Interprofessional Collaborative Organization Map and Preparedness Assessment (IP-COMPASS)

USER GUIDE
v1.0

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Glossary

Academic partner   An accredited educational organization/program from which IP students would come. Partnership may be supported by a formal academic agreement or contract.

Client/patient   A consumer of health care services, inclusive of family/community when appropriate. The terms client and patient are used interchangeably.[1]

Healthcare team   Any health care providers (regulated or unregulated), personal support workers, caregivers, volunteers or family members who work collaboratively and interdependently in order to provide health care services to a specific patient/client population.

Intentional learning experience   A learning experience that is planned in advance, with learning objectives.

Interprofessional   Referring to interaction among people from different professions.

Interprofessional Collaboration (IPC)   "The provision of comprehensive health services to patients by multiple health caregivers who work collaboratively to deliver quality care within and across settings."[2]

Interprofessional Education (IPE)   People from two or more professions learning with, from and about each other to improve collaboration and the quality of care.[3]

Multi-professional   Including people from more than one profession.

Student   A person engaged in an educational program at a phase of their studies prior to them practicing as an independent health care professional.

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[1] Adapted from: http://www.hc-sc.gc.ca/hcs-sss/hhr-rhs/strateg/interprof/chap-10-eng.php
[2] HealthForceOntario: http://www.healthforceontario.ca/WhatIsHFO/FAQs/IPCProject.aspx#catagory01
[3] Centre for the Advancement of Interprofessional Education (CAIPE): http://www.caipe.org.uk/about-us/defining-ipe/

Introduction

WHAT IS IP-COMPASS?

IP-COMPASS is a quality improvement framework to help clinical settings become better prepared to provide intentional interprofessional learning experiences (i.e., learning experiences that help students develop skills for interprofessional collaboration). It provides a structured process to help you understand the types of organizational values, structures, processes, practices and behaviours that, when aligned, can create an environment that is conducive to interprofessional learning.

The IP-COMPASS tool is for individuals or groups within a healthcare organization who are charged with developing and delivering interprofessional education. The tool will help them create an environment necessary for good interprofessional education to occur. This is not meant as a tool to provide interprofessional education to students.

While individuals or groups are able to use this tool on their own, this process is best accomplished with the guidance of a knowledgeable facilitator. For a list of individuals who can perform this role, please contact Kathryn Parker (kparker@hollandbloorview.ca) or Ivy Oandasan (i.oandasan@utoronto.ca)

Communication and engagement with senior leaders within your organization around this process may improve the success of your action steps moving forward. A brief summary of some strategies to obtain leadership buy-in from leadership are provided below.*

Strategy	*IP-COMPASS*
Determine your buy-in objective	What action do you want your leaders to take regarding the use of IP-COMPASS?
Establish your strategic storyline	To generate the action you want, what is the "big picture" or vision of the IPC/IPE future that you want your leaders to see?
Develop the story in three chapters that target your leaders agenda	What are your specific leader's needs, wants and goals? In the future that you are projecting, what are the three most important ways in which your leader's agenda will be fulfilled by using the IP-COMPASS tool?
Call your leaders to action	Ask for a commitment or first step towards using the tool.

*Walton, M. Generating Buy-In: mastering the language of leadership. New York: American Management Association, 2004.

WHAT IS THE IP-COMPASS *USER GUIDE*?

This *User Guide* is intended to help you make a more thorough assessment in areas you are not sure about, and to identify ways of improving areas you would like to strengthen. It provides additional details for each attribute identified in the framework, including a list of potential evidence and artifacts you might look for to assess their relative strength. It also provides additional details to consider when planning an interprofessional learning experience.

If the IP-COMPASS team finds it difficult to rate any particular attribute, you may wish to refer to this *User Guide*. However, remember that each organization expresses its attributes in different ways, and the list of evidence and artifacts in the *User Guide* is intended only to provide ideas about what you might look for to know how strong the attribute is in your setting.

The User Guide is one of 4 IP-COMPASS materials. The remaining 3 are; the tool itself, a glossary of terms and a report which detail how the tool was developed and pilot tested.

The Context

THE IMPORTANCE OF ORGANIZATIONAL CULTURE

The *culture* of an organization is comprised of widely shared and deeply held *values, beliefs and assumptions* of the people within it (Schein, 1993). Organizational culture affects everything. It is expressed in the organization's structures and practices. It shapes people's patterns of thought, their behaviours, and even their perceptions.

> *Organizational culture is "the way we do things around here".*

Organizational culture is a strong force. The underlying culture of a clinical setting can make it easy to deliver interprofessional education (IPE), or it can sabotage it completely. In most Canadian clinical settings, some aspects of the organizational culture are supportive of IPE, while other aspects undermine it. Which are which, in your organization? One way of improving the success of your IPE efforts is to understand your organizational culture, so that you can begin to make it more conducive to interprofessional learning.

THE IP-COMPASS ATTRIBUTES

IP-COMPASS provides a tool for understanding your organizational culture as it relates to IPE. It focuses on 22 specific *attributes* of clinical settings that influence the ability to deliver IPE. The attributes include values and beliefs, structures, practices and behaviours.

Table **1** (page 4) lists the attributes that are included in IP-COMPASS. (Please see *Appendix A* for a description of how these 22 attributes were chosen.)

The attributes are a *reflection* of the organization's culture. For example, the use of physical space (attribute 2.1) can provide clues as to the value placed on interprofessional collaboration (IPC) within a clinical setting. Are there spaces within the clinical setting where people from different professions meet to socialize or to work together? Are offices for the different professions intermingled, or is each profession sequestered in its own corner of the building?

The attributes also provide ways to change the organization's culture. In a clinical setting where people do not place much value on IPC, changing the locations of offices could increase interactions between people from different professions, which could gradually enhance people's appreciation of the value of IPC.

Table 1: IP-COMPASS Constructs and Attributes

1. Commitment to IPC

1.1 The importance of providing quality patient- / client-centered care is part of the organization's culture

1.2 IPC is part of strategic planning

1.3 Time, people & money are committed to IPC

1.4 Leaders promote IPC among team members

1.5 Multiple professions work together on the healthcare team

1.6 The interprofessional healthcare team functions collaboratively

1.7 The effectiveness of IPC is measured

2. Structures and supports for IPC

2.1 Physical space is designed and used in a manner that supports IPC

2.2 Common tools are available to support IPC

2.3 Roles & responsibilities make it possible for people from different professions to collaborate

2.4 Management structures & processes use an interprofessional approach

3. Commitment to IPE

3.1 Continual learning & development is part of the organization's culture

3.2 IPE is part of the organization's strategic planning

3.3 The goals for IPE are clearly defined

3.4 Time, people & money are committed to IPE

3.5 Leaders clearly demonstrate their personal support for IPE

3.6 Contributions to IPE are recognized, rewarded & celebrated by the organization

4. Structures and supports for IPE

4.1 Physical space is designed & used in a manner that supports IPE

4.2 Tools & resources are available to support IPE

4.3 Effective IPE champions are in place

4.4 IPE is a consideration when hiring & orienting new staff

4.5 Educators & staff have the knowledge & skills needed to support IPE

THE IP-COMPASS CONSTRUCTS

The IP-COMPASS attributes have been grouped into 4 overarching constructs. The first two constructs relate to IPC, based on the assumption that it is easier for professionals to learn with, from and about each other when they value IPC. Construct 1 focuses on overall commitment to IPC of the organization and the individuals within it, while Construct 2 focuses on more concrete structures and supports for IPC. The third and fourth constructs are similar, but relating directly to IPE.

Construct 1: Commitment to IPC

ATTRIBUTE 1.1: THE IMPORTANCE OF PROVIDING QUALITY PATIENT-/CLIENT-CENTERED CARE IS PART OF THE ORGANIZATION'S CULTURE

DESCRIPTION

This attribute focuses on the extent to which the organization is committed to an approach in which patients/clients are viewed in a holistic manner, integrating all aspects of issues impacting their health rather than focusing on treating the presenting illness or condition.

When this attribute is strong…
…all patient/client care is patient-/client-centered. The approach to treatment is based upon commonly accepted values, involving elements of advocacy, empowerment, and respect for the patient's/client's voice and autonomy. Patients/clients and their families feel that health caregivers respect them and the health care choices they make. They feel that the health care team works with them, across settings, to meet their health goals.

TIPS

- Culture can be a nebulous thing. When assessing this attribute, focus on the culture of the clinical setting where the interprofessional learning experience will take place (e.g., the unit or healthcare team).

- Particularly in larger organizations, the culture of the unit may be different from the culture of the organization as a whole. Therefore, while focusing on the culture of the unit, also consider cultural evidence and artifacts from the broader organization to the extent that they impact on the unit's culture.

- While it is sometimes difficult to identify direct evidence of an organization's culture, proxy indicators and facilitators, such as those identified on the following page may be helpful.

POSSIBLE EVIDENCE AND ARTIFACTS

How might you know if the importance of providing quality patient-/client-centered care is part of the organization's culture?

For each of the following evidence and artifacts of culture, focus on their presence in the unit. Consider their presence within the larger organization as a whole to the extent that they impact your unit's culture.

Values and beliefs support provision of quality patient-/client-centered care, for example…

- Are the following values and beliefs incorporated into, and demonstrated throughout, patient/client care and services?
    - Respect
    - Holistic approach
    - Universal access to care
    - Human dignity
    - Patients/clients are experts of their own lives
    - Continuity and consistency of care and caregiver

Patients/clients are respected and their autonomy recognized, for example…

- Are patients/clients and their families treated with respect? (consider findings of patient/client satisfaction surveys, focus groups, etc.)

- Are patients/clients and their families considered part of the team? (consider findings of staff surveys, focus groups etc.)

- Does the healthcare team treat patients/clients and their families like part of the team? (consider findings of patient/client satisfaction surveys, focus groups, etc.)

- Are healthcare goals patient/client driven? (patient/client charts, etc.)

There are organizational resources and processes that support quality patient-/client-centered care, for example…

- Are the decisions of clients/patients and their families supported by decision coaching and/or decision aids?

- Are patients/clients and/or their families included on policy development committees within the organization?

- Is patient/client safety a standing agenda item on relevant committees?

- Are there sustained resources dedicated to teaching staff and other team members about patient-/client-centered care?

Quality patient-/client-centered care is evaluated and assessed, for example…

- Do patients/clients have an opportunity to provide feedback?

- Is patient/client centered care part of staff performance reviews?

- Is the quality of patient-/client-centered care measured and acted upon (including continuity and consistency of care)?

