

# Interprofessional Practice Making it So

CIHR SPA

Toronto, Ontario

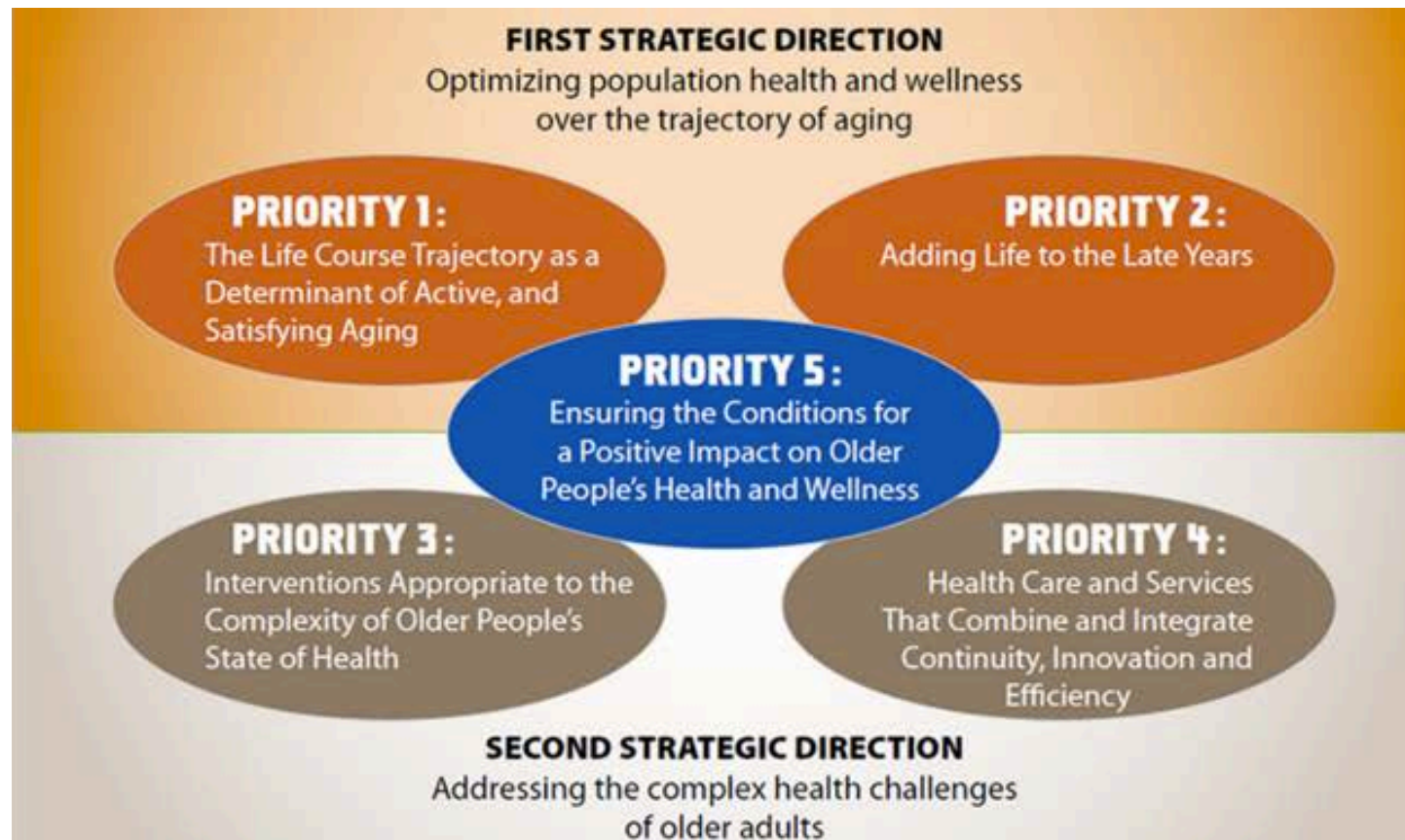
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# Link to The Institute of Aging Strategic Directions



<http://cihr-irsc.gc.ca/e/8671.html>

# Session Objectives

- Appreciate the compelling need for **interprofessional competencies** in caring for frail older adults
- Be able to identify and self-assess the competencies required for interprofessional practice
- Observe and discuss a simulation of interprofessional practice in action
- Discuss options for supporting interprofessional team based care in various contexts
- Learn from the experience of older adults who interact with interprofessional teams

