Environmental Scan Report:

Interprofessional Education and Accreditation Processes in Pre-Licensure Health Professional Education

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Executive Summary

The accreditation of programs in health professional education is a long-standing tradition in North America. Accreditation has been defined by the Association of Accrediting Agencies of Canada (AACC) as a process to determine and to certify the achievement and maintenance of reasonable and appropriate national standards of education for professionals. Academic accreditation processes have been linked to the continuous improvement of curricula and programs in the health professions, and have been identified as a pivotal agent for change related to systematic integration of interprofessional education (IPE) in health professions education.

The *Accreditation of Interprofessional Health Education (AIPHE)* project, funded by Health Canada, brings together a partnership of 8 national organizations that accredit pre-licensure health professional education. The overarching project goals are to develop common principles for the accreditation of IPE in six health professions and to educate a wider audience about the value of IPE. This report summarizes the findings from an environmental scan intended to inform the AIPHE project. The scan encompassed: an examination of peer-reviewed and grey literature related to accreditation and IPE; a systematic review of the accreditation documentation of Canadian accrediting organizations or bodies; and interviews with key informants representing the various professions comprising the AIPHE project.

The general findings from the environmental scan indicate that federal and provincial funding initiatives have fostered significant growth and development of IPE in post-secondary institutions across Canada. The Canadian Interprofessional Health Collaborative (CIHC) has been established as a network of faculty and other stakeholders with an interest in IPE. The National Health Sciences Students Association (NaHSSA) has been established to foster and promote interest at the student level and to develop future champions. The recent Primary Health Care Transition Fund (PHCTF) has also been an important impetus in fostering and promoting interprofessional collaboration as a fundamental pillar of the primary health care system in Canada. The Canadian Patient Safety Institute (CPSI) and the Royal College of Physicians and Surgeons of Canada (RCPSC) have also articulated interprofessional team/collaborator competencies for guiding education and training of future and current practitioners in the Canadian health system.

In the United States a significant level of work has taken place regarding academic accreditation and IPE. A number of national meetings involving key stakeholders from the health care, professional association, regulatory body and health professional education systems have taken place to discuss IPE and its relationship with accreditation, licensure and certification. In particular, the Institute of Medicine's (2003) recommendations have pinpointed accreditation and other oversight processes as major forces for change in health professional education, including the need for education and training to improve interdisciplinary teamwork competencies.

The findings from the systematic accreditation review indicates that aspects of the accrediting process in Canada for pre-licensure health professional education are similar across most professions, including: establishment of standards and criteria; site visits to an institution or program by peer reviewers to determine whether the institution or program meets the accreditation standards or criteria; and periodic reviews to ascertain whether the accredited institution or program continues to meet the standards or criteria. With the exception of the accreditation standards for Pharmacy, accreditation standards did not specifically address IPE.

In general, accreditation standards across the accrediting bodies neither encourage nor present specific barriers to IPE, but are largely silent about it. Many could be expanded to more specifically address IPE. Academic accreditation standards for the professions of medicine, social work, physiotherapy, and occupational therapy exhibited standards related to interprofessional collaboration rather than specific reference to IPE in the curriculum.

Key informants reported a high level of support for the AIPHE project. Key themes emerging from the interviews with key informants with implications for the AIPHE project were:

- Need for promotional strategies which highlight the rationale and need for accreditation standards which specifically promote IPE;
- Having IPE champions - profession-specific, specialty-specific and in some instances sub-specialty-specific;
- Effective strategies for consulting with academic, professional (e.g. professional associations, regulatory bodies) and public stakeholder groups concerning the need for the addition/revision of accreditation standards, as well as subsequent communications regarding impending changes;
- Having a common language which would be clearly understood across professions;
- Specific definition, description and guidelines to accompany any new standards and associated criteria related to IPE;
- Need for support for academic programs in adopting and applying new standards related to IPE;
- Need for evaluation of the impact of new standards on academic programs;
- Ensure the addition of new standards does not complicate or make the accreditation process more onerous - new standards related to IPE need to be flexible;
- Interprofessional collaboration occurs in community-based settings and health settings - accreditation standards need to reflect and acknowledge this diversity.

These findings will inform the work of the AIPHE Steering Committee in developing core principles/guidelines for IPE accreditation.

Working Glossary of Terms[1]

Curriculum is the overarching term for all those aspects of education that contribute to the experience of learning: aims, content, mode of delivery, assessment and so on (Freeth et al. 2005).

Interprofessional Collaborative Practice is a partnership between a team of health professionals and a client in a participatory, collaborative and coordinated approach to shared decision-making around health issues (Orchard and Curran, 2005, Medical Education Online, 10(11): 1-13).

Interprofessional Education occurs when two or more professions learn with, from and about each other to improve collaboration and the quality of care. (Centre for Advancement of Interprofessional Education, 2002)

An **Interprofessional Team** is a group of people from different professional backgrounds who deliver services and coordinate care programs in order to achieve different and often disparate service user needs. Goals are set collaboratively through consensual decision making and result in an individualised care plan which may be delivered by one or two team members. This level of collaborative practice maximizes the value of shared expertise and minimizes the barriers of professional autonomy. Often, one team member is appointed as a key worker or case manager for the service user; in this role they coordinate communication between practitioners and the patient or client or carer.

Practice Placement is used as the generic term to cover clinical placement, attachment, rotation, fieldwork placement, practicum and other terms used by different professions to describe opportunities for student to apply and develop their learning in the workplace (Freeth et al. 2005).

Practice site is the supervised clinical or community-based training that takes place in a practice setting such as a community health service, hospital, long-term care facility or practitioner's office. These student learning opportunities include practicums, placements, internships and residencies and are supervised by preceptors and clinical supervisors.

Pre-licensure: Level of professional education required to being licensed to practice a profession in Canada:

- Physiotherapy − currently requires a professional master's or baccalaureate degree to enter practice. The goal for all physiotherapy education programs in Canada is to graduate masters-prepared entry-level practitioners by 2010.
- Occupational therapy − currently requires a diploma or baccalaureate degree to enter practice. Effective 2008, only occupational therapy educational programs that lead to a professional master's degree in occupational therapy as the entry-to-practice credential will be accredited.

[1] Note: for consistency, "Inter-Professional" and "Inter-professional" has being changed to "Interprofessional."

- Pharmacy − requires a Bachelor's degree in pharmacy to enter practice.
- Nursing − requires a Bachelor of Nursing degree to enter practice as a registered nurse in every province except Manitoba and Quebec.
- Medicine − requires an undergraduate MD degree from an accredited medical school, and at least one year of post-graduate training (residency) to enter medical practice.

Teamwork is the process whereby a group of people, with a common goal, work together, often but not necessarily, to increase the efficiency of the task in hand. They see themselves as a team and meet regularly to achieve and evaluate those goals Regular communication, coordination, distinctive roles, interdependent tasks and shared norms are important features (Freeth et al. 2005).

1.0 Introduction

The *Accreditation of Interprofessional Health Education (AIPHE)* project, funded by Health Canada, brings together a partnership of 8 national organizations that accredit pre-licensure education for 6 Canadian health professions: physiotherapy, occupational therapy, pharmacy, social work, nursing and medicine. The long-term vision of the AIPHE project is that all students in health-related fields will develop the knowledge, attitudes and skills needed for collaborative, patient-centred practice as a result of interprofessional education (IPE) in health professional education programs. The overarching project goals are to develop common principles for the accreditation of IPE in six health professions and to educate a wider audience about the value of IPE.

Main project activities include an environmental scan (literature review, key stakeholder interviews and a background paper) and a national consultation process to create and implement draft core principles/guidelines via two face-to-face joint Steering Committee-Advisory Group meetings and a national forum on Accreditation of Interprofessional Education for stakeholders from the 6 participating professions. This report summarizes the findings of an environmental scan intended to build on the work that has been done to date in scanning Canadian and international literature and initiatives on program accreditation and IPE. The objectives of this environmental scan are to:

1. discuss the rationale and need for IPE in health professional education programs;
2. review the current, broad scale activities surrounding IPE funding and academic program initiatives in Canada;
3. identify nationally or internationally defined and accepted educational outcomes/competencies for IPE;
4. identify and describe best practices/successes/areas of innovation in how health professional education accreditation agencies are setting standards for IPE – nationally and internationally;
5. summarize the collaborative practice findings of projects funded through the Health Canada Primary Health Care Transition Fund (PHCTF);
6. describe the pre-licensure accreditation processes of each of the AIPHE partnering professions;
7. conduct a systematic review of the pre-licensure accreditation standards of each of the AIPHE partnering professions to identify the existence of standards which specifically support or relate to IPE;
8. identify potential barriers/challenges to incorporating new standards related to IPE in the accreditation process and standards of the academic accreditation processes of the AIPHE project partners.

The methodology used in conducting the environmental scan for the report included: an examination of peer-reviewed and grey literature pertaining to accreditation and IPE; a systematic review of accreditation documentation of each of the health professional programs comprising the AIPHE project; and interviews with key informants representing the various academic accrediting organizations or bodies comprising the AIPHE project.