List other evidence or artifacts in your organization:

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ATTRIBUTE 1.2: IPC IS PART OF STRATEGIC PLANNING

DESCRIPTION

This attribute focuses on the extent to which IPC is not only part of the formal strategic plan, but also the extent to which it is acknowledged and incorporated in planning processes and other related artifacts throughout the organization, including clinical units within which health providers work.

When this attribute is strong…
…IPC is almost always considered when strategic-level decisions are made that impact (a) how care providers work together and (b) how clients/patients are cared for. These decisions might be at any level (e.g., organization, program, department or unit).

TIPS

- The term "interprofessional collaboration" or "IPC" need not be used per se, but there should be some evidence that people are considering how their decisions will enable care providers from different professions to contribute and combine their knowledge and skills to improve patient/client care.

- Other terms that would suggest consideration of IPC include: team, teamwork, collaborative, collaboration, cross-professional, etc.

- While it is helpful for IPC to be included in formal planning documents, sometimes these documents are largely ceremonial and do not guide action. If that is the case in your organization, give greater weight to evidence that shows that IPC is a part of strategic decisions that actually do have an impact in the organization.

POSSIBLE EVIDENCE AND ARTIFACTS

How might you know if IPC is part of strategic planning?

IPC is in formal planning documents, for example…

- Is IPC in the organization's overarching strategic plan and/or scorecards?

- Is IPC in the program-, department- or unit-level strategic plan and/or scorecards?

- Is IPC part of the team, unit and/or program mission statements?

IPC is considered in meetings where strategic decisions are made, for example…

- Are there formal groups who are responsible for supporting, overseeing and/or driving IPC? (e.g., look at terms of reference for different groups, keeping in mind they may not necessarily have IPC in their title)

- Is IPC (or elements thereof) a standing item on the agenda of meetings where planning decisions are made?

List other evidence or artifacts in your organization:

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ATTRIBUTE 1.3: TIME, PEOPLE & MONEY ARE COMMITTED TO IPC

DESCRIPTION

This attribute focuses on the extent to which the organizational commitment to IPC is expressed through concrete resources such as time, people and money.

When this attribute is strong…

…IPC is adequately resourced. There is enough time for people to collaborate and consult with one another during their day-to-day work, as well as on special projects. People are able to take workshops or courses to further develop their interprofessional skills, because reasonable amounts of time and money are available for this. Specific individuals are dedicated to furthering IPC within the organization, and they have some resources to work with. Finally, individual or group contributions to IPC are recognized and rewarded.

TIP

- This attribute does not require an infusion of new resources to IPC (i.e., more than normally devoted to practice). It may be that existing resources are re-allocated in a manner that more directly targets and supports IPC.

- This attribute focuses on the allocation of resources for IPC amongst the unit's team members (and within the organization, generally, to the extent that this impacts the unit). It does not refer to the allocation of resources for IPE. That aspect will be covered in attribute 3.4.

POSSIBLE EVIDENCE AND ARTIFACTS

How might you know if time, people & money are committed to IPC?

Time is committed to IPC, for example…

- Are elements of interprofessionalism articulated in all personnel job descriptions?

- Is workload adjusted to enable individuals to devote some time to IPC and communication?

- Are people encouraged and given time to connect with those outside the organization about IPC (e.g., join and make contributions to the Community of Practice)? (look to policies & procedures, etc.)

- Are people released to participate in educational opportunities to develop their interprofessional skills/knowledge? (look to education funding rules and regulation or policies and procedures, etc.)

- Are learning opportunities related to interprofessional skills/knowledge distributed equitably across team members?

- Do records indicate that time has been allocated to the promotion of IPC?

People are committed to IPC, for example…

- Are there staff within the unit or organization that have "interprofessional" (or some variation) in their job title or role? (look to organizational charts, job descriptions, etc.)

- Do records indicate that people have been allocated to the promotion of IPC?

Money is committed to IPC, for example…

- Do records indicate that funding has been allocated to the promotion of IPC? (look to budgets, plans, etc.)

- Are there funds earmarked for development of interprofessional skills/knowledge? (e.g., consider funds used to purchase learning materials, to pay for workshop or tuition fees, and to develop internal training opportunities etc.; look to budgets, education funding rules and regulation or policies and procedures, etc.)

- Are all professions eligible to access these funds?

- Is there funding budgeted to backfill positions while people are attending IPC educational opportunities? (look to budget, education funding rules and regulation or policies and procedures, etc.)

List other evidence or artifacts in your organization:

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ATTRIBUTE 1.4: LEADERS PROMOTE IPC AMONG TEAM MEMBERS

DESCRIPTION

This attribute focuses on the extent to which formal leaders within the organization/team not only articulate their commitment to IPC, but also 'walk the talk'. Leaders may promote IPC through their behaviours, words and/or actions.

When this attribute is strong…
…formal leaders create opportunities for people to work interprofessionally through special projects, committees, professional development, meetings, and even the way day-to-day activities are structured. They encourage people to consult and collaborate with one another, and they make efforts to obtain the supports (e.g., time, space) needed for collaboration. They also model interprofessionalism by working collaboratively with people from a variety of different professions in carrying out their own work.

TIPS

- Formal leaders may include corporate management, unit managers, practice leaders, profession leaders, etc.

- This attribute is not concerned with people who are not in formal leadership roles but who nonetheless champion IPC.

- Any organization has a number of different formal leaders, and they may not all embrace IPC to the same extent. When making your rating, consider which leaders could have the largest impact on the healthcare team's ability to practice interprofessionally. Depending on your circumstances, it might be appropriate to give greater weight to some leaders than to others.

POSSIBLE EVIDENCE AND ARTIFACTS

How would you know if leaders promote IPC among team members?

Leaders create opportunities for IPC, for example…

- Do leaders design projects or activities that are intended to be carried out by interprofessional teams? (including defining and explaining roles, processes and expectations for working together; look at project proposals and terms of reference, etc.)

- Do leaders encourage participation in projects and/or meetings among all professions equally?

- Do leaders identify and support interprofessional development opportunities? (consider whether they post/circulate opportunities, establish cross-professional mentorships, etc.)

Leaders encourage and support IPC, for example…

- Do leaders advocate for time devoted to interprofessional activities (e.g., meetings, consultation, communication, relationship-building, shared projects, etc.)?

- Do leaders hold regular meetings that include discussion or consideration of IPC? (look at meeting agendas, etc.)

Leaders role model IPC, for example…

- Do leaders use inclusionary and multi-professional language? (e.g., referring to the "lounge" rather than the "nursing lounge" when it is a room used by all professions, using terminology that all professions will be familiar with, etc.) (consider staff opinions, newsletter articles or other communications written by leaders, etc.)

- Do leaders model IPC through their interactions with other professionals? (consider staff perceptions, who leaders consult with and take advice from, etc.)

List other evidence or artifacts in your organization:

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ATTRIBUTE 1.5: MULTIPLE PROFESSIONS WORK TOGETHER ON THE HEALTHCARE TEAM

DESCRIPTION

This attribute is about the mere existence of interprofessional teams to deliver patient/client care on the unit or within the program.

When this attribute is strong…
…the healthcare team(s) include individuals from two or more professions who work together to deliver patient/client care.

TIP

- This attribute is about the composition of the healthcare team and whether the individuals on the team work together. It is *not* concerned with the quality or effectiveness of the interprofessional working relationships. That aspect will be covered in attribute 1.6.

POSSIBLE EVIDENCE AND ARTIFACTS

How might you know if multiple professions work together on the healthcare team?

Different professions work together, for example…

- Are there two or more different professions represented and working together on the team to deliver patient/client care?

- Does the healthcare team have interprofessional meetings about patient/client care and/or team operations and functioning? (the quality of the communication during such meetings is less important than the occurrence thereof)

Documentation of interprofessional work, for example…

- Do documents exist that describe how interprofessional work is to be organized and carried out? (look for policies and procedures, operating rules, team charters, job descriptions, interprofessional standards of care, medical directives, etc.; the quality of these documents is less important than the existence thereof)

List other evidence or artifacts in your organization:

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ATTRIBUTE 1.6: THE INTERPROFESSIONAL HEALTHCARE TEAM FUNCTIONS COLLABORATIVELY

DESCRIPTION

This attribute focuses on the functioning and quality of the collaborative interprofessional working relationships of the healthcare team on the unit or within the program. It includes activities, dynamics, behaviours, actions and attitudes relevant to IPC.

When this attribute is strong…
…people from different professions are working together seamlessly to provide quality patient/client care. There are high levels of trust and respect, and everybody is able to contribute within their scope of practice. Team members call on one another when they need each others' expertise. All the members of the team speak the same language, so misunderstandings and frictions between the professions are rare. When misunderstandings or frictions do occur, they are resolved quickly.

TIPS

- This attribute is about behaviours, attitudes, and perceptions. You might observe how the healthcare team works together. You might also speak with several different members of the healthcare team to find out how respected and trusted they feel, how much they are able to contribute to the team, how often misunderstandings occur, etc.

- When speaking with members of the healthcare team, think about what might make them reluctant to express any dissatisfaction with the way the team operates. Perhaps the person in the next office might overhear, or they might be afraid you will tell others that they complained about them. How can you make them feel more comfortable speaking candidly?

- Keep in mind that, as trust levels rise, people may become more comfortable being constructively critical about the team's IPC. This could make it seem like the healthcare team is becoming worse at working collaboratively, when in fact it is improving.

POSSIBLE EVIDENCE AND ARTIFACTS

How might you know if the interprofessional healthcare team is collaborative?

Patient/client care is collaborative, for example…

- Do team members consult each other about patient/client care?

- Is there consistency amongst team members in their approach to patient/client care?

- Does the team engage in interprofessional rounds and/or case conferences and/or patient/client meetings (with or without patients/clients present) regularly (i.e., not intermittently)?

- Do team members read or review other professionals' consultation/ diagnostic/assessment and treatment reports and plans, as appropriate?

- Are errors and omissions attributable to lack of collaboration minimal? (look at patient safety reports, incident reports, etc.)

- Does the team have effective processes to reduce redundancies (e.g., processes that ensure the patient/client does not have to repeat the same information to multiple team members)?

- Do patients/clients perceive the healthcare team to be collaborative? (look at results of patient/client satisfaction surveys, patient/client report card, etc.)

There is trust and respect among team members, for example…

- Do team members trust one another?

- Do team members treat each other with respect? (look at whether staff indicate feeling respected in staff satisfaction survey results)

- Do team members accept responsibility for and address misunderstandings or conflicts?

