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INTERPROFESSIONAL PRACTICE EDUCATION

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INTERPROFESSIONAL EDUCATION : FROM THE ACADEMY TO PRACTICE (and back again).

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QUESTIONS

- Do all learners need to be at the same level of education to participate effectively in a team placement?
- Why is it so difficult to get learners from different professional programs together at the same time in the same place?
- How many different ways are there to describe an interprofessional learning experience in the practice setting?
- What should the relationship be between interprofesional learning in the academic setting and in practice?

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EXPOSURE, IMMERSION, MASTERY

Is a one week shadow experience enough for exposure?

How does immersion in the practice setting differ from immersion in the academy?

Is mastery achieved in the practice context after graduating?

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BARRIERS TO IPE IN THE PRACTICE SETTING

MACRO:
- Organization's mission and commitment
- Resources (fiscal and human)
- Resistance to change

MESO:
- Schedules (clinical and academic)
- Curriculum

MICRO:
- Interpersonal conflict
- Team skills

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PRINCIPLES

- Token integration must be avoided.
- Communication is a key to success.
- Partnerships between the academic and community locations for health professional education are critical.
- Addressing the full continuum of learning is necessary from attitudes to skills/knowledge to outcomes.
- Conflicts of interest must be identified early.

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POTENTIAL SOLUTIONS

DATA BASE:

- ***Establish an inventory of what is currently happening across professions in IPE in the practice setting (?and academic setting)***
- Integrate competencies when developed into practice education opportunities.
- Post a common data base (with permission) using a program such as Excel to capture names, locations, time frames etc.
- ***Post the blocks of practice education time for each health and human service program to the CHD web site.***
- Add IRPbc and InBC sites to the list of ***potential centres of excellence for IPE***.
- Ensure agreement is in place for sharing phone numbers, e-mail addresses etc.
- ***Define what makes a good IPE site – ground the description in the literature***.
- Look at existing sites and determine what makes them IPE.
- Include findings in a manual.
- CHD develop guidelines and criteria for IP experiences.
- ***Articulate common outcomes/competencies.***

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RECOGNITION/REWARD

- Address the issue of payment for preceptors to take students.
- Address issues of credit for workshops etc.
- Articulate success factors for IPE in the practice context e.g. space to meet, learning objectives etc.
- Watch for burn out in sites – organizational barriers, can ask too much. How much can we ask of sites and still evaluate the quality of the educational experience honestly?
- Attach credit value to IPE programs.
- ***Articulate how the IPE practice experiences fit into the overall curricula – not an add on; clear expectations.***
- Build in credit for IPE (e.g. 1 credit) and make it visible.
- ***Develop IP Health Education credits: courses, weekend workshops, placement etc***

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STUDENT INITIATIVES

- Look for GOSA and CHIUS for examples of student led initiatives.
- Have students shadow other students or practitioners.
- Harness students' initiative – let all students know (with permission) when students are out in practice in all of the professions.
- Require/encourage students to connect with each other.
- ***Survey students about IPE experiences including informal contact and teamwork.***
- Explore opportunities with international students.
- ***Bring students together to develop learning experiences***.
- Encourage involvement of ALL students.
- ***Implement the IP Scholar program .***
- Look at GOSA and CHIUS, IP models that capitalize on student initiative. (not representative of all students) Evaluate what is good about GOSA and CHIUS and develop criteria that can be built on
- Develop an IP seminar to complement the work at CHIUS, for example.
- Involve students in creating cases that can be discussed in a web based formal with a face to face session at the end.
- ***Look at the potential of the health care team challenge***.
- Encourage students to ask each other professional questions.
- ***Identify e.g. 20 teams (IP) and have those teams stay together throughout their - could use virtual and real teams of students.***

