No discipline is an island – but neither are we interconnected! Learning Together, to Work Together

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What this paper is about…..

- Brief description of an IPCE project
- Discussion of some of the issues that limit our ability to be interprofessional
- Suggestions and strategies for being more interconnected – for interprofessional learning and practice

About the Learning Together to Work Together project

- Funded by the Department of Human Services (DHS) Clinical Placements Strategy
- Collaboration between La Trobe University and Northern Health
- Allied Health: OT, Physio, Podiatry, Social Work & Speech Pathology (clinicians/ managers, academics and students)
- Context: public health care – acute, subacute and outpatient/day therapy services

IPCE Project Aim

- To develop, pilot and evaluate a model of inter-professional clinical education for allied health students.

Inter-Professional Clinical Education…..

……when students of more than one professional group are collaboratively engaged in the development of attitudes, knowledge and skills in a clinical setting.

They learn with, from and about each other….to improve collaboration and the quality of care.

CAIPE, 1997 and Freeth et al 2005

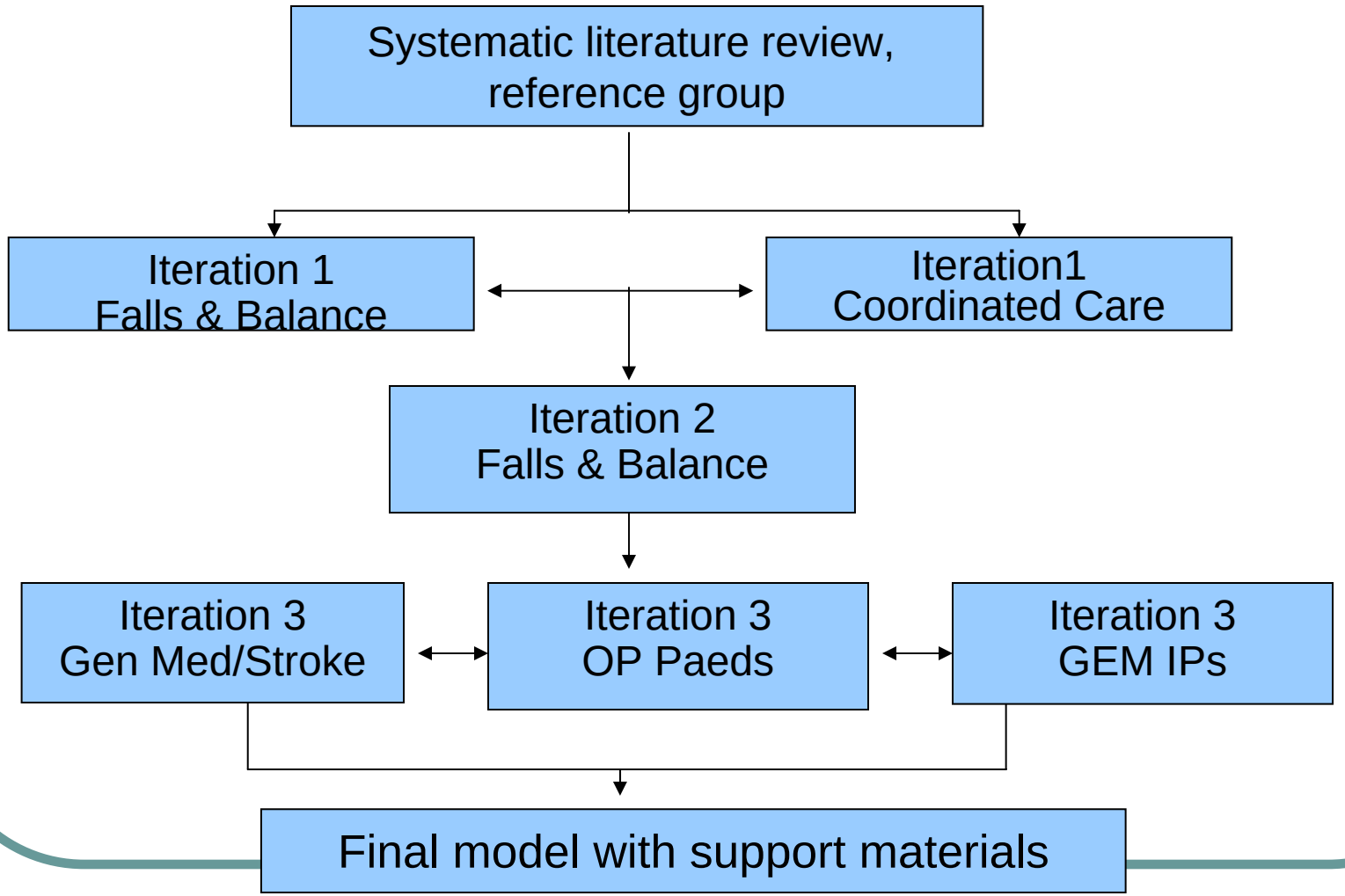
(nb: the goal *isn't* to develop generic practitioners!)

