators, health caregivers, organizational leaders, regulators, and patients about how to make the adoption of interprofessional care a reality.

The *Blueprint*, which was released in July 2007, was created to support HealthForceOntario (to view the report, go to www.healthforceontario.ca).

The Steering Committee created three Working Groups: Organizational Structure, Education, and Regulation. Each group comprised experts from a wide variety of organizations, including hospitals, community agencies, colleges and universities, regulatory bodies, professional associations, insurance agencies, and organized labour.

After a year-long process of reviewing the relevant research and holding consultations and meetings, the Steering Committee developed four key recommendations that provide an effective framework for implementing interprofessional care (see Figure 3).

Figure 3: *Blueprint* Recommendations at a Glance



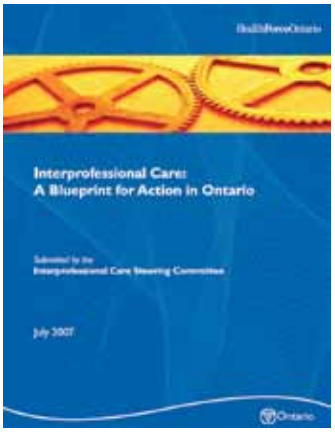


Figure 4 (see page 8) is a snapshot of the Steering Committee's recommended strategies and actions, which sprung out of the four identified directions.

Implementing the *Blueprint*

To put the principles of the *Blueprint* into action, the Interprofessional Care Strategic Implementation Committee (IPCSIC) was formed in December 2007. This Committee addressed the recommendation to "share the responsibility" for ensuring that IPC strategies are effectively implemented among interested parties. Committee members were experts in the fields of policy, education, practice, regulation, and organizational structure, and have demonstrated leadership and experience in interprofessional care.

The mandate of the Committee was to:

- oversee the systemic implementation of *Interprofessional Care: A Blueprint for Action in Ontario* in partnership with health care and education leaders and decision-makers, as well as patients, families, and communities; and
- serve as a key forum for effective IPC implementation, partnership, communications, and leadership in health care and education.

Guided by the recommendations and directions contained in the *Blueprint*, IPCSIC's mission was to:

- advise government on managing the implementation of IPC in Ontario;
- champion IPC;
- create linkages and partnerships that bridge interprofessional education and practice; and
- facilitate knowledge transfer and networking through stakeholder and public dialogue.

The Committee was made up of 15 members, including two co-chairs, with demonstrated leadership and experience in interprofessional care and education at the system, policy, practice, and organizational levels.

Talking interprofessional care

"It has been a privilege to help shape policy and strategy for the patient, health care provider, and Ontario in our quest to ensure sustainable and high-quality care delivery."

Marcy Saxe-Braithwaite
IPCSIC member

Figure 4: The *Blueprint*'s Recommended Strategies and Actions

Direction	Strategy	Recommended actions
A. Building the foundation	*Create a firm foundation upon which key interprofessional care activities can be implemented and sustained.*	1. Define core competencies for interprofessional care. 2. Clarify roles and responsibilities in an interprofessional care environment. 3. Develop interprofessional education curriculum models. 4. Agree on terms and conditions for adequate mandatory liability insurance. 5. Ensure that patients, their families, volunteer caregivers and acute and community support services have the tools and resources they need to participate actively in care decisions.
B. Sharing the responsibility	*Share the responsibility for ensuring that interprofessional care strategies are effectively implemented among interested parties.*	1. Establish a provincial Interprofessional Care Implementation Committee. 2. Develop a multi-level accountability framework. 3. Create a central provincial resource for knowledge transfer.
C. Implementing systemic enablers	*Provide systems, processes and tools that will allow interprofessional care to be taught, practiced and organized in a systemic way.*	1. Conduct a legislative review to identify opportunities for supporting interprofessional care. 2. Implement interprofessional care accreditation standards. 3. Build interprofessional care into service-based and collective agreements. 4. Incorporate interprofessional care into e-health strategies. 5. Provide incentives for practicing interprofessional care.
D. Leading sustainable cultural change	*Lead sustainable cultural change that recognizes the collaborative nature of interprofessional care and embraces it at all levels of the health care and education systems.*	1. Implement a public engagement strategy. 2. Support interprofessional care champions. 3. Provide support for interprofessional care and interprofessional education. 4. Evaluate system performance and outcomes.

Together, they provided expertise in the fields of policy, practice, education, change management, regulation, and organizational structure. (For a detailed membership list, see Appendix A.)

The Committee was a key resource for the implementation of interprofessional care and education by establishing linkages and partnerships, and creating a space for dialogue within the health care system; promoting IPC models and concepts; and providing guidance in the development and dissemination of relevant information.

It directed two Working Groups to address technical structures and processes to provide tools to support and facilitate IPC (e.g. core competencies and curricula). The Working Groups—the Interprofessional Education Curriculum Working Group (IPECWG) and the Core Competency Working Group (CCWG)—were established to address two key *Blueprint* recommendations:

- developing IPE curriculum models, and
- defining core IPC competencies.

The Interprofessional Education Curriculum Working Group (see Appendix B) was established to:

- develop a conceptual framework to assist curriculum developers and educators across health care programs in Ontario in identifying interprofessional learning opportunities in pre-entry-to-practice, post-registration, and continuing education;
- compile all of the curriculum development across the province and from selected projects both nationally and internationally; and
- propose a core curriculum that will guide IPE offered to health care professionals

The Core Competency Working Group (see Appendix C) was established to develop a core competency framework for health caregivers to support IPC in Ontario. The Group's membership comprised regulators, accreditors, educators, and health care professionals with demonstrated expertise in IPE and/or expertise in developing profession-specific competencies.

A "competency" is used to define discipline and specialty standards and expectations, and aligns practitioners, learners, teachers, and patients

Interprofessional care in action

The University Health Network's Certificate Course in Collaborative Change Leadership addresses foundation building and leadership in sustainable culture change. The course is a collaboration between two Academic Health Science Centres and two educational institutions:

The intention for this course is that over a year, we will work with a cadre of 60 people who are already committed to IP education and care and further develop them as a deeply skilled, experienced force who will continue to lead powerful and effective change efforts of all kinds for years to come.

Talking interprofessional care

"It really is a different way of thinking and approaching patient care. Instead of doing it all yourself, you harness the expertise of a number of individuals to bring the best care to the patient. Not only does the patient benefit, but we do too—we share the burden, which means less stress, less burnout, and greater job satisfaction."

David Price
IPCSIC member

with evidence-based standards of health care performance.[4] It includes the understanding and application of clinical knowledge, clinical skills, interprofessional care skills, problem solving, clinical judgment, and technical skills.

The CCWG project had four main objectives:

- identify, define, and validate the competencies for practising IPC;
- clarify the relationship between IPC core competencies and standards of practice;
- identify common IPC principles, values, and terminology for use across the health care system; and
- provide recommendations about teaching and practising interprofessional care competencies across the continuum of learning.

Talking interprofessional care

"Be open to the possibilities of what interprofessional care can do for you and the people you provide care to in Ontario."

