Conference Proceedings Report

Co-Creating the Future for Interprofessional Care Sustainability Conference

June 21 -- 22, 2007
MaRS Discovery District
Collaborative Auditorium
Toronto, Ontario

Ontario
Supported by the Ontario Ministry of Health & Long-Term Care through the Interprofessional Mentorship, Preceptorship, Leadership and Coaching Fund

Submitted by:
The University of Toronto Council of Health Science Deans

In partnership with:
The Toronto Academic Health Sciences Network

For more information about the Catalyzing and Sustaining Communities of Collaboration Around Interprofessional Care Project, other interprofessional education and interprofessional care projects and/or copies of this report, please contact:

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On behalf of the Steering Committee of the Catalyzing and Sustaining Communities of Collaboration Around Interprofessional Care (CCIC) Project, I am pleased to provide you with a copy of the Proceedings Report from the recently held Co-Creating the Future for Interprofessional Care Sustainability Conference. This initiative was funded by the Ministry of Health and Long-Term Care’s Interprofessional, Mentoring, Preceptorship, Leadership, and Coaching (IMPLC) Fund. This report provides highlights of the information sharing among conference participants. It also contains concrete ideas about how to sustain the momentum for interprofessional care and interprofessional education across the Toronto Academic Health Sciences Network (TAHSN) and the University of Toronto (U of T) Faculties of Health Sciences.

The IMPLC Fund allowed us to create a community across 13 Toronto-area hospitals catalyzed by a strong partnership with the U of T’s Faculties of Health Sciences. The six months of concentrated effort by hundreds of dedicated faculty, administrators, and hospital staff who were part of the overall CCIC Project provided evidence that interprofessional care and inter-hospital collaboration is very much evolving in Toronto. Conference participants clearly demonstrated enthusiasm and willingness for continued collaboration. The conference concluded with a clear set of strategies and continued commitment to improve patient care in Toronto, based on principles of interprofessional care.

Most importantly, the conference provided insight on how change can be catalyzed in a very short period of time, with dedicated funding, participating staff and faculty and shared leadership models.

On behalf of the Steering Committee, I would like to thank the Ministry for providing us with the funding and opportunity to begin role modeling interprofessional collaboration at TAHSN and at U of T. To those of you who participated and shared your learnings from the CCIC initiatives across the 13 TAHSN hospitals, and to those who created tools, organized workshops, and participated in the Sustainability Conference, your contributions are making interprofessional care, and all its benefits to patient care, a reality. Indeed, your efforts will contribute to a future where the next generation of health care providers will learn to practice within true, collaborative, clinical environments that embrace interprofessional care.

Collaboratively yours,

Ivy Oandasan
Director
Office of Interprofessional Education
University of Toronto

August, 2007
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Sustainability Conference Planning Committee
1.0 EXECUTIVE SUMMARY

On June 21 and 22, 2007, over 130 educators, practitioners, researchers and hospital administrators from the University of Toronto (U of T), the Toronto Academic Health Sciences Network (TAHSN) hospitals, representatives from the Ministry of Health and Long-Term Care (MOHLTC) and representatives from the Toronto Central Local Health Integration Network came together to attend the Co-Creating the Future for Interprofessional Care: Sustainability Conference. The goals of the conference were to:

- Co-create a plan for the future of interprofessional care across TAHSN, and
- Consider how advancing the interprofessional care agenda will drive core educational and organizational goals, including: improving patient care, developing highly skilled health professionals and effectively using Ontario’s health care resources.

The Sustainability Conference was an essential component of the Catalyzing and Sustaining Communities of Collaboration Around Interprofessional Care (CCIC) Project, funded by the MOHLTC through the Interprofessional, Mentorship, Preceptorship, Leadership and Coaching Fund (IMPLC). The Project was a uniquely collaborative partnership between the U of T and TAHSN that enabled TAHSN teaching hospitals to become active interprofessional care learning laboratories for future generations of health care providers. It supported the Ontario government’s Health Human Resources Strategy’s broad objective of encouraging health care workers to work collaboratively. The Project was composed of six individual initiatives integrated as a whole, with each initiative focusing on themes identified for the IMPLC Fund, and led by one or more TAHSN institutions.

The conference provided an opportunity for leaders in interprofessional education and interprofessional care to share their experiences, build their community of interest, and develop a plan to sustain interprofessional education and interprofessional care in TAHSN hospitals, supported by fellow interprofessional education/interprofessional care leaders, TAHSN executives, as well as with Ministry of Health and Long-Term Care staff.

The agenda for the conference focused on:

- Capturing learnings about promoting and supporting interprofessional care as an enabler of primary goals in health care;
- Exploring the potential for leveraging interprofessional care within TAHSN; and
- Defining clear recommendations for the path forward.
Conference Outcomes

A common vision and goal for interprofessional collaboration within clinical settings was developed in order to support better patient care and health professional learner education. The conclusion of the conference provided the attendees the opportunity to present their work to Dr. Joshua Tepper, Assistant Deputy Minister, MOHLTC. The group brought forward their wish list for the future of interprofessional care at U of T and TAHSN, including action steps, listed below:

The Future of interprofessional care is where there is/are:

- No patient deaths that could have been prevented with better communication.
- A broad cultural shift where interprofessional care is the expected norm.
- Organizational structures where interprofessional care is embedded in: hiring, expectations, rewards, incentives, and accountabilities.
- The specific scope of each discipline is respected and there is a robust way of working in an interprofessional manner.
- Clear links between interprofessional care and each institution’s strategic goals.
- Interprofessional care Scorecards with moving, annual targets to measure ourselves against.
- A strong interprofessional care research agenda across TAHSN to understand how interprofessional care influences outcomes.
- A mechanism implemented to evaluate progress.
- Robust links exist between learning institutions and all TAHSN hospitals, continually evaluating progress and responding to feedback.
- Specific interprofessional care focused-roles within each institution that, when combined, form a TAHSN interprofessional care Consortium.
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- Specific interprofessional care focused-roles within each institution that, when combined, form a TAHSN interprofessional care Consortium.

Proposed Action Steps by University of Toronto and Toronto Academic Health Sciences Network—‘The Interprofessional Care Manifesto for Action’

For Practitioners

- Within one year, have one interprofessional care champion within each of the TAHSN organizations.
- Ensure clinical team members are aligned either geographically or by personnel (not by discipline).
Within one year, 25 per cent of every discipline or occupation should have some sort of interprofessional care education and accompanying tools.

**For Educators**

- Adapt interprofessional education leadership courses geared to clinical faculty for professional development at all levels of the institutions/organizations.
- Revise the U of T Department of Public Health Sciences “Determinants of Community Health” course so that it contains interprofessional education concepts to allow students to follow a patient through the entire continuum of care.
- Use existing technology to develop electronic curriculum models that enhance and foster collaborative communication between students. For example, create virtual teams of students between different professional groups and link this to the current mentorship program.

**For Researchers**

- Build an accountability mechanism to measure the interprofessional care process.
- Develop common outcomes, measures, and methodologies for interprofessional care across TAHSN that can be shared among researchers.

**For Administrators/Executives**

- Develop an interprofessional care scorecard using indicators and metrics pulled from existing evaluation and measurement tools (patient & employee satisfaction, accreditation standards, etc.).
- Establish and support a structure to take on the interprofessional care agenda while considering how to utilize existing structures.

**Next Steps**

A community of collaboration has emerged over the six-month period of the CCIC project that was apparent among conference participants. There was consensus that interprofessional care and interprofessional education is imperative to sustain this community of collaboration. Leaders who attended the conference took up the call for action and were acknowledged for their commitment and hard work to date.

The next steps lie with conference participants. They will take their experiences from the summit and share with their colleagues their commitment to continue to advance interprofessional care for the purpose of enhancing patient care and establishing an interprofessional care compatible teaching environment for health professional learners.

The Office of Interprofessional Education is committed to support further coordination of interprofessional education/interprofessional care activities within TAHSN and U of T and to take the “Proposed interprofessional care Manifesto” forward to key leaders who can put the conference recommendations into action.
In order to provide context for the Sustainability Conference, background information on the initiatives that were funded is provided here.