Peer-reviewed English literature was searched using: MEDLINE, CINAHL, and ERIC. The Google Internet search engine was used to review grey-literature of national and

international scope. Key search terms included "a*ccreditation"* and *"interprofessional education"* or *"interdisciplinary education."* The search of PubMed resulted in 130 hits for *"accreditation"* and *"interprofessional education"* and 67 hits for *"accreditation"* and *"interdisciplinary education."* The search of CINAHL resulted in 57 and 59 hits respectively. The search of ERIC resulted in 2 and 1 hit(s) respectively. Abstracts were screened to identify articles for further review. The results of the database searches yielded 10 articles relevant to the purpose and scope of the environmental scan. The Internet search resulted in 12 reports or documents which were deemed to be relevant.

The key informant interviews were conducted with individuals representing the various organizations or bodies responsible for accrediting or administering accreditation programs at the pre-licensure health professional education level in Canada. Key informants were identified by membership of the Steering Committee of the AIPHE project. Requests for interviews were distributed via e-mail. Key informant interviews were conducted with thirteen (n=13) individuals. Interviews were conducted by telephone and recorded with the permission of the informant. The key informant interview script is presented in Appendix A and Appendix B provides a listing of the key interview informants.

2.0 Interprofessional Collaboration

Increased attention through governmental policy and greater societal expectations have increased the need to promote and foster more effective collaborative approaches in the health care system (Commission on the Future of Health Care in Canada, 2002; Health Canada, 2003; Health Council of Canada, 2005; Watson & Wong, 2005). It is widely known that the needs of many patients are beyond the expertise of any single profession and genuine patient-centered service requires interprofessional collaborative care (Freeth, 2001). According to Drinka (1996) interprofessional collaboration involves a group of health providers from different professions who engage in planned, interdependent collaboration in the provision of coordinated and integrated care. Way, Jones, and Baskerville (2001: p. 2) define collaborative practice as "an interprofessional process of communication and decision-making that enables the separate and shared knowledge and skills of care providers to synergistically influence the client/patient care provided." The Institute of Medicine (2003: p. 54) defines an interprofessional team as "composed of members from different professions and occupations with varied and specialized knowledge, skills, and methods." Interprofessional teamwork involves a process by which "team members integrate their observations, bodies of expertise, and spheres of decision making to coordinate, collaborate, and communicate with one another in order to optimize patient care" (Institute of Medicine, 2003: p. 54).

Interprofessional collaborative approaches are believed to have the potential for: improving professional relationships; increasing efficiency and coordination; increasing patient safety and reducing medical errors; decreasing cost of care; enhancing provider and patient satisfaction; and ultimately enhancing patient and health outcomes (Baldwin, 1996; Cullen, Fraser, & Symonds, 2003; Institute of Medicine, 2003; Reeves & Freeth, 2002; Wee, Hillier, & Coles, 2001). Effective interprofessional teams are characterized by the knowledge and understanding which team members demonstrate toward other professions, as well as their ability to appreciate one another's skills and contributions in patient care (Areskog, 1988; Clark, 1991; Drinka, 1996; Fitzpatrick, 1996).

A fundamental principle of primary health care (PHC) renewal in Canada has been the call for greater collaboration among health care providers. The Primary Health Care Transition Fund (PHCTF) provided $800 million between 2004 and 2006 to provinces, territories and health care system stakeholders, to accelerate the development and implementation of new models of PHC delivery. Specifically, it provided support for the transitional costs of making the shift to new models of PHC delivery, including team-based care. Curran (2007) prepared a synthesis report of the PHCTF which involved examining the key findings and outcomes in the area of "collaborative care" which emerged from funded projects. Across all Provinces – Territories there were a range of innovative and varying models of collaborative care involving interdisciplinary/interprofessional teams of health and social care providers. Models of collaboration were characterized by the nature of the collaborative (e.g. geographic region vs. patient type), role expansion of team members, regionalization of collaborative care, and delivery of collaborative PHC services based on population health needs (Curran, 2007). In some initiatives, the PHCTF was effective in establishing collaborative care teams, while in others the PHCTF was helpful in supporting existing strategies to implement new models of PHC collaboration. IPE at pre- and post-licensure levels, overall positive outcomes pertaining to patient and provider experiences with enhanced models of collaborative PHC, engagement of

professional associations and developing resources to foster collaborative care models were key trends which emerged across the funded projects (Curran, 2007).

The review of the PHCTF projects also indicated that collaborative care benefited from the availability of standards, policies and interprofessional protocols (Curran, 2007). Collegial development of collaborative care guidelines or practice manuals was an important interactional factor across some initiatives. Organizational structure, including administrative supports and leadership, was reported to be an important organizational determinant that fostered collaborative PHC. The professional system was also identified as a strong influence on the development of collaborative care approaches.

When health care professionals are expected to work and function collaboratively as part of interprofessional teams, they should be prepared to engage in these activities through their education, clinical training and professional development (Drinka, 2000; Gilbert, 2005). However, health professionals have traditionally been socialized with a strong professional identification to their own respective profession (Horsburgh, Lamdin, & Williamson, 2001; Hughs, 2005; Rogers, 2001). Such socialization is believed to result in very limited knowledge of other professionals on the team. Members of each profession know very little of the practices, expertise, responsibilities, skills, values and theoretical perspectives of other professionals and/or disciplines (Institute of Medicine, 2003; San Martin-Rodriguez, Beaulieu, D'Amour, & Ferrada-Videla, 2005). This is considered to be one of the main obstacles to collaborative practice in health care teams (Fagin, 1992; Mariano, 1989).

Traditionally, health professional students have experienced minimal contact with each other in the process of their education and even less collaborative learning experiences designed to promote interprofessional health care team relationships (Baldwin, 1996). This has largely been exacerbated by the fact that health professional education occurs largely in an environment of separately housed professional schools and separate clinical arenas (Hall & Weaver, 2001). As a result, health professionals are socialized in isolation, hierarchy is fostered, and individual responsibility and decision making are relied upon almost exclusively. A lack of appreciation of the potential contributions of each of the health professions is reinforced by such settings, and more important, students learn little about ways to coordinate and collaborate in providing quality care.

3.0 Interprofessional Education

Recent commissions, committees and policy documents in Canada have all identified the importance of reshaping educational preparation and the professional training of health care professionals (Commission on the Future of Health Care in Canada, 2002; Health Canada, 2003; Health Council of Canada, 2005). The Health Council of Canada (2006) has recommended the need to increase the number of interprofessional education (IPE) and training programs available in Canada, including recommendations that each university health sciences program in Canada offer an IPE program. IPE involves members (or students) of two or more professions associated with health or social care engaged in learning with, from and about each other (Barr et al., 2005). IPE is now widely perceived as a potentially effective method for enhancing collaborative practice between health and social care professionals because it provides opportunities for professionals or those in training to meet and interact, whereas uni-professional education does not. The origin of IPE is widely attributed to a World Health Organization (WHO) report published in 1988 *"Learning Together to Work Together for Health"* (WHO, 1988), which encouraged the development of IPE activities across the world to promote effective teamwork.

IPE initiatives are based on the notion that shared learning can lead to more comprehensive care and treatment for clients (Barr, 1994; Hawkins, 1997). There is evidence that IPE can result in more positive perceptions of other professions; increased insights into the work of other professional groups; enhanced interprofessional communication; and greater preparation for interprofessional working (Clark, 1991; Parsell & Bligh, 1999; Parsell, Spalding, & Bligh, 1998; Reeves & Freeth, 2002). The necessary prerequisites for successful IPE have been described as: appropriate faculty development; collaboration with other health care disciplines to develop, implement and evaluate new models of IPE; common goals and clear communication among involved parties; resolution of organizational and structural differences, such as scheduling and timing variations; and commitment of substantial institutional resources (Bulger, 1995; Fagin, 1992; Lindeke et al., 1999; Makaram, 1995; Mariano, 1999; Reeves & Pryce, 1998). Clarke (2004) recommends that sustainability of IPE is largely dependent upon sponsorship by an academic centre whose mission is to develop or sustain IPE (e.g. IPE unit); strong support of the highest university administrators; and key advocates and champions for IPE within the institution. Subject areas that have been reported to best fit with IPE include: biomedical sciences; patient-centred care; ethics and professionalism; evidence-based health care (e.g. use of technology for searching the literature, biostatistics, data analysis, study design, and basic research methodology); communication skills; behavioral science programs, teamwork and leadership workshops.

A number of barriers to IPE have been reported: lack of support from administration; lack of rewards and incentives for faculty involvement in IPE; overcrowded curricula; differences in student ages and academic preparation; scheduling; lack of physical proximity of different schools; and infrastructure costs associated with IPE (Barr et al., 1999a; Hammick, 2000; Rafter et al., 2006). The prospect for curricular collaboration among health sciences academic units is often contingent on internal and external funding. Even when IPE is introduced and perceived as successful, most are dependent on limited funding streams, most often grants. The question of the ideal timing in the curriculum for IPE also remains largely unanswered. Recommendations in the literature range from the belief that, before embarking on interprofessional teamwork, the student must first have a thorough knowledge of his or her discipline (Carpenter, 1995; Mariano,

1999) to the suggestion that the experience of shared learning should occur early in the curriculum (Headrick et al., 1998; Wahlstrom, Sanden, & Hammar, 1997).