Ivy Oandasan
IPCSIC member

From 2007 to 2009, in addition to the two working groups, IPCSIC undertook other activities to help implement *Interprofessional Care: A Blueprint for Action in Ontario*. As part of its IPC championing efforts, for example, IPCSIC participated in several speaking engagements across Ontario, delivering critical information about IPC to a broad audience comprising thousands of individuals working in hospitals, LHINs, health profession advisory committees, professional health associations, regulatory colleges, and faculties of education. (For a detailed list of stakeholder engagement activity, see Appendix D.)

The Committee also developed advice to government on an innovative approach to implementing IPC through the LHIN structure, while the Interprofessional Education Curriculum and Core Competency Working Groups made great strides in implementing key facets of the *Blueprint*. Details of their work follow.

Chapter 2:

A Framework for Interprofessional Education

The Interprofessional Education Curriculum Working Group (IPECWG) undertook a multitude of activities with the end goal of ensuring that health science educators have a greater capacity to integrate shared interprofessional learning opportunities into pre-licensure, post-licensure, and continuing health sciences education in Ontario.

Following their research and consultation, which is detailed below, the Working Group generated the following resources:

- *Scoping Review of Pre-Registration Literature of Curricula For Interprofessional Education*
- *Scoping Review of Post-Registration (Continuing Education & Post-Graduate) Literature on Curricula For Interprofessional Education*
- *Pre-Registration Strategies to Guide the Teaching and Assessment of Interprofessional Competencies in IPE Settings*
- *Post-Registration Strategies to Guide the Teaching and Assessment of Interprofessional Competencies in IPE Settings*
- *Interprofessional Education in Ontario College & University Site Visits (Fall 2008–Winter 2009)*
- *Core Curriculum Guide for Teaching Interprofessional Competencies in Pre-Registration Education Settings*

Detailed reports on the above tools and resources are available at www.healthforceontario.ca.

Laying the Groundwork

Scoping reviews were the first step in the Working Group's systematic approach to data gathering. These reviews involved a mix of peer-reviewed, non-peer-reviewed, and grey literature which were compiled as an inventory to inform the Working Group's work on curricula development. The scoping reviews present information on interprofessional education from Ontario, other Canadian provinces, and beyond.

The *Scoping Review of Pre-Registration Literature of Curricula For Interprofessional Education* identified 116 peer- and non-peer-reviewed and grey literature references associated with IPE in pre-registration years (before professional status is obtained). Articles were grouped by:

- profession
- type of learning (theory, clinical, or combined)
- content (e.g., anatomy, cardiac care, team work, rural practice)
- type of literature (articles, or grey literature from college and university websites)

The Scoping Review of Post-Registration (Continuing Education & Post-Graduate) Literature on Curricula For Interprofessional Education combines the literature search for post-registration (after professional status has been obtained but before entering practice) and continuing education (after entering practice).

The National Interprofessional Competency Framework of the Canadian Interprofessional Health Collaborative (CIHC) was used to guide the content for pre-registration IPE. The framework describes the following six national interprofessional core competencies (see www.cihc.ca/files/curricula/CIHCComp_OntarioRetreat_May2809.pdf):

- team functioning
- role clarification
- interprofessional communications
- collaborative leadership
- interprofessional conflict management
- patient/client/family/community-centred

Because the pre-registration scoping review was undertaken before the release of the final CIHC competencies, one competency—patient/client/family/community-centred—was not identified in the literature search. While topics related to community care and primary care exist in the scoping review, these categories were not defined in alignment with the above competency, and as such have not been included in the pre-registration review resource document. It is recommended that educators develop curricula with this competency in mind. Gaps in available IPE materials also existed for "collaborative leadership" and "interprofessional conflict management" topics.

Following the scoping reviews, site visits were undertaken at representative colleges and universities in Ontario so that Working Group members could learn firsthand about the perceived benefits of IPE and suggest ways to improve its implementation. Interviewees expanded from the institutions' deans and program leaders to include the faculty, staff, and students involved with interprofessional education in various capacities.

Project information and interview questions were sent ahead of the visit to key site contacts. The interviews were conducted with groups or individually, depending on the schedules of the interviewees. For some participants, telephone

Resources to guide IPE

- *Scoping Review of Pre-Registration Literature of Curricula For Interprofessional Education*
- *Scoping Review of Post-Registration (Continuing Education & Post-Graduate) Literature on Curricula For Interprofessional Education*
- *Pre-Registration Strategies to Guide the Teaching and Assessment of Interprofessional Competencies in IPE Settings*
- *Post-Registration Strategies to Guide the Teaching and Assessment of Interprofessional Competencies in IPE Settings*
- *Interprofessional Education in Ontario College & University Site Visits (Fall 2008-Winter 2009)*
- *Core Curriculum Guide for Teaching Interprofessional Competencies in Pre-Registration Education Settings*

Talking interprofessional care

"The thing that excites me most about interprofessional care/education is to witness health professionals actively involved in being the best they can be."

Ginette Rodger
IPCSIC member

conferencing was used. The site visit consultants found that all approaches worked equally well.

A total of 34 face-to-face site visits were made to nine representative colleges and 12 universities. Of these institutions, only two had not integrated IPE into their curricula. An interview guide containing 20 questions was used to direct the interviews at each site.

The Working Group found that at some sites, IPC competencies were built into the curriculum through clinical practicums, simulation labs, and case studies. All had different and varied IPE experiences in promoting and implementing IPE. The interviewees reported that IPE promotes communication and collaboration amongst students, facilitates an appreciation of each other's disciplines, promotes awareness of scope of practice, breaks down barriers and prevents duplication, and has the capacity to optimize patient outcomes.

Challenges identified during the interviews included the following: limited resources; limited IPE knowledge level and teaching skills of faculty; scheduling and space challenges for large numbers of students; working in cultures often resistant to change; and a need for new creative solutions to promote, implement, assess, and evaluate IPE. Despite this, the Working Group found that there is commitment to IPE across Ontario that can be sustained through the sharing of knowledge of IPE with all the schools and other partner organizations that are concerned with health sciences education.

The results of these visits were compiled in the *Interprofessional Education in Ontario College & University Site Visits (Fall 2008-Winter 2009)* resource document.

Talking interprofessional care

"IPE has been part of the vision for our Centre for Health Sciences for several years and is the key driver for the development and design of our new campus. The belief that students must learn with and about each other to support the provision of comprehensive health services has increasingly been embraced by the College's other academic programs and has resulted in more joint programming and planning."

Lorie Shekter-Wolfson
IPCSIC member

Finally, with outcomes of the scoping reviews in hand, as well as the information gathered through the site visits, the Working Group held a two-day member retreat in May 2009 to begin development of a conceptual framework and teaching guides.