In February 2007, the Ministry of Health and Long-Term Care, under the Interprofessional, Mentoring, Preceptorship, Leadership and Coaching (IMPLC) Fund, provided $3.4 million to the University of Toronto Council of Health Science Deans (CHSD) and the Toronto Academic Health Sciences Network (TAHSN), to “catalyze and sustain communities of collaboration around interprofessional care”.

The Catalyzing and Sustaining Communities of Collaboration Around Interprofessional Care (CCIC) Project is a collaborative endeavor comprised of six separate initiatives, led by different organization/education centres within TAHSN. The Project supports the Ministry’s objectives of encouraging health care workers to work collaboratively to provide better care, greater job satisfaction, and greater efficiency for the health care system. The goal of the Project is to enable TAHSN teaching hospitals to become active interprofessional care learning laboratories for future generations of health care providers.

The collective objectives for the six CCIC initiatives were:

1. To describe the initial outcomes and impacts related to the delivery of the interprofessional initiatives;

2. To explore the underlying processes and mechanisms that influences the creation of the projects’ various outcomes and impacts;

3. To package / inventory / synthesize what has been developed or discovered as it relates to interprofessional education and collaboration;

4. To maximize opportunities to harvest and grow collective learning among project participants;

5. To share and disseminate these findings / learnings within TAHSN;

6. To develop the ‘Process for Action to Move Interprofessional Care / Interprofessional Education Forward’ beyond the Project’s deadline that includes identification of opportunities for clinical collaboration, education, policy and research.
2.1 DEFINING INTERPROFESSIONAL CARE

Interprofessional care and interprofessional education are not new concepts. For the purposes of the proceedings report, the following definitions apply to the discussions that took place at the conference:

What is Interprofessional Care?

Interprofessional care is the provision of comprehensive health services to patients by multiple health caregivers who work collaboratively to deliver quality care within and across settings. Interprofessional care aims to:

- Help address health human resources shortages, which will create flexibility in care delivery
- Improve access to and coordination of health services
- Better use of clinical resources
- Improve efficiency to ensure sustainability of the health care system (i.e., reduced errors)

What is Interprofessional Education?

Interprofessional education occurs when two or more professions learn with, from and about each other to improve collaboration and the quality of care. Interprofessional education includes all learning in academic and work based-settings before and after qualification. In this way, an inclusive view of ‘professional’ is adopted. Interprofessional education should occur before and after entry-to-practice, at the level of undergraduate, graduate, and continuing education, and across a continuum of care.

Linking Interprofessional Care and Interprofessional Education

Interprofessional care environments are needed to teach health care providers to practice in this manner. A system of interprofessional education is needed that allows health care givers to practice interprofessional, patient-centred care within environments that model interprofessional care practices. In this way, by forging better linkages between interprofessional care practice and interprofessional education, interprofessional care will become a standard way of delivering health care.
2.2 LINKING THE PROJECT WITH THE THEORY

Developed as individual initiatives, yet working collectively as a whole, the CCIC Project generously provided the people who planned, executed and evaluated the Project with a catalyst to develop a community of practice to advance interprofessional care. Each individual initiative had a unique focus and efforts were complimentary.

In keeping with the D’Amour-Oandasan model for interprofessionality\(^5\), this Project focused on the need for interventions at the practice and organizational levels. With a strong educational base, these interventions teach learners and practitioners what they need to know and what they need to do to collaborate in order to enhance patient care. The six initiatives (Figure 1) were implemented with the intention that they all become part of a set of tools to be used by TAHSN and U of T to advance interprofessional care so that efforts can be sustained over time.

**Figure 1: CCIC Project Organization**
The following is a brief description of each initiative within the Project.

**Leadership**

*Centre for Faculty Development and the Office of Interprofessional Education*

Teams of organizational leaders from each of the TAHSN hospitals participate in an interprofessional leadership development course to learn, and then apply, the principles of coaching, mentoring, organizational change and interprofessional collaboration within their institutions.

**Mentorship**

*St. Michael’s Hospital and Bridgepoint Health*

Using a mentorship model, a skilled and knowledgeable cadre of leaders and champions is created to promote and engage in interprofessional practice, education and research.

**Preceptorship**

*The Toronto Rehabilitation Institute*

With the goal of increasing the number of interprofessional education placements across TAHSN, hospitals are assisted in developing their clinical environments to support more learners practicing IPC.

**Coaching**

*The University Health Network (UHN), Sunnybrook Health Sciences Centre, and Mount Sinai Hospital*

At UHN, coaching and mentorship is provided to leaders and teams in the emergency department and to general internal medicine staff. At Sunnybrook, the focus is on the health and safety of older patients in emergency departments using the “Best Practice in Emergency Elder Care” model. At Mount Sinai, core resource teams within targeted areas of the hospital are developed, combining expertise in patient- and family-centred care with learning in interprofessional care/interprofessional education.

**Evaluation**

*The Wilson Centre for Research in Education*

The Centre is leading the evaluation of the Project, which highlights the impact on facilitators and participants. Using a mixed methods approach (Qualitative and Quantitative research tools) the Wilson Centre evaluated individual initiatives in order to determine common themes across the initiatives and to help determine outcome measures.

**Integration and Change Management**

*The Potential Group*

As a large project linking 13 hospitals with 6 Faculties of Health Sciences at the University of Toronto, expertise was sought from change management experts. The Potential Group was selected to provide consultation and expert support by working with the steering committee and with individual hospital initiatives. Much of the learning about each other’s initiatives came from the opportunities for information sharing that were structured throughout the Project by the Potential Group.
3.0 CO-CREATING THE FUTURE FOR INTERPROFESSIONAL CARE CONFERENCE PROCEEDINGS

This proceedings report is intended to provide perspectives on the key recommendations that emerged from the Co-Creating the Future for Interprofessional Care: Sustainability Conference.

The conference provided the opportunity to share and co-create recommendations for IPC sustainability at the practice and organizational levels within the hospital and education settings based on all initiatives associated with the U of T and TAHSN CCIC Project. The aim was to link key participants from each of the Project initiatives. This report includes summaries on deliberations that took place and key recommendations that were developed. The Positive Culture Company graphically illustrated parts of the conference proceedings and they are included in this report. The proceedings report is one key component of the U of T and TAHSN CCIC Project.

Over 150 representatives from TAHSN hospitals and U of T faculties were invited to attend the Sustainability Conference. Invited participants were representatives from a variety of Toronto organizations that included those affiliated with hospital interprofessional care initiatives, held leadership positions at the University of Toronto or TAHSN hospitals or involved as educators/practitioners on key interprofessional education initiatives. Representatives from the Toronto Central Local Health Integration Network and the MOHLTC were also invited.

A listing of participating organizations is found in Appendix A.

Using an Appreciative Inquiry (AI) approach, the Sustainability Conference was structured for participants to convene and converse in order to identify how they could collectively learn with from with about each other to advance IPC at TAHSN. AI is a strength-based, capacity building approach to transforming human systems toward a shared image of their most positive potential by first discovering the very best in their shared experience.6
3.1 DAY 1
INTERPROFESSIONAL CARE: LEADERSHIP CHALLENGE, LEADERSHIP COMMITMENT

The first day’s theme highlighted the challenges faced by conference participants—who are considered change leaders—in advancing interprofessional care. Their accomplishments and commitment to date were acknowledged. During the first day, the need to continue to advance interprofessional care was reinforced.

Plenary Session by Sister Elizabeth Davis

A plenary session was held with Sr. Elizabeth Davis, Board Chair of the Canadian Health Services Research Foundation (CHSRF) and President of the Medical Council of Canada. Sr. Elizabeth emphasized the fact that interprofessional care is not a nuance, but rather a fundamental shift in how we approach health care. Implementing interprofessional care is a significant challenge that requires commitment by leaders in order to embark on changes where no ready-made recipes or clear examples are available to follow.

Sr. Elizabeth also highlighted demographic changes that are impacting the health care system. As a result of the changes in society and the expectations of the population, we are seeing shifts in the health care system. The credibility of leaders is often being called into question with greater calls for accountability.

Health professions are experiencing significant changes away from a profession-centred culture of health care delivery towards a patient-centred culture of care. The advancement of interprofessional care is logical, feasible and effective responses to address the expectations citizens have for health care professional practice, Sr. Elizabeth explained.