# Why is IP important for frail seniors?

- Frail elderly experience a number of co-morbidities and require complex care.
  - Evidence/impact of team based models of care in frail older adults
- Policy supports aging at home e.g., almost 90% of people over the age of 75+ currently living with frailty, live in their homes (RSGS, 2013)
  - Not only health services but also social services

# Why is IP important.....

- Experience/application of an integrated lens - better vision
- Moral distress of caregivers (formal and informal)
- Multidisciplinary teams
  - Interprofessional practice

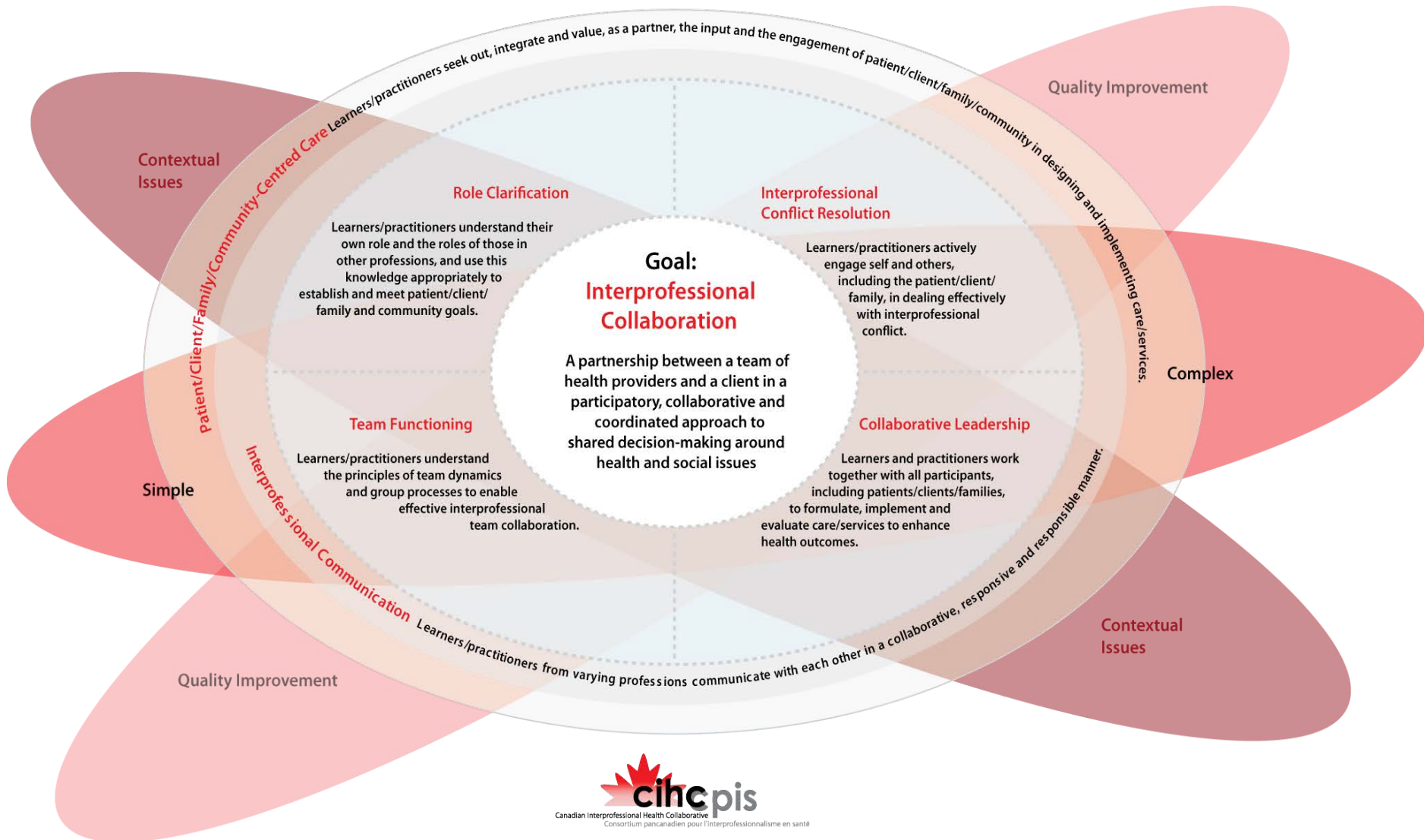
# Interprofessional Practice (IPP)

- “is the process of developing and maintaining effective interprofessional working relationships with learners, practitioners, patients/clients/ families and communities to enable optimal health outcomes” (CIHC, 2010)

# Identifying and self-assessing the competencies required for IP

- CIHC competencies
- NICE Gerontological Competencies
- Emerging work on IP Competencies for Geriatrics
- Yes but what does it REALLY look like?