Conceptual Framework and Teaching Guides

The IPECWG established the following desired features of the conceptual framework:

- easy to follow and concrete
- comprehensive yet pragmatic and succinct
- flexible enough to "fit" with existing regulated health professions while allowing for emerging professions
- embraces terminology and definitions already in existence—for example, Barr's definition of IPC[5]
- includes a glossary of terms
- addresses the novice-to-expert continuum
- uses "collaboration" constructs as the foundation—cooperation, coordination, partnership, and shared decision-making

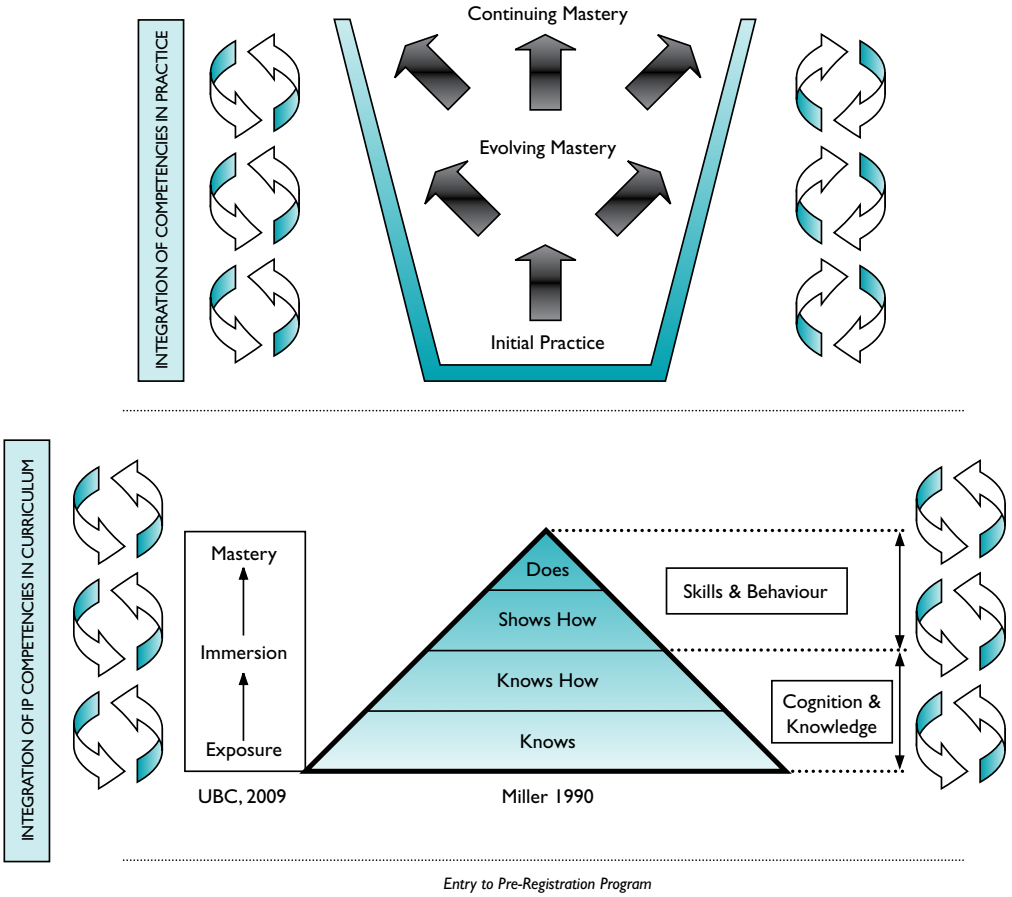
- evolves over time, to be revisited in the future
- practical in guiding the user to what is currently available

The conceptual framework diagram appears in two parts, one for pre-registration and one for post-registration/continuing education (see Figure 5). Together, they represent a continuum from early exposure to life-long learning.

This new framework was then used in conjunction with the *National Interprofessional Competency Framework of the Canadian Interprofessional Health Collaborative* (CIHC) (www.cihc.ca) to prepare guides for teaching and assessing interprofessional competencies.[6]

The *Pre-Registration Strategies to Guide the Teaching and Assessment of Interprofessional Competencies in IPE Settings* introduces a new model/conceptual framework for pre-registration IPE, which integrates knowledge from previous models gathered from the *Scoping Review of Pre-Registration Literature of Curricula For Interprofessional Education*.

Figure 5: Integrated Interprofessional Education Model[6]



Post-Registration Strategies to Guide the Teaching and Assessment of Interprofessional Competencies in IPE Settings (which includes continuing education) is comparable in format to the *Pre-Registration Strategies to Guide the Teaching and Assessment of Interprofessional Competencies in IPE Settings*. The same information gaps in "collaborative leadership" and "interprofessional conflict management" apply here.

The Interprofessional Education Curriculum Working Group prepared the *Core Curriculum Guide for Teaching Interprofessional Competencies in Pre-Registration Education Settings* as a guide for developing core curricula in interprofessional education. The *Guide* outlines possible topics and teaching methods to address interprofessional conflict and patient/client/family/community-centred care, competencies found to be lacking in the literature search. It should be emphasized that the integration of IPC competencies into the pre-registration curriculum, from exposure to immersion to mastery, occurs first on an individual level, then at the student intraprofessional and interprofessional levels.

Talking interprofessional care

"Interprofessional care was fully embraced by our group of rural primary care physicians as we launched our first-wave Family Health Team. The health care workers on our team have found greater professional satisfaction with both their enhanced scopes of practice and a more collaborative work environment. And my practice is now a whole lot more fun."

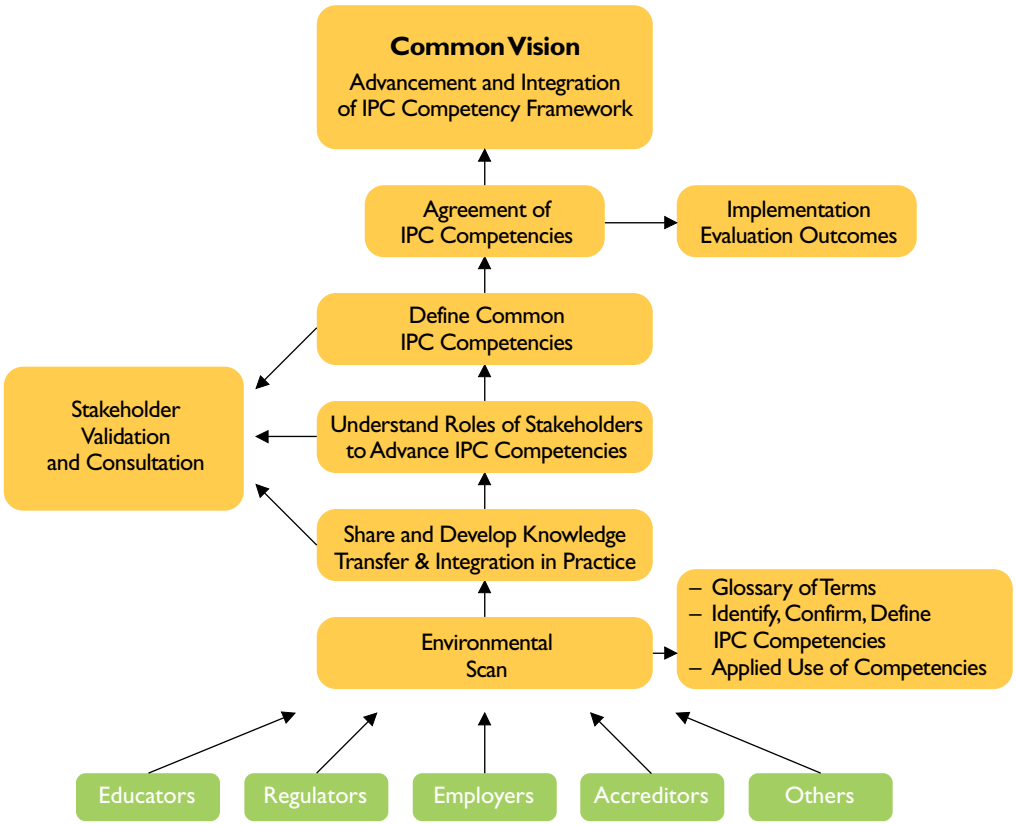
Eliseo Orrantia
IPCSIC member

Chapter 3:
Core Competencies for Interprofessional Care

The Core Competency Working Group's key mandate was to better understand and articulate the competencies and values needed for all health caregivers to teach and practise interprofessional care. Taking its direction from the *Blueprint* recommendations, the group turned its attention to "building the foundation," specifically, "defining core competencies for IPC" and "clarifying roles and responsibilities in an interprofessional care environment."