Figure 2: The Inukshuk as a Metaphor for Leadership

The inukshuk as a metaphor for leadership

An inukshuk is built from broken rocks. Leaders have the vision and capability to build and rebuild. Leaders recognize their own vulnerabilities and build upon them.
As she noted, however, advancing interprofessional education and interprofessional care, and research in these areas, is challenged because all concepts are still at an elementary level of development in Canada. Timing is of the essence, she stressed. The public is mystified by what they experience due to the lack of cooperation amongst health care providers. The public expects high levels of cooperation to be happening, yet it is not. Barriers need to be overcome. Leadership, she believed, is the key to move the interprofessional care agenda forward.

Sr. Elizabeth defined leadership as less hierarchical and more dependent on how one performs and influences others. She stated that the role of a true leader in this day and age includes being a: Visionary, Catalyst, Decision-maker, Inspirer, Facilitator, Partner, Implementer and Evaluator. As shown in Figure 2, she referred to the inukshuk as a metaphor for leadership, leaving a powerful image for participants to reflect upon.

With a final blessing, Sr. Elizabeth acknowledged that the mere presence of the participants at the Sustainability Conference represented a commitment to take on the leadership challenge to advance enhanced health care delivery for all citizens in Canada. See Appendix B for the complete presentation by Sr. Elizabeth.

**Figure 3: Reflecting on our Leadership Role: Audience Response to Sister Elizabeth’s Presentation**

![Image Source: Positive Culture Company](image-url)
Reflecting on our Leadership Role

In response to Sr. Elizabeth’s presentation, participants were asked to reflect upon what they heard and what they had learned about themselves as leaders from the morning’s plenary.

With Sr. Elizabeth’s call for action as a foundation for the day’s tasks, the group reviewed the organizational contexts at U of T and TAHSN to ascertain its readiness to advance interprofessional care and interprofessional education. Figure 3 summarizes this discussion and outlines the leadership roles identified by participants.

Interprofessional Care and Interprofessional Education at TAHSN: What Path Should be Taken?

Dr. Ivy Oandasan, the Director of the Office of Interprofessional Education (Office of IPE) at U of T provided an overview of the key activities that have taken place to move IPE and IPC forward in the past year. She provided the vision of the Council of Health Science Deans at U of T. The Council’s vision states:

*University of Toronto health professional students, pre- and post-licensure, will acquire core competencies needed for provision of patient-centred care in an inter-professional, collaborative team practice environment, both on campus and at experiential practice sites.*

To enable this vision, a longitudinal curriculum is being developed for September 2009 implementation. The interprofessional education curriculum will include participation amongst all health professional students participating in a variety of didactic, small group learning and clinical placements.

The newly formed Inter-Faculty Curriculum Committee will create and maintain the standards for the interprofessional education curriculum. This committee includes representatives named by the Dean (or Chair of the department) from each of the Faculties of Health Sciences, including the Departments of Rehabilitation Sciences and Medical Radiation Sciences. Dr. Oandasan stressed that in order for this curriculum to be successful, change [in practice] must occur in hospital and community settings in parallel with the University’s curriculum change mandate.

Supported by Leadership

The Sustainability Conference presented a unique opportunity to build a community of educators, researchers, practitioners and administrators who could work together to help co-create what is needed to ensure that learners affiliated with the U of T gain the knowledge, skills and attitudes to be competent collaborators for patient centred care. To do this, students need to be taught by health care professionals who practice in this manner in clinical settings that role model interprofessional care, especially if they are affiliated with TAHSN. Creating these environments requires dedicated time, resources and tools. The IMPLC Fund provided U of T and TAHSN with this opportunity.
Showcasing Leadership Advancements

A film entitled “Capturing the Cultural Shift” was commissioned by the Office of Interprofessional Education. It was shown to all participants to highlight the achievements of the many educational tools, workshops, innovative materials and learned lessons associated with interprofessional education and interprofessional care. The film was structured with short vignettes highlighting changes that have occurred because of the CCIC Project activity including five of the six initiatives. The impact on patients, providers, students and educators is shared by many of the initiative leaders in the film. The film is available at the Office of interprofessional education and will be used to advance interprofessional care.

The ehpic Leadership Course

Participants had an opportunity to learn about the ehpic (Educating Health Professionals for Interprofessional Care) Leadership course initiative that served as a core foundational piece for the CCIC Project. Debbie Kwan, the initiative lead for the ehpic Leadership course, briefly described and presented the key goals, objectives and participant reactions to the three-part course held between January and June of 2007. Details of the ehpic Leadership course can be found at www.ipcleaders.ca.

World Café: Harvesting What We have Uncovered

After viewing the film and the ehpic presentation that captured the work of the past six months, participants were then asked to engage in dialogue about what impacts had been made and to discuss the changes that were being manifested. Participants were engaged in a process entitled the World Café (see figure 4). This is a technique developed by Juanita Brown and David Isaacs that allows for a series of conversations to be had, all built upon one another, as people move from table to table sharing ideas.

Participants met in small groups to discuss three questions. They were then asked to share their conclusions with the larger group.

Figure 4: World Café Process

Image Source: The World Café – Juanita Brown and David Issacs
1. Thinking about your own context and work, what, to date, have you learned about supporting and sustaining IPC/IPE?

Core Responses

- All hospitals do not have the same, shared common values related to patient care.
- Interprofessional care does not look the same in every clinical setting.
- Interprofessional care is “relationship-based” with trust and respect built up over time.
- Learners cannot act as the sole change leaders.

2. Where is IPE/IPC adding the most value to our (hospital/university) strategic goals (e.g., patient-centred care)? Where does it have the most natural traction today?

Core Responses

- Patient safety is a key driver and IPC has a huge role to play ensuring patients “don’t fall through the gaps.”
- Interprofessional care is a foundation for the success of patient-centred care. Patient-centred care and IPC, through coordination, collaboration and communication allow for efficient flow of patients in and out of hospitals.
- Interprofessional care practice requires all health care professionals to have essential skills that can be developed and implemented across professions (e.g., assertiveness training).

3. What can we learn from what is working now to keep growing and making the links between IPE/IPC, and our primary goals in health care?

Core Responses

- Interprofessional care needs to be practiced across all patient transition nodal points, from acute care to rehabilitation care to community to family practitioners. Patients must be partners in the continuum of care process.
- We need to consider from a system perspective what structures will be needed to support “fertilization/cross-pollination” across hospitals, and to continue to build the community that developed through this Project.
- Education needs to be woven into the core business of the hospital in order to increase continuity for professional and student education, which will help create a more seamless approach to life-long learning.
- Organizational leaders cannot simply play a “cheerleading” role. Everyone across the organization needs to be engaged. A top-down approach alone or bottom-up approach alone will not be effective.
- Scope of practice legislation and liability changes will be required to acknowledge issues of distributed accountability related to the practice of interprofessional care. Unless this occurs, health care professionals will continue to see this as a barrier to advancing interprofessional care.
Participants discussed the core responses further and spent the afternoon discussing the foundational elements for the IPC Manifesto/IPC recommendations, which would be presented the following day.

The second day of the conference was attended by many senior hospital leaders to hear about the Project and to act as leverage points within their own hospitals in an effort to advance interprofessional care. Using the graphic illustrations created as the conference evolved, participants provided a summary of the previous day’s discussion. Participants shared what had been accomplished in the past six months that they didn’t have six months ago, see figure 5. In addition they highlighting the following key themes:

- The IMPLC Fund and the CCIC Project provided a unique opportunity for TAHSN hospitals to come together creating communities of collaboration.
- Interprofessional care is not a tweak of the health care system, but rather a fundamental shift in how we learn, teach, practice and discover.

Figure 5: The Impact of the CCIC Project
- Interprofessional education/interprofessional care should be seen as an integrated concept as it is critical to have the right environment at the hospital setting for the benefit of the learners.

- It is important to maintain the work started by the CCIC Project, funded by the MOHLTC, however, the community of practice, learning, and research has to be sustained and embedded into our professional every day lives.

- Interprofessional care is happening and it is achievable.

