



# **Interprofessional Care: A Blueprint for Action in Ontario**

*Submitted by the*  
**Interprofessional Care Steering Committee**

July 2007

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Dear Dr. Tepper,

We are pleased to submit the results of our work, *Interprofessional Care: A Blueprint for Action in Ontario* (Blueprint). Working on this project to help advance interprofessional care in Ontario has been a rewarding experience.

This document contains the results of months of collaborative, thoughtful discussion and input from some of the province's leading experts and decision-makers in the fields of health care and education, each of whom recognizes the value of interprofessional care to the transformation agenda, our health work force and enhanced quality of care for Ontarians.

The recommendations contained in this Blueprint focus on the need for partnership, integration, shared responsibility, communication, foundation-building and supporting change. We are confident that Ontarians will benefit from such a systemic approach to interprofessional care.

Thank you for the opportunity to develop this Blueprint.

Sincerely,



Tom Closson  
Co-Chair



Ivy Oandasan, MD  
Co-Chair

# Interprofessional Care Steering Committee

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# Acknowledgements

The Interprofessional Care Steering Committee (Steering Committee) would like to acknowledge the expertise and assistance of the members of the Education, Organizational Structure and Regulation working groups (see Appendix A for a listing) and thank them for their participation and contribution to the development of Interprofessional Care: A Blueprint for Action in Ontario (Blueprint). Their leadership and support have been invaluable and greatly appreciated. The development of this Blueprint was truly a collaborative, team-based effort.

Ontario health care and education leaders have also played a key role in the development of this Blueprint. They include representatives of regulatory bodies, health care professional organizations, academic institutions, hospitals, insurers, community and support agencies, researchers, patient/consumer groups and government. This Blueprint reflects their contributions to and support for the implementation of interprofessional care in Ontario.

Finally, the Steering Committee also wishes to acknowledge the following organizations for volunteering the use of their facilities for meetings and consultations during the development of this Blueprint:

Cancer Care Ontario  
College of Physiotherapists of Ontario  
Ministry of Health and Long-Term Care  
Ontario Medical Association  
University Health Network  
University of Toronto

While the input of many people has helped shape this Blueprint, it reflects only the views of the Steering Committee.

# Executive Summary

## At a Glance

The Ontario health care system will function more effectively if it embraces the practice of interprofessional care.

This Blueprint was developed following a year-long process of obtaining input from decision-makers and leaders in the health care and education sectors, as well as consumers.

Achieving effective implementation of interprofessional care requires a comprehensive action plan that identifies the roles each partner or participant should undertake.

This Blueprint provides direction on key foundational activities that should be carried out in the short, medium and long term.

## Interprofessional Care — The Context

Demands on the health care system are increasing. Chronic diseases such as cardiovascular disease, diabetes, respiratory disease and mental illness are on the rise, and patients and their families want to be actively engaged in managing their health conditions, expecting the right care at the right time. Health care organizations are feeling pressured to provide more timely services, while at the same time working with finite human and financial resources. For these reasons, new ways of approaching care are needed, and different solutions will be required to meet future demand.

A collaborative, team-based approach to care can be an enabler for improving patient care and meeting the demands that the system is facing. This process, called *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 can be systemically implemented to assist in health care system renewal and improved sustainability.

*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.*

Many work environments suffer from a lack of support for collaborative, team-based care, but improved collaboration and teamwork through interprofessional care will assist caregivers to work more effectively by helping to manage increasing workloads, reduce wait times and reduce patients' likelihood of suffering adverse reactions as a result of the care they receive.<sup>1</sup>

Interprofessional care is by no means a new idea. Some organizations have already developed approaches

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that make it easier for health caregivers to collaborate using teamwork principles. For example, teams organized around palliative care, geriatrics, critical care and mental health care are demonstrating that it is possible to organize structures and processes so that health caregivers can work more effectively together. The concept of a collaborative, team-based approach to care has been endorsed by governments throughout Canada and around the world, and recent initiatives in Ontario in the form of Family Health Teams, wait-times management and Local Health Integration Networks (LHINs) are intended to centre on a model of interprofessional care.

There is mounting evidence that an interprofessional care environment may offer multiple benefits, including the following<sup>1,2</sup>:

- Increased access to health care.
- Improved outcomes for people with chronic diseases.
- Less tension and conflict among caregivers.
- Better use of clinical resources.
- Easier recruitment of caregivers.
- Lower rates of staff turnover.

Caregivers must be competent to practice *interprofessional care*. It is acknowledged that interprofessional education and interprofessional care must be advanced simultaneously in order for success to be achieved.<sup>3</sup>

## Blueprint Development Process

Following an invitational summit in June 2006 that saw strong support for the adoption of interprofessional care, it was recommended that a blueprint be developed to assist in moving this strategy forward. The Interprofessional Care Project was struck in the Fall of 2006, and the Interprofessional Care Steering Committee (Steering Committee) was formed. It is comprised of experts in the fields of policy, education, regulation and organizational structure who were either decision-makers, implementers or influencers in interprofessional education and interprofessional care. The Steering Committee accepted the work of creating a blueprint that would provide guidance to government, educators, health care workers, organizational leaders, regulators and patients about how to make the adoption of interprofessional care a reality.

The Steering Committee created three working groups: Organizational Structure, Education and Regulation. Each group was populated with experts from a wide variety of organizations, including hospitals, community agencies, colleges and universities, regulatory bodies, professional associations, insurance agencies and unions.

After a year-long process of reviewing the relevant research and holding consultations and meetings, the Steering Committee has developed four key recommendations and associated activities that provide an effective framework for implementing interprofessional care.



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## Blueprint for Action

*Interprofessional Care: A Blueprint for Action in Ontario* (Blueprint) identifies approaches that will help to integrate interprofessional care into existing systems, legislation and infrastructures. The following directions identified during the consultation process should be addressed:

- **Building the foundation:** The building process begins with the education system, which needs to prepare current and future caregivers to work within interprofessional care models. New health care providers entering the system should be trained to provide care in a collaborative environment, and students should be encouraged to join their local interprofessional health science students' association. Educators at universities and colleges need to incorporate interprofessional education into existing curriculum or develop new curriculum. Professional development programs on interprofessional care should be offered to ensure maintenance of competency once health care providers are in practice.
- **Sharing the responsibility:** Professions need to review their standards of practice with a view to integrating interprofessional collaborative, team-based care approaches. Professions should practice within their full scope of practice, consistent with safe care. Unions and management should be open to including interprofessional care concepts in collective agreements.
- **Implementing systemic enablers:** Legislation and liability coverage for all health care providers must be reviewed, paying specific attention to the meaning of professional responsibility and accountability within team-based structures.
- **Leading sustainable cultural change:** All leaders must look for ways to integrate interprofessional care into existing strategies. Funding systems should be structured to provide incentives for the adoption of interprofessional care.

This Blueprint positions the adoption of interprofessional care as a change-management process and calls on everyone in the health care and education systems to adopt a common vision to improve communication and collaboration, ultimately leading to a more effective, integrated health care system in which:

- Patients and their families are part of the caregiving team.
- Patients are confident in the caregiving team's ability to take care of their health care needs.
- Health caregivers collaborate and communicate effectively.
- Health care settings embrace interprofessional care.
- Infrastructure, funding models and policies exist to support interprofessional care.

Below is a snapshot of the Steering Committee's recommendations.

## Blueprint Recommendations at a Glance

Direction	Strategy	Recommended actions
<b>A. Building the foundation</b>	<i>Create a firm foundation upon which key inter-professional care activities can be implemented and sustained.</i>	<ol style="list-style-type: none"> <li>1. Define core competencies for interprofessional care.</li> <li>2. Clarify roles and responsibilities in an interprofessional care environment.</li> <li>3. Develop interprofessional education curriculum models.</li> <li>4. Agree on terms and conditions for adequate mandatory liability insurance.</li> <li>5. Ensure that patients, their families, volunteer caregivers and acute and community support services have the tools and resources they need to participate actively in care decisions.</li> </ol>
<b>B. Sharing the responsibility</b>	<i>Share the responsibility for ensuring that interprofessional care strategies are effectively implemented among interested parties.</i>	<ol style="list-style-type: none"> <li>1. Establish a provincial Interprofessional Care Implementation Committee.</li> <li>2. Develop a multi-level accountability framework.</li> <li>3. Create a central provincial resource for knowledge transfer.</li> </ol>
<b>C. Implementing systemic enablers</b>	<i>Provide systems, processes and tools that will allow interprofessional care to be taught, practiced and organized in a systemic way.</i>	<ol style="list-style-type: none"> <li>1. Conduct a legislative review to identify opportunities for supporting interprofessional care.</li> <li>2. Implement interprofessional care accreditation standards.</li> <li>3. Build interprofessional care into service-based and collective agreements.</li> <li>4. Incorporate interprofessional care into e-health strategies.</li> <li>5. Provide incentives for practicing interprofessional care.</li> </ol>
<b>D. Leading sustainable cultural change</b>	<i>Lead sustainable cultural change that recognizes the collaborative nature of interprofessional care and embraces it at all levels of the health care and education systems.</i>	<ol style="list-style-type: none"> <li>1. Implement a public engagement strategy.</li> <li>2. Support interprofessional care champions.</li> <li>3. Provide support for interprofessional care and interprofessional education.</li> <li>4. Evaluate system performance and outcomes.</li> </ol>

## Implementation Plan

Achieving effective implementation of interprofessional care requires a comprehensive action plan that identifies the roles each partner or participant should undertake. The plan developed in this Blueprint is a starting point and will need to be updated and refined as the key parties take ownership of their responsibilities in its implementation.