A major focus was developing consensus on the terminology and knowledge platform for educators, learners, accreditors, regulators, employers, and caregivers regarding the behaviours required to practise interprofessional care. As well, the Group focused on identifying implementation opportunities in which IPC competencies can be used in policy and practice settings to facilitate IPC.

Figure 6: Approach to IPC Core Competencies



The CCWG developed a draft approach to the development of the IPC Competency Framework (see Figure 6) to assist in the application and implementation of interprofessional care. The approach outlined the steps needed to reach a common vision for IPC competence while building on existing IPC competency work conducted in Ontario and elsewhere.

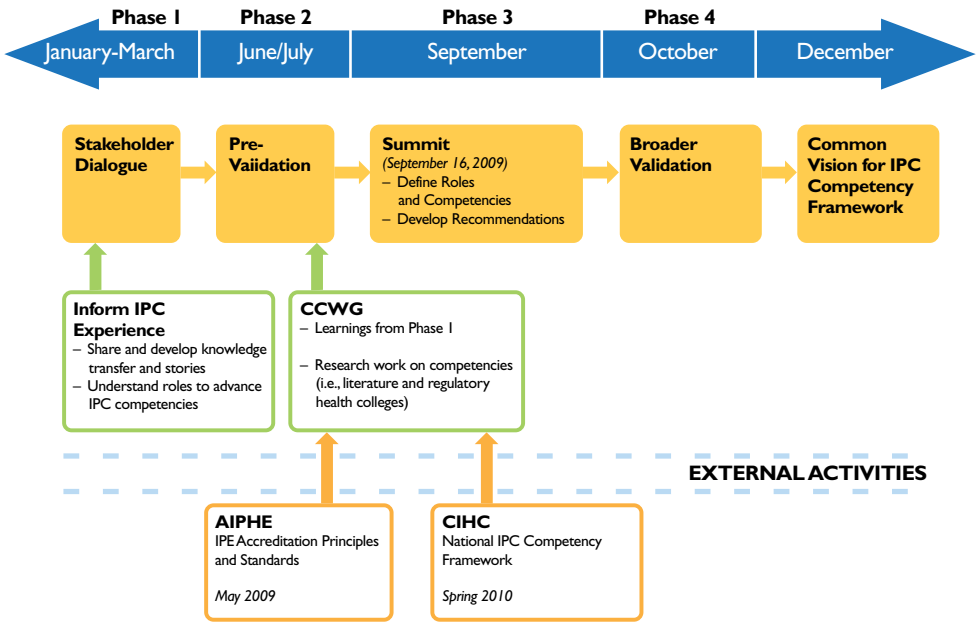
The Working Group felt strongly that stakeholder engagement was critical to ensuring the future success of the Competency Framework's integration within the health care system. To this end, a multi-stakeholder engagement plan was developed and implemented. The plan was executed in four stages, as shown in Figure 7.

Recognizing that the adoption of IPC into the health care system is part of a cultural shift, CCWG drew upon change theory to guide the steps required to mount its engagement process with stakeholders. Appreciative Inquiry,[7] an organizational approach strongly supported by the Ontario government, uses "dialogue" as a key mechanism for optimizing the search for innovative ways to effect change, and was adopted for this work.

Initial stakeholder engagement consisted of 18 key informant interviews, along with 10 focus groups that included 28 patients, 19 caregivers, and 49 leaders. The goal was to look at the impact of IPC core competencies on existing initiatives, policies, and legislation.

A summit was then held in September 2009. The goal was to seek input on a draft Charter and statements, understand and articulate the roles of

Figure 7: Stakeholder Validation and Consultation Engagement Process 2009



AIPHE = Accreditation of Interprofessional Health Education; CIHC = Canadian Interprofessional Health Collaborative.

health system leaders, and catalyze collaboration across health sectors. A total of 120 participants from across Ontario attended the summit by invitation. They included health care and education leaders representing education, clinical practice, associations, regulators, employers, accreditation, and patient groups.

A Charter on Expectation and Commitments

A key indicator for success for the CCWG was reaching consensus on a common language to describe IPC competencies among stakeholders across Ontario. As CCWG's work evolved, all stakeholders emphasized the need for simple language, in order to most clearly and effectively spread the IPC message. As a result, in June 2009, CCWG shifted the descriptive language used for its deliverables and renamed the IPC Competency Framework the *Advancing Competence in Interprofessional Care: Charter on Expectation and Commitments.*

The Charter is built upon the following assumptions:

- Interprofessional care is a cornerstone of the effective practice of patient-centred care.
- A patient is an active member of the health care team.
- All caregivers have a responsibility to practise IPC through the application of IPC competencies.
- Interprofessional care competence can be described, taught, practised, and assessed.
- All health care sectors and their leaders have a shared responsibility to advance IPC competence.

The Charter includes a number of behavioural statements aimed at health caregivers to help them meet patient expectations for the type of care patients would like to receive in Ontario. It was strongly endorsed through a series of validation processes after the summit.

In keeping with the imperatives set by *Interprofessional Care: A Blueprint for Action in Ontario* and the vision for IPC—in which interprofessional care is the provision of comprehensive health services to patients by multiple health caregivers who work collaboratively to deliver quality care within and across settings—the Charter sets out a common language for all audiences and users on what is expected when interprofessional care is practised. Competence in any area is a complex discussion and the Charter, based on the voices of patients and health caregivers, aims to transcend specific terminology and instead provide a descriptive model to talk about the behaviours and attitudes necessary to execute IPC.

The Charter provides a common platform upon which to create a clear vision and prompt a clear conversation about IPC. It is intended to:

- identify opportunities for IPC,
- challenge "siloed" care,
- position everyone in the conversation, and
- be used as a springboard for action.

This Charter is intended to be a resource that brings meaningful language and vision to the front-line caregiver and to those who influence the front line (educators, regulators, associations, employers, unions, and accreditors). It is focused on an overarching goal of safe, quality, patient-focused care.

While it reflects input from multiple stakeholders and multiple leaders, the Charter is but one element of the overall efforts of the *Blueprint*. It is not intended to address structure, incentives, or processes for IPC.