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INFRASTRUCTURE

- Manual for IPE for all health and social service students (based on GF Strong model).
- ***Define a model and find funding to implement and evaluate***.
- Use College as locus for developing IPE cases.
- ***Provide choices*** e.g midwifery would embrace a number of IPE opportunities in May, June and July.
- ***Examine the complexity for large professional programs such as nursing with large numbers and multiple entry points.***
- Employ a ***dedicated CHD person to organize and co-ordinate IPE options in the community.***
- Write PEIF proposal to support the infrastructure to develop the IPE options and framework, including co-ordination and evaluation.
- Need to train teams in IPE.
- Use the IHHS courses (e.g. team work).
- ***Provide a menu of options for on-line cases, course, modules etc.***
- Should IP in practice setting be facilitated later in professional programs to prevent misinformation?

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INNOVATIONS

- ***Dedicated common annual time for interprofessional learning activities including placements***. Timing of IPE in practice is important – need to communicate with communities.
- ***Identify focused IPE opportunities 3 – 4 times per year.Centres*** for students (teams or individuals) as dedicated sites for IPE. Examine the GFS example/precedent: barriers, on-site support, success factors.
- Look at units and provide UBC "stamp of approval" base on pre-determined criteria (e.g. room to book) grounded in competency work and literature.
- Develop 3 – 5 year plans for student placements with centres.
- Examine past McCreary prize winners and honorable mentions – a cohort of 40+ sites. Connect with them to see if we can build on their expertise.
- Check out feasibility. ***Become more flexible and innovative in the senior placements e.g. focus on global citizenship and application of professional skills in a social accountability context rather than a specific professional competence context.***
- ***Does the preceptor always need to be of own profession***?
- Can we relax our supervision approach to allow senior students to be supervise by another profession with a strong IP focus?
- Develop criteria for mandatory IPE experiences.Investigate clinical PBL as IPE method in clinical setting.Include a wide range of settings for IPE including ICU and home and community.
- North Island College has offered a one day workshop for nursing students to design a hypothetical wellness centre (space, staffing , roles etc.) Could this model be expanded to an IPE learning experience?
- Should UBC set up a series of workshops in the health authorities to guide the students' IPE learning experiences?
- Create electronic teams of senior students with learning requirements related to discussions among the team members, asking questions of each other about cases (anonymous patients) etc.
- ***Create teams electronically at diverse sites and bring them together at the end of the placement*** .In midwifery, face to face options might be difficult but online would work well.

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COMMUNICATION

- Communicate IPE opportunities, methods, precedents etc. though the web site.
- ***Work with health authorities to support IP teams with a mandate to take students***.
- ***Examine communication with specific units and provide certificate acknowledging that the unit has met the criteria for becoming a recognized IPE site.***
- Need sales job for the value of the IP activities.
- Get feedback from medical and other students about the value of the existing IP experiences (apparent value).
- Seating opportunities in the clinical setting will help.
- ***Must sell IP importance to students and curriculum leaders***.
- ***Must define "what's in it for them?" – students and practitioners.What are the screw ups that this will prevent that may impact "you"? How will IP help you to avoid adverse events? What is the negative 'sell"? Given that one third of a class will be into new things, one third will perhaps value new opportunities, and one third will always see new experiences as rubbish, how can we influence the two thirds that are not immediately enthusiastic?*** If we seat reflective practice in IPE in the clinical setting, will it be more relevant? need to articulate novel and innovative ways to sell the concept beyond face value.
- Need to develop some quick wins and to discuss the lessons learned.
- Need to develop short, medium and long term actions and evaluation approach.

