Integration of interprofessional as the norm: Aspiration or achievement’

Professor ELizabeth Anderson

“From research and interprofessional education to effectiveness in future social and health services”
New Centre for Medicine: Passivhaus
Definition

World Health Organisation 2010

To prepare you to be ‘workforce ready’

‘Occurs when two or more professions learn about, from and with each other to enable effective collaboration and improve health outcomes’

Context

1. My story into IPE

2. Delivery
   Forming a strategy for aligning IPE within modern curriculum- integration

3. Evaluation
   Does IPE make a difference?
1. My story into IPE
My beginnings
Prince Philip House: Leicester 1996
Prince Philip House - services available

- Primary Health Care Team
- GP Surgery
- Police Office
- Mental Health services
- Community Drug and Alcohol Services
- Community Dentistry
- Speech & Language Therapy Services
- Community Physiotherapy
- Podiatry Services
- Paediatric Services
- Neighbourhood Co-ordinator for the Primary Care Trust
- School Nurse
- Pregnancy Testing

- Refugee & Asylum Support
- Somali Advice & Support
- Somali Environment Project
- Swahili Advice & Support
- Community Health Liaison Officer
- The University of Leicester
- Information Advice & Guidance Services
- The Teaching Centre
- Community Rooms
- St Matthew’s Charitable Enterprise Trust
- Coffee Bar / Play Area
- The Learning for Better Health Research Project
- Parent & Toddler Group
- Welfare Benefits Advice
2. Delivery of IPE
Our Challenges

The context for design and delivery IP curriculum matters

• Situation in Finland
• Configuration of Higher Education Institutions
• Professional Regulators
UK designing more community-based services
Agencies working closer together
From Professional to Interprofessional

I must work with others to achieve these targets

Professional identify and territory

Work place intensification

My professional values
Period of Transition

Interprofessional education

Individual students

Team working collaborative practice mindset

Creative commons licences
The old NHS is a place of archaic hierarchies; where patients are incidental; where what is important is your job title; where experience; expertise and knowledge count for nothing; where a doctor assumes superiority of status and knowledge irrespective of their actual expertise and knowledge. A place where managers rule with an iron rod of fear, threatening any staff, patients or families who don't tow the line. A place where staff or families who raise concerns are threatened, bullied and abused. A place where social media is feared and those who use it are attacked if they step out of line; a place where healthcare is for the fit and healthy who have a fleeting illness from which they can 100% recover.

The new NHS is a very different world. Patients are at the centre of everything it does. Engagement, participation, feedback, values, #HelloMyNameIs and the 6Cs are not just hollow phrases but realities. All patients are valued, even cherished, no matter how elderly, frail, young or disabled. The new NHS is a partnership of equals where the organisations most senior staff engage with the NHS's most vulnerable patients in this partnership of equals. A place without hierarchies, where everyone from the CEO to the sickest child patient is valued for the experience and expertise they bring; not just to their situation whether as an employee, volunteer, director or patient, but to the organisation as a whole. A place where social media is embraced as a wonderful platform for the exchange of ideas and values.
<table>
<thead>
<tr>
<th>Dominantly medical led patient care</th>
<th>Some leadership movement away from doctors</th>
<th>Patients involved to some extent in shared decision making; more shared leadership</th>
<th>Patient centred interprofessional team-based practice</th>
</tr>
</thead>
</table>

Do you understand your local context?

Hierarchical System

Systems where there is collaborative practice
The Higher Education Institution Context
Challenges for HEI’s

• Set up to compete
• Individuals seeking promotional aspirations
• Territorial issues of curriculum
• Large cohorts!
Faculty Support

- Sign-up at the highest levels
- Working cohesive group members
- Reflect the values and principles of IPE
- Shared resources
- Commitment to sustainability
- Trial and error (local context)
Academics working together; no different from practice... working it out!
University Complexities

MEDICAL SCHOOL

Mediating tools
e.g. Assessment tools, learning activities,

Subject
Curriculum Developer

Rules and Norms
GMC Regulatory body requirements Timetables

Community
Administrators Students Service users Facilitators Practice facilitators

Division of labour
Facilitation Marking Admin of programme

Object/Activity
Curriculum development

Common activity:
IPE Curriculum development

Outcome:
Different expectations, priorities, culture.