The Charter is a series of bold statements (highlighted below) that should be recognized by those already committed to IPC, bring questions to those in a formative place, and create opportunities for others for initial engagement. It serves to support a multi-level strategy for collective leadership, initiating dialogue, and facilitating empowerment and accountability within and across the health care system, and is aimed at achieving safe, quality, patient-focused outcomes.

Charter Statements

Patient Expectation

As a patient in Ontario, I expect my health care to be provided by various health caregivers who respect me and the health care choices I make. My caregivers seek to know my health experience and are prepared to work with me across settings to combine their knowledge and skills to meet my health goals.

Caregiver Commitments

As a health caregiver in Ontario, in supporting the IPC vision,

1. I will seek to know the experience of those I care for, respect and strive to understand their needs, and work with them to develop their care plans that acknowledge their choices,
2. I will understand my role and understand the role and expertise of other health caregivers,
3. I will inform those who are caring for patients with me about the care I am providing with them,
4. I will ask questions, communicate to be understood, seek input and listen respectfully to generate options for care,
5. I will be aware of how my own behaviour and attitudes impact interprofessional care and how I actively foster a culture of collaboration, and
6. I will acknowledge that there are limits to what I know and will continue to learn from others so that care can be better integrated and guided by the best possible ideas.

Leader Commitments

To meet patient expectation and enable caregiver commitments in Ontario, as health system leaders,

1. We will align our language, processes, structures and resources to foster an IPC culture,
2. We will create opportunities to collaborate within and across sectors to integrate IPC into practice, education, policy and research,
3. We will measure and evaluate our IPC initiatives to know what is being achieved, and
4. We will continuously improve IPC in the health care system by identifying, promoting and implementing practices that make a difference to patient care.

The development of a Charter that articulates the behaviours and attitudes of patients, health caregivers, and health system leaders to enable the facilitation of IPC competence is a significant achievement that is unmatched anywhere in Canada.

Supporting Tools

An accompanying *Resource Guide for Interprofessional Care Competence* was developed to support the use and integration of the Charter into the work of individuals and organizations within the Ontario health care system.

The *Guide* includes resource tools to describe what the Charter addresses, suggestions for how to share the Charter with different stakeholders, ideas about integrating the Charter into practice/education/sector, a framework that helps to examine to what extent IPC language is common across sectors in the health care system, and self-reflection tools that help consider to what extent IPC is being practised.

The *Resource Guide* and the *Charter on Expectation and Commitments* are available at www.healthforceontario.ca.

What is an interprofessional care provider?

The following statements were expressed by health care providers during a focus group conducted by the Core Competency Working Group in March 2009. This information helped shape the development of the Charter on Expectation and Commitments.

- Is an effective communicator, driven by ideas.
- Understands who can contribute what to each patient.
- Demonstrates accountability.
- Knows how to access other team members when needed.
- Knows his or her team and trusts their environment.
- Is invested in the notion of IPC and believes IPC will succeed.
- Enables other people to mesh with each other to find a work rhythm.
- Respects the abilities of colleagues and respects differences of opinion while finding patient-oriented solutions.
- Shares ideas.
- Shares experiences with patients and determines whether they were effective.
- Can self-assess and reflect and modify behaviour.
- Is open to a variety of options and multiple solutions to a problem.
- Believes others can add value to his or her work.
- Spends time creating common goals.
- Is all about the patient.

Chapter 4:

Opportunities and Next Steps

The Interprofessional Care Strategic Implementation Committee wants to make IPC actionable and sustainable. As such, its deliverables need to be in the hands of everyone who has an interest in IPC/E and a desire to firmly integrate it into care delivery in Ontario. The health care system is in the early days of a paradigm shift in how care is delivered, and it is hoped that the Charter, in particular, will help to further support system-wide collective responsibility in advancing IPC.

While the Committee's mandate was time limited, it has a number of recommendations to further the momentum its efforts inspired.

Swift dissemination of the IPE materials is the first and most critical consideration. Key groups that should receive the documents include:

- every Ontario college and university, specifically the deans of health sciences and directors of all health education institutions/programs
- all provincial regulatory bodies, Accreditation Canada, the Patient Safety Council, and the Accreditation of Interprofessional Health Education (AIPHE)
- all provincial and territorial ministries of health
- the National Health Sciences Student Association

The materials should be accessible through the HealthForceOntario website (www.healthforceontario.ca). This site should be linked to other relevant sites, such as the Canadian Interprofessional Health Collaborative website, for as wide a reach as possible.

A second opportunity lies in the delivery of the materials. The documents must clearly highlight main messages to policy-makers, practitioners, and educators. They could also be combined into a toolkit for developing IPE curricula.

Third, to support application of the tools, incentives could be offered for health education institutions, health care organizations, and regulatory bodies to use the materials in the creation of a course or an education project. The incentive could be a call for funding proposals for innovative and effective ways

Opportunities to advance IPE

1. Disseminate materials to fuel the adoption and implementation of IPC.
2. Highlight main messages and/or include them in curricula.
3. Provide incentives to use the materials and support application of the tools.
4. Meet with regulatory bodies and AIPHE to increase awareness of the tools and stimulate uptake of interprofessional competencies into standards of care.
5. Connect with LHIN CEOs to facilitate linkages in support of the integration of IPE into health education institutions in their areas.

Talking interprofessional care

"The thing that excites me most about interprofessional care is that persons facing disability because of a chronic condition finally will get help with the quality-of-life issues that are outside their doctor's field of practice."

Stanley Mircheff
IPCSIC member

to demonstrate how the documents can be applied to fulfill HFO's mandate to expand IPE across Ontario universities and colleges. The proposals could include collaboration between some or all of the health education institutions in a LHIN, health care delivery organizations, and LHIN planners.

Fourth, meetings should be held with regulatory bodies and AIPHE to increase their awareness of the tools and to stimulate uptake of interprofessional competencies into standards of care. (AIPHE is a partnership of eight national organizations that accredit pre-licensure education for six health professions in Canada—medicine, nursing, pharmacy, physiotherapy, occupational therapy, and social work.) This might prompt interprofessional competencies to become part of accreditation standards.

The fifth opportunity lies in connecting with all of Ontario's LHIN CEOs to facilitate linkages for the development of IPE in the schools in their respective areas. To keep the Charter front and centre, the Committee recommends that cross-sectoral dialogue be continued, since the stakeholder engagement process was so fruitful. This would reinforce the momentum and serve to monitor the cultural change in the uptake of the IPC Charter within the health care system and its influence on the roles of health system leaders.

To strategically advance the work of the Charter and enable the Ontario government to demonstrate its ongoing commitment to the vision for IPC/E in accordance with the *Blueprint*, the Committee has outlined its recommendations below.

The Committee also believed that to ensure IPC was successfully integrated into the health care system, systemic supports needed to be developed. The model the Committee recommends be adopted is described in Chapter 5.