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CURRICULUM

- ***Incorporate IP content into assignments, possibly bringing students together periodically***.
- Do we have the capacity for our students to critique/analyse their own professions?
- ***Create learning assignments related to scopes of practice (overlap, clarity, examination of scope of practice).***
- Change existing courses to be more interprofessional rather than adding more to a packed curriculum.
- Do we make the IPE piece mandatory or not?
- Do we focus on the keeners to start? Require that all graduates must have demonstrate the IP competencies before they graduate.
- Use Directed Studies options if enough interest.
- Locate staff within CHD that could develop a Directed Studies "course", incorporating students in the development.Include referral practices and patterns in IP learning.
- Make groups of students relevant to actual role and not artificial.
- Need to break down "chauvinism" within professions.When groups work on cases, there is quickly interesting conversation.
- Could students engage in electronic discussions with each other with a mark attached at the end?
- Could this be centrally co-ordinated while students are on placement?
- ***Create real cases for PBL approach.Is the case the relevant part or is it what students do with it?***
- What are the ***key features*** of engaging in IP discussions from a discipline specific perspective?
- Need to monitor quality of responses when using on-line cases and discussions while students are on placement.PBL in medicine has a great system for student interactions and evaluation.
- Could this be used as a template for group discussions?Look at exposure, immersion, mastery model again.
- Need to understand levels of understanding and knowledge in order to build (novice model).
- Need to know scopes of practice.

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EXAMPLES OF PROJECTS IN THE PRACTICE SETTING IN BRITISH COLUMBIA

- IRPbc (Interprofessional Rural Program of BC)
  - Interprofessional teams of students
  - Community support
  - Funds to provide orientation for students and preceptors
  - Accommodation / travel

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EXAMPLES OF PROJECTS IN THE PRACTICE SETTING IN BRITISH COLUMBIA

- UBC Health Clinic
  - Formerly UBC Family Practice Clinic
  - Space, model of care, access, evaluation
  - "PBL in action"
  - Growing interest among other clinics
  - Medical residents, medical students, nurse practitioner students, pharmacy students, social work, and midwifery
  - Future for PT, OT, audiology, speech sciences etc.

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EXAMPLES OF PROJECTS IN THE PRACTICE SETTING IN BRITISH COLUMBIA

- Patients First
  - Northern BC
  - Three aboriginal communities
  - Interprofessional teams
  - Conference
  - Travelling workshops

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EXAMPLES OF PROJECTS IN THE PRACTICE SETTING IN BRITISH COLUMBIA

- Brighter Smiles
  - Hartley Bay Aboriginal community on North coast BC
  - Medical residents, dental residents and nurses to date but plans to expand interprofessional team
  - Oral screening including teaching the community
  - Expanding to diabetes screening and other chronic disease contexts
  - Expanded to Uganda and 4 medical clinics this past summer

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EXAMPLES OF PROJECTS IN THE PRACTICE SETTING IN BRITISH COLUMBIA

- CHIUS
  - Student-lead initiative in the downtown eastside of Vancouver
  - Medical students lead the way followed by nursing, PT, OT, Pharmacy, Nutrition, SLP and others
  - Matches social accountability with clinical skills and collaborative practice

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EXAMPLES OF PROJECTS IN THE PRACTICE SETTING IN BRITISH COLUMBIA

- HCTC (Health Care Team Challenge)
  - Two interprofessional teams
  - An audience
  - A progression of questions
  - Debriefing
  - Expansion / multiple uses
  - Evaluation / team members as well as observers

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SUMMARY MESSAGES

- The practice education context MUST be seen as a critical "place" for interprofessional education.
- There are multiple ways of describing and evaluating inter-professional learning experiences.
- Most of the non-formal and informal inter-professional learning happens in the practice setting.
- Academic and practice interprofessional learning are, or should be, connected.
- Interprofessional learning in the practice context can actively facilitate clinical skills, collaborative practice, and global citizenship as health professionals.

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Reminder of conference, November 2007….

PRA CTICE MAKES PERFECT

INTERNATIONAL INTERPROFESSIONAL PRACTICE EDUCATION CONFERENCE

Education of Health Professionals in
Clinical, Community and Simulated Settings

Vancouver, British Columbia, Canada More info: http://www.bcahc.ca

Supplying the health care system with required health service providers and with appropriate knowledge, skills, abilities, and attitudes, is an educational challenge in countries around the world. The practice or clinical component of health care provider education programs is a critical learning experience that puts theory into practice.

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