# National Interprofessional Competency Framework



Canadian Interprofessional Health Collaborative. (2010). A national interprofessional competency framework. Retrieved from [http://www.cihc.ca/files/CIHC\\_IPCompetencies\\_Feb1210.pdf](http://www.cihc.ca/files/CIHC_IPCompetencies_Feb1210.pdf)



[http://www.nicenet.ca/files/NICE\\_Competencies.pdf](http://www.nicenet.ca/files/NICE_Competencies.pdf)

# Evaluating Competence

## Application of the NICE Core Interprofessional Competencies for Gerontology to GAIN Teams

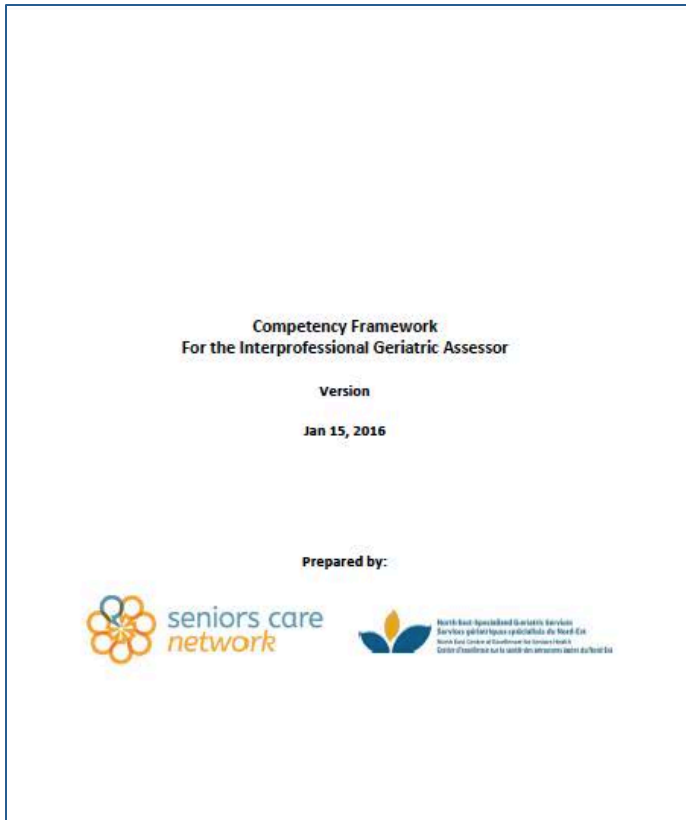
For complete competency document visit: [http://www.nicenet.ca/files/NICE\\_Competencies.pdf](http://www.nicenet.ca/files/NICE_Competencies.pdf)

Note: Please "hover" over competency areas to read definitions (e.g. Cell A7, A28, A40, A44, A56, A61, A67, A71)

Legend: L= May lead process  Participates directly  Participates indirectly

Competency Area and Key Competencies	NP	OT	Pharm	PT	RSW	MD	CCAC Care Coordinator	Clerical	Site Manager	Regional Office
<b>Clinician</b>										
1. Performs and refines assessment of the older adult in the domains of:										
a. Physical health and illness conditions	L					L				
b. Functional ability		L		L						
c. Cognitive ability and mental health		L			L					
d. Psychosocial function including social support system and life course changes.					L					
e. Spirituality					L					
f. Socio-environmental situation					L					
g. Safety and Security	L	L	L	L	L	L	L			
2. Selects/administers valid, reliable and ageappropriate assessment/ diagnostic/screening tools.	L	L	L	L	L	L	L			
3. Applies evidence-based standards/best practice guidelines to promote healthy activities in older adults.	L	L	L	L	L	L	L			
4. Involves older adults and their families in developing expected outcomes.	L	L	L	L	L	L				
5. Performs interventions to: promote health and optimal care; enhance quality of life; prevent disease, injury, and excess disability; maximize function; maintain desired level of autonomy and independence; promote rehabilitation; and provide palliative care to older adults	L	L		L		L				
6. Uses technology to support the care of older adults and to enhance their function, independence and safety.							L			
7. Recognizes and manages the interaction of normal aging and one or more persistent health conditions in an older person.	L	L	L	L	L	L	L			