Next steps

1. **Promote the IPC Charter.**
   - Market the Charter.
   - Promote the *Resource Guide*.
   - Launch an IPC Charter Portal, and launch a provincial IPC campaign.
2. **Catalyze health care sector accountability in the promotion and facilitation of the Charter.**
   - Develop sector-specific statements in the Charter.
   - Establish annual IPC forums.
   - Invest in IPC leadership development
3. **Evaluate IPC behaviours against social and economic factors to uncover their impact on patient outcomes and safety.**
   - Measure the impact of the Charter statements on patient care, safety, and outcomes.
   - Measure the impact and uptake of cross-sectoral dialogue.
   - Measure the influence of research in advancing IPC culture through IPC competence.
   - Implement evaluation indicators (short-, mid- and-long term).
4. **Establish the active role of patients in interprofessional care.**
   - Strengthen the wording of the IPC vision in the Charter.

Chapter 5:
A Model for Implementing Interprofessional Care

LHIN Model for Implementation

The Interprofessional Care Strategic Implementation Committee was mandated to focus on the implementation of IPC throughout Ontario. The Committee struck a LHIN Implementation Task Group to explore possible options that would enable the successful implementation of IPC at the LHIN level. LHINs are charged with planning, funding, and integrating health care services locally. They were created in 2006 under the *Local Health System Integration Act*.

Based on their recommendations, IPCSIC proposes the following:

using the LHINs as the springboard, identify one IPC lead/champion for each of the 14 LHINs, to move IPC/E forward and ensure sustainability.

One IPC lead per LHIN would be created. This person would act as the IPC champion and coach within the LHIN.

Each lead/champion would:

- ensure the implementation and evaluation of IPC initiatives within their LHIN;
- ensure sustainability through funding, support, and endorsement of funding models for IPC;
- showcase leading practices;
- promote technology to facilitate knowledge transfer amongst the 14 LHINs;
- foster teaching environments to facilitate the learning of IPC/E; and
- ensure alignment across the LHINs with the transformational agenda for IPC/E.

An additional role—a provincial IPC lead—would be created to guide the 14 LHIN leads, and to have overall responsibility and accountability for the implementation and coordination of collaborative-based care across Ontario. Reporting to the Ministry of Health and Long-Term Care, this person would liaise between the proposed provincial body and the LHIN IPC leads/champions. Responsibilities could include: providing system-level leadership that supports IPC/E in a strategic and sustainable manner, implementing and evaluating programs/initiatives related to grounding IPC/E into professional practice, promoting knowledge transfer of IPC/E, ensuring alignment of IPC/E with the transformation agenda of the Ministry of Health and

Interprofessional care in action

Care providers including physicians, nurses, physiotherapists, occupational therapists, pharmacists, family members, community groups, caregivers, and volunteers are working on a Village of Taunton Mills (a seniors' care community) project, which focuses on primary, cardiac, geriatric, and mental health care, as well as chronic disease management and rehabilitation care. This project hopes to improve the care of seniors through:

- Improved health outcomes for frail elderly
- Timely access to necessary health services and community supports
- Better coordination between specialized seniors' service providers
- Improved access and support around wellness, self-management, and prevention

Long-Term Care, and promoting patient-centred, evidence-based, ethical, and value-driven programs.

A provincial body would be created for a fixed period of time to support the development of the new structure related to IPC at the LHIN level and to consolidate IPC/E initiatives taking place across the province. This body would champion, guide, and monitor IPC/E implementation—thereby linking education, regulatory bodies, and government—and advise the provincial IPC lead. Specifically, this body could coordinate and monitor the integration of IPC/E and the *Blueprint* into each LHIN's approach to chronic disease and primary care, meet regularly with IPC LHIN Leads to engage in dialogue and strategizing for moving IPC/E forward in Ontario, and strengthen the LHINs' relationships with local academic centres/practices that have been successful in advancing IPC/E as consultants/mentors either formally or informally for their processes.

Creating a network of LHIN IPC leads/champions would allow for a collaborative to be created, with an organizational structure and function that enables the sharing of key initiatives and resources. A repository of information designed and posted on the HealthForceOntario website under "Interprofessional Care" would avoid duplication and enhance collaboration across the LHINs. In addition, having key IPC/E contacts would ensure accountability and facilitate information sharing and coordination among the LHINs.

The leads would need change management abilities and leadership skills, and be capable when it comes to embedding IPC principles into the planning processes for care delivery within the LHINs and developing IPC as a tool to address the needs of the health care system, in order to align their policies with the *Blueprint*.

They would also need to leverage the expertise of the Health Professionals Advisory Committees linked to each LHIN to design and develop accountability frameworks/models for IPC activities, support a diversity of initiatives related to IPC within the LHIN, clinically integrate an IPC approach into LHIN activities, support interorganizational collaboration, link with academic IPC leads, foster evidence-based practice, and ensure performance measurement. Finally, the Committee proposes that IPC efforts be initially focused on a key provincial health priority—the diabetes strategy.

Interprofessional care in action

A team of physicians, nurses, physiotherapists, occupational therapists, medical laboratory technologists, medical radiation technologists, pharmacists, and family members through the Northern Ontario School of Medicine is addressing leadership in sustainable culture change with a focus on chronic disease management:

The anticipated outcomes for health care providers include: gaining enhanced knowledge of the principles of interprofessional care, teaching, and facilitation skills development; academic leadership skills; skills to role model IPC/E; greater satisfaction in their role as a health care provider; and a greater understanding of role delineation and flexibility in roles of the various health care providers through interactions with students and their role.

Talking interprofessional care

"Interprofessional care/education offers an exciting way to engage all providers by working closely together to meet the needs and exceed expectations of current and future clients of the health system."

Mimi Lowi-Young
IPCSIC member

Leveraging the Diabetes Strategy

Diabetes is recognized as a prevalent chronic disease that requires significant investment and action. In July 2008, the Ministry of Health and Long-Term Care announced the diabetes strategy, a comprehensive approach to preventing, managing, and treating diabetes across the province. Key elements of this strategy include:

- increasing access to team-based diabetes care closer to individuals' homes.
- increasing the range of self-management and self-management support tools and resources.
- improving service by increased adoption of clinical practice guidelines by interprofessional teams.

Each LHIN focuses on integrated chronic disease care planning at the regional level. At the primary care level, diabetes care is being managed by a number of health caregivers: registered nurses, physicians, registered dietitians, and others. Interprofessional care is a key element of any such strategy as supported by the literature.

Each LHIN could design models of care delivery that incorporate the principles of IPC/E to meet the following deliverables:

- improved provision of diabetes care and management for those afflicted with the disease.
- increased team-based care management.
- more efficient use of resources by maximizing health caregivers' scopes of practice.
- alignment with current research.

By aligning IPC with the diabetes strategy at a LHIN level, the IPC leads/champions would be able to both implement and clarify their role in moving the IPC mandate forward and build an understanding and capacity that can transfer to other team-based collaborative care delivery models. At a minimum, each LHIN would initially focus on diabetes and then any other priorities that would entail an IPC approach.

As stated in the *Blueprint*, the adoption of IPC is seen as a change management process and requires that everyone in the health care and education systems adopt a common vision to improve communication and collaboration leading to a more effective health care system. Through its LHIN IPC leads/champions, Ontario can take the lead in fostering and sustaining an interprofessional health care delivery system.

What do you hope to get out of interprofessional care?

The following statements were expressed by patients during a focus group conducted by the Core Competency Working Group in March 2009. This information helped shape the development of the Charter on Expectation and Commitments.