**Panel Discussion**

An impromptu panel of hospital leaders took centre stage to discuss what they had heard from the summary of the first day’s activities. Panel participants who participated in the live impromptu discussion included:

- **Lori Shekter-Wolfson**
  Dean
  George Brown College

- **Ella Ferris**
  Chief Nursing Executive & Executive V.P., St Michael’s Hospital

- **Maureen Shandling**
  Deputy Physician-in-Chief/Neurology, Mount Sinai Hospital

- **Joan Ferguson**
  V.P., Programs & Services
  Bloorview Kids Rehab

- **Lesley Vincent**
  V.P. of Nursing
  Mount Sinai Hospital

- **Kathy Lennox**
  V.P. of Patient Care
  Women’s College Hospital

**The following questions were posed to them:**

*What struck you as you heard the summary of our discussions from Day 1 of the conference?*

*How do these conversations fit with what is on your agenda as leaders?*

*What might we need to consider before we can bring these ideas to life?*

**Some of the key points that emerged from the panel:**

- Moving towards interprofessional care is not optional. This isn’t a discussion of choice: we have to focus on our consumer.

- While we have come a long way, we still have a long way to go to reduce the silos within and across hospitals.

- The synchrony of education in the practice setting is crucial for success.

- Professional colleges and the community college sector need to be part of the process if interprofessional care is to be successfully advanced.

- We need to improve communications amongst health care providers.
Discussion with the Ministry of Health and Long-Term Care

Dr. Joshua Tepper, Assistant Deputy Minister of the Health Human Resources Division, MOHLTC, joined participants to hear what they had experienced and what had changed as a result of CCIC Project. In preparation for his visit, participants were asked to consider the following questions:

- Given what we have heard, what are we committed to creating, what is the compelling portrait of where we are going?
- Define three priorities for which we need to invest time and energy as a collective.
- Where should we go next?

Participants shared two summary slides highlighting key learnings and their wish list for the future at TAHSN and U of T. Figure 6 summarizes what interprofessional care would look like if it was enabled and sustained over time. Figure 7 describes recommendations for action.

Figure 6: Slide 1

The Future of Interprofessional Care – A Compelling Portrait

- No patient deaths that could have been prevented with better communication
- A broad cultural shift where interprofessional care is the expected norm
- Organizational structures where interprofessional care is embedded in: hiring, expectations, rewards, incentives, and accountabilities
- The specific scope of each discipline is respected and there is a robust way of working in an interprofessional manner
- Clear links between interprofessional care and each institution’s strategic goals
- Interprofessional care Scorecards with moving, annual targets to measure our success
- A strong interprofessional care research agenda across TAHSN to understand how interprofessional care influences outcomes. A mechanism implemented to evaluate progress
- Robust links exist between learning institutions and all TAHSN hospitals continually evaluating progress and responding to feedback
- Specific interprofessional care focused-roles within each institution that, when combined, form a TAHSN IPC Consortium
Figure 7: Slide 2

**Where should we go next?**

1. **Create cross-TAHSN focus on interprofessional care**
   - Co-create principles for care and education
   - Assure that students will consistently see interprofessional care in practice
   - Create publications related to interprofessional care across Toronto LHIN that are common to all institutions

2. **Create interprofessional care roles within every institution**

3. **Leverage the IMPLC Project participant community as a core group of champions**
   - Influence the Toronto Central LHIN
   - Take what is happening here today back to curriculum committees in educational institutions to integrate interprofessional care competencies into various programs and to build interprofessional care into curriculum evaluation

4. **Redefine language and how we talk about professions**
   - Create neutral spaces in hospitals and institutions across professions
   - Shift from profession-focused events to interprofessional events through more sharing of professional scope and care team focus

5. **Engage senior leaders of our institutions**
   - Create strategies for engaging Boards and CEOs in hospitals and learning institutions to link to corporate and performance objectives in hospitals for senior leaders

6. **Use resources we have created**
   - Make toolkits available to hospital administrators, educators and frontline health care professionals
   - Put organizational structural changes for interprofessional care/interprofessional education in place

7. **Expand this community of collaboration**
   - Incorporate student, higher level training representation and patients/families into this conversation for planning and implementation

8. **Use research on outcomes to expand understanding**
   - Develop a clear set of indicators that relate to staff outcomes
   - Share moments of truth, for example: “Where has interprofessional care been most effective?”
Showcasing the Enthusiasm

The most poignant moment of the Conference occurred when participants began to describe the changes they had seen over the past six months as a result of the CCIC Project and the IMPLC funding. Key changes included:

- A visible groundswell of energy across institutions.
- A change in language as interprofessional care/interprofessional education terms are being used much more.
- The development of tool kits that can be rolled out across the province.
- A higher level of commitment to interprofessional care among staff.
- Greater spirit of sharing between institutions.
- A strong sense of momentum to move interprofessional care forward.
- The recognition of available expertise among TAHSN partners.
- New scholarships being created to accompany interprofessional care and interprofessional education initiatives.
- A higher level of staff satisfaction and engagement using the theme of “building resilience”.

Showcasing the Initiatives

Representatives from some of the hospitals also provided institution-specific examples of their interprofessional care initiatives to Dr Tepper. Many of these were also displayed using posters at the entrance of the auditorium. (See Appendix C for conference posters) Some of these posters highlighted the following:

- At SickKids Hospital, families and children are engaged in initiatives and teams, and there is better communication across teams.
- At Women’s College Hospital, one educational committee for all health professions is now in place.
- At Mount Sinai Hospital, there is recognition that interprofessional care team building is a necessary pre-condition of patient-centred care.
- At St. Joseph’s Health Sciences Centre, a learning Project has inspired a groundswell of energy and vision.
- At Bloorview Kids Rehab, there is evidence of, and appreciation for, a greater spirit of sharing between institutions.
- At Sunnybrook, emergency room staff have received training and created a training program that can be delivered in other areas to live out interprofessional care with elderly patients experiencing delirium.
Response by the Ministry of Health and Long-Term Care

Dr. Tepper acknowledged the work that had been done in such a short time and was impressed with the knowledge, commitment and leadership demonstrated. Dr. Tepper shared information about the:

- **Interprofessional Care Project**: this Project identifies the priorities that will facilitate the systemic implementation of interprofessional care to improve patient-centred care in Ontario. An overview of the project can be found at www.healthforceontario.ca.

- **Interprofessional Care Blueprint for Action initiative**: this Blueprint will support innovation and excellence through the implementation of interprofessional care in health care and educational settings across the province. The Blueprint is available at: www.healthforceontario.ca.

Dr. Tepper acknowledged that many of the recommendations presented to him regarding the next steps that U of T/TAHSN to move IPC forward were consistent with themes outlined in the Blueprint for Action. Dr. Tepper concluded his remarks by congratulating all participants and expressing his appreciation for the quality and quantity of work undertaken through the CCIC Project.

Creating the Interprofessional Care Manifesto for Action

The final conference agenda activity involved having participants break into four groups according to common areas of interest/activity: hospital administrators/executives, practitioners, researchers, and educators. Each group was charged with creating a manifesto or plan of action for their specific area of affiliation. These recommendations, as listed below, provide the Office of Interprofessional Education and the Steering Committee for the CCIC Project with future considerations for strategic planning. Many of the recommendations listed in the manifesto recognize the need for:

- Organizational infrastructure and ongoing resources;
- Dedicated individuals identified who carry an interprofessional care/interprofessional education portfolio;
- Ongoing professional/faculty development;
- The creation of accountability structures; and
- Leveraging current opportunities rather than starting from scratch.
3.3 INTERPROFESSIONAL CARE MANIFESTO — RECOMMENDED NEXT STEPS FOR ACTION BY U OF T AND TAHSN

**Practitioner Group** (Identified themselves as the interprofessional care “doers”)

1. Within one year, have one interprofessional care champion within each of the TAHSN organizations;
2. Ensure clinical team members are aligned either geographically or by personnel (not by discipline);
3. Within one year, 25 per cent of every discipline or occupation should have some sort of IPC education and accompanying tools.

**Education Group** (Identified themselves the interprofessional care or interprofessional education teachers)

Identified the following key focus areas:

1. Adapt interprofessional education leadership courses geared to clinical faculty for professional development at all levels of the institutions/organizations;
2. Revise the U of T Department of Public Health Sciences “Determinants of Community Health” course so that it contains interprofessional education concepts to allow students to follow a patient through the entire continuum of care;
3. Use existing technology to develop electronic curriculum models that enhance and foster collaborative communication between students. For example, create virtual student teams of students between different professional groups and link this to the current mentorship program.
Dr. Oandasan told participants that the recommendations would be forwarded to TAHSN leaders and the U of T CHSD. Using these recommendations as part of a larger strategic plan, it is anticipated that the input provided by conference participants will help maintain momentum and fuel action for making meaningful changes in interprofessional care and interprofessional education.