## Closing Thoughts

Collaboration, partnership, communication and teamwork have been the hallmarks of the creation of the Blueprint. We trust that these core values will guide the successful implementation of interprofessional care in Ontario.

# Chapter I:

## Interprofessional Care — the Context

### At a Glance

Demands on the health care system are increasing; interprofessional care will be an important mechanism for assisting with system renewal and sustainability.

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.

Research documenting the benefits of interprofessional care is building.

The challenges of implementing interprofessional care must be understood and managed to achieve success.

### The Case for Interprofessional Care

Demands on the health care system are increasing. Chronic diseases such as cardiovascular disease, diabetes, respiratory disease and mental illness are on the rise (there are approximately 16 million Canadians living with chronic illnesses<sup>4</sup>), and population trends show a rapidly growing elderly population, longer life expectancy and increased prevalence of chronic diseases and disabilities among aging baby boomers.<sup>5</sup>

Along with these demands, patients and their families want to be more actively engaged in managing their health conditions, expecting the right care at the right time. Health care organizations are feeling pressured to provide more timely services, while at the same time working with finite human and financial resources.

For these reasons, new ways of approaching care are needed, and different solutions will be required to meet the future demand.

A collaborative, team-based approach to care can be an enabler for improving patient care and meeting the demands that the system is facing. This process, called 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 can be systemically implemented to assist in health care system renewal and improved sustainability.

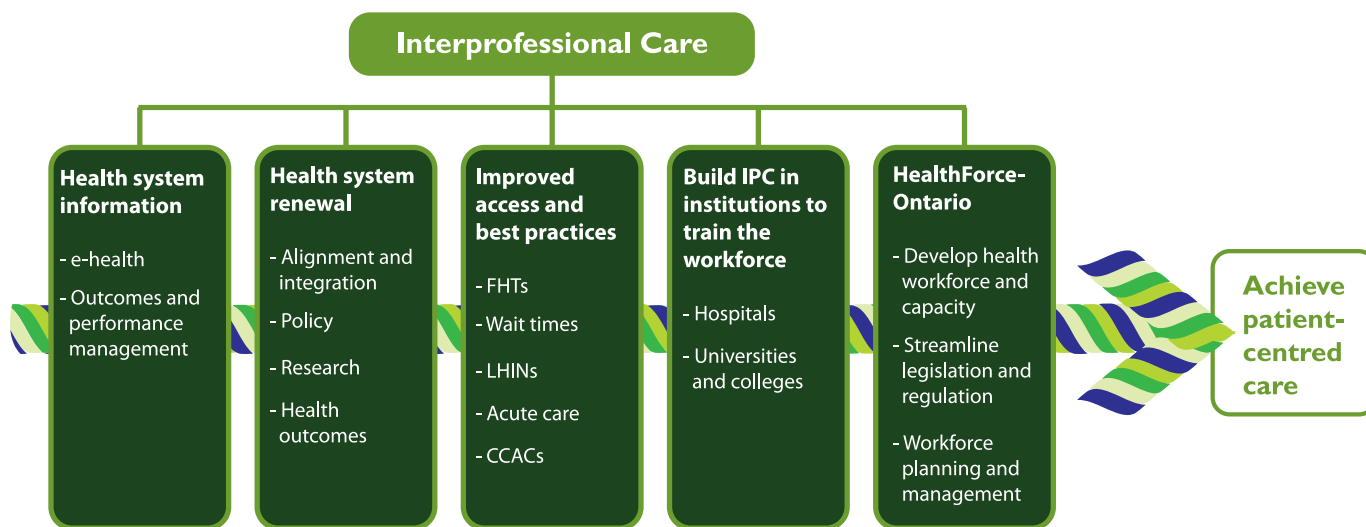
Many work environments suffer from a lack of support for collaborative, team-based care. Improved collaboration and teamwork through interprofessional care will assist caregivers to work more effectively by helping to manage increasing workloads, reduce wait times and reduce patients' likelihood of suffering adverse reactions as a result of the care they receive.<sup>1</sup>

The health care system is gradually being transformed to ensure that the patient is at the centre, delivery is timely, care is safe, continuity is maintained and access is guaranteed. For example, the creation of Family Health Teams is making it easier for patients to gain access to primary care services. Team-based models to reduce wait times for surgeries is another innovative approach to care. Organizations and care delivery agencies and settings are being held accountable for service delivery and performance and are working with Local Health Integration Networks (LHINs) to integrate and manage care within communities.

In Ontario, numerous initiatives grounded in the concept of interprofessional care have already been undertaken. Primary care reform had its genesis in the need to create team-based approaches to enhance the patient care experience, and a series of guides supporting interprofessional collaborative team practice have been developed for Family Health Teams. These guides include descriptions of how the different roles and responsibilities of health professionals can be integrated to enhance assessment, treatment, management, education, referrals and resources for patients.<sup>6</sup> In addition, a key focus of the LHINs is to enhance the seamless care delivery processes for patients as they move between sectors (e.g., patients moving from a hospital to a rehabilitation centre and then home).

Figure 1.1 shows how interprofessional care can be incorporated into current health care system renewal initiatives to help enhance patient care.

Figure 1.1 Enablers for Ontario Health Care and Education Systems



**Note:** CCAC denotes Community Care Access Centre; FHT, Family Health Team; IPC, Interprofessional Care; LHIN, Local Health Integration Network.

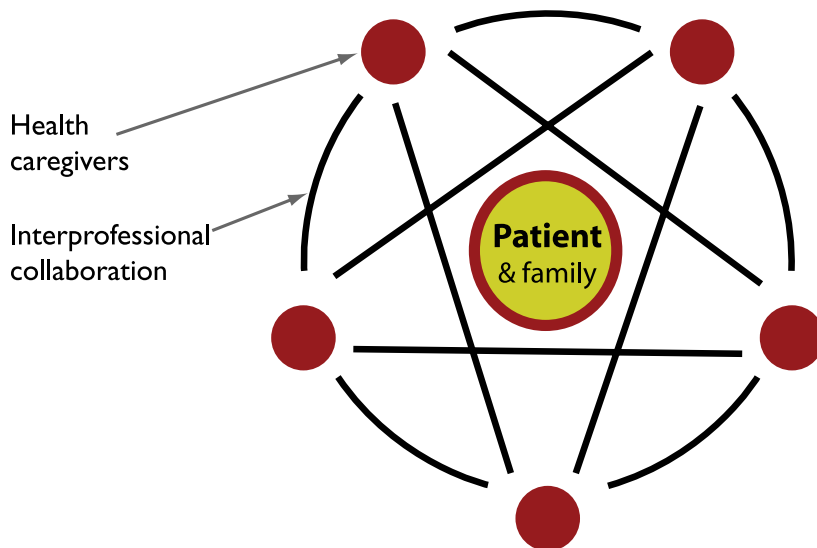
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## Interprofessional Care Defined

In this *Blueprint*, the Interprofessional Care Steering Committee (Steering Committee) is using the following definition for the term *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.” (Note: See the glossary for this definition and others.) Figure 1.2, illustrates the interconnected nature of this approach.

The term *health caregivers* was also chosen intentionally for use in this document because it acknowledges the different types of individuals who provide care for patients and their families. It recognizes that all those who provide care, including regulated and unregulated health caregivers, as well as the patient, family, friends and community volunteers, are active members of the health care team. In order to be inclusive and successful, all types of health caregivers must participate in implementing the recommendations presented here in this *Blueprint*.