SCHOOL OF NURSING AND MIDWIFERY

Mediating tools
e.g. Assessment tools, learning activities,

Subject
Curriculum Developer

Rules and Norms
NMC Regulatory body requirements Timetables

Community
Administrators Students Service users Facilitators Practice facilitators

Division of labour
Facilitation Marking Admin of programme

Object/Activity:
Curriculum development

Engeström 2001

Anderson et al., 2014
Teaching Abilities

- Recognition of the primacy of learning rather than teaching
- Recognition of integration of multiple professional perspectives

Facilitator skills

- Desire to facilitate
- Right to be a pedagogue
- Authority status as an expert
- Subject Knowledge

Expert

IPE Facilitator
Professional Bodies

- Set Standards
- Not yet aligned to current new thinking:
  - WHO Report (2010; 2016)
  - What is happening in Finland?
Writing an IP Curriculum Strategy

• Involve patients and students
• Build trust and relationships between staff
• Agree possibilities (give and take)
• Look at alignment to what exists
• From novice- expert (minimal at pre-registration?)
• Build in assessment
Being an Interprofessional Champion

‘Changing a college curriculum is like moving a graveyard-you never know how many friends the dead have until you try to move them.’

(Woodrow Wilson)

Safe Patients

- Relationship Building
- Team Training
- Human Factors
- Improvement Science
Leicester integrated IPE curriculum

**Strand Three**
- Patient safety workshops and simulations
- Interprofessional care planning
- Polypharmacy
- Mental health
- Homeless project
- Child health

**Aims of Strand Three**
- To apply the theoretical basis of team working
- To gain a richer appreciation of roles and responsibilities of practitioners
- To analyse effective collaborative team practice
- To consider your future contribution to person-centred team working

**Strand Two**
- Health in the Community
- Listening workshop
- Workshop early years education

**Aims of Strand Two**
- To apply the theoretical basis of team working
- To gain a richer appreciation of roles and responsibilities of practitioners
- To analyse effective collaborative team practice
- To consider your future contribution to person-centred team working

**Strand One**
- Introduction to team working
- Communication (DMU)

**Aims of Strand One**
- To explore what is meant by team working in health and social care
- To begin to apply a theoretical understanding to team work
- To become familiar with your chosen profession and others
- To consider the outcomes of team working for promoting person-centred collaborative care.

Assessed for developing interprofessional competence using an IPE Portfolio with additional professional requirements
In Practice: The Leicester Model

Preparation
- Alignment to curriculum
- Pre-reading
- Introduction
- Team formation

1. Experience
- Patient contact
- Community/ward

2. IP Reflection
- Theory
- Profession-specific perspectives

3. Assimilation
- New thinking
- Integrating perspectives
- Planning

4. Outcomes
- Joint presentation
- Debate
- Changing practice

Assessment; learning taken forward into practice

From profession specific...... to interprofessional working
Theory

- **Experiential learning** (D’Eon 2005; Clarke 2006)
- **Reflective practice** (Schön 1987; Dewey 1938)
- **Trialogical learning** (Hakkarainen & Paavola, 2007)
- **Synthesis** (Vygotsky, 1978; Wackerhausen, 2009)

What Happens
The Leicester Model: Short-Practice Placements

Preparation for practice

Theory
• Contact hypothesis (Allport 1979; Carpenter and Hewstone, 1996)
1. Learning and working with patients
   (hospital ward or community home visit)

Patients must be prepared to receive students home visits.

Theory
• Experiential Learning
  (Kolb, 1984; D’Eon, 2005; Clarke, 2006)
1. Learning and working with patients and practitioners (hospital staff or community staff)

Theory
• Experiential Learning (Kolb, 1984; D’Eon, 2005; Clarke, 2006)
Consent to participate in teaching healthcare students

Date.................................................................

Yes   No

I have received information about the training of medical and pharmacy students in the community ☐ ☐

I agree to hold a small group interview with students in my home or (another agreed place) for one hour ☐ ☐

I know that students will be provided with brief information about my past health, before my interview ☐ ☐

I am happy to talk with the students about my health problems and my medications, the role of professionals who are involved in my care ☐ ☐

I am aware that students will talk about the drugs I am taking with my General Practitioner and nurses ☐ ☐

I am aware that my case will be discussed anonymously in a feedback presentation session ☐ ☐
Ethics

- Preparation/support for patients (Hospital/Community)
- Consent process
- Confidentiality
- Student professionalism
2. Reflection on learning.
Students apply profession-specific understandings asking questions about what and why decisions have been made. Guided by facilitators.
3. Assimilation:
Students agree together potential solutions to problems and begin to make sense of their learning and prepare to present their findings.