- Is inclusionary language used in verbal and written communication? (i.e., use common language/terms that everybody understands)

There is opportunity for all team members to contribute, for example…

- Do all individuals feel they have a voice on the team (e.g., are there opportunities for all team members to present their perspectives or share opinions and ideas)? (look to staff satisfaction survey results related to this)

- Is input from relevant team members sought for performance reviews?

- Do team meetings include rotating roles and responsibilities (e.g., chairing, setting the agenda, taking minutes, etc.)?

List other evidence or artifacts in your organization:

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ATTRIBUTE 1.7: THE EFFECTIVENESS OF IPC IS MEASURED

DESCRIPTION

This attribute is based on the assumption that "what gets measured gets done." If IPC is measured, it sends a message to the healthcare team that this is an important aspect of their work. It also provides opportunities for improving interprofessional practice.

When this attribute is strong…
…there are measures in place to assess the effectiveness of IPC. These measures are carried out on a regular basis and the results are communicated to the healthcare team, who reflects and acts on them.

TIP

- *Effectiveness* is not just how well the members of the healthcare team work together. It is also the effect of IPC on things like patient/client safety or quality of care.

POSSIBLE EVIDENCE AND ARTIFACTS

How might you know if the effectiveness of IPC is measured?

There are measures in place to assess IPC, for example…

- Is there at least one metric in program-, department- or unit-level scorecards that measures the effectiveness of IPC?

- Are assessments of collaborative team functioning carried out periodically?

Assessment results are used, for example…

- Are results of these assessments communicated to the healthcare team?

- Do collaborative teams periodically reflect on how they can better work together? (look at meeting agendas, minutes, etc.)

IPC research is carried out, for example…

- Are research projects being carried out about the impact of IPC on:
    - the healthcare team?
    - the organization?
    - the quality of patient-/client-centered care within the unit or organization?

List other evidence or artifacts in your organization:

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Construct 2: Structures and Supports for IPC

ATTRIBUTE 2.1: PHYSICAL SPACE IS DESIGNED & USED IN A MANNER THAT SUPPORTS IPC

DESCRIPTION

This attribute focuses on the extent to which physical space is designed and used in a manner that supports IPC among healthcare team members. While it is recognized that some amount of uni-professional space is both appropriate and desirable, and that existing space in most organizations is limited, the use of physical space is viewed as an artifact/reflection of the organizational culture and can shed light on the strength of IPC in the workplace.

When this attribute is strong…
…team members have access to appropriate spaces to engage in a range of interprofessional activities, including discussions (one-on-one and larger group), consultations, patient treatment, networking, collaboration, and informal conversations.

TIPS

- Consider how professionals on the healthcare team tend to interact, and if there are other ways they could interact more effectively. If so, is physical space the limiting factor? Are there modifications to the way physical space is used that could help professionals to interact more effectively?

- Informal relationships can have a powerful effect on IPC. If people know one another on a social level, they are more likely to call on one another professionally. Consider how the layout and use of physical space affects the formation of informal relationships (e.g., through proximity, exposure to one another, etc.).

- This attribute is about whether physical space is designed and used in a manner that supports IPC between healthcare team members. It is *not* concerned with how physical space is designed and used to support IPE. That aspect will be covered in attribute 4.1.

POSSIBLE EVIDENCE AND ARTIFACTS

How might you know if physical space is designed and used in a manner that supports IPC?

There are interprofessional common spaces, for example…

- Are there common physical spaces designated within the organization for team members to interact professionally? (e.g., for interprofessional consultation about a patient/client, to carry out joint projects, etc.)

- Are there common physical spaces designated within the organization for team members to interact socially? (e.g., lunch rooms, lounges, etc.)

- Is there a good mix of large and small common spaces available, considering the range of interprofessional interaction required? (e.g., brief/spontaneous consults between two professionals, larger group or committee meetings, etc.)

- Are designated interprofessional spaces convenient and welcoming to all professions? (consider location of the space, language used in the label/name of the space, etc.)

- Are designated interprofessional spaces actually used by team members from different professions simultaneously? (e.g., observe who uses the space, consult room booking schedules, etc.)

- Is external space used to support IPC if suitable internal space is not available?

There are spaces conducive to interprofessional patient/client care spaces, for example…

- Are patient/client care spaces sufficiently large to accommodate interprofessional rounds and/or interprofessional patient/client care?

- Can patient/client care spaces be used by different professions? (e.g., multi-purpose examination rooms, etc.) (consider whether the spaces include appropriate resources/equipment for different professions, etc.)

Physical space planning takes IPC into consideration, for example…

- Do office locations support interprofessionalism? (consider if offices from different professions are intermixed, as in "team hubs," if they are close enough to one another to allow for easy communication, etc.)

- Do space allocation policies support interprofessionalism and/or consider IPC needs? (consider who within the organization is responsible for making decisions about use of space and how those decisions are made)

- Is the use of physical space part of the conversation when IPC issues and/or plans are being discussed and decided?

- Are IPC needs considered when new space is being designed/constructed?

List other evidence or artifacts in your organization:

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ATTRIBUTE 2.2: COMMON TOOLS ARE AVAILABLE TO SUPPORT IPC

DESCRIPTION

This attribute focuses on the tools and resources in place to support collaboration among professionals in providing patient-/client-centered care.

When this attribute is strong…
…the healthcare team has the tools and resources that it needs to make IPC easier, such as integrated care plans and charting practices.

TIP

- Tools and resources can be used to overcome other limitations or barriers to IPC. For example, videoconferencing can be used to facilitate communication over long distances, and phone or e-mail can be used to do the same when team members' offices are far apart in the building. When distance is not an issue, these tools might be less important. You will need to judge the importance of different tools or resources, and place greater or lesser weight on them as appropriate to your circumstances.

POSSIBLE EVIDENCE AND ARTIFACTS

How might you know if common tools are available to support IPC?

There are resources/tools for patient/client care that support IPC, for example…

- Does each patient/client have a single, integrated care plan?
- Are information sharing agreements in place so team members can collaborate about a patient/client?
- Are charting practices integrated?
- Is the patient/client health record used by all team members as a communication tool?
- Are patient/client education tools interprofessional? (e.g., team involvement in development of pre-surgery tools, patient/client handbooks that include information from the perspectives of different professions, etc.)

There are tools for communication that support IPC, for example…

- Is technology used to enhance IPC (e.g., e-doc tool, e-mail, voicemail, web forums, web cameras, videoconferencing, etc.)?

List other evidence or artifacts in your organization:

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ATTRIBUTE 2.3: ROLES & RESPONSIBILITIES MAKE IT POSSIBLE FOR PEOPLE FROM DIFFERENT PROFESSIONS TO COLLABORATE

DESCRIPTION

This attribute focuses on the ways roles and responsibilities are defined and understood to make it possible for people from different professions to collaborate with one another.

When this attribute is strong…
…each team member understands their own roles and responsibilities, as well as those of the other team members. Job descriptions, performance reviews, collective agreements, and other documents or processes present no barriers to IPC, and in fact include an expectation that people will collaborate and consult with individuals from other professions.

TIP

- When roles are rigid and inflexible, it is easy to know what each person is responsible for, but it can be hard for people with different roles to work together. When roles are very flexible, it is easier to collaborate, but people may become confused about what each person's role really is. When reviewing this attribute, consider the extent to which the healthcare team has struck a balance between the two, enabling both clarity and flexibility.

POSSIBLE EVIDENCE AND ARTIFACTS

How might you know if roles and responsibilities enable IPC?

Defined responsibilities enable IPC, for example…

- Do job descriptions include an expectation that team members will communicate and consult with one another?

- Is IPC included in staff performance reviews?

- Are collective agreements consistent with interprofessional care principles?

- Are roles and responsibilities of team members flexible enough for them to take advantage of new opportunities to collaborate? (look to job descriptions, team charter, etc.)

Defined roles enable IPC, for example…

- Do documents clearly articulate the respective roles of all team members in patient/client care? (look to documents such as medical directives, collaborative treatment plans, interprofessional standards of care, team charters, in-service training materials, orientation materials, etc. for information about what roles the different professions have in specific circumstances, such as wound management or pain management)

- Are medical and other directives used in a manner that breaks down barriers between the professions? (e.g., they may be used to expand the limits of team members' scopes of practice in a manner that increases the range of opportunities for team members to work together)

Team members understand roles and responsibilities, for example…

- Is the team charter, or similar document, accessible to (e.g., posted or available in a prominent location) and referenced by all team members?

- Do all team members understand each other's roles and know how each contributes to patient/client care? (consider whether appropriate referrals are being made, patients/clients not falling through the cracks, professionals practicing within their scope, etc.)

- Are roles and responsibilities of all team members included as part of orientation of new staff? (look at orientation materials, etc.)

List other evidence or artifacts in your organization:

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ATTRIBUTE 2.4: MANAGEMENT STRUCTURES & PROCESSES USE AN INTERPROFESSIONAL APPROACH

DESCRIPTION

This attribute focuses on the structures and processes used when managing a team of health professionals, such as staff meetings, communications, and directives. It does not speak to the quality of management.

When this attribute is strong…

… the organization's management structures and processes both model and support IPC. All relevant management processes, such as meetings, committees, directives, and communications reflect interprofessional practice.

TIP

- Management structures and processes are both influential on and reflective of the organizational culture. The indicators/evidence suggested on the following page may or may not be relevant to your organization. When rating this attribute, consider all potential management structures and processes relevant to your organization and the extent to which they reflect interprofessionalism.

- Types of management structures and processes include, but are not limited to, staff meetings, communication (e.g., circulation of meeting minutes), and directives.

POSSIBLE EVIDENCE AND ARTIFACTS

How might you know if management structures and processes use an interprofessional approach?

Management structures use an interprofessional approach, for example…

- Is there a mix of professions in management/leadership roles? (look to the organizational chart, HR descriptions and/or databases, etc.)

- Are policies and protocols developed by multi-professional teams? (look to policy and protocol documents, terms of reference, meeting minutes, etc.)

- Are there newsletters, memos, e-mails, and other communications that are interprofessional? (look to distribution lists and the content of the newsletters, etc.)

Management processes use an interprofessional approach, for example…

- Are there regular meetings/forums that include discussion or consideration of IPC? (look to meeting agendas for standing items related to interprofessional care, etc.)

- Do regular meetings include attendees from multiple professions? (look to meeting agendas, minutes, or distribution lists, etc.)

- Do all involved professions feel they have a voice in meetings? (look to staff satisfaction survey results, etc.)