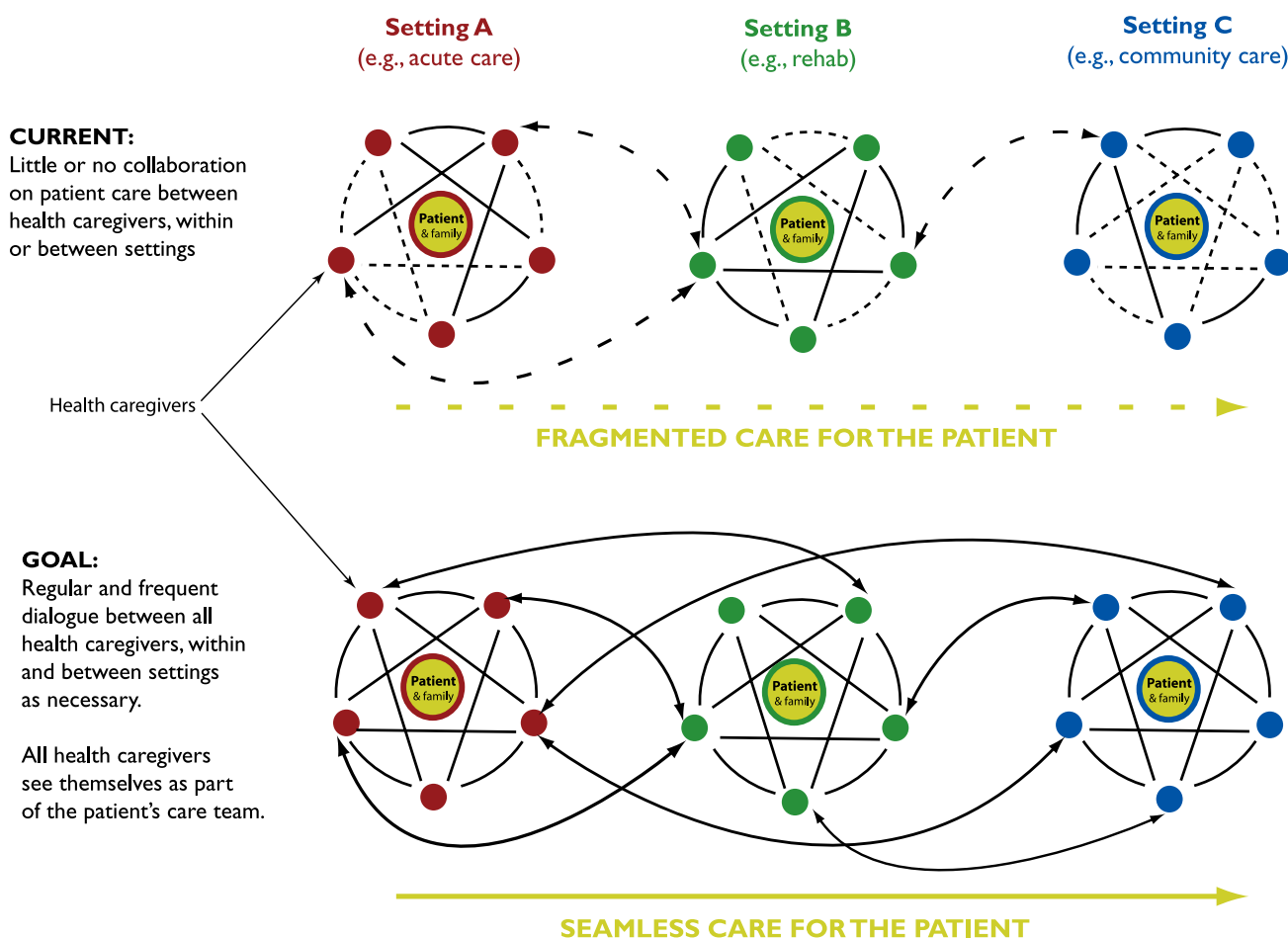
Figure 1.2 Interprofessional Care Defined



Our health care system often separates caregivers rather than uniting them; each group of caregivers is trained in its own discipline, many belong to a different professional association and many report to a separate regulatory body. However, some organizations have created approaches to make it easier for health caregivers to collaborate using teamwork principles. This can occur both within a care delivery setting and across settings (i.e., hospitals, home care, etc.). For example, teams

organized around palliative care, geriatrics, critical care and mental health care are demonstrating that it is possible to organize structures and processes so that health caregivers can work more effectively together. Better outcomes can be achieved by optimizing the expertise of all caregivers involved in the care process, including the patient and his or her family, leading to seamless care for the patient, as shown in Figure 1.3.

Figure 1.3 Spectrum of Patient Care



**Note:** Broken lines depict non-existent or inconsistent level of communication between settings and among health caregivers and patients. Solid lines depict the open and transparent communication and interaction that occurs as a result of interprofessional care practices and processes.

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The manner in which health caregivers deliver care should be based on the principles of collaborative practice. Communication, trust, confidence in oneself, confidence in other health care partners, autonomy, mutual respect and a feeling of shared responsibility are essential elements in collaboration.<sup>7</sup> Functioning in a team is a key part of collaboration and helps guide the decision-making process. Rather than having many individuals working in silos to make decisions for the patient, a team of people works collaboratively with the patient and family to provide care. The process occurs across the continuum of a patient's care, with health caregivers who agree to communicate and collaborate, regardless of setting.

Interprofessional care is by no means a new idea. The concept of collaborative, team-based approaches to care has been endorsed by governments throughout Canada and around the world; the federal, provincial and territorial governments, through the 2003 and 2004 Health Accords,<sup>8,9</sup> have identified interprofessional care as a priority for health care system renewal; and many Canadian jurisdictions have incorporated interprofessional care into their health human resources planning. It is recognized that caregivers must be competent to practice interprofessional care, "...if health care providers are expected to work together and share expertise in a team environment, it makes sense that their education and training should prepare them for this type of working arrangement..."<sup>39</sup> Interprofessional education and interprofessional care must be advanced simultaneously in order for success to be achieved.<sup>3</sup>

Federally commissioned reports have provided a better understanding of the complex nature of interprofessional care and the need for broad participation among the multiple stakeholders within and

across the health care and education systems.<sup>1,10,11</sup> Moreover, there is mounting evidence that an interprofessional care environment may offer multiple benefits, including the following<sup>1,2</sup>:

- Increased access to health care.
- Improved outcomes for people with chronic diseases.
- Less tension and conflict among caregivers.
- Better use of clinical resources.
- Easier recruitment of caregivers.
- Lower rates of staff turnover.

## Evidence of the Benefits of Interprofessional Care

Health care systems research indicates that interprofessional care can provide numerous benefits, including improved patient care and safety, enhanced provider satisfaction and better organizational efficiency. Interprofessional care can also contribute to system innovation and sustainability. Examples of research into the benefits of interprofessional care include the following:

- Improved communication reduces medical errors,<sup>1</sup> in one study lowering emergency department clinical error rates from 30.9 to 4.4%.<sup>12</sup>
- Lack of coordination results in redundancy in medical testing, leading to additional costs.<sup>12</sup>
- A study of closed claims in a hospital showed that improved teamwork could have prevented or mitigated the events leading to malpractice claims in 43% of the events under study.<sup>13</sup>
- A non-controlled study of the impact of a medical emergency team in a 300-bed hospital found that the incidence of unexpected cardiac arrest declined by 50%.<sup>14</sup>

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Evidence continues to build around the benefits of interprofessional care. In Ontario, the number of interprofessional care projects being initiated by health care and education organizations continues to grow (examples are highlighted in Appendix B), and each project offers an opportunity to learn more about the potential benefits of interprofessional care.

## Addressing Challenges to Interprofessional Care Implementation

Partnership, communication and collaboration are the key principles of a highly effective interprofessional care environment. There are many variables and challenges at play in the current health care system that will have implications for the successful implementation of interprofessional care. To achieve this goal, it will be important to manage these challenges, including the following:

- **Dealing with change:** Creating an interprofessional care environment within and across care delivery settings will require changes in the way care is currently delivered. Health caregivers will need to adopt common patient care goals and help break down the silos and power structures that hamper interprofessional care.<sup>15</sup>
- **Legislation/regulations:** Existing legislation and regulations are perceived to be barriers to health professions fully functioning to their scope of practice, thus resulting in underutilization of health human resources. One challenge is identifying ways to utilize the enablers within legislation to support interprofessional care. An example is the *Regulated Health Professions Act, 1991 (RHPA)* which is not an exclusive scope of practice

model but a regulatory model that allows for overlapping scopes of practice and delegation which provides an ideal base for encouraging the professions. However, other pieces of legislation governing specific types of care that reference health care professions may specify a narrower range of activities that might be possible under the framework of RHPA and reduce interprofessional care opportunities.

- **Funding:** Obtaining funding to support interprofessional care models is challenging because of other competing demands for financial resources. Internationally, reimbursement models are being introduced to enable integrated health teams to practice effectively.<sup>15</sup> Ontario has funded several initiatives, providing financial incentives that support interprofessional care.
- **Education and training:** Educating health caregivers based on interprofessional care curriculum has been a challenge. It has been difficult to incorporate such curriculum into university and college programs so that health caregivers can receive the education and training they need to practice in an interprofessional care setting. Further, faculty are needed to teach interprofessional education and care, not only for new graduates but also for those at the post-graduate level. Accreditation processes do not always include standards for interprofessional practice as a requirement. Most professional development programs are not currently focused on training practitioners and caregivers to work together to enhance patient care.