3.1 Interprofessional Education Evidence

According to Cooper et al. (2004) the drive towards IPE has raised questions about its value, about what types of interventions can produce most benefit and about its effects on service users (Wood, 2001). Various reviews and reports have attempted to address these questions (Barr, 1999a; 1999b; 2002; Cooper et al., 2001; Freeth et al., 2002; Zwarenstein et al. 1999; 2000; 2005). The emerging evidence suggests that IPE at the pre-licensure level for both health and social care students can contribute to: raising knowledge of team working and of roles and responsibilities; altering students' attitudes towards each other; and facilitating the acquisition of group working skills. However, the transfer of these effects into professional practice and/or healthcare outcomes is not yet known, primarily because studies have lacked methodological rigour and longitudinal perspectives.

Hammick, Freeth, Koppel, Reeves and Barr (2007) have conducted the most recent, best evidence systematic review of evaluations of IPE. Two approaches were used to locate the studies used in this review. The first included a bibliographic database search (Medline 1966-2003, CINAHL 1982-2001, BEI 1964-2001, ASSIA 1990-2003). The second method included a targeted hand search of journals that were repeatedly publishing high quality IPE evaluations. Studies were considered if they met the following criteria:

- Involved education experiences that included two or more professions learning with, from, and about each other;
- Involved formal IPE experiences (where explicit planning of IPE occurred);
- Involved learners from at least two professional groups in health and social care;
- Discussed outcomes to either service organizations, learners' reactions, changes in learners' skills knowledge or perceptions of and attitudes towards others, and changes in learners' behaviour;
- Were peer reviewed;
- Were published or had an abstract, and were in English or French.

Studies were scored out of five for the quality of the study and the quality of the information provided. Only studies that received at least four out of five on both factors were included in the review. The aim was to enhance the effectiveness of future IPE and maximize the potential for interprofessional learning to contribute to collaborative practice and better care. The initiatives all had the objective of improving care; and enabled learning with, from and about one another. Biggs (1993) 3-P model (presage, process, product) and Kirkpatrick's (1967) four-level model of educational outcomes were adapted as analytical frameworks for the systematic review.

This systematic review brought together evidence from 21 of the strongest contemporary evaluations of IPE. The studies were published between 1981 and 2005, were from North America and Europe, with the majority (15) evaluating IPE delivered to undergraduate health professional students, with each study involving between two and six different professions. IPE has been developed in response to the need to meet new government policies surrounding health care as well as in support of the notion that teamwork training can reduce medical errors. With

regards to geography and demographics (i.e. age, gender, and ethnicity) there was little information found dealing with their effect on IPE programs. The number of learners and professions involved differed across studies, however most described IPE that limited complexity by including no more than four professional groups. Finally, time, spatial factors and management support have all been confirmed as key components in establishing and sustaining IPE initiatives.

It was found that students who were more mature and who had more educational experience were more favourably disposed towards IPE, however little evidence has been found on the influence of previous IPE on attitudes towards ensuing IPE activities. Some studies found that reluctance to participate in IPE was often times linked to structural issues such as differences with profession-specific teaching or inequalities in assessment, more so than due to general opposition. A number of studies also identified stereotyping of other professional roles as a factor. One study in particular found that many first year students had entered their professional courses with a stable set of negative stereotypes of other professionals.

Several factors were found to influence the process of interprofessional teaching and learning including facilitation, curriculum design, learner choice, customization and authenticity, reflection, and informal learning. The need for ongoing coaching and mentoring by interprofessional facilitators emerged as a factor to assist learners to develop and maintain their teamwork skills. Curriculum design was also deemed a key factor in the process of IPE. It has been suggested that adults tend to learn best when there is collaboration between the learners and facilitators and when there is mutual respect. With regards to learner choice, a very mixed picture was presented. One study that did measure differences in outcomes between voluntary and mandatory attendance in an IPE course reported no discernable differences between the groups. IPE activities that included simulated patients (SPs) were found to be tremendously useful. Students enjoyed the authenticity of these activities as it provided them with a powerful learning experience. Several studies reported the use of team reflection time as being beneficial to participants as well. Finally, it was found that social factors (such as time spent together socially) were a key part of the IPE experiences of the learners.

It should be noted that not all changes are for the better, as some studies have found that IPE can in fact worsen attitudes, however for the most part more positive outcomes have been reported. This is particularly true for learners' reactions to IPE and changes in knowledge and skills. The findings showed that IPE is generally well received, enabling knowledge and skills necessary for collaborative working to be learnt. Staff and faculty development is a key influence on the effectiveness of IPE and all learners in IPE bring unique values about themselves and others. IPE that reflects the authenticity of practice is more effective. In quality improvement initiatives IPE is frequently used as an effective way of enhancing practice and improving services. Approximately one third of the studies reviewed in this synthesis described changes in service delivery of patient care.

4.0 Accreditation and Interprofessional Education

Accreditation is a world-wide phenomenon with large-scale investments in accreditation mechanisms in many industries and organisations. Essentially, accreditation processes are concerned with the measurement of performance and ensuring that organisations satisfy pre-designated standards, are regularly examined and continuously improve (Batalden et al., 2002). Institutional accreditation is normally predicated on the application of nationally and/or internationally agreed standards for assessing and benchmarking the performance of organisations (Braithwaite et al., 2006). Typically, this involves certification by an external body, often following formalised visits by peer assessors or surveyors.

The manner in which health professionals are educated and maintain their competence is subject to a myriad of oversight structures and processes, some voluntary and some mandatory. As an oversight process, accreditation is *"a system for recognizing educational institutions, and the professional programs affiliated with those institutions, as having a level of performance, integrity and quality that entitles them to the confidence of the educational community and the public they serve"* (CSWE, 1994, p.3). Cocolas and Rubin (1991: p. 399) describe accreditation of health professional education as *"a voluntary process attesting to educational quality; when linked by legislation to the certification or licensure of professionals, it can become mandatory.*" Academic accreditation is usually a self-regulatory activity created by the academic and professional education communities, and often administered by non-governmental associations of institutions, programs, and professionals in particular fields. In essence, it involves judgments of the quality and effectiveness of an institution or program, as measured against a set of expectations (standards, criteria).

Accreditation agencies or associations typically provide the established standards and criteria specifically related to admission requirements, types of degrees, and educational program needs by which educational institutions are judged. These organizations assess the educational programs to determine if the content and learning experiences are designed to produce competent graduates (Institute of Medicine, 2003). Accrediting organizations for health professional education have four major functions:

- to establish criteria for evaluation of education in their health profession;
- to conduct surveys that encourage universities to maintain and improve their programs;
- to determine compliance with the established criteria for accreditation; and
- to provide ongoing consultation to the relevant educational programs (Gelmon, 1996).

Accreditation is a means of assuring the public of educational program quality and of promoting continuing review and self-improvement by educational units (Gelmon, 1996). The Association of Specialized and Professional Accreditors (1993) identifies aaccreditation of health professional education as serving many benefits to various "publics" including:

- advancing/enhancing the profession or discipline;
- supporting access to the profession or discipline;
- encouraging and facilitating professional mobility;
- supporting individual credentialing processes;
- providing consumer protection; and
- affording opportunities for funding of educational programs.

Four elements are essential in any accreditation process (Council on Social Work Education, 1999):

1. A statement by the institution of its educational goals and objectives;
2. A directed self-study assessing the extent to which the goals and objectives have been met;
3. An on-site evaluation by a selected group of peers; and
4. A decision by an independent accrediting body that an institution or specialized unit has met the appropriate standards and criteria and is worthy of accreditation.

Accreditation has great potential for leading and fostering change. Gelmon (1996: p. 218) suggests that accreditation of health professional education should be *"responsive to an evolving health services system, stimulate new ideas and practices, and be receptive to and encouraging of innovation."* According to Clarke (2004) accreditation, licensure, and certification requirements are useful impetuses for change in universities and additional forces to overcome academic inertia. Accreditation guidelines can influence many decisions around an educational program, such as the types of learning experiences students undertake. Gelmon (1996) indicates that as models of IPE are developed in the health professions, standards and procedures for accreditation will need to be revised to address the unique characteristics of IPE (Gelmon, 1996). Bakken (1996) suggests that IPE efforts can be supported by accreditation requirements that are more flexible and rigorous. Placing explicit language about IPE in accreditation standards would go a long way toward eliminating accreditation as a perceived barrier to the growth of IPE (Bakken, 1996). Clarke (2004) suggests that the development of accreditation standards that mandate IPE experiences provides for their necessary inclusion in the curriculum. Table 1 summarizes proposed "accreditation standards" identified by Gelmon (1996).