4. Outcomes:
Students present their findings and propose solutions in discussion with experts. Clinical errors are referred back to the clinical team.

Theory
Synthesising for change
(Vygotsky 1978)

• Changes to patient care
• Students take forward their learning
COMMUNITY INTERPROFESSIONAL LEARNING:
Management of Medicines Optimisation in the Community

CONFIDENTIAL

*Exchange of patient important information from teaching to clinical practice*

Professional Feedback Form from students to the Patients General Practitioner

**PATIENT NAME:**

**Practice:**

**DATE (student assessment of the patient):**

*Clinical Analysis: Findings from pharmacy and medical students*

<table>
<thead>
<tr>
<th>Background</th>
<th>Issues/details</th>
</tr>
</thead>
</table>
Students supported to make meaning together
References: The Leicester Model


ABSTRACT
Offering undergraduate and post-qualified learners opportunities to take part in, and reflect on, the nature of interprofessional working when in practice remains an important goal for interprofessional educators. There are a plethora of opportunities within hospital and community care for learners to actively participate in health and social care delivery where collaborative practice prevails. However, it remains challenging to know how to establish and sustain meaningful interprofessional practice-based learning. This is because profession-specific teaching is prioritised and many teams are under-resourced, leaving little time for additional teaching activities. In some instances, practitioners lack the knowledge concerning how to design meaningful interprofessional learning and often feel unprepared for this teaching because of limited interprofessional faculty development. Others are simply unaware of the presence of the different students within their practice area. This guide offers key lessons developed over many years for setting up practice-based interprofessional education. The learning model has been adapted and adopted in different settings and countries and offers a method for engaging clinical frontline practitioners in learning with, and from learners who can help support and in some instances advance care delivery.

ARTICLE HISTORY
Received 19 June 2015
Revised 26 January 2016
Accepted 26 February 2016

KEYWORDS
Ethical values; faculty development; interprofessional education; interprofessional learning; practice-based; reflective learning; theory
Assessment


- Knows knowledge
- Knows How competence
- Shows How performance
- Does action

Affective, feeling and emotional
Psychomotor manual or physical skills
Cognitive mental knowledge

Novice
Expert

Excellent
Very good
Good
Average
Poor

Blooms learning domains (1956)
Assessment

‘Practice ready collaborative practitioners’ (WHO, 2010)

• Competency-based assessment

Similarly to professionalism, abstract concepts are difficult to define and measure

How will you measure collaboration?

Concerns about administering valid, reliable, acceptable feasible assessments

Constructivist principles of alignment

Level of competence or capability; what is the minimum standard?

Mastery of one domain/competence or all? Individual or within a team?
Building IPE curriculum success

• Faculty development
• Patient involvement
• Student involvement
Challenging and changing

The what and the how
2. Evaluation: Does IPE make a difference
IPE going forward

• Lack of theoretical research
• What does evidence look like
• The questions that need answering
• Money for IP educational research
Theoretical context of evaluation

- Theory offers an explanatory lens for empirical work
- Deeper understanding of the constructs that interact
- Offer structure, rigour and guidance
- When tested empirical data can modify and re-define the theory
A BEME systematic review of the effects of interprofessional education: BEME Guide No. 39


*Centre for Health & Social Care Research, Kingston University and St George’s, University of London, London, UK; **Centre for the Advancement of Interprofessional Education, London, UK; ***Sheffield Teaching Hospitals NHS Foundation Trust, Sheffield, UK; ****Faculty of Medicine, University of Ottawa, Ottawa, ON, Canada; *****Faculty of Health & Social Sciences, University of Bedfordshire, Bedford, UK; ****AKM-STATS, Scotland, UK; ****Department of Medicine, University of California, San Francisco, CA, USA

ABSTRACT

Background: Interprofessional education (IPE) aims to bring together different professionals to learn with, from, and about one another in order to collaborate more effectively in the delivery of safe, high-quality care for patients/clients. Given its potential for improving collaboration and care delivery, there have been repeated calls for the wider-scale implementation of IPE across education and clinical settings. Increasingly, a range of IPE initiatives are being implemented and evaluated which are adding to the growth of evidence for this form of education.