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- **Liability:** Liability insurance coverage has been perceived as a major challenge to interprofessional care implementation, but many teams have been able to work in an interprofessional care environment without incident.<sup>16</sup>

The challenges that the health care system faces in delivering quality, patient-centred care through an interprofessional care approach can be overcome. We need to work together to address these challenges and create solutions for the successful implementation of interprofessional care.

# Chapter 2:

## Blueprint Development Process

### At a Glance

This Blueprint has been developed to produce a concrete action plan, building on the dialogue that occurred at an invitational summit in June 2006.

A Steering Committee was formed following the summit, which used working groups to develop recommendations and actions that could provide a framework for implementing interprofessional care in Ontario.

This *Blueprint* was created to support HealthForceOntario. HealthForceOntario is a collaborative, multi-year strategy designed to enhance patient care by strengthening the province's health workforce. Its mandate is to develop strategies to address the province's health human resources needs, work with the education system to develop people with the right knowledge and skills and advance the practice of interprofessional care.

Following an invitational summit in June 2006 that saw strong support for the adoption of interprofessional care, it was recommended that a blueprint be developed to assist in moving this strategy forward.<sup>15</sup> The Interprofessional Care

*The Steering Committee consisted of experts in the fields of policy, education, regulation and organizational structure who are either decision-makers, implementers or influencers in interprofessional education and practice.*

Project was initiated in the Fall of 2006, and the Interprofessional Care Steering Committee (Steering Committee) was formed. It consisted of experts in the fields of policy, education, regulation and organizational structure who are either decision-makers, implementers or influencers in interprofessional education and practice. The Steering Committee accepted the responsibility of creating a blueprint that would provide guidance to government, educators, health care workers, organizational leaders, regulators and patients about how to make the adoption of interprofessional care a reality.

As part of its mandate, the Steering Committee was to develop recommendations that would have a high likelihood of being implemented and put into practice. The recommendations were to be:

- Feasible
- Built from current programs
- Cost-effective
- Broadly applicable
- Readily adaptable across a range of health and education sectors

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Priority was placed on strategies supported by published research or interprofessional care projects showing benefits to patients, caregivers, organizations and the overall health care system. The Steering Committee was also to ensure that its recommendations would be aligned with other priorities, such as wait times, chronic disease management and initiatives under the HealthForceOntario Strategy. Figure 2.1 shows the steps involved in creating the *Blueprint*.

### Seeking Expert Input

In order to obtain input from decision-makers and leaders in interprofessional care, the Steering Committee created three working groups: Organizational Structure, Education

and Regulation. Each group was populated with experts from a wide variety of organizations, including hospitals, community agencies, colleges and universities, regulatory bodies, professional associations, insurance agencies and unions (Appendix A provides a list of working group members).

The Steering Committee directed the three working groups to identify the key action-oriented activities and priorities that would facilitate interprofessional care through all levels of the health care and education systems.

Figure 2.1 Blueprint Development Process



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## Interprofessional Care Framework

Each working group developed its own report and identified the specific activities and strategic directions that would be necessary to promote interprofessional care. From these reports, four common themes emerged:

- A. Building the foundation
- B. Sharing the responsibility
- C. Implementing systemic enablers
- D. Leading sustainable change

These themes and corresponding actions were presented at a stakeholder consultation session, an opportunity for 150 leaders across the health care and education sectors to provide input and feedback on the proposed strategy for advancing interprofessional care. Stakeholders supported the themes outlined above and recommended that an infrastructure be put into place to stage the implementation of interprofessional care in a flexible manner, with grassroots involvement.

As a result of this collaborative and consultative process, the Steering Committee developed four overarching recommendations, with actions flowing from each one (*see Chapter 3*). These actions, if given appropriate attention, can provide an effective framework for implementing interprofessional care.

# Chapter 3:

## Blueprint for Action

### At a Glance

All stakeholders must work in partnership to implement an effective interprofessional care strategy.

This Blueprint addresses the four directions needed for interprofessional care to be practiced:

- A. Building the foundation
- B. Sharing the responsibility
- C. Implementing systemic enablers
- D. Leading sustainable cultural change

This *Blueprint* for action identifies approaches that will help to integrate interprofessional care into existing systems, legislation and infrastructures. All participants in the health care and education sectors must do their part to ensure the successful implementation of these directions and actions. The following directions identified during the consultation process (*see Chapter 2*) should be addressed:

- **Building the foundation:** The building process begins with the education system, which needs to prepare current and future caregivers to work within interprofessional care models. New health care providers entering the system should be trained to provide care in a collaborative environment, and students should be encouraged to join their local interprofessional health science students' association. Educators at universities and colleges need to be supported to incorporate interprofessional education into existing curriculum or develop new curriculum. Professional development programs on interprofessional care should be offered to ensure maintenance of this competency once health care providers are in practice.
- **Sharing the responsibility:** Professions need to review their standards of practice with a view to integrating interprofessional collaborative, team-based approaches. Professions should practice within their full scope of practice, consistent with safe care. Unions and management should be open to including interprofessional care concepts in collective agreements.
- **Implementing systemic enablers:** Legislation and liability coverage for all health care providers must be reviewed, paying specific attention to the meaning of professional responsibility and accountability within team-based structures.

*All participants in the health care and education sectors must do their part to ensure a successful implementation.*

- Leading sustainable cultural change:** Leaders across the health care and education systems from front-line clinicians, organizational decision-makers, educators, patients and families, policy-makers and senior government must look for ways to integrate interprofessional care into existing strategies. Funding systems should be structured to provide incentives for the adoption of interprofessional care.

In order for interprofessional care to be effectively implemented, these four directions must be coordinated and integrated; work on the directions should be interconnected for maximum effect (see Figure 3.1).

A summary of the Steering Committee recommendations can be found in Figure 3.1. The recommendations are targeted at both the health care and education sectors, as they must both play important leadership roles in implementing the recommendations.

Figure 3.1 Interprofessional Care Implementation Framework



Table 3.1 Blueprint Recommendations at a Glance

Direction	Strategy	Recommended actions
<b>A. Building the foundation</b>	<i>Create a firm foundation upon which key interprofessional care activities can be implemented and sustained.</i>	<ol style="list-style-type: none"> <li>1. Define core competencies for interprofessional care.</li> <li>2. Clarify roles and responsibilities in an interprofessional care environment.</li> <li>3. Develop interprofessional education curriculum models.</li> <li>4. Agree on terms and conditions for adequate mandatory liability insurance.</li> <li>5. Ensure that patients, their families, volunteer caregivers and acute and community support services have the tools and resources they need to participate actively in care decisions.</li> </ol>
<b>B. Sharing the responsibility</b>	<i>Share the responsibility for ensuring that interprofessional care strategies are effectively implemented among interested parties.</i>	<ol style="list-style-type: none"> <li>1. Establish a provincial Interprofessional Care Implementation Committee.</li> <li>2. Develop a multi-level accountability framework.</li> <li>3. Create a central provincial resource for knowledge transfer.</li> </ol>
<b>C. Implementing systemic enablers</b>	<i>Provide systems, processes and tools that will allow interprofessional care to be taught, practiced and organized in a systemic way.</i>	<ol style="list-style-type: none"> <li>1. Conduct a legislative review to identify opportunities for supporting interprofessional care.</li> <li>2. Implement interprofessional care accreditation standards.</li> <li>3. Build interprofessional care into service-based and collective agreements.</li> <li>4. Incorporate interprofessional care into e-health strategies.</li> <li>5. Provide incentives for practicing interprofessional care.</li> </ol>
<b>D. Leading sustainable cultural change</b>	<i>Lead sustainable cultural change that recognizes the collaborative nature of interprofessional care and embraces it at all levels of the health care and education systems.</i>	<ol style="list-style-type: none"> <li>1. Implement a public engagement strategy.</li> <li>2. Support interprofessional care champions.</li> <li>3. Provide support for interprofessional care and interprofessional education.</li> <li>4. Evaluate system performance and outcomes.</li> </ol>

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## A. Building the Foundation



**Strategy:** Create a firm foundation upon which key interprofessional care activities can be implemented and sustained.

Key elements required to build the foundation include the following:

- Agreement on the knowledge, skills, competencies and attitudes required to practice interprofessional care.
- Clarity on opportunities for health caregivers to optimize their roles within an interprofessional care setting.
- A clear understanding of the relationship between these optimal roles and accountability among health caregivers.

### Recommendations

#### 1. Define core competencies for interprofessional care

It is recommended that educators and regulators work together to define and agree on core interprofessional care competencies. Through the development of a common competency framework, it will be clear what is required for all caregivers to practice in this type of health care environment.

#### 2. Clarify roles and responsibilities in an interprofessional care environment

Processes should be developed and implemented to help caregivers, professional

associations and organizations understand their scope of practice, competencies, roles, responsibilities and accountabilities in order to have a fully functioning interprofessional care environment that supports open and clear communication. Effective communication within and across settings will enhance understanding among caregivers, creating opportunities to clearly describe the scope of each caregiver's role and accompanying responsibilities.