Table 1 Proposed IPE Accreditation Standards (Gelmon, 1996: p. 220)

In seeking accreditation, programs will:
• demonstrate that they adopt a systems (or similar) approach in designing and presenting the interdisciplinary learning experiences to illustrate the interrelated nature of the components of the health services system and the many health professionals;
• adopt an outcomes orientation that focuses curriculum efforts on customer needs and is responsive to the knowledge and skills required of new health professionals;
• illustrate how these interdisciplinary experiences meet and fulfill the stated mission and objectives of the involved programs and schools;
• demonstrate that key stakeholders are involved at all stages of curriculum conceptualization, design, implementation, and evaluation;
• ensure equal representation and support from all programs and faculty, based on relevant expertise, in the educational design and delivery of core content;
• involve all key faculty in curriculum design, specification of learning objectives, development of reading lists, and specification of curriculum content, to ensure

- implement means to promote and reward innovations in teaching methods and learning opportunities;
- offer intensive orientation and preparation for faculty teaching in these experiences to build a spirit of collaboration and teamwork and ensure that faculty are prepared for this kind of teaching;
- offer these interdisciplinary learning experiences in formats and at times convenient to all relevant health professions students; and
- foster regular review and evaluation by a representative stakeholder group to identify program strengths and areas in need of enhancement and respond in short time frames to students' concerns.

5.0 Collaborator Competency Statements

Competency-based curriculum has become widely accepted in health professional education as a way to define the knowledge, skill and attitudinal outcomes expected of the pre-licensure learner. According to Barr et al. (2005) the need for competency-based outcomes in IPE has been largely based on the *"belief that changing attitudes alone is not enough to prepare practitioners for collaboration in complex situations"* (Barr et al., 2005: p. 84). Experts in the field of competency-based education define "competency" as an integrated set of knowledge, skills, attitudes and judgments that enable one to effectively perform the activities of a given occupation or function to the standards expected in employment (Roegiers, 2000; Scallon, 2004; Tradif, 2006). A competency extends beyond the notion of the learning objective because it is related to a specific context and describes the characteristics a person needs to develop in order to demonstrate effective performance in a given situation or environment. Competencies apply to learners of varying levels of education and experience and should guide growth and development throughout one's working life.

Nearly three decades ago the World Health Organization (WHO) published an important report by McGaghie et al. (1978) entitled "Competency-based Curriculum Development in Medical Education". This document argued that competency-based curriculum was necessary to bring about a better match between education for the health professions and the corresponding needs of our health systems. In recent years there has been a growing emphasis on competency-based education principles in the design and evaluation of health professional education curricula (Davis & Harden, 2003). Competency-based education has been defined as *"an educational system that emphasizes the specification, learning and demonstration of those competencies that are of central importance to a given task, activity or career"* (Alspach, 1996: p. 15). The fundamental characteristics of a competency-based curriculum include: organized around and contributing to the learner's competency development; based on real world performance requirements; derived from and validated by practitioners; structured by competency statements and performance criteria; learner-centred; flexibility in instructional strategies; shared expectations with learners; and opportunities for remedial instruction as necessary. A logical and essential aspect of competency-based education approaches is the assessment of student's achievement of the necessary competencies (Davis & Harden, 2003).

Oandasan and Reeves (2005) have identified a number of sources in the literature which define interprofessional collaborative competencies. In one source, Way et al. (2001) reported seven essential elements which are required for successful collaborative practice: cooperation; assertiveness; responsibility/accountability; autonomy; communication; co-ordination; mutual trust and respect. In another, Pollard, Ross, and Means (2005) report the critical behaviours for effective interprofessional collaboration are: mutual respect; non-hierarchical team structures; clear communication channels; shared decision-making; and developed interpersonal skills. In another study, D'Amour, Beaulieau, San Martin-Rodriguez, and Ferrada-Videla (2004) conducted a systematic review of the teamwork literature and identified a number of key determinants for collaborative practice: knowledge of each other's roles; good communication including negotiation skills; willingness to work together; trust related to self-competence and confidence in other's abilities; and mutual respect implying knowing other health professionals and their contributions to patient care. San Martin-Rodriguez, Beaulieu, D'Amour, and Ferrada-Videla (2005) further refined these statements and identified four interactional determinants: willingness to collaborate; trust; communication; and mutual respect. Hall and Weaver (2001)

also discuss content specific issues for IPE and suggest that students should learn issues related to professional role demarcation vs. role blurring, group skills, conflict resolution skills and leadership skills. Barr (2002) defines collaborative competencies as those necessary to work effectively with others and has also identified a number of competencies for collaborative practice (Table 2):

Table 2 Collaborative Competencies (Barr et al., 2005)

- Cooperating and communicating between professions and between agencies
- Providing assessments of client need on which other professions can act
- Managing confidentiality between professions and between agencies
- Negotiating working agreements with other professions and agencies
- Coordinating a team and conducting interprofessional meetings
- Coping with conflict
- Contributing to joint service planning, implementation, monitoring and review
- Describing one's roles and responsibilities clearly to other professions and discharging them to the satisfaction of others
- Recognising and respecting the roles, responsibilities and competence of other professions in relation to one's own, knowing when, where and how to involve these others through agreed channels
- Working with other professions to review services, effect change, improve standards, solve problems and resolve conflict in the provision of care and treatment
- Working with other professions to assess, plan, provide and review care for individual patients

Oandasan and Reeves (2005) suggest that interprofessional collaborator competencies should be shared amongst all health professional faculties, licensing, certification and accreditation bodies involved. In the United States, the Institute of Medicine (IOM) has brought together health professionals, educators, consumers, policy makers, regulators and students to develop a core set of competency requirements that all clinicians, regardless of their discipline, should possess to meet the needs of the twenty-first century health system. The report *Health Professions Education: A Bridge to Quality* (Institute of Medicine, 2003: p. 45-46) summarizes these core competencies as:

- *Provide patient-centered care*: identify, respect, and care about patients' differences, values, preferences, and expressed needs; relieve pain and suffering; coordinate continuous care; listen to, clearly inform, communicate with, and educate patients; share decision making and management; and continuously advocate disease prevention, wellness, and promotion of healthy lifestyles, including a focus on population health.
- *Work in interdisciplinary teams*: cooperate, collaborate, communicate, and integrate care in teams to ensure that care is continuous and reliable.
- *Employ evidence-based practice*: integrate best research with clinical expertise and patient values for optimum care and participate in research activities to the extent feasible.
- *Apply quality improvement*: identify errors and hazards in care; understand and implement basic safety design principles, such as standardization and simplification; continually

understand and measure quality of care in terms of structure, process, and outcomes in relation to patient and community needs; and design and test interventions to change processes and systems of care with the objective of improving quality.
- *Utilize informatics*: communicate, manage knowledge, mitigate error, and support decision making using information technology.

In terms of the teamwork competency, the Institute of Medicine (2003: p. 56) has characterized effective interdisciplinary teamwork as requiring health professionals to:

- Learn about other team members' expertise, background, knowledge, and values;
- Learn individual roles and processes required to work collaboratively;
- Demonstrate basic group skills, including communication, negotiation, delegation, time management, and assessment of group dynamics;
- Ensure that accurate and timely information reaches those who need it at the appropriate time;
- Customize care and manage smooth transitions across settings and over time, even when the team members are in entirely different physical locations;
- Coordinate and integrate care processes to ensure excellence, continuity, and reliability of the care provided;
- Resolve conflicts with other members of the team;
- Communicate with other members of the team in a shared language, even when the members are in entirely different physical locations.

Also in the United States, the Professional Affairs Committee of the American Association of Colleges of Pharmacy (AACP) has reported that to demonstrate interprofessional competence students should:

- Share a common language that facilitates communication among health care professionals.
- Demonstrate an understanding of the health professions – understanding the value that each profession adds to the delivery of health care.
- Learn how to work effectively as a team that utilizes the unique and complementary talents of each member through interprofessional courses, seminars, activities, clinical experiences and research projects.
- Be able to promote the interprofessional delivery of health care in all practice settings.

The Council on Social Work Education (CSWE), also in the United States, has identified a list of objectives defining the competencies that students should acquire from interprofessional learning. The CSWE suggests that these competencies identify a standard which programs may strive to achieve or to which programs may compare to their own efforts. The specific standards are not meant to be restrictive, prescriptive, or proscriptive. It is assumed that programs will develop operational definitions against which it will evaluate its own successes. IPE should provide professionals with the knowledge, skills, and values to accomplish the following:

- Work in teams, across traditional lines of programs, agencies, disciplines, professions, and communities;

- Value teamwork as the preferred mode of work;
- Understand what each member brings to the team – and value and respect what they bring;
- Identify who should be included on the team when asking "who do you need to succeed?";
- Recognize what a professional in a single field does not know and be able to resist "the myth of self-sufficiency, for knowing who and how to ask for help effectively requires an understanding of the focus and philosophy of practice of different disciplines";
- Bring people from the periphery to the center for decisions;
- Resolve conflicts between and among members;
- Facilitate dialogue, problem solving, and decision making in groups;
- Plan and conduct effective interprofessional meetings and disseminate reports of the same;
- Be willing to embrace clients and community members as part of the team;
- Create consensus when compromise is essential, unanimity when there is only one choice, and harmony when different choices can exist; and
- Understand organizational dynamics across multiple settings and apply that knowledge to effective action.