- Are multiple professions involved in incident reviews, as appropriate? (look to incident debriefs, etc.)

- Are the contributions that people/teams make to IPC recognized and acknowledged? (look to performance review forms, formal awards and recognition, meeting minutes, etc.)

Human resources management uses an interprofessional approach, for example…

- Are there some positions open to a range of different professions (as appropriate)?

- Are cross-professional job opportunities posted where many different professions will have access to them?

- Are all job interviews conducted by interprofessional teams?

List other evidence or artifacts in your organization:

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Construct 3: Commitment to IPE

ATTRIBUTE 3.1: CONTINUAL LEARNING & DEVELOPMENT IS PART OF THE ORGANIZATION'S CULTURE

DESCRIPTION

This attribute focuses on the extent to which there is a culture of learning and teaching present within the organization. This may be manifested through the value and commitment that staff and leadership place on ongoing learning and development, as well as reflective practice. Learning is aimed at enhancing the professional development of current healthcare providers as well as students.

When this attribute is strong…
… healthcare team members, managers, and organizational leaders have a genuine desire to learn and improve on an ongoing basis. They wish to improve their programs, their service, and their own knowledge and skills. There is no shame associated with trying something new and failing; instead this is viewed as a valuable learning experience. Team members frequently seek feedback from those who are impacted by their work, reflect on their practice to identify ways of improving it, and engage in professional development to improve their skills.

TIPS

- Culture can be a nebulous thing. When assessing this attribute, focus on the culture of the clinical setting where the interprofessional learning experience will take place (e.g., the unit or healthcare team). Also consider cultural evidence and artifacts from the broader organization to the extent that they impact on the unit's culture.

- This attribute focuses on the presence of an overall culture of continual learning and development within the unit and broader organization (e.g., you may want to ask yourself, is there support for members of the health care team to seize learning and professional development opportunities?). It is *not* about the commitment to specific methods or approaches to learning, such as IPE. That aspect is covered in attribute 3.2.

POSSIBLE EVIDENCE AND ARTIFACTS

How might you know if continual learning and development is part of the organization's culture?

Feedback mechanisms are learning-focused, for example…

- Are performance reviews learning-focused?

- Are there opportunities for staff to seek feedback outside of performance reviews?

- Are there opportunities for staff to receive feedback in a non-punitive manner?

Reflective practice is part of the culture, for example…

- Do team members openly share knowledge, thoughts, ideas and concerns with other team members?

- Do team members accept responsibility to reflect and talk about misunderstandings and other conflicts?

- Is reflective practice encouraged and rewarded?

- Do managers model reflective practice in their day-to-day operations and activities? (consider whether managers seek critical feedback and input from staff and colleagues, recognize when an approach has not worked, try different ways of doing things when the original attempt did not work, participate in professional development activities, etc.)

Learning opportunities and events exist, for example…

- Are structured learning opportunities offered to staff and team members?

- Are there organization-wide learning events? (e.g., annual Education Days, etc.)

- Are there structured opportunities to share lessons learned and contribute to planning (e.g., retreats, camps, etc.)?

- Are patients/clients and families involved in educating staff and other team members?

Innovation is valued, for example…

- Are staff encouraged to innovate and try new things?

- Are staff and team members receptive to new ideas and new ways of working?

- Does the organization have a recent history of innovation?

List other evidence or artifacts in your organization:

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ATTRIBUTE 3.2: IPE IS PART OF THE ORGANIZATION'S STRATEGIC PLANNING

DESCRIPTION

This attribute focuses on the extent to which IPE is not only part of the organization's formal strategic plan, but also the extent to which it is acknowledged and incorporated in planning processes and is widely understood by members of the organization.

When this attribute is strong…
…IPE is almost always considered when strategic-level decisions are made that could impact educational training and development. These decisions might be made at any level (e.g., organization, program, department or unit).

TIPS

- Keep in mind that decisions that *could impact* training and development are not restricted to decisions *about* training and development. Decisions about use of space, hiring processes, resources, and many other things can impact training and development.

- While it is helpful for IPE to be included in formal planning documents, sometimes these documents are largely ceremonial and do not guide action. If that is the case in your organization, give greater weight to evidence that shows that IPE is a part of strategic decisions that actually do have an impact in the organization. Particularly in larger organizations, strategic planning within the unit may be different from strategic planning within the organization as a whole. Therefore, while focusing on strategic planning within the unit, also consider evidence and artifacts from the broader organization to the extent that they impact on the unit's strategic planning.

POSSIBLE EVIDENCE AND ARTIFACTS

How might you know if IPE is part of the organization's strategic planning?

IPE is in formal planning documents, for example…

- Is IPE articulated in the organization's overarching strategic plan and/or scorecard?

- Is IPE aligned with other important organizational goals and priorities?

- Is IPE articulated in the program-, department- or unit-level strategic plan and/or scorecards?

- Is IPE articulated in the team, unit and/or program mission statements?

- Is IPE part of the organization's educational strategy? (e.g., annual operating plans)

- Are these indicators reported to the organization's governing body?

IPE is considered in meetings where strategic decisions are made, for example…

- Do committees, groups, or other bodies exist that are responsible for supporting, overseeing, and/or driving IPE strategies within the organization and/or units? (look at terms of reference for different groups, keeping in mind they may not necessarily have IPE in their titles)

- Is the composition of these groups representative of the different professions?

- Is IPE (or elements thereof) a standing item on the agenda of meetings within the organization where planning decisions are made?

List other evidence or artifacts in your organization:

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ATTRIBUTE 3.3: THE GOALS FOR IPE ARE CLEARLY DEFINED

DESCRIPTION

This attribute focuses on how clearly the organization (or relevant subgroups of the organization, such as the unit or healthcare team) has articulated what it hopes to achieve by engaging in IPE.

When this attribute is strong…
… organizational leaders, interprofessional educators, members of the healthcare team all have a clear understanding of the reasons the organization is investing in IPE. There are measures in place to assess the achievement of these goals.

TIPS

- This attribute is not concerned with the student-specific learning objectives. Instead, focus is on goals at the unit and organization levels.

- Goals might include desired outcomes for the healthcare team or the organization, or desired contributions to medical education.

POSSIBLE EVIDENCE AND ARTIFACTS

How might you know if the goals for IPE are clearly defined?

IPE goals are defined, for example…

- Have leaders determined the reasons they wish to develop and host a structured interprofessional learning experience (e.g., what they hope to contribute and/or ways the organization might benefit)?

- Have other organizational goals and priorities been considered in the development of the goals for IPE? Is there alignment?

IPE goals are communicated, for example…

- Have the IPE goals been articulated in strategic planning documents, annual reports, and/or operational plans?

- Have the goals for IPE been articulated using language that is accessible, understandable, and familiar to all staff and other team members?

- Is there a plan to communicate the goals for IPE consistently to all staff and other team members on an ongoing basis (including communication of goals during orientation of new staff)? (consider whether there is a communication and engagement strategy explicitly outlining how IPE goals are to be communicated)

- Are the organization's goals for IPE highlighted in the organization's internal and external communications (i.e. intranet and/or internet)?

- Is verbal communication about the IPE goals consistent with what is formally set out in documents?

IPE goals are measured, for example…

- Are the organization's goals for IPE measurable? (i.e., successful achievement can be identified and measured)

- Does the organization plan to report on the achievement of the IPE goals in relevant annual reporting processes?

List other evidence or artifacts in your organization:

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ATTRIBUTE 3.4: TIME, PEOPLE, & MONEY ARE COMMITTED TO IPE

DESCRIPTION

This attribute focuses on the extent to which the organizational commitment to IPE is expressed through concrete resources such as time, people and money.

When this attribute is strong…

… IPE is adequately resourced. There is enough time for people to connect and consult about IPE within and outside the organization. People are able to take workshops or courses to further develop their IPE skills, because reasonable amounts of time and money are available for this. Specific individuals are dedicated to furthering IPE within the organization, and they have some resources to work with. Finally, the organization supports individuals or groups in making contributions to the IPE research body.

TIP

- This attribute does not require an infusion of new resources to IPE (i.e., more than normally devoted to teaching). It may be that existing resources are re-allocated in a manner that more directly targets and supports IPE.

- This attribute focuses on the allocation of resources for IPE purposes. It does not refer to the allocation of resources to support IPC amongst the unit's team members (and within the organization as a whole, to the extent that it impacts the unit). That aspect is covered in attribute 1.3.

POSSIBLE EVIDENCE AND ARTIFACTS

How might you know if time, people, and money are committed to IPE?

Time is committed to IPE, for example…

- Are people encouraged and given time to connect with those outside their organization about IPE?

- Are people encouraged to attend IPE professional development opportunities?

- Are people given release time to attend IPE educational opportunities?

- Are people given release time to provide intentional IPE experiences to students?

- Are elements of IPE articulated in all personnel job descriptions?

- Are time and infrastructure allocated for research and publication related to IPE? (e.g., research assistant, etc.)

- Do records indicate that time has been allocated to the promotion of IPE?

People are committed to IPE, for example…

- Are there formal IPE lead and IPE coordinator positions?

- Do records indicate that people have been allocated to the promotion of IPE?

Money is committed to IPE, for example…

- Do records indicate that funding has been allocated to the promotion of IPE?

- Are there funds earmarked for IPE-specific training and professional development?

- Are all professions eligible to access these funds?

- Are there mechanisms or processes in place to regularly review the appropriateness of IPE resource allocation (i.e., to take into account the evolving and changing needs)? (look at financial planning and budgeting policies, board governance policies, etc.)

List other evidence or artifacts in your organization:

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ATTRIBUTE 3.5: LEADERS CLEARLY DEMONSTRATE THEIR PERSONAL SUPPORT FOR IPE

DESCRIPTION

This attribute focuses on the extent to which formal leaders within the organization (e.g., corporate management, unit managers, practice leaders, profession leaders, etc.) not only articulate their commitment to IPE, but also demonstrate the value they place on IPE through their own behaviours, words, and/or actions.

When this attribute is strong…
…formal leaders communicate about IPE on a regular basis in a variety of forums. They are willing to contribute whatever is required, including their own time, to keep IPE on the agenda and move it forward within the organization. They also take every opportunity to encourage others to become involved in IPE initiatives.

TIPS

- Formal leaders might include corporate management, unit managers, practice leaders, profession leaders, etc.

- This attribute is not concerned with people who champion IPE but who are not in formal leadership roles. That aspect will be covered in attribute 4.3.