There is also a need to identify opportunities to optimize current roles and scope with respect to interprofessional care (for example, by promoting existing and new authorizing mechanisms through delegation). This may include creating broad provincial delegation processes to ensure consistency in its application across settings and facilitate interprofessional care. The Federation of Health Regulatory Colleges of Ontario has developed an interprofessional guide on delegation and a toolkit that should assist health professionals in practicing interprofessional care.<sup>17</sup> Clarifying and optimizing roles will help address health human resources challenges and introduce interprofessional care changes at the practice level.



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### 3. **Develop interprofessional education curriculum models**

Health caregivers will be working in increasingly interprofessional environments in the future. For this reason, it is important to equip them with the theory, techniques and practical clinical experience they will need to be successful. Interprofessional education should be incorporated into curriculum throughout the full range of education, from undergraduate through to postgraduate and continuing education.

Deans and principals of colleges and universities must provide a mandate for developing curriculum for entry-level health caregivers that incorporates the competencies required for interprofessional care. This can be accomplished by adapting curriculum already developed at some Ontario colleges and universities and from those from the United Kingdom,<sup>18</sup> the United States<sup>11</sup> and other parts of Canada.<sup>11</sup>

It will be necessary to connect education and practice through appropriate clinical placements in order to develop an effective interprofessional care model for new health caregivers.

### 4. **Agree on terms and conditions for adequate mandatory liability insurance**

In Canada, liability structures have traditionally been individually based. Adequate mandatory liability protection coverage is required for all caregivers if the practice of interprofessional care delivery is to be advanced.<sup>16</sup> A key concern among professions is the issue of who would ultimately be responsible and held accountable if an adverse event were to occur as the result of interprofessional care. For this reason, mandatory adequate liability insurance should be introduced for all caregivers participating in

interprofessional care.<sup>16</sup> Interprofessional care needs to be addressed from the perspective of providing clarification on roles and responsibilities with respect to legal liability.

### 5. **Ensure that patients, their families, volunteer caregivers and acute and community support services have the tools and resources they need to participate actively in care decisions.**

Action should be taken to ensure that patients and their families are also seen as partners in interprofessional care, along with unregulated and regulated health care professionals. Families play an integral role in supporting patients who require care, but they are not consistently included in the decision-making process. As patients navigate through the health care system from setting to setting, it becomes more difficult for them and their families to participate in care decisions.

Approximately three million Canadians act as family and volunteer caregivers.<sup>19</sup> It is estimated that these caregivers provide 80% of the required care in the home, yet their role in the delivery of primary care is barely acknowledged by the health care system. Such lack of acknowledgment of the invaluable contribution of these caregivers often increases the stress they experience in these roles.<sup>19</sup> They must be considered part of the health care team. This is of particular issue as health care policies shift care from institutional to community-based settings. Given the experience of family and volunteer caregivers, they should be involved not only in patient care decision-making but also in developing health care and education policies and programs.

Clear communication, partnership and leadership of all partners are necessary in order to achieve interprofessional care.

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## B. Sharing the Responsibility



**Strategy:** Share the responsibility for ensuring that interprofessional care strategies are effectively implemented among interested parties.

All health caregivers, educators, decision-makers and policy-makers have a shared, collective responsibility for the implementation of interprofessional care. For this reason, sharing the responsibility has been identified as a key principle for interprofessional care implementation. Implementation of interprofessional care should not fall to any one group; we are all responsible for making interprofessional care a success in Ontario.

### Recommendations

#### 1. Establish a provincial Interprofessional Care Implementation Committee

An Interprofessional Care Implementation Committee (Implementation Committee) should be established for ongoing interprofessional care coordination, dialogue and decision-making; playing a key role in building the foundation for interprofessional care; and overseeing the implementation of activities.

It is proposed that the Implementation Committee have a three-year mandate to oversee system-wide implementation of this *Blueprint*. Supported by the provincial government, the Implementation Committee should consist of members involved in current programs and initiatives aimed at

incorporating interprofessional education and interprofessional care practices at the grassroots level. It is recommended that activities of the Implementation Committee commence in the Fall of 2007. Appendix C provides further information on the proposed mandate and scope of the Implementation Committee.

#### 2. Develop a multi-level accountability framework

Effective implementation of interprofessional care will require accountability mechanisms at appropriate levels in the health care and education systems — from patient care to health care organizations, to Local Health Integration Networks (LHINs), to the provincial government. LHINs will play an increasingly active role in determining care-delivery needs and integrating care among multiple caregivers by means of their accountability agreements.

Shared accountability mechanisms may include interprofessional care expectations for all delivery organizations, such as the following:

- Organizational agreements to introduce interprofessional care structures and processes.
- A portion of government and LHIN funds tied to progress in interprofessional care.

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- Multi-level indicators measuring performance in settings that have adopted interprofessional care.

### 3. Create a central provincial resource for knowledge transfer

A knowledge-transfer process is recommended for sharing best practices, training interprofessional care implementers and providing support to those in the field. This will include the creation of an Ontario-specific body of knowledge of relevance to all participants in interprofessional care implementation.

Some provincial demonstration projects are already underway that provide opportunities for knowledge transfer with respect to interprofessional education and interprofessional care delivery, including the Interprofessional Mentorship, Preceptorship, and the Leadership Coaching Initiative; the Interprofessional Health Education Innovation Fund; and the recently completed Primary Health Care Transition Fund.

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## C. Implementing Systemic Enablers



**Strategy:** Provide systems, processes and tools that will allow interprofessional care to be taught, practiced and organized in a systemic way.

There are many systemic enablers that will have a significant impact on the health care system's ability to implement interprofessional care; indeed, numerous systems, processes and tools are already in place that could be built upon.

### Recommendations

1. Conduct a legislative review to identify opportunities for supporting interprofessional care

A review by government and regulators of the legislative framework should identify areas that may not require legislative changes, as well as legislation that may need amendment to ensure incorporation of interprofessional care.<sup>20</sup> Such a review should begin with health profession legislation in Ontario, the *Regulated Health Professions Act 1991*, in order to examine the impact it may have on the implementation of interprofessional care. The review should focus on how the Act can enable flexibility and system changes through interprofessional care. A subse-

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quent review should examine what changes to more general legislation would have the greatest impact in facilitating interprofessional care.

## 2. **Implement interprofessional care accreditation standards**

Accreditation has been shown to be an effective lever for change in achieving better care environments for providers and patients<sup>21</sup> and better education environments for students. There are current accreditation processes in place within health care organizations, regulatory bodies and academic institutions that can facilitate interprofessional care and interprofessional education.<sup>22</sup>

It will be essential to amend organizational accreditation systems to include interprofessional care, as well as to promote the inclusion of interprofessional care principles in accreditation models:

- Provider organizations must adapt to the new interprofessional care accreditation standards developed by the Canadian Council on Health Services Accreditation.<sup>23</sup>
  - Educational institutions must ensure that standards of education for professionals include interprofessional care curriculum and programs through accrediting education bodies, such as the Association of Accrediting Agencies of Canada. In May 2007, Health Canada commissioned the Association of Faculties of Medicine of Canada to help develop a national educational accreditation approach targeting medicine, nursing, pharmacy, social work, physiotherapy and occupational therapy.
- Regulators must develop, establish and maintain standards and quality improvement programs that will enable professions to practice interprofessional care. Initiatives are underway in developing accreditation criteria on how to practice interprofessional care within institutions.<sup>24</sup>

## 3. **Build interprofessional care into service-based and collective agreements**

Service-based agreements, funding models and memoranda of understanding are important vehicles for enhancing interprofessional care. Collective agreements should also reflect interprofessional care principles. Appropriate funding models will be needed to fully integrate interprofessional care concepts into patient care. This includes sustainable funding models for health caregivers to work in interprofessional teams and for educators to teach interprofessional care. Efforts should be made to determine what resources and support systems will be needed to enable caregivers to practice interprofessional care.

## 4. **Incorporate interprofessional care into e-health strategies**

E-health strategies have the potential to facilitate efficient and effective patient care delivery. Stakeholders have noted that e-health initiatives, such as the electronic health record, have the potential to be an enabler of interprofessional care.<sup>25</sup> Collaboration is needed with e-health leaders to establish standards for data and information-sharing that allow care teams within and across sectors to have ready access to patient information when making care deci-

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sions. The government has made a commitment to e-health as a way to enhance care delivery.<sup>26</sup> The success of e-health depends on skilled caregivers who can deploy the technology to provide optimal care. Interprofessional care practices will rely on e-health and, as such, should be acknowledged in the e-health agenda.