The National League for Nursing (NLN) has also established an interprofessional presidential panel on IPE and practice for the health professions.[2] This panel of representatives of the major health professions was charged with developing a consensus statement regarding IPE. Table 3 summarizes the underlying assumptions, core content and educational philosophies underlying IPE which this panel proposed.

Table 3 Recommendations of the National League for Nursing (NLN) Presidential Panel on Interprofessional Education and Practice

Assumptions: underlying assumptions for educating students to value IPE and practice include the following:

1. Interdisciplinary education is better served by a health model than by a medical model
2. Learning together will lead to working together
3. Learning together will enhance understanding of problems and solutions
4. Learning necessarily involves self-awareness and self-disclosure; one must develop integrity that is both personal and professional
5. Professionals have a responsibility for life-long learning
6. Professionals must accept responsibility and accountability for their own actions
7. Professionals can learn to respect and trust persons from other disciplines
8. Models of authority do not foster relationship-centered practice

[2] Interdisciplinary Health Education Panel of the National League for Nursing. (1998). Building community: Developing skills for interprofessional health professions education and relationship centered care. *Nursing and Health Care Perspectives, 19*(2), 86-90.

9. Professional identity (collegiality) is strengthened by sharing and diversity
10. Solutions should be based on need (demand-side rather than supply-side oriented)
11. Community building is a basic human need
12. Professional service/stewardship is rooted in the principle of social justice

Core Content - taught across disciplinary boundaries, core content should integrate the values and process components of professional behaviour. The following skills and common knowledge areas should be included:

- Behavioural sciences
- Change and the change process
- Common terminology
- Community health
- Death and dying
- Ethics and values
- Growth and development (including aging)
- Health assessment
- Health care systems
- Health informatics
- Health promotion and prevention
- Interpersonal and communication skills
- Nutrition
- Relationship-centered care
- Role theory
- Skills for community building
- Skills for teamwork and teaming
- Socialization and professionalism

Educational philosophies and beliefs underlying IPE include the following:

1. Knowledge and skills go hand in hand
2. Affective learning will enhance didactic learning
3. Experiential learning will enhance skills development
4. Problem-based learning will enhance cognitive learning
5. Self-learning flows from group learning
6. Diversity of views enhances group learning
7. Personal awareness and self-esteem flow from interpersonal interaction
8. Dignity and respect are basic requirements for student well-being and learning
9. Faculty and students should be companions in learning, the adage being "guide by the side" rather than "sage on the stage"

In Canada, the Medical Council of Canada's (MCC) Considerations for Cultural-Communication, Legal, Ethical and Organizational Aspects of the Practice of Medicine (C_2LEO) have defined specific objectives related to Collaborator (Medical Council of Canada, 2007). Interprofessional collaboration is also a key competency area identified in the CanMEDS role of

Collaborator. The CanMEDS framework is a competency framework; a guide to the essential abilities physicians need for optimal patient outcomes. This framework of core competencies includes the Roles of Medical Expert (the central role), Communicator, Collaborator, Health Advocate, Manager, Scholar and Professional. This framework now forms the basis of the standards of the educational mission of the Royal College and has been incorporated into accreditation, evaluation and examinations, as well as objectives of training and standards for continuing professional development (Royal College of Physicians and Surgeons of Canada, 2007). As Collaborators, "physicians work within a healthcare team to achieve optimal patient care. Physicians work in partnership with others who are appropriately involved in the care of individuals or specific groups of patients. This is increasingly important in a modern multi-professional and multi-disciplinary environment, where the goal of patient-centered care is widely shared. Modern healthcare teams not only include a group of professionals working closely together at one site, such as a ward team but also extended teams with a variety of perspectives and skills, in multiple locations. It is therefore essential for physicians to be able to collaborate effectively with patients, families and an interprofessional team of expert health professionals for the provision of optimal care, education and scholarship" (Royal College of Physicians and Surgeons of Canada, 2007). Key competencies of the Collaborator role are:

"Physicians are able to…

1. *Participate effectively and appropriately in an interprofessional healthcare team;*
2. *Effectively work with other health professionals to prevent, negotiate, and resolve interprofessional conflict."* (Royal College of Physicians and Surgeons of Canada, 2007)

The Canadian Patient Safety Institute (CPSI) has also undertaken work to develop a Canadian interprofessional competency-based framework for patient safety through collaborative efforts. CPSI has partnered with the Royal College of Physicians and Surgeons of Canada in coordinating and facilitating the development of *The Safety Competencies Framework.* The Safety Competencies define seven core domains of abilities for all health professionals to incorporate into their work and identifies the key knowledge, skills and attitudes related to patient safety for institutions and individuals responsible for education and professional development of practitioners in medicine, nursing, pharmacy and the therapy groups (PT, OT, RT). Table 4 summarizes the 7 domains and specifies the content within *"Domain 2: Working as a Team"*.

Table 4 The Safety Competencies Domains (Canadian Patient Safety Institute, 2008)

Domain 1: Creating a Culture of Patient Safety The ability of health professionals to contribute to healthcare organizations, large or small, in ways that promote patient safety in their structure and function.
Domain 2: Working as a Team The ability of health professionals to effectively collaborate with others to maximize patient safety and the quality of care. All health professionals need to be able to effectively collaborate interprofessionally and intraprofessionally within their practice context to provide high quality

patient-centred care. Content in this domain could include, but is not limited to:

- Awareness of team members, their competencies, roles, expertise, and scope of practice
- Respect and professionalism
- Conflict prevention and management
- Effective handovers, transfers, and care transitions
- Shared authority and decision making, as appropriate
- Team learning, including setting team goals and measuring them
- Continuity of care
- Appropriate and effective consultation
- Team dynamics and authority gradients
- Feedback
- Debriefing / team support
- Readbacks

Domain 3: Communicating Effectively
The ability of health professionals to effectively receive and convey information and facilitate the interpersonal and interorganizational relationships needed to support safe and effective patient care.

Domain 4: Using Safe Strategies to Enhance Practice
The ability of health professionals to incorporate best practices in patient safety into daily activities.

Domain 5: Managing Human Factors and Cognitive Processes
The ability of health professionals to recognize the relationship between human performance and human and cognitive factors that may lead to adverse events.

Domain 6: Managing High-Risk Situations
The ability of health professionals to recognize, mitigate, and avoid common high risk clinical practices.

Domain 7: Responding to an Adverse Event
The ability of health professionals to recognize an adverse event when it occurs and respond effectively to mitigate harm, ensure disclosure and prevent it from happening again.

6.0 National (Canadian) Initiatives on IPE

In Canada, the Interprofessional Education for Collaborative Patient-Centred Practice (IECPCP) initiative[3] of Health Canada has funded 20 IPE projects across Canada involving universities and community colleges. The specific objectives of the IECPCP initiative have been to:

- promote and demonstrate the benefits of interprofessional education for collaborative patient-centred practice;
- increase the number of educators prepared to teach from an interprofessional collaborative patient-centred perspective;
- increase the number of health professionals trained for collaborative patient-centred practice before, and after, entry-to-practice;
- stimulate networking and sharing of best educational approaches for collaborative patient-centred practice; and
- facilitate interprofessional collaborative care in both the education and practice settings.

A complementary project funded through the IECPCP initiative has been the Canadian Interprofessional Health Collaborative (CIHC).[4] CIHC is described as a national hub for IPE, collaboration in healthcare practice and patient-centred care. A main goal of CIHC is to strengthen the knowledge base about IPE and to share this knowledge with those who make policy, planners in the health and education systems, health professionals and educators. As a Canada-wide initiative, the CIHC has also allowed all interprofessional projects across the country funded through Health Canada's IECPCP initiative to have a shared venue for exchanging ideas and promising practices related to IPE, collaborative practice and patient-centred care.

A related group which has emerged within Canada with initial funding support through the IECPCP initiative has been the National Health Sciences Students' Association (NaHSSA).[5] NaHSSA is the first and only national interprofessional student association in the world and seeks to involve Canada's health and human service students in IPE while promoting the attitudes, skills and behaviours necessary to provide collaborative patient-centred care. NaHSSA objectives include:

- promoting interprofessional education for collaborative patient-centred practice;
- facilitating opportunities for interprofessional interaction;
- fostering student champions to lead interprofessional efforts now and in the future.