A strong call for action amongst all who attended was urged. Given that the community has developed a vision of what a compelling portrait of what interprofessional care could look like, every person who attended the Conference was sensitized to the valuable role he or she has in catalysing and sustaining interprofessional education and the interprofessional care momentum.

There is robust support for interprofessional education and interprofessional care as documented provincially in the MOHLTC Blueprint for Action Report, and nationally with the Health Canada Interprofessional Education for Collaborative Patient-Centred Practice Initiative. In addition, as the integration between hospitals and the academic community within the Toronto Central LHIN takes place, an opportunity exists to use a vision of interprofessional care as a platform to enhance patient care. With the belief of more future funding opportunities available, U of T and TAHSN have a great potential to carry on the initial work already conducted to provide leadership within the province that is depicted in the following illustration (figure 8, next page).

**Research Group**
Focus on systems, knowledge translation, patient health outcomes and evaluation. Advocate for an innovative, iterative research agenda to improve patient/provider outcomes.

1. Create an interprofessional care consortium research network;
2. Build an accountability mechanism to measure the interprofessional care process;
3. Develop common outcomes, measures, and methodologies for interprofessional care across TAHSN that can be shared among researchers.

**Administrator and Executive Group**
1. Develop an interprofessional care scorecard using indicators and metrics pulled from existing evaluation and measurement tools (patient & employee satisfaction, accreditation standards, etc.);
2. Establish and support a structure to take on the IPC agenda while considering how to utilize existing structures.
Figure 8: Moving the Interprofessional Care Agenda Forward

Image Source: Positive Culture Company
The Sustainability Conference was successful in:

- Sharing the learnings and experiences gained through the CCIC Project,
- Mobilizing a larger community of interprofessional care/interprofessional education supporters,
- Setting out an agenda to maintain the current momentum, with recommended next steps for practitioners, educators, researchers, and administrators within hospital and academic settings.

As a number of participants noted throughout the Conference, the question is no longer: “should we adopt interprofessional care/interprofessional education within our institutions?” but rather, “how can we move the interprofessional care/interprofessional education agenda forward as effectively as possible for the benefit of patients, providers and the future of the health care system?”

Key points underscored by conference participants and the community at U of T and TAHSN include:

- Interprofessional care is happening
- Interprofessional care is achievable
- Interprofessional care is not optional

To enhance the care provided to the citizens of this province, it is part of our professional responsibility to rise to the leadership challenge and to resolutely take action to make interprofessional care the norm.

---

**Interprofessional care is happening!**

**Interprofessional care is achievable!**

**Interprofessional care is not optional!**

—Conference participants, Co-Creating the Future for Interprofessional Care: Sustainability Conference, 2007
APPENDIX A: PARTICIPATING ORGANIZATIONS

We would like to thank the over 130 participants including the Assistant Deputy Minister of Health, CEOs, Vice and Associate Deans, VP Academics, VP Nursing, Directors, Researchers, Educators and consultants from the following organizations for their participation in the “Co-Creating the Future for Interprofessional Care: Sustainability Conference”:

- Baycrest Hospital
- Bloorview Kids Rehab
- Bridgepoint Health
- “Co-Creating the Future for Interprofessional Care: Sustainability Conference” Planning Committee
- Centre for Addiction and Mental Health
- Council of Health Science Deans – University of Toronto
- Educators and Researchers affiliated with the Faculties of Dentistry, Medicine, Nursing, Pharmacy, Physical Education & Social Work – University of Toronto
- Hospital for Sick Children
- IMPLC Project (Interprofessional, Mentoring, Preceptorship, Leadership and Coaching) Steering Committee
- Michener Institute
- Ministry of Health and Long-Term Care
- Mount Sinai Hospital
- North York General Hospital
- The Potential Group
- Script Programme Research Team - University of Toronto
- St. Joseph’s Health Centre
- St. Michael’s Hospital
- Sunnybrook Health Sciences Centre
- Toronto Central LHIN
- Toronto East General Hospital
- Toronto Rehabilitation Institute
- University Health Network
- Women’s College Hospital
APPENDIX B: PLENARY PRESENTATION BY SISTER ELIZABETH DAVIS

CO-CREATING THE FUTURE FOR INTERPROFESSIONAL CARE: SUSTAINABILITY CONFERENCE

INTERPROFESSIONAL CARE: LEADERSHIP CHALLENGE
LEADERSHIP COMMITMENT

June 21, 2007

Crucial to finding the way is this: there is no beginning or end. You must make your own map.

Joy Harjo
A Map to the Next World! Poems

OVERVIEW OF REFLECTIONS

✓ Setting the context in today's society
✓ Knowing changes in the health system
✓ Understanding Professionalism and Interprofessionalism
✓ Readying ourselves to be leaders and champions

CHANGING SOCIETY

✓ Demographic shifts
✓ Increasing urbanization
✓ Increasing cultural diversity
✓ Impact of computerization
✓ Culture of consumerism
✓ Increasing gap between rich and poor
✓ Role of women
✓ Realities of violence and poverty
✓ Understanding of health of environment
✓ Expectations of public service
✓ Credibility of leaders

Four generations of citizens, patients and professionals
✓ Elders/Traditionalists/Silent Generation (pre-1946)
✓ Boomers (1946–1965)
✓ Generation X (1965 – 1980)
✓ Millennials (1980 – )
**Generational Values**

- **Elders:** Dedication, sacrifice, hard work, conformity, law and order, patience, respect for authority, duty before pleasure, adherence to rules, honour
- ** Boomers:** Optimism, teamwork, personal gratification, health and wellness, personal growth, youth, work, involvement
- **Generation X:** Diversity, thinking globally, balance, techno-literacy, fun, informality, self-reliance, pragmatism
- **Millennials:** Confidence, civic duty, achievement, sociability, morality, diversity, street smarts

**Emerging Network Age**

- From the Industrial Age to the Information Age to the Network Age
- **Network Age**
  - Distributed culture
  - Decentralized
  - Citizen-centered not institution-centered

**Today’s Cultural Mindset**

- Computers are not technology but part of life
- Internet is better than TV
- Reality is no longer real
- Doing is more important than knowing
- Learning more closely resembles Nintendo than logic
- Multitasking is a way of life
- Typing is preferred to handwriting
- Staying connected is essential
- There is zero tolerance for delays
- Consumer and creator of information are blurring

*Jason Freid (2002)*

**Understanding of Health**

Health is a state of complete physical, emotional, social and spiritual well-being; it is a resource for everyday living.

**Implications:**

- Value of one’s own experiences
- Social, psychological and spiritual factors
- Gender as health determinant
- Health of person, family, community, population and earth

**Shifts in Healthcare System**

- Increased Government control with more complex policies and regulations
- Balance: community/home/institution
- Involvement of clients in decisions
- Focus on coordination/integration
- Governance restructuring
- Alternate therapies
- Focus on outcomes
- Ethical decision-making
- Accountability/Transparency
- Increased levels of stress for professionals

**Expectations of Citizens**

- **Rights** – to health and health care
- **Balance** – individuals and populations
- **Comprehensiveness** – treat illness, ease suffering, minimize disability, prevent disease, promote health
- **Cooperation** – with those served, with each other, with those in other sectors
- **Improvement**
- **Safety**
- **Openness** = being open, honest and trustworthy

*Toffler Principles (2001)*
CHANGING HEALTH PROFESSIONS

✓ Move from traditional inward-looking, reactive culture to outward-looking, proactive culture
✓ Shift from profession-centred to patient-centred culture
✓ Blurring professional boundaries
✓ Changes in law re scope of practice/responsibilities
✓ Increased expectations of interprofessional collaboration in education and practice
✓ Focus on evidence-informed practice
✓ Increasing demands for accountability/transparency
✓ Internationalization

IMPLICATIONS

✓ Leadership no longer legitimated or expressed through authority or dominance - being the boss does not make you the leader
✓ Interprofessional practice in health care a logical, feasible and effective response
✓ Interprofessional practice presumes interprofessional education and research
✓ Interprofessional practice/education/research still at elementary level of development

COLLABORATION

Collaborative patient-centered practice is designed to promote the active participation of several health care disciplines and professions. It enhances patient-, family-, and community-centred goals and values, provides mechanisms for continuous communication among health care providers, optimizes staff participation in clinical decision making (within and across disciplines), and fosters respect for the contributions of all providers.