**5. Provide incentives for practicing interprofessional care**

Appropriate interprofessional care incentives must be provided so that health caregivers can

achieve an effective interprofessional care environment. Incentives can be a lever for encouraging interprofessional care; for example, they could be linked to “preferred provider” designation for community agencies.<sup>27</sup> In hospitals, resources such as interprofessional care courses could be provided to staff as an incentive for professional and career development.<sup>28</sup> Health care and education decision-makers and leaders need to consider a variety of alternative incentive mechanisms, approaches and models that will encourage health caregivers to practice interprofessional care.

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## D. Leading Sustainable Cultural Change



**Strategy:** Lead a sustainable cultural change that recognizes the collaborative nature of interprofessional care and embraces it at all levels of the health care and education systems.

The implementation of interprofessional care represents a significant cultural change. It must be aligned with other relevant government initiatives in a systematic, explicit manner, and in order for meaningful change to occur, it also needs to be sustained over time. A comprehensive, sustainable cultural change strategy should target all levels of the health care and education systems.<sup>29</sup>

### Recommendations

**1. Implement a public engagement strategy**

Implementing a public awareness campaign about interprofessional care will help to create a deeper understanding of its benefits on the part of key target audiences. The public’s understanding of and support for the change brought about as a result of interprofessional care

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are necessary components of implementation; without it, the success of implementation may be limited. Toolkits that support organizations, providers, regulators, educators, patients and families may be helpful in providing “how to” information for interprofessional care implementation.<sup>1</sup>

## 2. Support interprofessional care champions

Support will be needed to help leaders who are committed and dedicated to ensuring positive outcomes by promoting and advocating interprofessional care, whether in an educational or practice setting. It will be important to provide resources and tools for identifying, engaging and nurturing interprofessional care champions who will facilitate communication and leadership development across the continuum of health care and education settings.

## 3. Provide support for interprofessional care and interprofessional education

Interprofessional care must be incorporated into continuing education programs and activities, including the following:

- Instituting coaching teams/mentorship programs.
- Providing support for entry-to-practice learners so that they can embrace interprofessional care at the outset.
- Ensuring clinical placements are appropriately aligned to support entry-to-practice learners.

Context or setting is critical in understanding how to teach or practice interprofessional care in the community, acute care or long-term care setting.<sup>2</sup> Given the diversity of health care settings, cultural change will be needed to influence the structures and processes for health care teams and how they interact with teams in other health care settings. Continuing education programs in interprofessional care will need to be flexible and adaptable to ensure that what is taught is relevant to the context or setting within which interprofessional care will be practiced.

## 4. Evaluate system performance and outcomes

Evaluation and public reporting processes must be part of the implementation process in order to identify which activities are working well and help determine which need further attention. An evaluation framework may include the following:

- Funding targeted at interprofessional care projects to highlight positive or negative results and determine why projects have or have not been successful.
- Performance-monitoring and public-reporting mechanisms.
- Means of providing evidence on the outcomes and benefits of interprofessional care.
- Means of sharing collective performance measures among peers.
- Descriptions of interprofessional care in different practice settings (e.g., home care, acute care, long-term care, primary care, etc.) and its impact on a range of patient populations.

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## Summary

This *Blueprint* positions the adoption of interprofessional care as a change-management process and calls on everyone in the health care and education systems to adopt a common vision to improve communication and collaboration, ultimately leading to a more effective health care system in which:

- Patients and their families are part of the caregiving team.
- Patients are confident in the caregiving team's ability to take care of their health care needs.
- Health caregivers communicate effectively and collaborate.
- Health care settings embrace interprofessional care.
- Infrastructure, funding models and policies exist to support interprofessional care.

Collectively, all those involved in health care and health care education have a role to play in ensuring the successful implementation of interprofessional care. If one group fails to carry out its role, the implementation plan will be compromised. It is for this reason that the four directions must be viewed together and be addressed and enacted collectively.

# Chapter 4:

## Implementation Plan

### At a Glance

Achieving effective implementation of interprofessional care requires a comprehensive action plan.

Achieving effective implementation of interprofessional care requires a plan that identifies the roles each partner or participant should undertake. The plan developed in this *Blueprint* is a starting point and will need to be updated and refined as the key parties assume responsibility for its implementation.

Tables 4.1 to 4.4 outline a phased approach to engaging, developing, implementing and evaluating the proposed interprofessional care implementation activities over the short, medium and long term. Some of these activities have already been initiated and are at various stages of implementation.



Table 4.1 Building the Foundation

Create a firm foundation upon which key interprofessional care activities can be implemented and sustained				
Proposed Actions	Short term/ Immediate	Medium term	Long term	Participants
<b>Define core IPC competencies</b>	Agree on core IPC competencies.	Develop mechanisms for implementation.	Determine whether refinement is necessary.	Educators, regulators, professional associations.
<b>Clarify roles and responsibilities in an IPC environment</b>	Confirm mechanisms that promote IPC roles and responsibilities (e.g., delegation).	Develop resources for IPC practices within current environments.	Conduct survey to monitor progress.	Regulators, professional associations, delivery organizations.
<b>Develop interprofessional education programs</b>	Develop interprofessional education curriculum for entry-level students and health caregivers.  Develop and implement an interprofessional education faculty development program.	Implement interprofessional education curriculum.	Monitor progress on curriculum implementation.	Educators, regulators, professional associations, academic placement sites.
<b>Agree on terms and conditions for adequate mandatory liability insurance</b>	Explore options to address patient and profession-specific needs.  Define liability protection options.	Obtain consensus on what is adequate mandatory protection.	Monitor progress on implementation.	Insurance and malpractice community, regulators, professional associations, government, delivery organizations.
<b>Ensure that patients, their families, volunteer caregivers and acute and community support services have the tools and resources they need to participate actively in care decisions</b>	Create awareness of key partners (including patients and families).	Initiate engagement strategy across the health care and education systems.	Monitor/report on progress of strategy.	IPC Implementation Committee, government (all partners), consumers.

\*IPC denotes interprofessional care.

Table 4.2 Sharing the Responsibility

Share the responsibility for ensuring that interprofessional care strategies are effectively implemented among interested parties				
Proposed Actions	Short term/ Immediate	Medium term	Long term	Participants
<b>Establish a provincial IPC Implementation Committee</b>	Create a committee to support IPC implementation.	Oversee multi-sector implementation.  Monitor and report on progress.	Develop long-term strategic plan for IPC sustainability.	IPC Implementation Committee, government.
<b>Develop a multi-level accountability framework</b>	Develop and consult on accountability framework for IPC in alignment with system accountability.	Implement accountability framework.	Monitor progress.	IPC Implementation Committee, professional associations, regulators, delivery organizations, LHINs, government.
<b>Create a central provincial resource for knowledge transfer</b>	Establish partnerships and provide funding to establish central resource for knowledge-transfer activities.	Identify role models and best practices for IPC.  Implement comprehensive data collection and information sharing on IPC models.	Develop and disseminate regular reports on best practices.	Accreditors, IPC Implementation Committee, government, researchers.

IPC denotes interprofessional care; LHIN, Local Health Integration Network.

Table 4.3 Implementing Systemic Enablers

Provide systems, processes and tools that will allow interprofessional care to be taught, practiced and organized in a systemic way				
Proposed Actions	Short term/ Immediate	Medium term	Long term	Participants
<b>Conduct a legislative review to identify opportunities for supporting IPC</b>	Examine the Regulated Health Professions Act and the health profession acts to identify areas of impact and opportunity for interprofessional care, including any crossover legislation (e.g., <i>Healing Arts Radiation Protection Act, Laboratory and Specimen Collection Centre Licensing Act</i> ).  Recommend legislative changes.	Conduct qualitative review of all relevant health legislation and identify recommendations for facilitating IPC (e.g., <i>Community Care Access Corporations Act, Long-Term Care Act, Health Insurance Act and Public Hospitals Act</i> ).  Recommend legislative changes.	Implement legislative changes, if required.	Government, regulators, professional associations.
<b>Implement IPC accreditation standards</b>	Determine appropriate accreditation standards for professions, education and organizations.  Conduct an inventory of current standards and their relevance to IPC implementation.	Refine accreditation systems.	Evaluate progress of standards to determine whether further refinement is necessary.	Accreditors, regulators, educators, professional associations, organizations.
<b>Build IPC into service-based and collective agreements</b>	Review current service agreements and identify IPC opportunities in consultation with providers/unions.  Determine approaches to the provision of sustainable payment systems for health caregivers and educators to perform IPC.	Develop agreements that support IPC.  Develop funding models that foster IPC.	Monitor progress and determine whether further modifications are necessary.	Government, delivery organizations, professional associations, unions, LHINs, educators.
<b>Incorporate IPC into e-health strategies</b>	Consult with e-health agencies to ensure that systems foster IPC principles and processes.	Develop agreements incorporating IPC into e-health activities.	Monitor progress.	IPC Implementation Committee, government, LHINs.
<b>Provide incentives for practicing IPC</b>	Establish funding models that provide incentives for IPC implementation.	Oversee implementation of IPC funding models.	Conduct survey on effectiveness.	Government, LHINs, delivery organizations, professional associations.