In Ontario, IPE has been identified as a cornerstone of the *HealthForceOntario* strategy[6]; a comprehensive Health Human Resources Strategy to ensure Ontario has the right number and mix of appropriately educated health care providers. In support of IPE, the Province of Ontario established the Interprofessional Health Education Innovation Fund (IHEIF) in 2006-07 to fund

[3] Health Canada. http://www.hc-sc.gc.ca/hcs-sss/hhr-rhs/strateg/interprof/index_e.html
[4] Canadian Interprofessional Health Collaborative (CIHC). www.cihc.ca
[5] National Health Sciences Students' Association (NaHSSA). http://www.nahssa.ca/index.php?lang_en
[6] HealthForce Ontario. http://www.healthforceontario.ca/

IPE in post-secondary institutions. Eight main proposals and seventeen seed proposals received funding. Successful projects provided opportunities to enhance IPE in universities, community colleges and teaching practice sites, to use simulation labs to prepare learners to work in cohesive, collaborative teams and to develop a comprehensive approach to IPE - including modules on interprofessional competencies, clinical placements, assessment tools, faculty courses and preceptorship programs in universities.

In 2007-08, the Ontario government, through the Ministry of Training, Colleges and Universities (MTCU) and the Ministry of Health and Long-term Care (MoHLTC) also established the Interprofessional Care/Education Fund (ICEF).[7] Priority has been given to two types of proposals: new project ideas that support and further interprofessional care and IPE; and proposals that advance the work of projects that received funding from the Interprofessional Leadership, Mentorship, Preceptorship and Coaching Fund or the IHEIF in 2006-07 and will build on, and further support interprofessional care or education.

A number of organizations have also begun to review standards pertaining to accreditation of IPE. The Canadian Association of Schools of Nursing (CASN) has established a Taskforce on Interprofessional Education[8] *"to provide advice and recommendations regarding strategic directions on how CASN can demonstrate leadership in creating a role for nursing education within the context of IPE."* This Taskforce has been mandated by CASN to work collaboratively with other nursing organizations and health professionals to establish a role for nursing in the current initiatives for IPE; develop a position statement on IPE; and identify interprofessional initiatives, either currently in place or planned for implementation, in CASN member schools.

In 2004-05 McVicar et al. (2005) conducted a survey on behalf of the Canadian Collaborative Mental Health Initiative (CCMHI)[9] regarding the current state of collaborative mental health care education amongst: Canadian universities and colleges; national and provincial professional/territorial associations; national and provincial/territorial regulatory organizations; and mental health advocacy societies and associations. The purpose of this study was to examine the level and specific characteristics of IPE offered in collaborative mental health care across Canada. The focus was on current training offered at the pre-licensure (undergraduate- and graduate level education) and continuing education levels. At the time, the majority of respondents did not report offering formal pre-licensure, post-licensure, or continuing professional education involving collaborative mental health care. Some of the barriers to IPE which were reported included: a lack of financial resources; scheduling concerns; a lack of administrative/executive support; rigid curriculum; and a lack of reward for faculty. Key recommendations for IPE in collaborative mental health care, included the following: fostering co-operation and collaboration among faculty members, senior administrators, and other key players within existing institutions to support the development of IPE in collaborative mental health care; addressing logistical barriers, such as rigid curriculum and scheduling concerns, to make interprofessional courses more accessible; and allocating more funding to create and sustain IPE, as well as to reward faculty members responsible for the programs.

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[7] HealthForceOntario. *Interprofessional Care/Education Fund (ICEF) 2007-08. Program Description/Request of Proposals Document. Ministry of Health and Long-term Care. Ministry of Training, Colleges and Universities.* https://www.healthforceontario.ca/upload/en/whatishfo/icef%202007-08%20program%20description_request%20for%20proposals.pdf

[8] CASN. *Taskforce on Interprofessional Education*. http://www.casn.ca/content.php?doc=136

[9] Canadian Collaborative Mental Health Initiative (CCMHI). http://www.ccmhi.ca/

Barker (2004) also conducted a survey of Canadian initiatives in IPE during the year 2003. One hundred and seventy-seven (177) respondents reported that they knew of an IPE program. Of the 162 respondents who went on to describe the IPE program of which they knew, successful programs were reported in 96.9% of cases. When respondents reported why they described the programs/initiatives as "successful" or not, some respondents highlighted various enablers and barriers to the programs, or what features either encouraged or discouraged the success of the programs. These are summarized in Table 5.

Table 5 Enablers and Barriers to Interprofessional Education Programs

Enablers	Barriers
• Sound program logistics & administration • Balanced participation from different professional/discipline groups • Programmatic and financial sponsorship • Organizational support • Critical mass of learners • Participant compensation • Quality improvement paradigm	• Regarded as non-typical experience • Lack of one's own role understanding • Timing (lack of time, scheduling) • Lack of organizational-culture support • Curriculum leaders failed to introduce course material

Respondents to Barker's (2004) survey were also asked to classify where the program took place: 50% specified higher education institution; 10% service setting; and 40% mixed setting (a higher education with service setting links or vice versa). Seventy seven respondents reported the characteristics of learners participating in IPE programs. The professions which were reported as participating the most included: Medicine (74%), Nursing (70.1%), Physiotherapy (50.7%), Occupational Therapy (49.4%) and Pharmacy (45.5%). Respondents were asked to also identify the education levels of the IPE program participants and the majority of programs in post-secondary institutions (80%) included pre-licensure learners. Regarding funding, 71% of respondents stated the educational programs received funding and 73% that ran 3 or more times received funding versus 33% of those programs that ran once or twice. Respondents also indicated that 89.3% of programs were evaluated.

7.0 International Initiatives on IPE

7.1 United Kingdom (UK)

In the United Kingdom, there is a clearly articulated policy agenda (Department of Health 1998a; 1998b; 1999; 2000a; 2000b) and legislation (e.g. Health Act 1999 and the Health & Social Care Act 2001) that has paved the way for change around IPE (Cooper et al., 2004). The UK's National Health Services Plan (NHS) has called for the development of new common foundation programs for healthcare professionals which would enable students and staff to switch careers and training paths more easily, promote teamwork, partnership and collaboration, skill mix and flexible working, and lead to the development of new types of workers (Cooper et al., 2004). Partly in response to these policy directives there has been a large increase in the UK in the proportion of IPE at the undergraduate level.

The Quality Assurance Agency for Higher Education in the UK has proposed *"subject benchmark statements"* for the health and social care professions.[10] The education and training of certain professions in the UK is governed by subject benchmarks statements which serve to describe the general academic characteristics and standards of programs of study across the UK. These statements also articulate the attributes and capabilities that those possessing such qualifications should be able to demonstrate. Subject benchmark statements are an external source of reference when new programs are being developed and provide general guidance for articulating and evaluating program learning outcomes. The statements result from an extensive consultation process involving appropriate specialists drawn from higher education institutions, subject associations, service commissioners and providers, and the professional and statutory regulatory bodies.

In the UK, cross-professional benchmarks and statements of common purpose have been developed in response to integrated service delivery in the NHS as well as the growth in IPE. The challenge confronting the establishment of such cross-professional statements has been to not subsume one discipline or professional activity into another, but to integrate perspectives in a manner that maximises the synergies and distinctive contributions of each. Appendix D summarizes the proposed cross-professional subject-specific benchmark statements in health and social care.

7.2 United States

In the United States, a number of initiatives related to IPE and academic accreditation have taken place over the years. Historically, recommendations by the Pew Health Professions Commission, the American Association of Colleges of Nursing (AACN), the National League for Nursing (NLN), and the Council on Graduate Medical Education (COGME) have all emphasized the need for IPE to assure that collaboration is enhanced (AACN, 1995; COGME, 1999; O'Neil, 1993; Watson, 1996). Initiatives by the W.K. Kellogg Foundation, the Institute for Healthcare Improvement, and Area Health Education Consortiums have been successful in implementing IPE, primarily in outpatient settings (Headrick et al., 1996; Lough et al., 1996;

[10] The Quality Assurance Agency for Higher Education. *Statement of common purpose for subject benchmark statements for the health and social care professions.* http://www.qaa.ac.uk/academicinfrastructure/benchmark/health/StatementofCommonPurpose06.asp

Zungolo, 1994). Significant initiatives by the National Academies of Practice, Institute of Medicine, American Council on Pharmaceutical Education and the American Association of Colleges of Pharmacy are described.

The National Academies of Practice (NAP) is an organization of practice-oriented health professionals from ten disciplines: dentistry, medicine, nursing, optometry, osteopathic medicine, pharmacy, podiatric medicine, psychology, social work, and veterinary medicine. The NAP mission is to improve health care quality through interdisciplinary care by promoting education, research, and public policy. A consensus conference in April 2000 was intended to serve as a starting point for defining interprofessional health issues and initiating collaboration with other groups to promote interdisciplinary health care (Brashers et al., 2001). NAP undertook a review of the mission or goal statements of the organizations representing the academic interest of nine of the ten NAP disciplines to determine what similarities and differences existed among them. None of the reviewed statements made reference to, or implied collaborative or other interprofessional relationships with another discipline. The review also failed to identify any organization that articulated a position concerning IPE.