# Emerging Work in IP Competencies



Pan-LHIN work to define the knowledge, skills, attitudes and judgments required to participate in team-based comprehensive geriatric assessment

# Sample Process of Role Clarification

From the Geriatric Assessment and Intervention Network  
(GAIN)

## Local

- Daily negotiation of “who does what” at the patient/provider interface (e.g. team huddles, rounds)
- Explicit discussion of contributions of team members in presentation of cases/issues during Grand Rounds

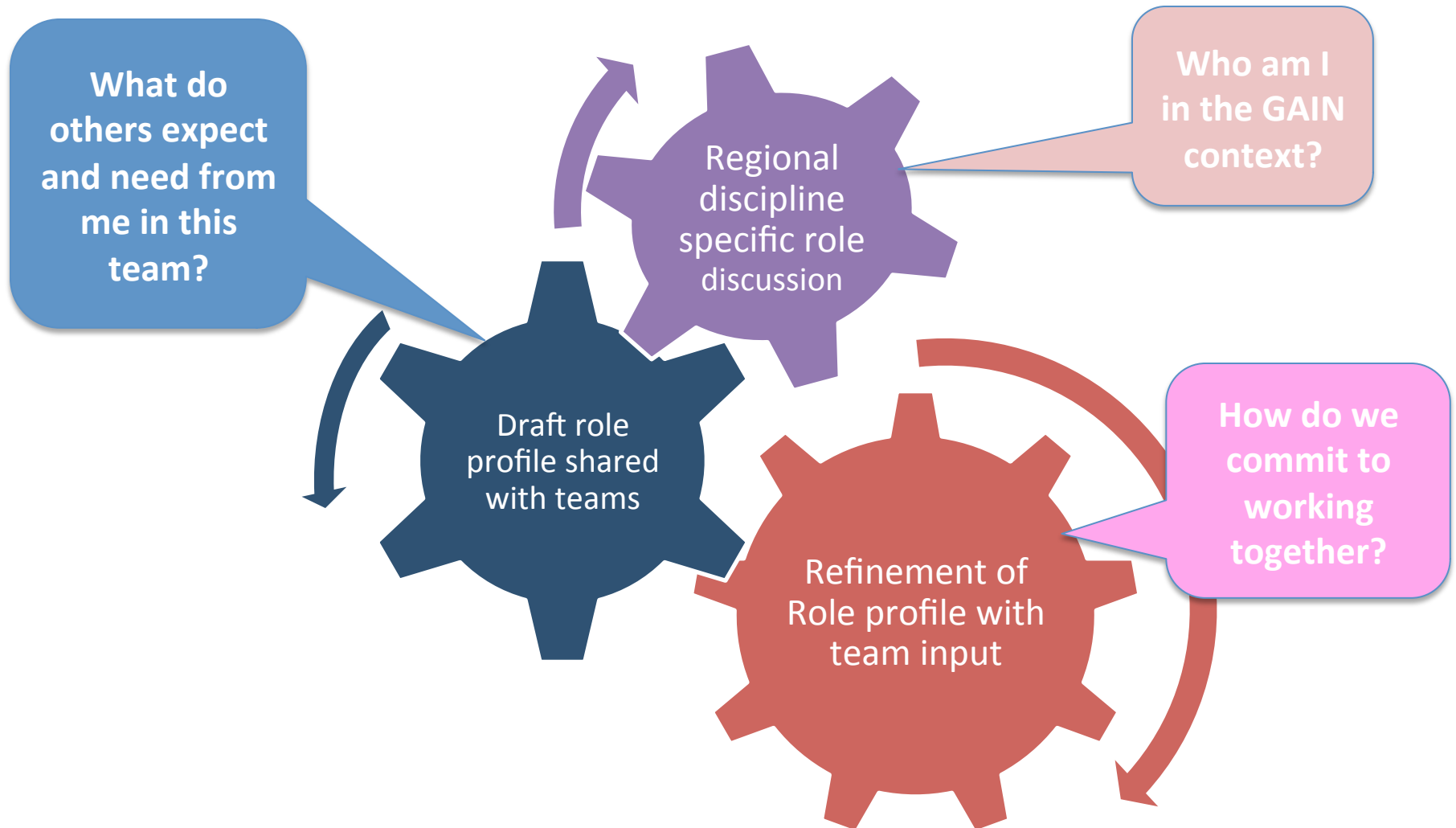
## Regional

- Regional engagement of discipline groups to explore the opportunities for their discipline within GAIN
- Development of generalized role profiles to articulate the role of each profession within the team