IPC denotes interprofessional care; LHIN, Local Health Integration Network.

Table 4.4 Leading Sustainable Cultural Change

Lead a sustainable cultural change that recognizes the collaborative nature of interprofessional care and embraces it at all levels of the health care and education systems				
Proposed Actions	Short term/ Immediate	Medium term	Long term	Participants
<b>Implement a public engagement strategy</b>	<p>Develop an awareness campaign that targets patients, their families and health caregivers about the role and benefits of IPC.</p> <p>Develop “how to” communication resources to learn, teach and practice IPC.</p>	Provide an interim report on IPC implementation awareness progress.	Evaluate progress to determine level of understanding and support.	IPC Implementation Committee, professional associations, government, consumers, LHINs, delivery organizations.
<b>Support IPC champions</b>	Identify, develop and promote a roster of IPC champions.	Provide support to champions in promoting IPC.	Conduct a survey with champions and explore future opportunities.	Government, delivery organizations, educators.
<b>Provide support for interprofessional education</b>	<p>Develop an inventory of current programs.</p> <p>Develop professional development programs.</p> <p>Provide support for coaching and mentorship programs.</p>	Develop and implement an evaluation mechanism to ensure quality delivery and compliance.	Facilitate broad use of aggregate regulatory information and data to enhance IPC.	Educators, professional associations, regulators, government.
<b>Evaluate system performance and outcomes</b>	<p>Conduct an inventory of current Ontario projects related to IPC.</p> <p>Develop performance reporting mechanisms.</p>	<p>Develop an evaluation mechanism.</p> <p>Engage multi-sectoral participation in evaluating the success and effectiveness of IPC implementation.</p> <p>Develop measurement tools to evaluate caregiver, organization and system outcomes.</p>	Determine future activities necessary for IPC sustainability.	IPC Implementation Committee, delivery organizations, educators, government, researchers, IPC experts, professional associations, regulators, LHINs.

IPC denotes interprofessional care; LHIN, Local Health Integration Network.

# Chapter 5:

## Closing Thoughts

**At a Glance**

Collaboration, communication and partnership must guide the successful implementation of interprofessional care in Ontario.

This *Blueprint* is intended to be action-oriented. It offers a comprehensive set of actions and identifies the likely participants for each one. It also suggests which actions should receive priority attention in the short, medium and long term.

As the health care system transforms and new initiatives are introduced, every effort must be made to ensure that interprofessional care

practices are adjusted and aligned with these new initiatives. Further evidence regarding the effectiveness of interprofessional care will be gathered as implementation takes effect across the health care and education sectors. The following outcomes (Table 5.1) are anticipated at the practice, organization and system levels as a result of implementing interprofessional care.

**Table 5.1 Anticipated Outcomes**

Building the foundation	Sharing the responsibility	Implementing systemic enablers	Leading sustainable cultural change
Flexibility for professions to practice interprofessional care, regardless of health care setting.	Infrastructure that supports knowledge translation within health care and education sectors.	Greater efficiency of health human resources.	Increased student, educator and provider satisfaction.
Enhanced patient access to care delivery.	Developed, tested and implemented modules for use by students, preceptors and practitioners to advance interprofessional care and education	Increased provider satisfaction.	Increased patient/family satisfaction.
Increased provider competencies in interprofessional care.	A provincial interprofessional care framework that guides implementation of best practices.	Improved integration of health services.	Improved clinical outcomes.
Improved recruitment and retention.		Improved health care system effectiveness.	Strengthened link between education and practice to facilitate interprofessional care.
Flexible workforce with the skills to respond to health needs.		Increased commitment to interprofessional care at organizational and system levels.	Increased sustainability of the health care system.

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Interprofessional care is by no means a new idea. Palliative care, geriatric care, critical care and mental health care teams are examples of teams that are currently practising interprofessional care. This *Blueprint* provides the opportunity to expand on these examples and create new interprofessional care environments across settings, resulting in excellence in interprofessional care.

This *Blueprint* has outlined recommendations and actions that can foster the type of health care environment we all desire — one in which:

- Patients are at the centre of the health care system and are confident in the system's ability to help them address their needs.
- Health caregivers in teams communicate effectively and collaborate on the best course of action in diagnosing and treating patients.
- Health care settings embrace interprofessional care and offer incentives for successful adoption and practice.
- The system aligns to ensure that the right infrastructure, funding models and policies exist to support interprofessional care in health and education.

Collaboration, communication and partnership have been the hallmarks of the creation of this *Blueprint*. We trust that these core values will also guide the successful implementation of interprofessional care in Ontario.

# Appendix A:

## Expert Working Group Participants

The following is a list of working groups and their members who provided support to the Interprofessional Care Steering Committee. The terms of reference for these working groups were to develop the specific priorities and action plans that would advance interprofessional care from the perspectives of education, organizational structure and regulation within health care, education and practice settings.

### Education Working Group

Louise Nasmith, Professor and Chair, Department of Family and Community Medicine, University of Toronto (Principal of the College of Health Disciplines at the University of British Columbia as of June 1, 2007), Lead

- Alexandra Harris, President-Elect, Queen's Health Sciences Students' Association
- Kenneth Harris, MD, Chair, Post-Graduate Education, Council of Ontario Faculties of Medicine, University of Western Ontario
- Milka Ignjatovic, President, Interprofessional Healthcare Students Association
- Linda Jones, Clinical Instructor, School of Nursing, University of Ottawa
- Renee Kenny, Dean, School of Community and Health Studies, Centennial College
- Bev Lafoley, Manager, Health Sciences Clinical Education, Northern Ontario School of Medicine
- Kathleen MacMillan, Dean, School of Health Sciences, Humber Institute of Technology and Advanced Learning
- Siobhan Nelson, Dean and Professor, Faculty of Nursing, University of Toronto
- Margo Paterson, Associate Professor and Chair, School of Rehabilitation Therapy, Queen's University
- Mary Preece, Provost and Vice-President, Academic, at the Michener Institute
- Scott Reeves, Associate Professor, Department of Family & Community Medicine, University of Toronto; Director of Research, Centre for the Faculty Development, St. Michael's Hospital; Scientist, Wilson Centre, University Health Network
- Peter Walker, Former Dean, Professor, Faculty of Medicine, University of Ottawa
- Frances Lamb, Manager, Policy and Programs, Universities Branch, Ministry of Training, Colleges and Universities

## Organizational Structure Working Group

Judith Shamian, President and CEO, Victoria Order of Nurses, Lead

- Helen Angus, Vice-President, Planning and Strategic Implementation, Cancer Care Ontario
- Paula Burns, College of Respiratory Therapists
- Marilyn Emery, Former CEO, Central East Local Health Integrated Network (CEO, Women's College Hospital, as of July 16, 2007)
- Linda Haslam-Stroud, President, Ontario Nurses' Association
- Ruby Jacobs, Director, Health Sciences, Six Nations of the Grand River
- Vickie Kaminski, President and CEO, Sudbury Regional Hospital
- Louise Lemieux-Charles, PhD, Chair, Department of Health Policy, Management and Evaluation, University of Toronto
- Camille Orridge, Executive Director, Toronto Community Care Access Centre
- David Price, MD, Chair, and Associate Professor, Department of Family Medicine, McMaster University
- William Shragge, MD, Chief of Staff, Niagara Health System
- Mary Beth Valentine, Assistant Deputy Minister, Health, Social, Education and Children's Policy, Cabinet Office

## Regulation Working Group

Jan Robinson, Registrar, College of Physiotherapists of Ontario, Lead

- Zubin Austin, Associate Professor, Education Research in the Health Professions, Faculty of Pharmacy, University of Toronto
- Anne Coghlan, Executive Director, College of Nurses
- Susan Donaldson, Former CEO, Ontario Association of Community Care Access Centres
- Rocco Gerace, MD, Registrar, College of Physicians and Surgeons of Ontario
- Willi Kirenko, Past-President, Nurse Practitioners' Association of Ontario
- Barb LeBlanc, Executive Director, Health Policy, Ontario Medical Association
- Deb Saltmarche, Former Vice-President, Policy and Professional Practice, Ontario Pharmacists' Association
- Jackie Schleifer-Taylor, Director, Health Disciplines Practice and Education, St. Michael's Hospital
- James Sproule, MD, Director, Physician Consulting, Canadian Medical Protective Association
- Barbara Sullivan, Chair, Health Professions Regulatory Advisory Council
- Frank Schmidt, Manager (A), Programs Policy Unit, Health Professions Regulatory Policy and Programs, Ministry of Health and Long-Term Care



# Appendix B:

## Best Practices in Interprofessional Care

### — Selected Case Studies

There are many examples of interprofessional care–related initiatives that demonstrate enhanced patient care, improved efficiencies and cost savings. Some of them are outlined below.