The Council on Social Work Education (CSWE) in the United States, as part of a project titled *"Preparing Human Service Workers for Interprofessional Practice: Accreditation Strategies for Effective Interprofessional Education"* examined: the goals and purposes of accreditation; how accreditation balances with IPE; and how accreditation standards or practice may interact with other forces (i.e., credentialing, licensing, or university practices) that may impede program development. Table 6 summarizes a series of recommendations put forth by the CSWE related to accreditation and IPE.

Table 6 Council on Social Work Education (CSWE) Recommendations for Accreditation and IPE

Engage Accrediting and Credentialing Organizations

- **Include language specific to interprofessional education in accreditation standards and curriculum policy statements.** Such explicit language affects policy and helps keep interprofessional education from being marginalized.

- **Engage accreditors in listening to the field.** Accreditation bodies may make changes supportive of interprofessional education if they develop close links to collaborative efforts in the field, rather than relying solely on input from single-disciplinary practice. Accreditation processes should take into account community context and community needs, using a broader definition of community than just the "nursing community" for nurses or the "social work community" for social workers. The bodies that develop Curriculum Policy Statements that guide curriculum standards for accreditation must also be involved in and listening to practice.

- **Strengthen focus on outcomes in accreditation processes, including outcomes defined by communities.** Possible methods include community scorecards, report cards, and asset-mapping.

- **Find ways for accreditation bodies to work cooperatively to reduce duplication and improve efficiency in accrediting disciplines that work together in the field.** Such cooperation may reduce some of the challenges of the accreditation process by reducing the variety of ways that programs have to comply with accreditation standards.

- **Include information related to interprofessional education in site visitor training, selection, and identification.** Site visitors are crucial to the accreditation process. Interprofessional education should be an area of interest and expertise included in the profile for site visitors. There should also be continual training and retraining of site visitors, including sensitivity to changing educational modalities, such as interprofessional education including interprofessional teams in field sites.

- **Include accreditation "in the loop" when changing practice modalities are examined, recognizing that practice change has implications for professional education and accreditation.** Accreditation bodies need ongoing communication mechanisms with professional associations, licensing boards, and a broad community of practitioners.

- **Examine issues of licensing and title protection in specific professions in light of interprofessional education and practice.** Diversity among professions, turf issues, and community needs should be taken into account and balanced with the protection and quality assurance that licensing provides.

In 2001 the Institute of Medicine (IOM) published the report *"Crossing the Quality Chasm: A New Health System for the 21st Century"* (Institute of Medicine, 2001). This report concluded that a major overhaul of the health care system in the United States was required and stressed that such a redesigned system should be predicated on interdisciplinary teams. A follow-up IOM report *"Health Professions Education: A Bridge to Quality"* (Institute of Medicine, 2003) identified a new vision for clinical education in the health professions centered on a commitment to, first and foremost, meeting patients' needs:

> *"All health professionals should be educated to deliver patient-centered care as members of an interdisciplinary team emphasizing evidence-based practice, quality improvement approaches, and informatics."* (Institute of Medicine, 2003: p.3, 45, 121)

From this vision, the IOM also identified a set of five core competencies (previously described) that all clinicians should possess, regardless of their discipline, to meet the needs of the twenty-first century health system. The IOM recommended that these core set of competencies - shared across the professions – should be integrated into health professions oversight processes. Health professions oversight processes, such as accreditation, were viewed as a key leverage point for system wide change. The IOM report recommended that it was imperative to have linkages among accreditation, certification, and licensure as *"it would be pointless if accreditation standards set requirements for educational programs, yet these requirements were not then reinforced through testing on the licensing exam"* (IOM, 2003: p. 7).

According to the IOM (2003) strategies for incorporating the competencies into oversight processes would need to differ across the oversight framework based on history, regulatory approach, and structure. The IOM also recommended the oversight bodies should proceed with extensive consultation on draft language, initial testing of new requirements (e.g. provisional standards), and monitor new requirements to ensure they were useful and not overly burdensome.

A review conducted by the IOM (2003) revealed that accrediting organizations varied in their approach to the recommended core competencies, ranging from assessing such competencies in their standards, to requiring related curricula and education experiences, to encouraging educational institutions to include the competencies. The IOM recommended that any collective movement by the health professions to reform education would need to begin with defining a shared language that would enable the professions to communicate and collaborate with one another. Table 7 summarizes the findings from a scan of how the standards of various accrediting organizations in the United States mapped to the Interdisciplinary Team competency as set forth in the Institute of Medicine (2003) report.

Table 7 Accrediting Organizations and Standards Addressing the Five Competencies

Accrediting Organization	Interdisciplinary Teams
Medicine	
Undergraduate	
Liaison committee on Medical Education (LCME)	X
American Osteopathic Association (AOA)	
Residency	
Accreditation Council for Graduate Medical Education (ACGME)	X
American Osteopathic Association (AOA-Grad)	X
Pharmacy	
Undergraduate	
American Council on Pharmaceutical Education (ACPE)	X
Residency	
American Society of Health-System Pharmacists (ASHP)	X
Physician Assistant	
Accreditation Review Commission on Education for the Physician Assistant (ARC-PA)	X

Nursing	
National League for Nursing Accrediting Commission (NLNAC)	X
Commission on Collegiate Nursing Education (CCNE)	X
Occupational Therapy	
Accreditation Council for Occupational Therapy Education (ACOTE)	X
Clinical Laboratory	
National Accrediting Agency for Clinical Laboratory Sciences (NACCLS)	X
Respiratory Therapy	
Committee on Accreditation for Respiratory Care (C-ARC)	

Licensure was a further oversight process examined by the Institute of Medicine in the 2003 report. In the United States, like in Canada, professional licensure laws are enacted to assure the public that practitioners have met the qualifications and minimum competencies required for practice. Licensing boards evaluate when a health professional's conduct or ability to practice warrants modification, suspension, or revocation of the license. To be licensed, licensees must pass an examination - sometimes national, and in the United States sometimes administered by the state, or both. The committee reviewed national licensure examinations for content related to the five competencies and found only the registered nursing exam had content on interdisciplinary teams.

As a result of the work of the IOM, a number of professional associations in the U.S. have responded. The American Association of Colleges of Pharmacy (AACP) has identified IPE as a key strategic goal. Goal VII of the 2004 AACP Strategic Plan states that AACP will *"provide leadership for the development of inter-professional and multidisciplinary education, research, and patient care opportunities for faculty and students at all colleges and schools of pharmacy."* The AACP Professional Affairs Committee[11] was also tasked with studying and offering recommendations on strategies that could advance the goals to significantly improve IPE and practice. The Committee determined that the ultimate objective for efforts to build IPE was to thread meaningful interprofessional coursework and experiences from the earliest opportunity and throughout the course of study with all relevant disciplines. The Committee endorsed the recommendation from the IOM "*Bridge to Quality"* report that urged the accrediting bodies of health professions education programs to coordinate their efforts and revise

[11] American Association of Colleges of Pharmacy. *Getting to Solutions in Interprofessional Education. Report of the 2006-07 Professional Affairs Committee.* http://www.aacp.org/Docs/AACPFunctions/Governance/8442_GettingtoSolutionsinInterprofessionalEducationfinal.pdf

their standards. The Accreditation Council for Pharmacy Education (ACPE) also responded to the IOM recommendations and included the "Interdisciplinary Team" core competency statement verbatim in the accreditation standards for pharmacy education that will be effective in July 2007 (Accreditation Council for Pharmacy Education, 2006)[12].

[12] Accreditation Council for Pharmacy Education. (2006). Standards and Guidelines for the Professional Program in Pharmacy Leading to the Doctor of Pharmacy Degree (adopted January 15, 2006). http://acpe-accredit.org/pdf/ACPE_Revised_PharmD_Standards_Adopted_Jan152006.DOC
Accessed April 26, 2007.

8.0 Accreditation Processes and Standards

A systematic review of the pre-licensure academic accreditation process of each accrediting body for the various professions comprising the AIPHE project was undertaken. This review included a review of documentation describing the accreditation process and interviews with key informants. The findings of this review indicate that the accreditation processes across the accrediting bodies for each profession were very similar in nature. In general, the accrediting processes are overseen by accreditation committees with an arms-length relationship to professional and/or academic bodies. These committees have responsibility for overseeing and implementing the accreditation process and for the development and revision of appropriate and relevant accreditation standards. The general process followed across professional accreditation bodies begins with the institution or program conducting a self-study. Completion of the self-study is followed by a site visit, a report of the visit, comments and responses, and the accreditation decision. The following section describes the specific academic accreditation process of each profession.

8.1 Medicine (Undergraduate Medical Education)

Accreditation for undergraduate medical education programs is the responsibility of the Committee on Accreditation of Canadian Medical Schools (CACMS) of the Association of Faculties of Medicine in Canada (AFMC) in cooperation with the Liaison Committee for Medical Education (LCME). The United States Department of Education recognizes the LCME for accreditation of programs of medical education leading to the M.D. in the United States. For Canadian medical education programs, the LCME engages in accreditation in collaboration with CACMS. The partnership arrangement for accreditation ensures that graduates of Canadian medical schools are accredited to pursue residencies and practice in the United States and Canada.