- To be seen not as an OHIP number, not as a patient, but as a person who is valued.
- Health professionals coaching and cheerleading me.
- One-stop shopping in medical care.
- A personal family doctor with a team around him that communicates. I want the coach. I want the cheerleader.
- A team working together, communicating the care I want to receive.
- Providers who are very good at explaining what they are doing as they are doing it.
- To be heard. Everyone's problem is not a book problem.

Chapter 6:
Closing Remarks

The values that underscored the efforts of the Interprofessional Care Strategic Implementation Committee in producing this report—collaboration, communication, and partnership—are the same values at the heart of interprofessional care. At its essence, IPC envisions patients as active members of the health care team, confident in the health care system's ability to meet their needs; and health caregivers as effective communicators and professionals committed to working collaboratively to deliver the best possible care.

This ideal standard of care sets the stage for improved patient outcomes and quality work environments for health caregivers. It is hoped that the systematic approach to IPC described in these pages will serve as a solid foundation for further discussion and action in support of the implementation of IPC in Ontario's health care system.

Appendix A:

Interprofessional Care Strategic Implementation Committee Members

- Peeter Poldre (co-chair), Vice President, Medical Education and Professional Practice, Sunnybrook Health Sciences Centre
- Jackie Schleifer Taylor (co-chair), Vice President, Quality, Equity & Performance, Chief of Health Disciplines, Women's College Hospital
- Frances Lamb, Manager, Policy and Programs, Ministry of Training, Colleges and Universities
- Mimi Lowi-Young, Chief Executive Officer, Central West Local Health Integration Network
- Jennifer Medves, Director, School of Nursing and Associate Dean, Faculty of Health Sciences, Queen's University
- Stanley Mircheff, Patient Representative
- Ivy Oandasan, Associate Professor and Research Scholar Department of Family & Community Medicine, Faculty of Medicine, University of Toronto; Academic Family Physician, Toronto Western Family Health Team
- Eliseo Orrantia, Physician, Marathon Family Health Team; Assistant Professor, Northern Ontario Medical School; Associate Clinical Professor, Department of Family Medicine, McMaster University
- David Price, Chair and Associate Professor, Department of Family Medicine, McMaster University
- Jan Robinson, Registrar and Chief Executive Officer, College of Physiotherapists of Ontario
- Ginette Rodger, Senior Vice President, Professional Practice and Chief Nursing Executive, Ottawa Hospital
- Marcy Saxe-Braithwaite, Health Care Consultant
- Lorie Shekter-Wolfson, Assistant Vice-President, Waterfront Development, Dean of Community Services and Health Sciences, George Brown College
- William Shragge, Professor Emeritus, Department of Surgery of the Michael G. DeGroote School of Medicine, Faculty of Health Sciences, McMaster University
- Marilyn Wang, Director, Health Professions Regulatory Policy and Programs Branch, Ministry of Health and Long-Term Care

Appendix B:

Interprofessional Education Curriculum Working Group Members

- Jennifer Medves (co-chair), Director, School of Nursing and Associate Dean, Faculty of Health Sciences, Queen's University
- Marcy Saxe-Braithwaite (co-chair), Health Care Consultant
- Debbie Aylward, Perinatal Coordinator, Perinatal Partnership Program of Eastern and Southeastern Ontario
- Lori Boyd, Director of Policy, College of Medical Radiation Technologists of Ontario
- Della Croteau, Deputy Registrar/Director of Programs, Ontario College of Pharmacists
- Kelly Mannen, Dental Hygienist, Faculty, Dental Programs, Interprofessional Facilitator, Georgian College
- Carole Orchard, Head of University Interprofessional Education Office, University of Western Ontario
- Kelly Ann Reilly, Interprofessional Education Program Lead, Northern Interprofessional Centre of Health Education, Laurentian University
- Cory Ross, Associate Dean, Health Sciences Program, George Brown College
- Ann Russell, Cognitive Science, Michener Institute
- Patty Solomon, Head of University Interprofessional Education Office, McMaster University
- Salvatore Spadafora, Associate Dean-Postgraduate Medicine, Schulich School of Medicine and Dentistry, University of Western Ontario
- Natalie Whiting, Palliative Care Consultant, Regional Clinical Education Leader, Peterborough
- Mary Woodman, Prince Edward Family Health Team, Picton

Project Team

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- Megan Edgelow, Research Associate
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- Elizabeth Tata, Queen's Faculty (retired), Consultant (site visitor)
- Jane Johnston, Queen's Faculty, Consultant (site visitor)

Appendix C:

Core Competency Working Group Members

- Ivy Oandasan (co-chair), Associate Professor and Research Scholar Department of Family & Community Medicine, Faculty of Medicine, University of Toronto; Academic Family Physician, Toronto Western Family Health Team
- Jan Robinson (co-chair), Registrar and Chief Executive Officer, College of Physiotherapists of Ontario
- Angela Carol, Family Physician, Medical Officer, College of Physicians and Surgeons of Ontario
- Lynn Casimiro, Director, Profession and Interprofessional Education, Montfort Hospital
- Danielle Dorschner, Director, National Services, Accreditation Canada
- Trish Dryden, Associate Vice-President, Research and Corporate Planning, Centennial College
- Mary Lou Gignac, Registrar and Executive Director, College of Dietitians of Ontario
- John McBride, Director of Pharmacy, Lennox and Addington County General Hospital
- Ian Nicholson, Manager, Psychology Practice, University Hospital, London Health Sciences Centre
- Ellen Rukholm, Research Fellow, Centre for Northern & Rural Health; Professor Emerita, Laurentian University (formerly Executive Director, Canadian Association of Schools of Nursing)
- Lisa Schwartz, Associate Professor, Clinical Epidemiology and Biostatistics, McMaster University

Project Team

- Carmela Bosco, Project Manager and Managing Director
- Amorell Saunders N'Daw, Coordinator
- Layne Verbeek, Graphics Designer
- Angela Elia, Administrative Assistant

Appendix D:

IPCSIC Member Speaking Engagement Activity

	Committee Member	Name of Event	Date	Location	Audience Size
1.	Peeter Poldre & Jackie Schleifer Taylor	Interprofessional Care: Advancing Collaboration to Enhance Health Care Delivery – Ontario Hospital Association	April 17, 2008	Toronto	243
2.	Jackie Schleifer Taylor	Advisory Group for Interprofessional Practice within the Niagara Health System	May 7, 2008	St. Catharines	N/A
3.	Peeter Poldre	Sunnybrook Health Sciences Centre IPC/IPE Orientation Workshop	May 13, 2008	Toronto	30
4.	Peeter Poldre	Ontario Association of Non-Profit Homes and Services for Seniors (OANHSS) Interprofessional Care – The Way Forward	May 14, 2008	Toronto	76
5.	Lorie Shekter-Wolfson	Canadian Association of Allied Health Programs Annual General Meeting and Conference	May 6, 2008	Ottawa	45
6.	Peeter Poldre	Professional Practice Network of Ontario (PPNO)	June 2, 2008	Quinte Health Care, Belleville	Approx. 40
7.	Peeter Poldre	Sunnybrook Health Sciences Centre IPC/IPE Orientation Workshop	June 3, 2008	Toronto	35
8.	Lorie Shekter-Wolfson	Ontario College of Social Workers and Social Service Workers – Principles of Professionalism 2008	June 18, 2008	Toronto	500
9.	Peeter Poldre & Jackie Schleifer Taylor	Orientation for First-Year Health Professions Students of the University of Toronto	October 8, 2008	Toronto	1,500
10.	Peeter Poldre & Jackie Schleifer Taylor	The Ontario Hospital Association HealthAchieve 2008: Interprofessional Care	November 4, 2008	Toronto	25
11.	Peeter Poldre	St. John's Rehab Hospital	November 24, 2008	Toronto	Approx. 120
12.	Peeter Poldre & Jackie Schleifer Taylor	Interprofessional Education Ontario 2009	January 18-20, 2009	Toronto	Approx. 300
13.	Mimi Lowi-Young	Central East LHIN Health Professions Advisory Council Members	February 4, 2009	Ajax	Approx. 14
14.	Jennifer Medves	Registered Nurses' Association of Ontario – Building Positive Inter-Professional Relationships in Health Care (TIPS) Final Summit	February 26 & 27, 2009	Toronto	Approx. 50
15.	Eliseo Orrantia	Northern Ontario School of Medicine, Pan-Northern Interprofessional Education and Care	March 23 & 24, 2009	Sault Ste. Marie	41
16.	Peeter Poldre & Jackie Schleifer Taylor	Federation of Health Regulatory Colleges of Ontario (FHRCO) Annual Meeting	April 15, 2009	Toronto	40
17.	Peeter Poldre	Regional Stroke Centre & Neuroscience Alliance Sunnybrook Health Sciences Centre	May 7, 2009	Toronto	130
18.	Ginette Rodger	Ontario Psychiatric Outreach Program	September 2, 2009	Ottawa	N/A
19.	Jan Robinson	College of Medical Laboratory Technologists of Ontario, Council Members	September 16, 2009	Toronto	Approx. 20
20.	Peeter Poldre	Southlake Hospital Senior Leadership Team	September 29, 2009	Newmarket	Approx. 40
21.	Peeter Poldre	Orientation for First-Year Health Professions Students of the University of Toronto	October 8, 2009	Toronto	1,273

Appendix E:

Glossary of Terms

Accreditation is a process that aims to achieve optimum patient care by maintaining high educational and practice standards in a program for a given profession or academic/health care institution in the provision of education and health care delivery. Accreditation can validate a program or institution's quality and improvement procedures and is usually conducted by an outside, arms-length agency or relevant legislative and professional authorities. Accreditation status is granted when a program or institution has met or exceeded pre-determined standards.[1]

AIPHE is Accreditation of Interprofessional Health Education.

Appreciative Inquiry (AI) is a methodology for managing cultural change that searches for innovative and positive ways to achieve effective leadership and positive change. AI is an engagement approach to encourage imagination, innovation, and flexibility by building upon the positives that already exist. It seeks to identify what is working well or opportunities for positive change.

Blueprint refers to *Interprofessional Care: A Blueprint for Action in Ontario*, a report released in July 2007 by the Interprofessional Care Steering Committee to the Government of Ontario.

CCWG is the Core Competency Working Group, which reported to the Interprofessional Care Strategic Implementation Committee.

Charter refers to *Advancing Competence in IPC: A Charter on Expectation and Commitments*, a deliverable of the Interprofessional Care Strategic Implementation Committee.

CIHC is the Canadian Interprofessional Health Collaborative.

Clinical education means any on-location teaching environment, ranging from one-to-one training between a licensed or registered health care provider and a student, to training in a health clinic or hospital, with or without a residency program.

Clinical placement is a planned period of learning, normally outside the academic institution at which the health care student is enrolled, where the learning outcomes are an intended part of the program of study. This will enable the student to learn and develop the skills and required competencies to practise health care delivery.[1]

Collaborative patient-centred practice "promotes the active participation of each health care discipline in patient care. It enhances patient- and family-centred goals and values, provides mechanisms for continuous communication among caregivers, optimizes staff participation in clinical decision-making within and across disciplines and fosters respect for disciplinary contributions made by all professionals."[8]

Collaborative practice is "an interprofessional process for communication and decision-making that enables the knowledge and skills of care providers to synergistically influence the client/patient care provided."[9] Collaborative practice is linked to the concept of teamwork.

Competency is used to define discipline and specialty standards and expectations, and to align practitioners, learners, teachers, and patients with evidence-based standards of health care performance.[10] It includes the understanding and application of clinical knowledge, clinical skills, interprofessional care skills, problem solving, clinical judgment, and technical skills.[1]

CPSI is the Canadian Patient Safety Institute.

Delivery organizations encompass hospitals, home care, and other health care delivery agencies.[1]

Entry-to-practice is the educational qualification identified in legislation for health professions as the requirement for an individual to be considered for registration or licensure to practise. Students or trainees in any health care discipline require clinical supervision in the delivery of health care.[1]

Health caregivers are regulated and unregulated health care providers, personal support workers, caregivers, volunteers, and families who provide health care services at the organizational, practice, and community levels.[1]

HealthForceOntario (HFO) is Ontario's health human resource strategy that was launched in May 2006 to ensure that Ontarians have access to the right number and mix of qualified health caregivers, now and in the future. The strategy is a joint initiative of the Ministry of Health and Long-Term Care and the Ministry of Training, Colleges and Universities.

HealthForceOntario Marketing and Recruitment Agency (HFO MRA) is an agency created under the HealthForceOntario strategy.

HPACs are Health Professionals Advisory Committees. Established for each LHIN, these multi-disciplinary committees are responsible for providing advice to the network on how to achieve patient-centred health care.

HPRAC is the Health Professions Regulatory Advisory Council, an independent agency of the Ontario government created under the *Regulated Health Professions Act, 1991*.

Interprofessional care is the provision of comprehensive health service to patients by multiple health caregivers who work collaboratively to deliver quality care within and across settings.[1]

Interprofessional education is the process by which two or more health professions learn with, from, and about each other across the spectrum of their life-long professional/educational journey to improve collaboration, practice, and quality of patient-centred care.[11]

Interprofessional Care Steering Committee is the group struck by the Ministry of Health and Long-Term Care to create the *Blueprint*.

IPCSIC is the Interprofessional Care Strategic Implementation Committee, a group struck to implement recommendations as outlined in the *Blueprint.*

IPECWG is the Interprofessional Education Curriculum Working Group, which reported to the Interprofessional Care Strategic Implementation Committee.

LHINs are Local Health Integration Networks.

MOHLTC is the Ministry of Health and Long-Term Care.

MTCU is the Ministry of Training, Colleges and Universities.

Team is a collection of individuals who work interdependently, share responsibility for outcomes, and see themselves and are seen by others as an intact social entity embedded in one or more larger social systems (for example, business unit or corporation) and who manage their relationship across organizational boundaries.[12]

Teamwork describes an interdependent relationship that exists between members of a team. It is an application of collaboration. "Collaboration" deals with the type of relationships and interactions that take place between coworkers. Effective health care teamwork applies to caregivers who practise collaboration within their work settings.[13]

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