IPCE Project Objectives

To develop, pilot & evaluate a model of inter-professional clinical education for allied health students that:

- Prepares graduates to be more work ready in for clinical care and in inter-professional working
- Evaluates applicability of model across clinical programs
- Has potential for wider application to other disciplines i.e. medicine and nursing.
- Is efficient and economically sustainable
- Promotes a culture of interdisciplinary practice - `patient-centred care'

Project model



Initial placement structure

- Final year students (usually last placement)
- Groups of 4 – 6 students (n = 14, 3 placements)
- 3 - 4 different disciplines
- 2 days/week for four weeks in IPCE placement working with IPCE team facilitators
- Balance of their placement in a “discipline specific” role with discipline supervisors

Program evaluation

Participants:

- Students
- Clinical educators
- Academic educators
- Patients

After each iteration: focus groups, patient semi-structured interviews

Post program follow-up phone-call to students (4-5 months post qualification)

Typology for outcomes of inter-professional education

1 Reaction - learners' views on the learning experience and its inter-professional nature

2a Modification of attitudes/ perceptions

2b Acquisition of knowledge/ skills

3 Behavioural change

4a Change in organisational practice

4b Benefits to patients/ clients, families and communities

Reference: Freeth et al. 2005, *Effective Interprofessional Education*, Blackwell, Oxford

Our Experience

What have we experienced in this project to date?

Systematic Review Findings

- IPCE: Huge diversity in the models, team composition (students and facilitators), duration, timing, aims, teaching/learning methods, outcome measures and evaluation practice.
- Literature gives guiding principles but little clear direction re best model or approach.
- Logistics and overcoming structural issues are among the biggest IPCE barriers
  - Silo arrangement of undergraduate training
  - Timing, allocating and negotiating student placements
  - Recruiting faculty and students (if a voluntary program)
  - Creating appropriately matched student teams

Islands in the stream…….what holds us back from connecting?

- Lack of common language or misunderstandings:
  - Multi-disciplinary/ multiprofessional
  - Inter-disciplinary/ interprofessional
  - Transdisciplinary (????generic!)
  - Everyone, doing everything together, all of the time!
- Structures
  - Compartmentalised approach – both in the university and in the health service
  - Learn and practice in silos
  - Registration, supervisory and accountability requirements
  - Logistics/organisational demands are very high

Islands in the stream…….what holds us back from connecting?

- Relationships
  - Trust, interpersonal relationships and understanding of each other's roles, responsibilities and expectations
  - Appreciation of each other, interdependence
- Swimming against the tide – culture change
  - Few challenges to the status quo of multidisciplinary team practice – need prompts to reflect on practice and change behaviour
  - Training students in interprofessional working is training in a model or approach that is still uncommon in health care practice
  - Few role models of effective interprofessional team practice
  - Limited high quality or consistent evidence on the efficacy and value of interprofessional practice – can be difficult to "sell"

Is interprofessional practice a discipline specific skill?

- Task related, discipline specific skill based competencies
  - perceived as *VITAL* and
  - of highest priority in the placement setting
- Process related team and interprofessional competencies
  - seen as *SECONDARY*
  - “soft skills”…….“icing on the cake”
  - something you can “pick up as you go along”
  - something you do if you have time

What gets measured gets done…….

- Interprofessional learning needs to be part of the assessment process for the placement
- Analysis of student assessment process
  - Mapped discipline assessment formats (all very different) against the IPCE placement objectives
  - Team skills usually included under only 1 item – “professional attributes” or “professional and communication skills”
  - Was not labelled or in flashing lights!

It’s about the patient…….

- Patient centred care is a good driver for interprofessional learning & working:
  - It’s not about “us”, it’s about the patient
  - Team collaboration, with the patient, provides a range of perspectives on patient needs, interventions and outcomes
- Still many “discipline” or “service” centric approaches

Integrated or special?

- IP learning & practice:
  - Not yet commonplace
  - Balancing act between making IP learning “special” and encouraging it as “routine”
  - Structural and logistic barriers = a degree of “specialness” –> still a minority behaviour
  - WIIFM factor can be difficult to explain and promote

What helps IP placements to work?

- Willing collaborators with the energy, enthusiasm and time to swim against the tide
- Organisational support and leadership
- Lots of ground work and organisational development
- Resources to enable effective project management, supervision and support to manage the logistics and the learning
- Pragmatic, flexible and adaptable approach
- Skilled facilitators who provide good role modelling
- Reframe IP skills as core (?“discipline specific”) skills

What helps IP placement to work? (Cont.)

- Students have an opportunity to get to know one another
- Students have direct experience of each other's work
  - Sharing assessment and treatment sessions with patients provides a hands on opportunity to better understand and appreciate others roles, skills and contribution
- Experience "process" focus as well as "task"
  eg. reflecting on and learning how teams work
- Follow patients through an episode of care
- Integration of IP learning with balance of placement
- Focus on the patient, rather than the disciplines!
- IP competencies are part of placement assessment

Planning – Iteration 3

- Planning a more `Integrated Model' – `IPCE activities' throughout placement rather than specific `IPCE days'
- Shared patients, plus structured, shared learning sessions
- Clinical supervision: train and support discipline supervisors to take more of a team facilitator role
- Input from a team facilitator working with discipline supervisors
- Planned IPCE clinical placements for 2nd Semester 2007: Aged Care Inpatient Unit; Acute Medical / Stroke Unit; Paediatric Outpatient Clinic

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