- Any organization has a number of different formal leaders, and they may not all embrace interprofessional education to the same extent. When making your rating, consider which leaders could have the largest impact on the healthcare team's ability to provide IPE. Depending on your circumstances, it might be appropriate to give greater weight to some leaders than to others.

POSSIBLE EVIDENCE AND ARTIFACTS

How might you know if leaders clearly demonstrate their personal support for IPE?

Leaders communicate about IPE, for example…

- Do leaders identify and/or create opportunities to speak publicly about IPE (internal and external)? (look for PowerPoint presentations, speakers' notes, lists of presentations in leaders' résumés, etc.)

- Do leaders talk about IPE (and/or related concepts) in publications, written communications and newsletters (internal and external)?

- Do leaders hold regular meetings that include consideration of IPE? (meeting agendas, etc.)

- Do leaders make efforts to ensure IPE is a standing item on the agendas of appropriate meetings?

Leaders promote IPE, for example…

- Do leaders encourage staff to take part in IPE events and initiatives? (consider memos, e-mails, verbal communication, IPE conference registration lists, etc.)

- Do leaders identify and support interprofessional learning opportunities? (consider whether they post/circulate opportunities, establish cross-professional mentorships, etc.)

- Do leaders promote IPE equally among all professions? (consider whether the leaders convey consistent messaging and expectations to staff and other team members from all professions)

Leaders contribute to IPE, for example…

- Do leaders attend IPE-related events (internal and external)? (look at minutes, participant lists, etc.)

- Do leaders sit on internal or external committees concerned with IPE?

- Do leaders give necessary approvals and/or support to ensure that IPE-related initiatives can move forward successfully? Do they do so in a timely manner?

List other evidence or artifacts in your organization:

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ATTRIBUTE 3.6: CONTRIBUTIONS TO IPE ARE RECOGNIZED, REWARDED & CELEBRATED BY THE ORGANIZATION

DESCRIPTION

This attribute focuses on the extent to which the organization recognizes and celebrates contributions to IPE. Formal and informal recognition encourage staff/physician contributions by reinforcing that they are worthy and valuable.

When this attribute is strong…
…the organization regularly (i.e., not occasionally or intermittently) rewards contributions to IPE both formally (through promotions, compensation, awards, and communications) and informally. IPE champions and leaders feel that their contributions are recognized, appreciated, and celebrated.

TIPS

- It is important that organizations mix both formal and informal rewards, recognitions, and celebrations since these are mutually reinforcing.

- Each organization will have its own methods/activities for recognition, reward, and celebration. When assessing this attribute, consider those methods/activities most meaningful to people within your organization.

- Also consider the methods/activities for recognition, reward, and celebration at the unit level, as they may be different from the methods/activities implemented at the organization level.

POSSIBLE EVIDENCE AND ARTIFACTS

How might you know if contributions to IPE are recognized, rewarded, and celebrated by the organization?

There is formal recognition of contributions to IPE, for example…

- Does the organization acknowledge and recognize IPE through hiring and promotion practices?

- Is there formal recognition of contributions to IPE? (consider whether there are awards or certificates for IPE contributions, etc.)

- Are IPE-related awards displayed in prominent places and/or presented at significant organizational events?

- Are IPE efforts showcased? (consider whether IPE presentations are on the agenda of events or meetings, if there is a section on IPE in newsletters, if IPE contributions are included in relevant annual reporting, etc.)

- Are IPE efforts showcased at events that are significant within the organization? (e.g., the annual Research Day, the annual Education Day, etc.)

There is informal recognition of contributions to IPE, for example…

- Is there informal acknowledgement for IPE and related activities and contributions? (consider "hallway talk", pats on the back, emails, etc.)

- Are IPE leads and coordinators compensated fairly and adequately (at a level that that indicates the importance and value of the role)?

List other evidence or artifacts in your organization:

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Construct 4: Structures and Supports for IPE

ATTRIBUTE 4.1: PHYSICAL SPACE IS DESIGNED & USED IN A MANNER THAT SUPPORTS IPE

DESCRIPTION

This attribute focuses on the extent to which physical space is designed and used in a manner that supports interprofessional learning among students.

When this attribute is strong…
…students have access to appropriate and comfortable spaces for a full range of interprofessional learning and social activities, including presentations, discussions, consultations, observations, group work, and informal conversations.

TIPS

- In rating this attribute, consider how spaces can help students interact with one another and with the healthcare team. IPE tends to be less didactic and more discussion-based. Consider how the design and use of physical space affects the provision and occurrence of IPE learning activities amongst students within the unit.

- This attribute is concerned with how physical space is designed and used to support interprofessional learning among students. This attribute is not concerned with how physical space is designed and used to support *IPC* amongst the *members of the health care team*. That aspect is covered in attribute 2.1.

POSSIBLE EVIDENCE AND ARTIFACTS

How might you know if physical space is designed and used in a manner that supports IPE?

There are interprofessional common spaces for students, for example…

- Are there common physical spaces designated within the organization for students to interact professionally with each other and/or other team members? (e.g., to support interprofessional consultation about a patient/client, to make it possible to carry out joint projects, etc.)

- Are there common physical spaces designated within the organization for students to interact socially? (e.g., common lunch rooms and/or lounges)

- Is interprofessional space located close to where learning occurs?

- Are designated interprofessional spaces actually used by students from different professions simultaneously? (make observations to see who uses the space, consult room booking schedules, etc.)

There are spaces appropriate for interprofessional learning, for example…

- Is space designed in a manner that provides students interprofessional observation opportunities (e.g., either larger observation rooms and/or use of one-way mirrors, etc.)?

- Is there a good mix of large and small meeting spaces available, considering the range of learning activities planned?

- Is external space used to support IPE, if suitable internal space is not available?

Physical space planning takes IPE into consideration, for example…

- Do space allocation policies support interprofessionalism and/or consider IPE needs? (consider who within the organization is responsible for making decisions about use of space and how those decisions are made)

- Is the use of physical space part of the conversation when IPE issues and/or plans are being discussed and decided?

- Are IPE needs considered when new space is being designed and/or constructed?

List other evidence or artifacts in your organization:

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ATTRIBUTE 4.2: TOOLS & RESOURCES ARE AVAILABLE TO SUPPORT IPE

DESCRIPTION

This attribute focuses on the availability of tangible resources and materials that can be consulted, used, or otherwise drawn upon to support interprofessional learning.

When this attribute is strong…
…interprofessional educators, coordinators, and students have access to high quality, relevant educational materials to support their teaching and learning. The organization makes a conscious effort to identify, acquire, and share materials that are relevant to IPE. Students and teachers also have access to technology as needed for coordination, communication, and internet research.

TIPS

- Consider whether the resources available help to ensure that IPE is delivered in a consistent and informed manner.

- Some types of tools or resources identified on the following page (e.g., videoconferencing) may mitigate the limitations posed by lack of interprofessional space. They may or may not be relevant in the context of your organization.

- Consider if there are other limitations within your organization that could be mitigated by appropriate tools or resources.

POSSIBLE EVIDENCE AND ARTIFACTS

How might you know if tools and resources are available to support IPE?

There are IPE tools/resources for educators/coordinators, for example…

- Are there tools and resources (in written or multi-media format) about IPE to support clinical educators (may be organization-specific or community wide)?

- Are these tools authoritative, high quality, relevant, current, and focused?

- Are there IPE coordination tools? (e.g., centrally accessible interprofessional placement calendars, clinical placement software such as HSPnet that indicates what students are where when)

There are IPE tools/resources for students, for example…

- Are there tools and resources (in written or multi-media format) to support students as they develop interprofessional skills and knowledge (may be organization-specific or community wide)?

- Are these tools authoritative, high quality, relevant, current, and focused?

- Is there informational material that describes the organization, roles of staff and other team members, and the clients/patients served by the organization? (look for detailed orientation material)

- Are there technological tools that can be used to help mitigate space limitations? (e.g., webcams, virtual rounds, video training, web learning software such as "Blackboard", etc.)

- Are all professions and students made aware of and provided access to interprofessional communication tools (e.g., Link Health Pro, interprofessional web forums, email, etc.)?

There are processes for acquiring and sharing IPE resources/tools, for example…

- Is there a process in place to identify and acquire new IPE tools and resources on an ongoing basis as they come available? (consider, for example, whether the organization's "librarian" is aware of need for IPE resources)

- Are these tools and resources readily available to all who may need them? (e.g., are tools/resources in one central location or dispersed? is there a list of all available resources? is acquisition of new resources communicated? etc.)

- Are there opportunities for cross-organization sharing of IPE tools and resources?

List other evidence or artifacts in your organization:

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ATTRIBUTE 4.3: EFFECTIVE IPE CHAMPIONS ARE IN PLACE

DESCRIPTION

This attribute focuses on the existence of champions who consciously and consistently promote IPE within the organization. These would be individuals who have 'taken up the IPE cause.'

When this attribute is strong…
…there are one or more people within the healthcare team (or the broader organization) who are pushing forward the idea of IPE. These people are liked and respected by others, and they have a wide network. Their enthusiasm is contagious, and each day they motivate more and more people to become more involved in IPE.

TIPS

- Champions do not necessarily need to be in upper management positions, but may be enthusiastic and influential individuals at any level of the organizational structure. The role of the champion does not need to be formalized, but the person(s) in the champion role should be actively role modelling and advocating IPE within the unit and/or organization. Commitment to IPE by organization leaders is covered in attribute 3.5.

- Champions play a crucial role in moving new initiatives forward and making things happen. As new initiatives or ways of working become more entrenched, champions become less important. When considering the existence and efficacy of champions within your organization, consider where your organization is at in terms of moving IPE forward, and accordingly, what it currently needs from its champions.

- Particularly in larger organizations, champions of IPE may exist at the organization level and/or unit level. Therefore, while focusing on champions within the unit, also consider whether there are champions of IPE at the organization level to the extent that they impact on the presence of such champions at the unit level. Conversely, in smaller organizations, champions of IPE may only exist at the organization, and not unit, level. If this is the case, focus on the champions at the organization level and not on the absence of champions within the unit.

POSSIBLE EVIDENCE AND ARTIFACTS

How might you know if effective IPE champions are in place?

IPE champions exist, for example…

- Are there individuals in the organization and/or on the healthcare team who are especially passionate about IPE?

- Are there individuals in the organization and/or on the healthcare team who have a vision for IPE that they wish to achieve?

- Have these IPE champions been formally or informally identified/recognized within the organization and/or healthcare team (i.e., by title, assigned responsibilities, public mention, self identification, or peer identification, etc.)?

IPE champions are effective and influential, for example…

- Do IPE champions engage staff from all professions? (consider who the champion interacts with on a day-to-day basis, etc.)