Aim: The overall aim of this review is to update a previous BEME review* published in 2007. In doing so, this update sought to synthesize the evolving nature of the IPE evidence.

Methods: Medline, CINAHL, BHE, and ASSIA were searched from May 2005 to June 2014. Also, journal hand searches were undertaken. All potential abstracts and papers were screened by pairs of reviewers to determine inclusion. All included papers were assessed for methodological quality and those deemed as ‘high quality’ were included. The presage–process–product (3P) model and a modified Kirkpatrick model were employed to analyze and synthesize the included studies.

Results: Twenty-five new IPE studies were included in this update. These studies were added to the 21 studies from the previous review to form a complete data set of 46 high-quality IPE studies. In relation to the 3P model, overall the updated review found that most of the presage and process factors identified from the previous review were further supported in the newer studies. In regard to the products (outcomes) reported, the results from this review continue to show far more positive than neutral or mixed outcomes reported in the included studies. Based on the modified Kirkpatrick model, the included studies suggest that learners respond well to IPE, their attitudes and perceptions of one another improve, and they report increases in collaborative knowledge and skills. There is more limited, but growing, evidence related to changes in behavior, organizational practice, and benefits to patients/clients.

Conclusions: This updated review found that key context (presage) and process factors reported in the previous review con-
Systematic Reviews IPE

• (21 + 25) = 46 High Quality IPE studies
• 19 UK studies
• Positive findings:
  – Student attitudes
  – Collaborative knowledge and skills
• More evidence still required:
  – Changes in behaviour
  – Changes to patient care
  – Organisational impacts
Theoretical Context IPE

BEME systematic review of the contribution to the design, delivery and evaluation of interprofessional curricula using a framework synthesis. Forthcoming

Hean, S., Green, C., Anderson, ES., O’Halloran, C., Pitt, R, John, C

Findings of papers prior 2013: n=70

• Theory helps us explain why....
  – Personal level: Contact hypothesis- contact matters
  – Educational theory: How to make meaning
  – Complexity: Systems theories
  – Cannot state which theory is most helpful and why
    • Rise in systems theories
i) Match between theoretical underpinning of curriculum design and the evaluation (consistency)- evidence tests the validity of the theory

ii) Theory underpinning original design not used to underpin the evaluation - may identify outcomes to feedback into the curriculum design.
Theoretical context of evaluation

Institute of Medicine (2015)

Problems

• **Context** of educational reform is rarely integrated with health systems redesign. Education and practice rarely work together (quality improvement agenda an exception)

• **Clarity on a Framework** about educational training models: Length, complexity (what, when and how)
Theoretical context of evaluation

• Need to strengthen the evidence-base
  – What has occurred (attitudes changes etc.)
  – Why and How (?)

• Need for rigorous evaluation methods
  – Mixed methods (what and the why?)
    • Use instruments; valid and reliable
  – Qualitative investigations
    • Realist synthesis
    • Action research
Theoretical context of evaluation

• Systems Theory

  Logic Model (Frechtling 2007): Considers Inputs-Activities-Outputs and Outcomes


  3 P’s Model: Presage, process and product (Biggs 1993). Again consider the interplay and relationships between the different components of learning

  Realist Evaluation (Pawson & Tiley 1997). An in-depth analysis of what works for whom and in what context creating an appreciation of C-M-O
Evaluating an interprofessional education curriculum: A theory-informed approach

ELIZABETH ANDERSON¹, ROGER SMITH² & MARILYN HAMMICK³*
¹University of Leicester, UK, ²University of Durham, UK, ³International Education and Research Consultant, UK

Abstract

Background: This paper retrospectively reports on an evaluation framework applied to a local interprofessional education (IPE) curriculum design. The theoretically informed IPE curriculum spans the undergraduate health and social care programmes of over 10 professions as a curriculum theme. The teaching design and its impact were informed by psycho-social and learning theories.

Aims: This meta-analysis is presented to share the importance of longitudinal IPE, whole curriculum evaluation for comparisons and to advance our understandings of what works and why.