Health Canada, 2003

SPECTRUM OF INTERPROFESSIONALISM

✓ Climate of mutual respect and trust
✓ Cooperation = formal communication, independent decision-making
  - Shared information
  - Consultation
✓ Coordination = defined roles, some shared decision-making
  - Shared vision, goals and planning
  - Shared resources

SPECTRUM OF INTERPROFESSIONALISM

✓ Collaboration = defined roles, frequent communication, shared decision-making, one system
  - Teamwork - specific tasks, patient-centered
  - Collective responsibility - organizational integration
  - Shared leadership, control, risk and accountability

BARRIERS TO INTERPROFESSIONAL COLLABORATION

✓ Differences in history and culture
✓ Historical interprofessional and intraprofessional rivalries
✓ Differences in language and jargon
✓ Differences in schedules and professional routines
✓ Varying levels of preparation, qualifications and status
BARRIERS TO INTERPROFESSIONAL COLLABORATION

- Differences in requirements, regulations and norms of professional education
- Fears of diluted professional identity
- Differences in accountability, payment and rewards
- Concerns regarding clinical responsibility

[Heidrich, Wilcock & Butzelden (2000)]

ROLES OF LEADERS

- Visionary
- Catalyst
- Decision-maker
- Inspirer
- Facilitator
- Partner
- Implementer
- Evaluator

RESPONSE FROM PROFESSIONS

- Have confidence that your professions are mature, competent and creative enough to be leaders in this new reality
- Re-think the strengths of your professions to ensure viability in this new reality
- Envision a new way of being as health professionals in an interprofessional reality

IMPLICATIONS OF FAILURE TO RESPOND

- No significant improvement of health outcomes in chronic disease management, continuity of care
- Continued major challenges re access to care
- Failure to achieve promises of health promotion and disease prevention
- Failure to emphasize population health
- Decreasing patient and provider satisfaction

IMPLICATIONS OF FAILURE TO RESPOND

- Continued challenges re recruitment and retention of all health care professionals
- Failure to effectively use the competencies and skills of all health professionals
- Failure of health professionals to be valued and credible leaders in this changing health care environment
- Failure to create a truly responsive health system for the 21st century
I’m sittin’ on my stage-heel lookin’ out at where Slipper Joe Irwin’s schooner is ridin’ at her moorin’ ... thinkin’ about how weak are the things that try to pull people apart - differences in colours, creeds and opinion - weak things like the ripples tuggin’ at the schooner’s chain. And thinkin’ about how strong are the things that hold people together - strong, like Joe’s anchor, and chain, and the good holdin’ ground below.


INFLUENCING THE FUTURE

T Hold the vision
T Know your strengths
T Develop new skills/competencies
T Envision creatively the ways
T Build on the best
T Be patient but persistent
T Be collaborative but challenging
T To change the culture of the health care system, you must be willing to change yourself

BLESSING

May you be present in what you do.
May you never become lost in blind absences.
May the day never burden.
May dawn find you awake and alert, approaching your new day with dreams, possibilities and promises.
May evening find you gracious and fulfilled.
May you go into the night blessed, sheltered and protected.
May your souls calm, console and renew you.

Adapted from
John O’Donohue, A Soul Care
Catalyzing and Sustaining Communities of Collaboration
Around Interprofessional Care
Interprofessional Mentorship, Preceptorship, Leadership And Coaching
LEADING AND COACHING AN INTERPROFESSIONAL TRANSFORMATION: A Case Study in General Internal Medicine at UHN

IMAGINE & ENVISION???
WHAT'S WORKING WELL?
WHAT COULD BE?

APPRICATIVE
COLLABORATIVE
NARRATIVE
REFLECTIVE

RENEWAL CYCLE

INTER-PROFESSIONAL

CO-CREATE ACTION PLANS

HOW DO WE MAKE THIS HAPPEN?

INTER-PROF
ROUNDS

WHAT HAVE WE LEARNED?

REVIEW SUCCESS, REFLECT & LEARN

TURN PLANS INTO ACTIONS

Critical Success Factors

Use an Appreciative Approach
• Provoke collaboration through a compelling mandate
• Engage an interprofessional team at the point of care
• Emphasize what already works
• Focus on a vision for the future

Be Strategic
• Support and coach interprofessional leaders to lead the change
• Obtain senior management endorsement and support
• Link with the balanced scorecard
• Leverage project management resources
• Communicate in multiple venues
• Attend to tangible outcomes vs. concepts

Build the Infrastructure
• Continually co-create the case for transformation
• Ensure leadership time
• Secure replacement costs
• Use consulting support
• Develop internal resources for facilitation

Plan for Sustainability
• Integrate with existing projects and activities
• Link with human resources and performance management departments
• Build in resources for coaching and clinical education
• Create spaces for reflective practice and leadership development

This project was supported through the Ministry of Health and Long Term Care Interprofessional Mentoring, Preceptorship, Leadership and Coaching Fund.
Co-Creating the Future for Interprofessional Care: Sustainability Conference Proceedings Report Appendices

Introduction
- The need for an inter-professional (IP) model to meet the complex needs of older patients has been recognized for decades in geriatrics, but is not well documented in the Emergency Department (ED).
- We adapted an existing IP best-practice for preventing delirium for use in the emergency department (ED).
- We refer to this co-created best practice as IPPod
- Interprofessional prevention of delirium in the ED

Objective
- To evaluate IP learners assessment of the IPPod educational (IPE) strategy
- To evaluate whether roles impacted IP learners assessment of the IPPod strategy

Methods
- Strategy designed to promote viral uptake and involved targeting informal opinion leaders and a multi-media marketing campaign.
- Participants from 12 different professions and disciplines participated in 9 facilitated workshops and completed an anonymous evaluation after workshops.
- Study approved by Sunnybrook REB

Results
- Evaluations completed by 111/126 (88%) of participants
- Mean age = 37.5 years, mean years of experience = 10.8 and 61% of participants were female.
- Nurses: 43% of participants
- MD’s: 14% of participants
- Paramedics: 13% of participants
- Allied Health / Other: 30% of participants
- We grouped Nurses and MDs together as Role A (n=63), and compared their evaluations to all others, Role B (n=48)

Analysis
- We compared participants evaluations by role using the non-parametric Wilcoxon Rank Sum statistic

Table 1: Participant Evaluation of IPPod

<table>
<thead>
<tr>
<th>Question</th>
<th>Mean</th>
<th>Interquartile Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall Rating</td>
<td>4.46</td>
<td>4.00 – 5.00</td>
</tr>
<tr>
<td>Helped you to understand delirium?</td>
<td>4.50</td>
<td>4.00 – 5.00</td>
</tr>
<tr>
<td>Lectures informative and helpful?</td>
<td>4.59</td>
<td>4.00 – 5.00</td>
</tr>
<tr>
<td>Breakout group discussions?</td>
<td>4.44</td>
<td>4.00 – 5.00</td>
</tr>
<tr>
<td>IPPod helpful in the ED?</td>
<td>4.47</td>
<td>4.00 – 5.00</td>
</tr>
<tr>
<td>Possible to prevent delirium in the ED?</td>
<td>4.01</td>
<td>3.00 – 5.00</td>
</tr>
<tr>
<td>Provided networking opportunities?</td>
<td>4.34</td>
<td>4.00 – 5.00</td>
</tr>
</tbody>
</table>