Contributes to

Strategic Priority #1:  
Optimal utilization of team members

# The GAIN Process of Role Profile Development



# What is needed to implement IPP?

- Very few opportunities for students from the different health professional programs to learn, with, from, and about each other
- Few opportunities for interprofessional education (IPE)
- IPE enhances the understanding and respect for other professions by developing communication and interpersonal skills to work collaboratively

# One strategy – use of simulated learning models (SLMs)

- Interactive learning in the:
  - classroom, clinical setting and/or continuing education (CE)
- Support the acquisition and development of IP competencies
  - role clarification
  - team functioning
  - collaborative leadership
  - interprofessional communication
  - interprofessional conflict resolution and
  - patient/client/family/community -centred care to enhance collaborative practice.

# Simulated models for IPP



# Debriefing questions

- How did this simulation make you feel?
- What do you think was happening?
- Why?
- What was the purpose of the simulation?
- Can this simulation help in real life practice
- What were the take home messages of the simulation?

# Context matters!

Consider the impact of these different contexts

- Comprehensive and consistent teams, such as rehabilitation, residential care, and paediatric care
- Units where health care providers may work together only for a short period of time before shifts change and patients are discharged, such as Emergency Unit or a high turnover acute medical unit
- A community setting where a family has a frail senior who attends programs at a senior centre and the community program director also plays a role in the senior care

# Ideas for supporting interprofessional team based care in various contexts

- Impact of virtual teams on trust
- Scheduling time for the collaborative conversation
  - if you don't build it they won't come
- Intentional KT between team members (e.g. 10 medication tips for the non-pharmacist)
- Team Function evaluation (example D-TEAM)

*What has worked in your setting?*

# The Dimensions of Teamwork Annual Survey (D-Team)

- Customer and inter-team issues
- Team member strengths and skills
- Communication and conflict management
- Roles and interdependence
- Clarity of team goals
- Decision-making and leadership
- Perceived organizational support

Ryan, D.P., Liu, B. & Cott, C.A. (n.d.). *Thinking through issues in inter-organizational collaboration in health care*. Toronto, ON: Geriatrics Interprofessional Interorganizational Collaboration, Regional Geriatric Program of Toronto.

# Complexity

Identify the range of IP practice considerations as the care of a frail older patient progresses from simple to complex.

Consider a frail person from these perspectives

- Good retirement income, strong family support
- Care provided by a spouse, whose cognition is declining
- Rural dwelling frail senior, frequent falls, with substandard housing and history of mental health & addictions concerns

*How does interprofessional practice change with complexity in these scenarios?*

# Why include frail seniors on interprofessional teams (IPT)?

- Policy supports patient centred care
  - “Providing care that is respectful of and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions.” (IOM)
- Enhance patient outcomes
  - Maximizing patient safety and satisfaction
  - Increasing the quality of outcomes
- Optimizes healthcare workers' performance and increase job satisfaction

# Why include the caregivers?

In 2012, about 8.1 million individuals, or 28% of Canadians aged 15 years and older, provided care to a family member or friend with a long-term health condition, disability or aging needs

# How to include seniors on IPT

- Support the participation of Residents/families as partners in care
- Share information with Resident/families in a respectful and understandable manner
- Listen respectfully to the expressed needs of every person

# Learning from the experience of older adults who interact with IP teams

## System Design Framing Questions

- ❑ Have we actively engaged frail older people and their family caregivers in the system design, including hearing their stories of their healthcare experiences?
- ❑ Do we clearly understand the needs of frail older people and the current gaps and challenges that they encounter?
- ❑ Will this design truly meet the care and support needs of older people? How will we know?
- ❑ Will this design provide service **to** older people and families, **for** older people and families or **with** older people and families?
- ❑ Will this design add any value or service to older people?
- ❑ Have we shown empathy in the design of services for older people?

- Inclusion of older adult perspectives in system design
- Emerging work on patient experience
  - What measures can be included in patient experience work that signal high functioning teams?

Adapted from the work of A.M. Yaraskavitch & R. Filinski (2013)

# Concluding remarks

- Maintaining effective interprofessional working relationships with learners, practitioners, patients/clients/ families and communities to enable optimal health outcomes is key to the success of interdisciplinary teams
- It just does not happen but requires life long learning

# Acknowledgements

- With gratitude to the patients, families and health professionals who participate in the specialized geriatric services of the Central East LHIN
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# Questions ?

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