- Do IPE champions have influence (i.e., are respected and liked by colleagues, have a broad network, etc.)? (consider who the champion interacts with on a day-to-day basis, etc.)

- Are IPE champions able to energize their colleagues about IPE? (e.g., spread their enthusiasm)

- Do IPE champions participate in IPE initiatives/activities outside of the organization? (consider membership on committees or groups related to IPE, etc.)

- Do other people (inside and outside the organization) seek input/advice from the IPE champion(s) on matters related to IPE?

- Do IPE champions present, publish and/or write about IPE issues (internally or externally)?

- Do IPE champions talk positively about IPE on a regular basis?

List other evidence or artifacts in your organization:

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ATTRIBUTE 4.4: IPE IS A CONSIDERATION WHEN HIRING & ORIENTING NEW STAFF

DESCRIPTION

This attribute focuses on the extent to which the unique needs of IPE are considered in the structures and processes related to the on-boarding of new staff.

When this attribute is strong…

…there is recognition that all staff play a role in IPE. Accordingly, as part of the standard hiring process, the organization actively looks for people with qualities and characteristics that will support IPE. The concept of IPE is explained to new hires, and they are oriented to the role they will play with respect to IPE.

TIPS

- Consider whether hiring processes include an appropriate emphasis on IPE, given the role the staff member will play. Staff will not be involved in IPE to the same degree within the health care setting. When hiring an IPE coordinator, for example, there may be much more emphasis on IPE knowledge and skills than when hiring other staff members who will be less involved in the interprofessional learning experience. However, some characteristics (e.g., attitudes towards working with students from different professions) might be important in almost all hiring decisions.

POSSIBLE EVIDENCE AND ARTIFACTS

How might you know if IPE is a consideration when hiring and orienting new staff?

IPE is considered in hiring processes, for example…

- Are skills, knowledge and experience that are conducive to IPE considered important in all new hires? (e.g., attitude toward and interest in teaching, valuing the role of students from all professions, willingness to collaborate, IPC experience, etc.)

- Do job descriptions clearly articulate expectations related to IPE?

- Do job interviews include standard questions relevant to IPE needs (e.g., designed to uncover attitudes, opinions and perceptions about elements of IPE)?

IPE is included in orientation processes, for example…

- Do all staff orientations include information about IPE and the role they are expected to play?

List other evidence or artifacts in your organization:

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ATTRIBUTE 4.5: EDUCATORS & STAFF HAVE THE KNOWLEDGE AND SKILLS NEEDED TO SUPPORT IPE

DESCRIPTION

This attribute focuses on the extent to which those who will contribute to the interprofessional learning experience (either directly or peripherally) are well prepared in terms of having and further developing the skills, knowledge, and attitudes they will need to fulfill the role they will be expected to play in supporting students' interprofessional learning.

When this attribute is strong…
…educators, as well as each member of the healthcare team, understand the ways in which they will be expected to support students' interprofessional learning. Furthermore, they have the necessary skills, knowledge, and attitudes to fulfil their respective roles. They are well qualified to support the students' interprofessional learning, while at the same time maintaining a positive working environment and safeguarding patient safety. None of them feel "in over their head" or confused about what they will need to do.

TIPS

- Keep in mind that this attribute is about being qualified to host an interprofessional learning experience. The requisite qualifications of each health care team member, will vary relative to the role they will play in providing the interprofessional learning experience.

- Students in particular identify this as an important attribute. When assessing the extent to which educators and staff are well prepared within your organization, it may be helpful to try to consider things from the student's perspective. How might they perceive the educators and staff within your organization? What, in particular, might be important to them?

POSSIBLE EVIDENCE AND ARTIFACTS

How might you know if educators and staff have the knowledge and skills needed to support IPE?

Educators and staff receive IPE orientation and training, for example…

- Have educators and healthcare team members been effectively oriented to the expectations and operations of the interprofessional learning experience? (orientation materials for the healthcare team, meeting minutes, etc.)

- Have educators and healthcare team members been (or will they be) provided with professional development and training that will help prepare them for their role in the interprofessional learning experience? (consider whether IPE courses on the official course list, look at training participant lists, etc.)

- Have educators received training in teaching students using an IPE approach? Have educators receiving training in teaching students about IPE?

Educators and other team members have requisite knowledge, for example…

- Do educators and healthcare team members understand the role they are to play in the interprofessional learning experience?

- Do educators and healthcare team members have the knowledge, skills, capacity and characteristics to fulfill their expected roles in the interprofessional learning experience? (consider experience and backgrounds of the individuals as relevant)

- Do educators know how to deal with student issues for all professions? (e.g., who to take the issues to, when to contact the responsible university /college regarding certain non-performance issues, etc.)

- Do educators understand how to provide cross-professional feedback?

Relevant policy issues have been considered and addressed, for example…

- Have concerns and issues related to medical/legal implications of cross-professional supervision been identified, acknowledged and addressed to the satisfaction of all educators, staff and other team members?

- Have cross-professional supervision policies been established that take into account medico-legal issues (e.g., boundaries, responsibilities) to safeguard patient/client safety?

List other evidence or artifacts in your organization:

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Planning an Intentional Interprofessional Learning Experience

This section provides some guidelines for planning an interprofessional learning experience. It includes five steps:

- ❑   Define appropriate student IPE learning objectives

- ❑   Review the available evidence about effective practices in IPE

- ❑   Carefully plan the composition of the student group so that it is conducive to IPE

- ❑   Keep in mind your interprofessional learning objectives when designing the schedule and activities for the interprofessional learning experience

- ❑   Put mechanisms in place to measure the effectiveness of the interprofessional learning experience

DEFINE APPROPRIATE STUDENT IPE LEARNING OBJECTIVES

Prepare a clear, written description of what interprofessional skills and knowledge the students should have by the end of the learning experience. These "learning objectives" are common to all students, and are appropriate given the stage of student development and the expectations of any academic partners. Develop plans to communicate the learning objectives to the students *and* those who will be working with them.

TIPS:

- Learning objectives are often framed similarly to the following: "by the end of the learning experience, students will …"

- You might also plan a formal process for students to define their own IPE learning goals, in addition to the common learning objectives, once they have been oriented to the learning experience.

REVIEW THE AVAILABLE EVIDENCE ABOUT EFFECTIVE PRACTICES IN IPE

This is about making a conscious effort to use an evidence-based approach when planning the interprofessional learning experience. There is no need to reinvent the wheel when you can draw on what others have learned and done. Put mechanisms in place to look for and consolidate the latest knowledge and expertise related to IPE, so that you have a pool of effective practices to consider when designing your interprofessional learning experience.

Here are some ideas of how you might learn about current thinking in IPE:

- Review literature about adult education, IPC, and IPE

- Consult with other organizations that have expertise in IPE (e.g., CAIPE, CIHC, University of Toronto Office of IPE, etc.)

- Review guidelines for IPE that have been developed by your own organization or others

- Consult with other teams or organizations that have delivered IPE

- Review evaluations of IPE efforts

- Attend conferences or other learning events related to IPE or IPC

TIPS:

- In addition to IPE-specific knowledge, it may be useful to consider the extent to which your organization draws on knowledge from other, related fields, such as adult education.

- Consider whether all appropriate sources have been identified/used, and if there are others that might be of some benefit.

- Keep in mind that, for a variety of reasons, it may not be appropriate to implement certain "effective practices" within your organization. Consider whether the planners have thought about how well the effective practices suit your context, rather than simply using them because they worked elsewhere.

- Do your own research about IPE and share your findings with others

CAREFULLY PLAN THE COMPOSITION OF THE STUDENT GROUP SO THAT IT IS CONDUCIVE TO IPE

When students are learning interprofessional skills in a group, it is ideal if the group includes:

- students from at least two professions, and preferably more;

- a balanced number of students from the different professions, so that one profession does not significantly outnumber the others;

- few enough students from each profession so that cross-professional friendships/relationships are encouraged; and

- students who are at a relatively similar stage in their education.

TIP:

Before determining the composition of the group, consider the types of learning activities that are planned. For example, students appreciate learning with other students who are at a similar stage in their education. However, it may still be possible to have a good learning experience with students at different stages, if the learning experience is structured to accommodate that.

KEEP IN MIND YOUR INTERPROFESSIONAL LEARNING OBJECTIVES WHEN DESIGNING THE SCHEDULE AND ACTIVITIES FOR THE INTER-PROFESSIONAL LEARNING EXPERIENCE

Interprofessional learning experiences are different from uni-professional learning experiences in that there needs to be coordination of students from different professions, who may be on different schedules. Activities likewise need to be interprofessional, and need to be designed to help students develop interprofessional competencies in addition to skills related to their own profession.

You should design the interprofessional learning experience to allow students ample time to learn about, with and from one another, and/or from other professionals on the healthcare team. Social activities and formal learning activities should be designed in a way that fosters interprofessional knowledge and skills.

TIPS:

The following are questions you can ask yourself as you are planning the interprofessional learning experience. Some of these will be more important than others, so consider them in light of your learning objectives.

- Does the schedule allow for interprofessional interaction among the students? E.g.,
  - Have students' clinical placement schedules been mapped together, to determine when students from different professions overlap?
  - Does the overlap allow for sufficient interaction between the students from different professions?
  - Have other scheduling factors been identified that might disrupt interprofessional time among the students, such as vacations or the timing of students' shifts (e.g., night shift, different days)?
  - Have plans been made to address these disruptive factors?

- Do the plans include protected interprofessional learning time for the students at least once per week? (i.e., time that cannot be encroached upon by other responsibilities)

- Are there plans to orient the students and the healthcare team to the idea of protected interprofessional learning time (e.g., explaining which activities take precedence over the interprofessional learning time, and which do not)?

- Have the stated IPE learning objectives been considered in the development of learning activities? Is there alignment?

- Are interprofessional social events planned, in addition to more formal learning opportunities?

- Do the planned activities align with the activities expected by academic partners (if any)?

- Do the planned activities align with effective IPE practices/guidelines? (e.g., opportunities to learn from other professions; opportunities for discussion and reflection; appropriate instructors; etc.)

- Is IPE integrated into the overall expectations for the students' learning, rather than being an "added on" responsibility?

PUT MECHANISMS IN PLACE TO MEASURE THE EFFECTIVENESS OF THE INTERPROFESSIONAL LEARNING EXPERIENCE

This is based on the assumption that "what gets measured gets done." If the effectiveness of IPE is measured, that sends a message to the healthcare team that this is an important aspect of their work. It also provides opportunities for improving IPE.