IPC benefits to...	Case study: IPC in action
<p><b>Patients</b><sup>12,13,30</sup></p> <ul style="list-style-type: none"> <li>• Shorter wait times for care.</li> <li>• Greater access to a broad range of comprehensive health care services for care.</li> <li>• Increased satisfaction with care provided.</li> <li>• Better health outcomes.</li> <li>• A more active role in health care.</li> </ul>	<p>The Stanford's Chronic Disease Self-Management Program is a community-based self-management program that assists patients with chronic illnesses. It provides patients with the skills to coordinate and manage their care along with caregivers. After 1 year of the program, most patients experienced significant improvements in a variety of health outcomes and had fewer emergency department visits.<sup>31</sup> This program has been adapted by some community service agencies in Ontario.</p>
<p><b>Health care providers</b><sup>1,32</sup></p> <ul style="list-style-type: none"> <li>• Greater job satisfaction.</li> <li>• Less stress and burnout.</li> <li>• The opportunity to work within the full scope of practice and contribute to enhanced patient outcomes.</li> <li>• An improved professional environment that supports clinical practice, provides access to peers for support and advice, and ensures greater predictability within the interprofessional workplace environment.</li> </ul>	<p>The establishment of Family Health Teams and the recently announced anesthesia teams and intensive care strategy are based on interprofessional care models that focus on providing support for providers to work in a collaborative environment.</p> <p>Preliminary findings have revealed that successful integration depended on the working relationships among all health caregivers with respect to their understanding of scope of practice.</p>
<p><b>Health care organizations</b><sup>33</sup></p> <ul style="list-style-type: none"> <li>• Greater efficiency and capacity — ability to provide care for more people, enhancing patient satisfaction.</li> <li>• Decreased staff turnover with enhanced staff morale.</li> <li>• Improved recruitment and retention.</li> <li>• Increased patient safety and fewer treatment errors.</li> <li>• Enhanced opportunities to develop ongoing quality improvement and accountability measures in health care delivery.</li> </ul>	<p>Checklist development and implementation in operating rooms improved preparation of teams for surgery and reduction in potential errors.<sup>34</sup></p> <p>Checklists help team members identify critical information, equipment needs and tasks.</p> <p>Aviation crew team training in emergency room teams in nine hospitals found significant reduction in clinical error rates.<sup>12</sup></p>

IPC benefits to...	Case study: IPC in action
<b>Education system</b>	
<ul style="list-style-type: none"> <li>• Health care providers adequately prepared to work in a wide variety of settings.</li> <li>• An increased number of providers prepared to work in interprofessional care.</li> <li>• Education linked with practice.</li> <li>• Partnerships forged between colleges, universities, hospitals and community practice settings.</li> </ul>	<p>The Council of Ontario Universities has led a pilot project on behalf of the Council of University Programs in Nursing and the College of Applied Arts and Technology Heads of Nursing to test the use of HSPnet (Health Sciences Placement Network), a web-based application that facilitates the coordination of placements for practice education (clinical placements).</p> <p>In this pilot, three regions of Ontario used HSPnet to coordinate clinical placements for registered nurse and registered practical nurse students. In one pilot site, placements for personal support workers and paramedics were also included. The pilot was very successful. This system has the capacity for and could potentially facilitate interprofessional care placements across multiple health sciences programs.</p>
<b>Health care system<sup>14,35,36</sup></b>	
<ul style="list-style-type: none"> <li>• Support for coordinated health care delivery among multiple settings.</li> <li>• Increased access to the system and reduced patient wait times.</li> <li>• Enhanced opportunities to develop ongoing quality improvement and accountability measures in health care delivery.</li> <li>• Increased potential to link and coordinate all aspects of health care and education.</li> </ul>	<p>HealthForceOntario was established to promote a system-wide approach to care. Strategies are in place to recruit more health care workers who are skilled in interprofessional care, and funding has been provided to support interprofessional care projects. HealthForceOntario is bringing health care and education sector leaders together to work on implementing interprofessional care in a consistent, centralized way.</p> <p>In June 2006, Ontario provided funding of up to \$20 million toward supporting education and health care professionals on innovative approaches to patient care delivery aimed at effective use of Ontario's health workforce.</p>

# Appendix C:

## Interprofessional Care Implementation Committee — Mandate and Suggested Scope

The Interprofessional Care Implementation Committee (Implementation Committee) will work with government, Local Health Integration Networks (LHINs), health care delivery organizations, health professional groups, regulators, educators, and patients and their families to guide the process of interprofessional care implementation.

### Mandate

- To oversee the systemic implementation of Interprofessional Care: A Blueprint for Action in Ontario (Blueprint) in partnership with health care and education leaders and decision-makers, as well as patients, families and communities.
- To serve as a key forum for effective interprofessional care implementation, partnership, communication and leadership in health care and education.

### Suggested Scope

- Develop a detailed plan for Blueprint implementation.
- Facilitate the coordination and integration of Blueprint activities.
- Provide advice and guide efforts on the implementation of interprofessional care in health and education sectors.
- Establish linkages and partnerships with government bodies, LHINs and stakeholders for information-sharing, and identify opportunities for advancing interprofessional care.

- Within the research community, explore strategies to effectively develop and support interprofessional care evaluation and knowledge transfer.

### Proposed Membership

The Implementation Committee should incorporate input from the following:

- Education sector (i.e., colleges and universities with health science programs, Council of Universities)
- Ontario Joint Policy and Planning Committee
- Joint Provincial Nursing Committee
- Health Care Providers Alliance
- Federation of Health Regulatory Colleges of Ontario
- Ontario Health Quality Council
- Family Health Teams
- e-Health Council
- Local Health Integration Networks
- Experts in interprofessional care/interprofessional education
- Provider organizations
- Physician Services Committee
- Patients and families
- Coalition of Ontario Regulated Health Professions' Associations
- Ministry of Health and Long-Term Care
- Ministry of Training, Colleges and Universities

The Implementation Committee should have only eight to ten members and use task forces and forums to ensure that all participants are actively involved.

# Glossary of Terms

**Accreditation** is a process that aims to achieve optimum patient care by maintaining high educational and practice standards in a program for a given profession or academic/health care institution in the provision of education and health care delivery. Accreditation can validate a program or institution's quality and improvement procedures and is usually conducted by an outside arms-length agency or relevant legislative and professional authorities. Accreditation status is granted when a program or institution has met or exceeded pre-determined standards.

**Clinical placement** is a planned period of learning, normally outside the academic institution at which the health care student is enrolled, where the learning outcomes are an intended part of the program of study. This will enable the student to learn and develop the skills and required competencies to practice health care delivery.

**Clinical education** means any on-location teaching environment, ranging from one-to-one training between a licensed or registered health care provider and a student to training in a health clinic or hospital with or without a residency program.

**Collaborative patient-centred practice** "promotes the active participation of each health care discipline in patient care. It enhances patient and family centred goals and values, provides mechanisms for continuous communication among caregivers, optimizes staff participation in clinical decision-making within and across disciplines and fosters respect for disciplinary contributions made by all professionals."<sup>9</sup>

**Collaborative practice** is defined as "an interprofessional process for communication and decision-making that enables the knowledge and skills of care providers to synergistically influence the client/patient care provided."<sup>37</sup> Collaborative practice is linked to the concept of teamwork.

**Competency** is used to define discipline and specialty standards and expectations and to align practitioners, learners, teachers and patients with evidence-based standards of health care performance.<sup>38</sup> Competency includes the understanding and application of clinical knowledge, clinical skills, interprofessional care skills, problem solving, clinical judgement and technical skills.

**Delivery organization** encompasses hospitals, home care and other health care delivery agencies.

**Entry-to-practice** is the educational qualification identified in legislation for health professions as the requirement for an individual to be considered for registration or licensure to practice. Students or trainees in any health care discipline require clinical supervision in the delivery of health care.

**Health caregivers** are regulated and unregulated health care providers, personal support workers, caregivers, volunteers and families who provide health care services at the organizational, practice and community levels.

**HealthForceOntario** is a provincial strategy that was launched in May 2006 to help address the shortage of health care professionals in key areas, create competitive job opportunities and better equip the province to compete for health care professionals. A key initiative of the strategy is to support health care providers in working collaboratively in their workplace, thereby strengthening the health workforce.

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

**Interprofessional education** is the process by which two or more health professions learn with, from and about each other across the spectrum of their life-long professional educational journey to improve collaboration, practice and quality of patient-centred care.<sup>3</sup>

**Team** is a collection of individuals who work interdependently, share responsibility for outcomes, and see themselves and are seen by others as an intact social entity embedded in one or more larger social systems (for example, business unit or corporation) and who manage their relationship across organizational boundaries.<sup>32</sup>

**Teamwork** describes an interdependent relationship that exists between members of a team. It is an application of collaboration. "Collaboration" deals with the type of relationships and interactions that take place between coworkers. Effective health care teamwork applies to caregivers who practice collaboration within their work settings.<sup>35</sup>

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