Method: The meta-analysis used the Presage, Process and Product conceptual framework outlined by Biggs in 1993, and the Kirkpatrick in 1996, evaluation outcome model. Data are shared on the final overall learning from evaluating the teaching and the outcomes from students, teachers, practitioners, patients and carers.

Results: The evaluation highlighted cyclical issues relating to students experiences, facilitators abilities and highlights the challenges of learning in practice which was highly praised by students. The problems and challenges were solved through the application of theory to illuminate our understandings.

Conclusion: We lament at missed opportunities for the application of theoretically informed research, questions that still require to
What is happening (processes)

Systematic data collection to consider; Improvement, monitoring and justification. Leading to changes
Looking with a more powerful lens

Why might students not like the IPE?
- Non-alignment
- Misunderstood
- Teacher issues/faculty issues
- Mature students in the mix
- The myriad of issues bringing students together without forethought and understanding
Four Channel Flow Model: Engaging learners

Csikszentmihalyi, M 1990
• The research we need to do...

http://whoeducationguidelines.org/blog/moving-interprofessional-education-forward
Moving Interprofessional Education Forward

23 Jul, 2014  by John H.V. Gilbert  5 Strongly agree

The definition of Interprofessional Education: when students from two or more professions learn with, from and about each other, for the purposes of collaboration, to improve the quality of care.

• What concepts are needed to test "about" "with", "from", and "about" within the contexts of collaboration and quality of care? For example: how do collaborators think about their professions? How do collaborators talk about their professions? How do collaborators view the "good" of what they do? How do collaborators conceptualize their interactions?

• Using theories & methods from other domains of scholarship we can: OBSERVE i.e. watch and record interactions and track changes [Anthropology]. QUESTION the participants in surveys, focus groups and deliberative dialogue [Sociology]. COST the interactions [Economics]. RECORD & ANALYZE communication [Linguistics]. MEASURE the start, mid-term and end points of IPE into collaborative practice [Statistics]. ORGANIZE behaviours [Psychology]. Examine the legal implications.

• If theories and methods from these and other domains can be applied, what would constitute a set of testable items? In almost all respects, the literature on IPE points to features of education, learning and practice that serve as barriers to IPE. That literature also frequently suggests mechanisms that might facilitate IPE. How might these then be articulated in curricular reform/change so that they might serve as testable items within the context "about, with, and from"? Recognizing that measures need to be taken before, during and after the application of IPE, using both cross-sectional and longitudinal studies.
The main challenges

- How do collaborators *think* about their professions?
- How do collaborators *talk* about their professions?
- How do collaborators view the “good” of what they do?
- How do collaborators *conceptualise* their interactions?
Main challenges

- More **observational** studies
- More **economics** of IPE collaboration
- More looking at organisational and personal behaviour in teams (psychology and systems)
Research challenges

‘As the community of interprofessional educators has matured over the past 50 years the need to develop its basis in scholarship has become increasingly important. The scholarship of IPE may find theoretical bases in a number of different academic disciplines such as sociology, philosophy, anthropology, economics, political science et al’.
Research challenges

‘Learning from these disciplines may indeed help IPE to use their theories to develop models from which may be derived testable hypotheses, which may then be tested to provide data that hopefully lend credence and acceptability to IPE’.
In Summary
Collaborative Patient-centred Practice

1. Getting ready
2. Working together to assess, diagnose and plan care
3. Delivering care
4. Reviewing care

Reflecting on Teamwork throughout the process

Step 1
Getting Ready for Collaborative Teamwork

Step 2
Teamwork to:
• Gather information
• Determine the required health/social needs
• Obtain further information
• Set goals and the treatment plan to address identified patient/family needs
• Develop guidelines to measure progress toward patient care goals

Step 3
Implementing Patient Treatment Plan

Step 4
Assessment of Progress for:
Achievement, revision, expansion of patient treatment goals

Underpinning Competence Framework www.cihc.ca
• Interprofessional Communication
• Patient/family/community centred care
  • Role clarification
  • Team functioning
  • Collaborative leadership
  • Interprofessional conflict resolution
Final thoughts: Aspirational but achievable

IPE: Iterative development, using local and relevant national context and possibilities
THANK-YOU

esa1@le.ac.uk
References