Table 2: Participant Evaluation by Role

<table>
<thead>
<tr>
<th>Question</th>
<th>Role A (n=63)</th>
<th>Role B (n=48)</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall Rating</td>
<td>4.33</td>
<td>4.63</td>
<td>0.036</td>
</tr>
<tr>
<td>Helped you to understand delirium?</td>
<td>4.45</td>
<td>4.56</td>
<td>0.516</td>
</tr>
<tr>
<td>Lectures informative and helpful?</td>
<td>4.53</td>
<td>4.67</td>
<td>0.600</td>
</tr>
<tr>
<td>Breakout group discussions?</td>
<td>4.43</td>
<td>4.36</td>
<td>0.941</td>
</tr>
<tr>
<td>IPPod helpful in the ED?</td>
<td>4.40</td>
<td>4.55</td>
<td>0.484</td>
</tr>
<tr>
<td>Possible to prevent delirium in the ED?</td>
<td>3.98</td>
<td>4.06</td>
<td>0.555</td>
</tr>
<tr>
<td>Provided networking opportunities?</td>
<td>4.28</td>
<td>4.42</td>
<td>0.295</td>
</tr>
</tbody>
</table>

Limitations
- Non-validated tool
- Hawthorne effect: Participation in the intervention may have biased evaluation
- Data on impact on practices and patient outcomes pending

Conclusions
- Participants rated the IPE strategy highly overall
- Evaluations by participants from different backgrounds were highly similar overall
- Role B participants overall evaluations were significantly higher than Role A participants, although the difference was small

Discussion
- Participants role had minimal impact on their evaluation of the IPPod IPE strategy
- Role B participants may feel particularly empowered by participating in this IPE strategy
- Further research will evaluate the impact of the IPPod IPE strategy on:
- practice patterns and
- patient outcomes

References:

Acknowledgements
This project was supported through the Ministry of Health and Long Term Care’s Interprofessional, Mentoring, Preceptorship, Leadership and Coaching Fund (IMPLC).
interprofessional prevention of delirium... working together to prevent delirium in the ED

Introduction
- The need for an inter-professional (IP) model to meet the complex needs of older patients has been recognized for decades in geriatrics, but is not well documented in the Emergency Department (ED)
- We adapted an existing IP best-practice1 for preventing delirium for use in the emergency department (ED)
- We refer to this co-created best practice as: IPPOD
- Interprofessional prevention of delirium in the ED
- We then developed strategies to embed this IP best practice model within the ED.

What we learned:
- Participants were enthusiastic about the IPC concept as well as delirium prevention
- Non-clinical participants (e.g., Volunteers, PAAs, PSPs) were more focused on clinical information. Being included in this type of education made them feel valued.
- Participants who were familiar with the clinical information were enthusiastic about the "team building" and IPC concepts.
- Bringing together diverse team members fostered a strong sense of empowerment – especially among groups that traditionally were less involved in decision-making.
- Success in coaching IPC skills among workshop participants depended on the skill of the facilitator.
- With more experience facilitators were better able to foster IPC and encourage broader participation.

What's Next?
- Introduction of the IPPOD project in Thunder Bay
- Evaluation of impact on patient outcomes
- Peer-reviewed grant applications
- Scholarly Publications
- Learning needs assessment: next IPE topic for the Sunnybrook IP coaching team!
- IPPOD website

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Table 1: Who Participated?

<table>
<thead>
<tr>
<th>Participants</th>
<th>N=111</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurses (ED, GEM, Mental Health)</td>
<td>48</td>
<td>43</td>
</tr>
<tr>
<td>PAAs</td>
<td>10</td>
<td>9</td>
</tr>
<tr>
<td>Paramedics</td>
<td>14</td>
<td>13</td>
</tr>
<tr>
<td>Physicians</td>
<td>15</td>
<td>14</td>
</tr>
<tr>
<td>PSPs</td>
<td>8</td>
<td>7</td>
</tr>
<tr>
<td>Security</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Social Work</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Volunteers</td>
<td>7</td>
<td>6</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>Mean Age in yrs. (IQR)</td>
<td>37.3 yrs. (22-44)</td>
<td>-</td>
</tr>
<tr>
<td>Mean Experience in yrs. (IQR)</td>
<td>10.8 yrs. (3 to 16)</td>
<td>-</td>
</tr>
<tr>
<td>Female Gender</td>
<td>61%</td>
<td>-</td>
</tr>
</tbody>
</table>

References:
Interprofessional Education: Making a Difference for Collaborative Patient and Family Centered Care

Introduction
- Mount Sinai Hospital’s (MSH) focus is to develop core resource teams within targeted areas of the hospital for collaborative patient and family centered care. A variety of Interprofessional (IP) coaching strategies were developed to bridge the gap between Interprofessional education (IPE) and service delivery within a patient and family centered model of care (IPFCC).

The IP core project team modelled the principles of collaborative patient-centered teams. Patient advisors were recruited as team members to ensure inclusion of the patient and family voice. The IP care project team met weekly to identify project strategies and determine priorities. Target groups for the coaching and education initiatives were identified.
- A model and framework were developed to guide the initiative.

Methods
- Phase 1 (January – April 2007): MSH IP Core Project Team training in IP coaching, mentoring and organizational change. IP Core Project team meets weekly to integrate the IPFCC principles into the delivery of service at MSH.
- Phase 2 (February – May 2007): Development of targeted curricula that will support the dissemination and knowledge transfer of IPFCC for the introductory, clinical team and organizational leadership levels.

Outcomes
- eLearning Module: e-learning module developed to build awareness of Interprofessional Collaboration and Patient and Family Centered Care.
- Interactive modules, 20 minutes in length aimed at meeting individual learning needs. Needs to be made available to existing staff and in orientation with new staff.
- Reality-based testing module with physicians.

Coaching Clinical Teams
- Step 1: Recruitment of clinical teams (General and Sub-Specialty Medicine – GMS) - self-identified process improvement initiative ("Interprofessional Patient and Family centered rounds at the bedside")
- Step 2: Preworkshop assessment to understand the clinical team and their patient and family partnerships
- Step 3: Development of interactive workshop
- Step 4: Delivery of workshop
- Feedback from the staff:
- -持 each other accountable to the vision.
- - Team needs to be representative and inclusive of both patients and professionals.
- - Link projects to organization’s goals and objectives.
- - Use existing performance indicators to guide implementation, determine needs and measure outcomes.
- - Understand the role of patient and family advisors.
- - Engage patients and families as partners in process improvement initiatives
- - Infrastructure is needed to support this strong level of participation.
- - Involve patients when and where they can participate, recognizing their contributions.
- - Interprofessional workshops provide opportunities for improving the depth of understanding of professional roles.
- - Builds team cohesion and morale.
- - Builds understanding that interprofessional collaboration is essential to provide care that counts.
- - Building understanding that patients and families are part of this interprofessional team.

Lessons Learned
- Live the values from the start.
- Hold each other accountable to the vision.
- Team needs to be representative and inclusive of both patients and professionals.
- Link projects to organization’s goals and objectives.
- Use existing performance indicators to guide implementation, determine needs and measure outcomes.
- Understand the role of patient and family advisors.
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"Patients and Families are key members of our interprofessional teams – we collaborate to achieve their health care goals."
CAMH PROJECTS THAT SUPPORT INTERPROFESSIONAL COLLABORATION

The Electronic Interdisciplinary Plan of Client Care (eIPCC)

- This interdisciplinary documentation tool was developed to embed collaborative practice into the care planning process.
- It is an essential component of CAMH’s electronic health record.
- All professional disciplines document on this tool.
- The domains are recovery oriented and reflect principles of health promotion and holistic care.
- On-line training supports staff in using this tool.
- CAMH is willing to host a site visit for anyone wishing to view this tool.

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The Clinical Supervision Handbook

- In collaboration with the Faculty of Social Work, University of Toronto, we are developing a clinical supervision handbook that defines an Interprofessional model for clinical supervision at CAMH.
- The handbook will outline processes to conduct Interprofessional supervision.
- An exploratory study of perspectives of clinicians about clinical supervision will be conducted.

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Definition of Core Clinical Practice Competencies

- CAMH has defined core clinical practice competencies required by professionals who work in the field of mental health and addictions.
- These core competencies apply to all professional disciplines at CAMH.
- This framework enables clinicians to set career milestones and establishes a standard by which clinicians are reviewed for competency.

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LEADERSHIP IN ACTION
Advancing Inter-Professional Practice to Lead Practice, Policy, Education & Administration Changes Locally, Nationally and Internationally
Michele Durrant, RN, MSc, ANPE, Karen Breen-Reid, RN, MN, ANPE, Heather Ferries, RN, MEd, ANPE

Introduction
‘Leadership in action’ is an education program that demonstrates excellence in creating a culture of inter-professional collaboration enhancing quality care. This innovative, evidence-based program is based on leadership research by J. Kouzes and B. Posner. This poster describes the evolution of this workshop and its ability to foster inter-professional collaboration, enhance patient care outcomes.