Develop a plan to assess the effectiveness of your IPE efforts. Plan to collect feedback from students about important aspects of their learning experience, as well as from the healthcare team. You might use interviews, surveys, and/or focus groups. Make plans to analyse the findings and share them in a timely way with the clinical and educational teams. Think about how you can encourage people to take action based on the findings.

TIPS:

- Effectiveness includes the quality of the interprofessional learning experience from the student's point of view as well as the healthcare team's.

- It also includes the impact of the interprofessional learning experience. In addition to improving students' knowledge and skills, the interprofessional learning experience may have impacts on various other things, such as team functioning, recruitment/retention, the organization's reputation, and/or patient/client safety.

- Consider sharing your findings at conferences, through journals, or through other forums so that other organizations can learn from your experiences.

Background: The Interprofessional Culture Alignment Framework (ICAF)

Since 2004, Health Canada through its "Interprofessional Education for Collaborative Patient Centred Practice (IECPCP)" Initiative has been making huge strides in addressing the Pan Canadian Health Human Resource Strategy for this country. One of the key areas that still needs to be targeted is ensuring that practice settings are ready to receive students to learn how to work in an interprofessional manner. In Romanow's report (2002), teaching students about teamwork was identified as critical for preparing them to work effectively in healthcare teams. The IECPCP framework *(see Figure 3, page 62)* developed by D'Amour, Oandasan et al. (2004) provided an initial view for how the university/college education system could work with the practice settings to foster a new generation of healthcare professionals who are competent to work interprofessionally for patient centred care. Five years later, with more research conducted, it is recognized that the framework could be further enhanced in order to better articulate what researchers, educators, practitioners, leaders and policy-makers need to do to advance IECPCP in this country.

In 2009, through funding from HealthForceOntario, a research team from the University of Toronto received a grant to conduct a study that aimed to define factors that facilitate the advancement of IPE and IPC in the practice setting clinical settings. The IP-Compass study involved an environmental scan of healthcare organizations within the Toronto Academic Health Sciences Network (TAHSN) that had experience implementing IPE in clinical settings.

The original intent was to compare the findings from the environmental scan with the factors described in the IECPCP evolving framework by D'Amour and Oandasan (2005). Unexpectedly, many similar yet different factors were identified in considering critical indices for practice settings to successfully bring IPE into their clinical environments. In the end, eight major constructs emerged as factors that influence the ability for clinical settings to provide IPE learning (*Table 2, page 58*).

> **IP-COMPASS STUDY - APPROACH**
> A multiple case study approach was used across five teaching hospitals that provided IPE learning to students between 2007 – 2009 with a range of clinical units (family practice, acute care, emergency, surgery etc.). Forty interviews using a semi-structured interview guide were conducted, individually or through focus groups, with hospital leaders, managers, educators, IPE facilitators, preceptors and clinical staff. Using a grounded theory approach, the transcribed data was analyzed by three independent researchers who came together to negotiate and gain consensus on common themes.

The eight constructs align with many of the factors found in a model of cultural alignment (Evans, 2009) that provides a language and a structure to examine whether the clinical environment is "culturally" ready to provide learners with an IPE experience (*Figure 1, page 59*). Based upon these empirical findings, an enhanced framework is proposed to help further articulate the linkages between the education and practice systems within and across organizations to advance IPE in clinical settings. This proposed Interprofessional Culture Alignment Framework (ICAF) builds upon the IECPCP evolving framework using a culture and systems lens (*Figure 2, page 60*).

Table 2: Factors that Influence the Ability of Clinical Settings to Provide IPE Learning

1. **Values Beliefs and Assumptions**: Values, beliefs and assumptions are shared by healthcare professionals learning and working together to deliver quality patient-centred care within the organization.

2. **Vision and Leadership**: IPE and IPC are important elements of the organization's vision and strategy. Champions actively work to gain commitment and buy-in to the practice of IPE and IPC in the organization.

3. **Priority Setting and Goal Alignment:** Goals, expectations and measures for IPE and IPC clearly position this as a priority in the organization.

4. **Structures:** Formal and informal organization arrangements support the introduction, practice and sustainability of IPE and IPC.

5. **Processes:** A series of actions required to implement and sustain IPE and IPC exist.

6. **Resources and Tools**: People, time, money, materials and tools support IPE and IPC in the organization.

7. **Behaviours:** The words and actions of healthcare professionals and leaders demonstrate support for IPE and IPC in the organization.

8. **Government Policies:** The policies and programs of government bodies support IPE and IPC. This includes government funding formulas.

CULTURE ALIGNMENT

Building upon prior organizational and culture alignment models as well as Living Systems Theory, Evans (2009) provides the Culture-Strategy Alignment model (*Figure 1*) that we propose has relevance to the IPE world. This model depicts organizations as open systems with feedback loops that ensure the organization is constantly learning and adapting. Within each organization, there are many subsystems that are operating together to turn the organization's mission and strategy into the desired outcomes or results. For example, within teaching hospitals there is a clinical practice system and a clinical education system that have their own yet congruent mission, strategy, goals and so on (see the description of the Interprofessional Culture Alignment Model (Figure 2) introduced below). Each of these systems is striving to achieve internal alignment, as well as alignment with other systems required for the organization to achieve its goals.

At the top of the model is the environment which provides the context within which the organization interacts. This acts upon the organization to influence its mission and strategy which defines what is important to get done. For example, the Romanow Report (2002) and subsequent policy decisions had a significant influence on healthcare organization strategy related to IPE and IPC.

In the middle are the elements of the organization's infrastructure including its processes, structures, technology, tools, and use of physical space. These define how things get done. For example, how decisions are made is affected by structure including roles and accountabilities. The

establishment of IPE Advisory Councils to guide and/or direct action is an example of a structure introduced to support achievement of an IPE strategy.

Figure 1: Culture Alignment Model

On the left of the model are the elements of the work of the organization or what gets done. This is defined by the goals that are set, the tasks assigned to achieve these goals, the measures used to track progress and completion, the rewards assigned to success and the corrections applied to missed goals and objectives. In the IP-Compass Study this included hosting IPE student placements and implementing interprofessional teams in clinical units.

On the right are elements of the organization's culture that defines the way that things get done. This includes the organization's values which describe desired behaviours such as the need to collaborate across professions. Assumptions are the beliefs that guide action such as the belief that collaboration across professions is the best way to provide quality patient-centred care and learner-centred education. Artefacts are the observable manifestation of the organization's culture that includes symbols, tools and rituals such as posters promoting IPE and IPC and workbooks for hosting IPE sessions. Behaviours are the way that people act that demonstrates interprofessionalism and their belief that this is important. Finally, practices are the repeated routines that define the way things are done such as conducting IP rounds. These differ from processes which define how things are done. For example, a process might be assessing patient care needs whereas a practice is the way this is done such as creating interprofessional patient care plans.

At the bottom are the results or the outcomes of the transformation process that involves work, culture and infrastructure. These results include quality patient-centred care and learner –centred education. Whatever the actual outcomes, there is a feedback process that tells the organization what has worked, what hasn't and whether change is needed.

All of this acts dynamically with feedback occurring in a constant flow of information within and beween the elements of the organization. Keeping in mind that each element is interrelated, changes in one affect the others which in turn can lead to change in a constant and continual adaptive manner.

THE INTERPROFESSIONAL CULTURE ALIGNMENT FRAMEWORK

The Interprofessional Culture Alignment Framework (Figure 2) differentiates the academic education system (formal university and college learning) from the clinical education system that exists within a clinical setting and the practice system that exists within that same clinical setting. The premise is that cultural alignment amongst these systems can be discerned by looking at the organization's structures, processes, practices and behaviours which in turn demonstrate alignment in support of the shared values of interprofessional education, interprofessional collaboration and patient-centred care. This conclusion is drawn from an exploration of organization culture theory, living systems theory, complex adaptive systems theory and organizational congruence/alignment theory.

Figure 2: The Interprofessional Culture Alignment Framework (ICAF)

A CULTURAL ALIGNMENT FRAMEWORK TO ADVANCE IPE IN CLINICAL SETTINGS
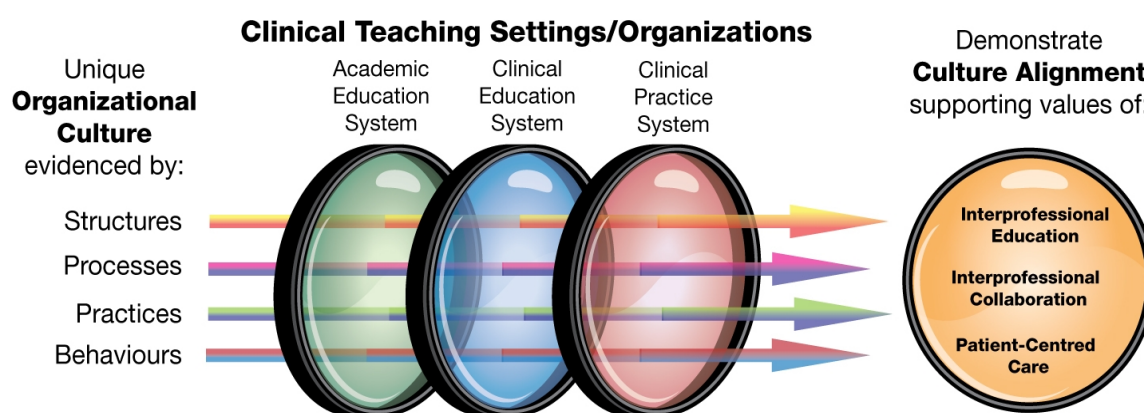
This is different from the original IECPCP evolving framework (Figure 3) which distinguished two organizations – the academic institution (university, college) that provides the formal learning and clinical organizations that provide clinical care (family practice settings, hospitals, community settings). This framework indicated that students graduate and move into a clinical setting to practice and while there behave as clinicians to provide interprofessional care. The original framework did not recognize the educational system that may exist within the clinical setting.

Move forward five years, the IP-Compass Study found that, in teaching hospitals for example, the provision of education requires an organized process for implementation in partnership with the academic institutions of which they are affiliated (e.g., clinical placements for learners to meet requirements of their health professional programs. Furthermore, the academic institution with its health professional programs is dependent upon clinical settings to provide the mandatory clinical learning required. As noted by John Gilbert's 60/40 rule – 60% of education is provided in the university/college setting and 40% is provided in clinical settings. The ICAF addresses this by identifying both the academic education system (green disc) and the clinical education system (blue disc). These are connected by congruent structures, processes, practices and behaviours that are necessary for both systems to deliver quality learner-centered interprofessional education (orange disc on the right).