Leadership Programming
This workshop focuses on:
➢ leadership principles and practices necessary to provide leadership at a micro and macro level
➢ self-reflection processes necessary to examine the leadership skills participants possess, develop leadership competencies & apply these to practice.

Three programs that develop leadership capacity target:
1) Clinical support nurses,
2) Inter-professional staff in formal leadership roles,
3) Inter-professional teams advancing an IPP focused initiative.

 Experienced Registered Nurses advance a local leadership initiative.
 Staff develop a leadership plan at the workshop
 Unit Managers are recommended mentors
 Staff in formal leadership roles advance a leadership initiative locally or hospital wide.
 Staff develop experience in using strategies they can implement to advance their change initiative

OHS Directors are recommended as mentors

Outcomes
Leadership initiatives to date have include:
➢ creating a healthy work environment
➢ advancing professional practice
➢ advancing local patient safety initiatives
➢ advancing pain management strategies
➢ enhancing education and administrative systems

Advancing IPP Programming
In order to address IPP we’ve focused on teams engaged in advancing change to improve quality care.

This IPP pilot workshop is tailored to meet the needs of:
➢ Inter-professional staff advancing a leadership initiative as a team influencing local, national & international patient outcomes.

Piloted with Critical Care Unit staff advancing pain management practice, policy, & education.

Teams are given tools necessary to enhance their leadership initiatives and to increase the success moving initiatives from local to national and international forums through the use of knowledge transfer strategies.

Bringing teams together to achieve a common goal supports team development. The programming is enhanced by:
➢ focusing on teams committed to and engaged in advancing change to improve quality care
➢ teaching strategies that encourage team reflection and development
➢ knowledge transfer strategies that enhance the uptake of leadership tips, tools and key messages
➢ team facilitation and mentorship that enhances products, process and outcomes

Next Steps
Leadership Reflection & Development
➢ Move from individual to team reflection regarding leadership competences and strategies
➢ Strengthen the membership infrastructure to align people with strategic initiatives
➢ Enhance knowledge transfer capability

Team Reflection & Development
➢ Assessment of team skills and capabilities
➢ Enhance sustainability – develop team facilitation skill

Consultation Process & Mentoring
➢ Establish a leadership project data base
➢ Establish networking opportunities to share work in progress & build recognition systems

Conclusions
To date we have collected data that demonstrates:
➢ strong learning and satisfaction outcomes
➢ IPP focused programing changes enhance the leadership capability of team members, change implementation and sustainability. As a result, we will evaluate outcomes that
➢ demonstrate leadership capacity of IPP teams
➢ change sustainability
Taking the Pulse of Interprofessional Practice

C. Baker, RN, President and CEO; K. Adamson, MSW; J. Dionne, RRT; S. Graney, MSW; E. McLaney, OT Reg.(Ont.); Dr. Y. Shargall; L. Strathern, RN; L. Vesik, RD.

Question
What is the lived experience of interprofessional practice (IPP) at St. Joseph’s Health Centre (SJHC)?

Background
Educating Health Professionals for Interprofessional Collaboration (EHPIC) is a project partnering with University of Toronto and the Toronto Academic Health Sciences Network. The goal is to develop approaches for delivery of care based on the collaboration of all the professionals involved in the care of a patient and family.

Learning Project
At St. Joseph’s Health Centre the IPP team used 3 tools to obtain a ‘snapshot’ of the lived experience of interprofessional practice. Information was collected using:
- Survey
- Direct observation of team meetings
- Focus groups.

"I am satisfied with interprofessional collaboration within my team"

Role Awareness
- Opportunities exist for further learning and understanding of each others’ roles.
- At times, understanding of a team member’s role is based more on personal relationship than primary scope of practice.
- New staff and students have the greatest need to learn about other professions.

Language
- There is not currently a consistent definition of IPP at SJHC.
- Terminology used with the Health Centre is not always supportive of IPP.

Relationships
- Team trust and willingness to collaborate were found to be high.
- Trust is a key component of successful collaboration.
- When not all team members are regularly present, remaining group may grow or compensate for their absence.
- Based on perceived difference in status, not all staff feel equally heard, valued, and appreciated.

Infrastructure
- In a fast-paced setting, space and time does not always allow for optimal team meetings.
- Students do not have dedicated space to interact.
- Opportunities exist for refining student and staff orientation to encourage interprofessional practice.

Themes
Role Awareness
Language
Communication
Relationships
Infrastructure

Future Directions
Role Awareness
- Development of interprofessional events within Health Centre to improve role awareness and clarity.
- Improved orientation for new staff, students, and residents to facilitate understanding and appreciation of other health professions.

Language
- Develop and communicate a common definition of IPP.
- Refine terminology that supports IPP.

Relationships
- Create a culture where the contributions of all team members (including patient) are equally valued.
- A shared decision-making approach will optimize health outcomes and improve trust within teams.
- Continual celebration and recognition of all staff to enhance the work environment.

Infrastructure
- Examine opportunities for dedicated time and space of interprofessional team meetings.
- Flexibility of team meetings to accommodate specific needs and schedules.
- Invest in internal capacity building to promote interprofessional leadership and practice.
- Create a dedicated space where students from all professions can meet to learn from, with, and about each other.

Take Home Messages
1) IPP should not be rigidly implemented, but rather be based on common principles which allow for variability of focus and culture in different areas of the Health Centre.
2) To fully leverage individual and team capacities for IPP, a broader understanding of “team” including patients, families, regulated and non-regulated staff is necessary.
Interprofessional Wound Care Module Pilot

BACKGROUND TO THE PROJECT

Women’s College Hospital (WCH) is an ambulatory hospital with a focus on women’s health that is fully affiliated with the University of Toronto. The Wound Healing Initiative (WHI) and the Interprofessional Continuing Education Initiative (IPEI) provide continuing education opportunities in wound care and are facilitated by the Education and Research Office of the Women’s College Hospital. The WHI’s mandate is to provide wound healing opportunities for healthcare providers in the Greater Toronto Area (GTA) through collaboration with various stakeholders. The IPEI’s mandate is to promote interprofessional learning opportunities and experiences for healthcare providers in the GTA.

PURPOSE OF THE PROJECT

The purpose of the project was to pilot an interprofessional educational module that would serve as a future framework for the development of subsequent interprofessional modules.

OBJECTIVES

- To promote interprofessional collaboration among healthcare providers
- To enhance understanding of wound care among healthcare professionals
- To improve interdisciplinary communication among healthcare providers
- To increase awareness of wound care and its impact on patient outcomes

METHODS

- A pilot interprofessional wound care module was developed and implemented
- Participants included healthcare providers from various disciplines
- The module included didactic learning, interactive sessions, and case studies

RESULTS

- Pre- and post-assessment demonstrated significant improvement in knowledge of wound care among participants
- Participants reported enhanced collaboration and communication skills

CONCLUSION

The pilot interprofessional wound care module was successful in achieving its objectives. The module provided a platform for healthcare providers to share knowledge and improve collaborative practice in wound care.
Achieving Excellence through Interprofessional Education & Care

Our Evolving Vision
1. IPE & IPC aligned with NYGH vision – each role is essential!
2. Optimize patient/family quality care and safety
3. A Centre of Excellence for IPE & IPC

Our Values
Listening, Learning, Leading,
Collaboration, Communication, Trust, Respect

Strategy
- ehpic Leadership Project
- IP Faculty Development
- Interprofessional Mentoring
- Scope of Practice Workshops

Skills
- NYGH’s Strategic Alignment Model

Structure
- IP Orientation
- IP Awareness Week
- IP Model of Care
- Infrastructure to promote IPE & IPC
- IPE Committee
- Rewards & Incentives
- Physician Engagement

Culture
- Learning Organization
  - IP Framework – Learning About, From, With each other
- Common Language
- Stewardship
- Culture of Collaboration

North York General Hospital
Including the NICU Outpatient Centre
Embracing Health
www.nygh.on.ca
REFERENCES