The clinical education system and clinical practice system exist within teaching hospitals and other clinical organizations participating in the provision of interprofessional education. These systems are interrelated meaning that they are mutually dependent. A change in one is likely to affect the other. The challenge is to achieve sufficient congruence of structures, processes, practices and behaviours so that both systems are contributing in an effective manner to the achievement of quality patient-centred care and learner-centred education.

When the three systems are aligned and working together, values that emphasize the importance of interprofessional collaboration and education, and patient-centred care are manifested in the behaviours of organization members and other cultural artefacts. The result is an effective organization that is achieving its goals through an interprofessional approach to learning and practice.

INFORMING THE DEVELOPMENT OF INDICATORS

The Interprofessional Culture Alignment Framework is intended to assist leaders in both academic institutions and clinical organizations in preparing their organizations to provide interprofessional learning experiences to students. Indeed those who look towards educating health professional learners may want to use this model in considering aspects to provide evidence in the alignment for outcomes desired.

This User Guide makes this possible by taking the model and the data that informed its development and creating indicators that are described in clear, practical language. In effect, it transforms theory into practice that we hope will assist leaders and their organizations in achieving quality learner-centred interprofessional education and patient-centred care.

Figure 3: Interprofessional Education for Collaborative Patient-centred Practice: An evolving framework
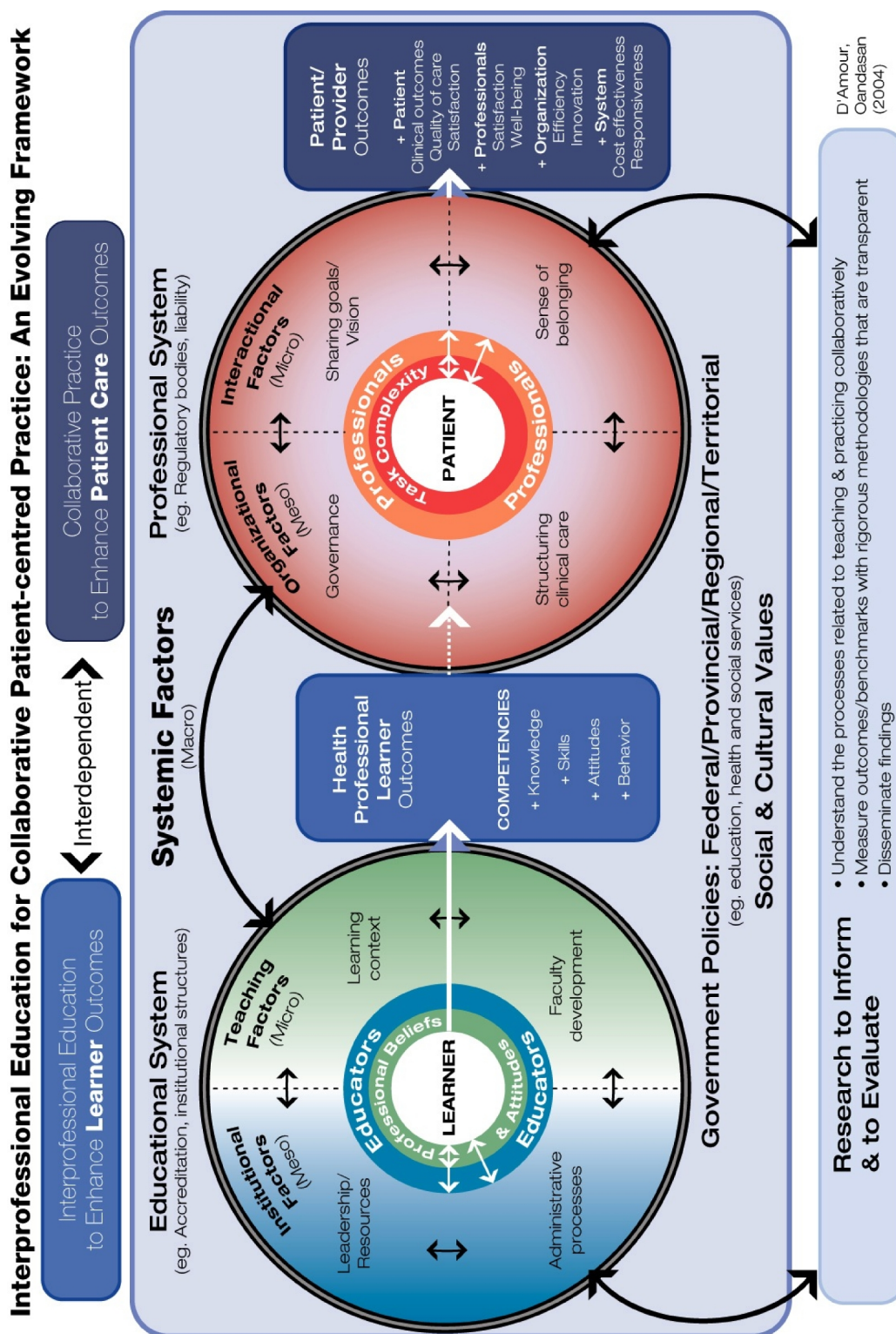
References

D'Amour, D. & Oandasan, I. (2005), 'Interprofessionality as the field of interprofessional practice and interprofessional education: An emerging concept'. *Journal of Interprofessional Care*, May 2005, Supplement 1, 8-20.

D'Amour, D. & Oandasan, I. (2004), 'Chapter 10: IECPCP Framework'. In I. Oandasan, D. D'Amour, M. Zwarenstein, B. Barker, M. Purden, M.D. Beaulieu, S. Reeves, L. Nasmith, C. Bosco, L. Ginsburg & D. Tregunno, *Interdisciplinary Education for Collaborative, Patient-Centred Practice: Research and Findings Report*, Health Canada, 240-250.

Evans, N.J. (2009), *Culture Dynamics in Organizations.* Book in progress.

Romanow, R. (2002). Building on Values: The Future of Health Care in Canada. *Final Report of the Commission of the Future of Health Care in Canada*, November 2002.

Tosti, D. & Jackson, S. (1994), Organizational alignment: What it is and why it matters. *Training, 31* (4), 58-63.

Appendix A: Resource Guide

The following is a **partial list** of resources to help clinical departments/sites enhance their preparedness for IPE. They are grouped by product (such as educational offerings, media products, etc.), people who have extensive learning/experience in developing and delivering IPE/IPC and recent literature highlighting best practices in preparing for IPE. This document, while provided in hard copy here, is a dynamic resource which will be placed on the COMPASS website. The content of the resource guide will grow as new resources become available.

Current as of: Tuesday, March 30, 2010

The resources are grouped into the following three categories:

- **Products**: Assessment tools, planning tools, and educational offerings
- **People**: Organizations or individuals with expertise in aspects of IPE or IPC
- **Information and Literature**: Published articles, books, and websites concerning IPC or IPE

PRODUCTS

This section includes assessment tools, planning tools, and educational offerings that are relevant to IPC or IPE.

TOOLS

The following is a partial list only; a more comprehensive list of resources should continue to be developed.

Tool	Description	Contact Information

Manual/Toolkit – available for download
 	
Sinclair, L., Lowe, M., Paulenko, T. & Walczak, A. (2007) *Facilitating interprofessional clinical learning: Interprofessional education placements and other opportunities.* University of Toronto, Office of Interprofessional Education: Toronto.
	This initiative developed resources and processes to assist any hospital to develop their clinical environments and to support IPE.
	
	Contents include:
	1. Facilitating Interprofessional Clinical Learning: Interprofessional Education (IPE) Placements and Other Opportunities
	  ▪ Getting Ready for Interprofessional Education (IPE) Placements
	  ▪ Leading and Coordinating Interprofessional Education (IPE) Placements
		http://www.ipe.utoronto.ca/initiatives/ipc/implc/preceptorship.html

Tool	Description	Contact Information
	▪ Hosting Interprofessional Education (IPE) Placements ▪ Developing Interprofessional Education (IPE)Facilitator Skills ▪ Supporting Other Interprofessional Learning Opportunities ▪ Interprofessional Education (IPE) Websites and Key References 2. Facilitating Interprofessional Collaboration with Students DVD	
Clinical Team Self-Assessment on Interprofessional Practice	Developed by Buyere, this self assessment tool provides feedback to a clinical team on how well they collaborate, make decisions, communicate and resolve conflict.	This section will list contact information for all products. It will be complete pending permission from the individuals.
Interprofessional Development Multimedia Toolkit	Comprised of 6 DVD's this resource was created for the purpose of enhancing collaboration and improving the lines of communication among healthcare providers. The toolkit consists of Powerpoint presentations, facilitator notes, DVD clips and participant handouts.	http://www.ipe.utoronto.ca/resources/dvd.html

EDUCATIONAL OFFERINGS

To be developed.

PEOPLE

To be developed.

INFORMATION AND LITERATURE

The following include publications and other publicly-available information about IPE and IPC.

ONLINE RESOURCES

The following is a partial list only; a more comprehensive list of resources should continue to be developed.

- **Canadian Interprofessional Health Collaborative (CIHC).** http://www.cihc.ca/

- **Centre for the Advancement of Interprofessional Education (CAIPE).**
  http://www.caipe.org.uk

- **University of Toronto Office of Interprofessional Education**. http://www.ipe.utoronto.ca/

- **World Health Organization** (2010). Framework for Action on Interprofessional Education &
  Collaborative Practice Available at:
  http://www.who.int/hrh/resources/framework_action/en/index.html

SCHOLARLY ARTICLES

The following is a partial list only; a more comprehensive list of resources should continue to be developed.

- Lindqvist, Susanne Marie and Reeves, Scott (2007) Facilitators' perceptions of delivering
  interprofessional education: a qualitative study, Medical Teacher, 29:4, 403 – 405.

- Sargeant, J. (2009). Theories to aid understanding and implementation of interprofessional
  education. Journal of Continuing Education in the Health Professions, 29(3):178-84.

- Steinert, Y. (2005). Learning to teach together: Interprofessional education and faculty
  development. *Journal of Interprofessional Care*, Supplement 1: 60-75.

BOOKS

- Howkins, E. & Bray, J. (Eds.) (2008). *Preparing for Interprofessional Teaching: Theory and
  Practice.* Radcliffe Publishing: Oxford

- Carpenter, J. & Dickinson, H. (2008). *Interprofessional Education and Training.* The Policy
  Press: Bristol.