Responsibility for overseeing the process of accreditation resides in the AFMC office with the Executive Director of AFMC acting as Secretary. The Canadian Medical Association (CMA) and AFMC appoint members to the Accreditation Committee, which is an arms-length group working in collaboration with the LCME. The committee also has medical student representation appointed by the Canadian Federation of Medical Students (CFMS) and the equivalent body in Québec. As well, there is public representation on the committee. The CACMS serves as a mechanism to ensure high standards on a national basis as well as meeting accreditation standards of the American counterpart, the LCME. The Chair and the Secretary of CACMS both sit on the LCME which has reciprocal membership on CACMS.

There is an eight year formal cycle of accreditation for Canadian medical schools. Each faculty undergoes a full on-site assessment visit by a team of trained surveyors consisting of senior leaders, educators and students. There is an LCME member on the survey team of each Canadian school, and the CACMS chair and secretary are frequent surveyors for American schools. The cycle includes an 18-month self-study process which produces an institutional database and self-study report. The team prepares a formal survey report, which is reviewed independently by CACMS and the LCME. Each body makes its own determination of the school's state of compliance with the standards and determines the status of accreditation. Each will decide on the accreditation status to be granted: they can deny accreditation, give interim accreditation, or full accreditation. Even in the latter case, follow up requirements such as a

written report or a more limited site visit may be included to ensure compliance with particular standards.

In the United States, LCME is accredited by the US Department of Education. There is an expectation that regular review of standards and processes will occur. Standards for accreditation are detailed in the LCME document "Functions and Structure of a Medical School".[13] The following categories of standards are used:

- Institutional Setting - governance and administration, and academic environment;
- Educational Program for the M.D. Degree - educational objectives, structure, teaching and evaluation, curriculum management, and evaluation of program effectiveness;
- Medical Students - admissions, student services, and the learning environment;
- Faculty - numbers, qualifications, functions, personnel policies, and governance;
- Educational Resources - finances, general facilities, clinical teaching facilities, and information resources and library services.

Since both Canada and the United States use the same accreditation standards and the same survey process, development and review of accreditation standards is the responsibility of a subcommittee on standards with Canadian and American representatives. *"It is a conjoint process with the United States"*. Reviews occur on a regular basis, although not on a set schedule. The subcommittee will survey schools and accreditation site survey teams to see how well standards are understood and, where necessary, annotations are added to the standards to ensure clear understanding. Suggestions for new standards can come from a variety of sources including the general public, medical students, and responses to wider-ranging societal issues such as "family violence".

> "*Anyone can approach the two governing bodies the Liaison Committee on Medical Education (LCME) in the US and the Committee on Accreditation of Canadian Medical Schools (CACMS) in Canada with a need for a new standard or a change to a standard"*.

New standards are approved by the four parent bodies (American Medical Association, Association of American Medical Colleges, Canadian Medical Association, and Association of Faculties of Medicine of Canada). Decisions to make changes are based on the value the change or new standard will have on health care, *"does this serve patients better?"* This process is slow to respond to emerging trends and needs. Schools are provided fair notice about changes in standards and are given about a year to come into compliance with new standards.

> "*It usually takes 1-2 years for a new standard to be developed due to the complexity of the process. Modifications to existing standards happen more quickly since they already exist and changes to the descriptive annotation of a standard happen even faster"*.

8.2 Medicine (Post-Graduate Medical Education)

The Accreditation Committee of the College of Family Physicians of Canada (CFPC) is responsible for overseeing the accreditation process and standards for post-graduate training programs in Family Medicine in Canada. The College is responsible for accreditation of family

[13] Available online from, http://www.lcme.org/standard.htm.

medicine, emergency medicine, and enhanced skills residency programs based in departments of family medicine in Canadian university faculties of medicine. Programs in Palliative Medicine are considered for accreditation under a conjoint process with the RCPSC. The survey team selected by the College's Accreditation Committee usually includes: two committee members and a dean of postgraduate medical education for a Canadian medical school. In addition, the team is often accompanied by representatives from other organizations, such as the Federation of Medical Licensing Authorities of Canada, the Canadian Association of Interns and Residents (CAIR), or the Fédération des médecins résidents du Québec, as well as by CFPC staff members.

The Committee's accreditation process is based on two elements: an assessment of an application for accreditation that describes the residency program and its resources, and an onsite survey. On-site visits to residency training programs occur on a six year cycle or as recommended. The medical school provides pre-survey documentation for review by the accreditation surveyors. A typical site visit takes approximately one week, during which members of the survey team meet with each specialty/subspecialty program. Members of the team also meet with the postgraduate medical education office to examine the internal review process for the university.

Within six weeks of the conclusion of the site visit, a survey report is drafted then returned to the university for its response. This report contains the survey team's observations and recommendations for the program. It is provided to the university so that it may correct any errors or omissions and respond directly to the survey teams recommendations. The team also makes recommendations concerning the accreditation status of the training program, which is provided to the university and to the College's Accreditation Committee. The Accreditation Committee reviews the survey team's report and the response of the training program. The university and training program are invited to send representatives to this meeting and discuss the content of the report with the committee. The category of approval for the program is determined by the Accreditation Committee and communicated to the program; there is a formal process for appeals of accreditation decisions.

The following categories of approval are possible:

- New program approval: internal review of the program by the faculty postgraduate medical education committee is expected to take place within two years;
- Full approval (6 years): may be requested to submit reports of progress toward the solution of problems identified;
- Provisional approval: granted for no more than three years; follow-up by mandated internal review, modified internal review, or special on-site survey by CFPC reviewers;
- Notice of intent to withdraw accreditation: granted to programs already on provisional approval which have failed to provide evidence of compliance with standards within the required time frame; may also be applied to programs with multiple major; term of notice no longer than two years;
- Withdrawal of accreditation;
- Inactive: granted in cases where program meets accreditation standards but does not have registered residents.

The Board of Directors of the CFPC is ultimately responsible for the approval of accreditation standards. This is a complex process which recognizes the voluntary nature of membership within the discipline and relies on input from members of the College, committees

of the College, and universities and colleges. The Accreditation Committee is responsible for vetting any changes or new standards for submission to the Board. Review of standards does not follow a formal schedule or process; it tends to be reactive to changes in the profession. A request for a change or addition to accreditation standards will generally go to the Accreditation Committee. The Section of Teachers Executive of the College vets all requests for changes to standards. They review all requests and if they deem them worthwhile, they are passed on to the Accreditation Committee for the development of new standards. The triggers for change to accreditation standards can come from a variety of sources. One of the major roots for change comes from the patient care committees that are directly educationally oriented.

> *"They [patient care committees] have all asked at some time for the Accreditation Committee to review how their content area is defined within the standards".*

Another is when external organizations make recommendations that come through the Board that might then be passed on for consideration. Regular curriculum review also looks at new standards. Primary care reform and the move towards teamwork in family medicine could also act as triggers for change. Information usually considered during the process of review and development would have to do with the impact on patient care and changes in the health care standards. The whole process usually takes about 12 months. After a new standard is adopted it is implemented right away. Schools would be expected to use the new standards in their next review.

The standards for accreditation of training programs in family medicine are based the following four principles of family medicine:

- The family physician is a skilled clinician.
- Family medicine is community-based.
- The family physician is a resource to a defined practice population.
- The doctor-patient relationship is central to the role of the family physician.[14]

General standards for principles and objectives, learning environment, evaluation, faculty development, and scholarly activity are detailed in relation to these principles. Program-specific standards are also defined for family medicine, family/emergency medicine, enhanced skills, care of the elderly, family practice – anesthesia, and (jointly with the RCPSC) palliative medicine.

The Royal College of Physicians and Surgeons of Canada (RCPSC) accredits residency programs in 30 specialties and 30 subspecialties for all 17 medical schools in Canada. Accreditation site visits are coordinated with the CFPC. The accreditation committee comprises a chair, and at least 16 members appointed by the Executive Committee. The chair reports directly to the Education Committee, which in turn reports directly to the Council of the RCPSC. Voting members are appointed for a two-year term, up to a maximum of three terms. The composition of the Accreditation Committee is as follows:

[14] Complete standards are available online at http://www.cfpc.ca/English/cfpc/education/accreditation/default.asp?s=1

Voting members include the following selected by the organizations they represent:

- two voting representatives from the Association of Faculties of Medicine of Canada (AFMC);
- one voting representative from the Federation of Medical Regulatory Authorities of Canada (FMRAC); and,
- one voting representative from each of the resident associations, the Canadian Association of Interns and Residents (CAIR), and the Fédération des médecins résidents du Québec (FMRQ).

In addition, there are several permanent (non-voting) observers, one from each of the:

- College of Family Physicians of Canada (CFPC),
- Collège des médecins du Québec (CMQ),
- Federation of Medical Regulatory Authorities of Canada,
- Association of Canadian Academic Healthcare Organizations (ACAHO),
- Canadian Resident Matching Service (CaRMS),
- Resident associations.

There are also two observers from the Accreditation Council for Graduate Medical Education (ACGME), from the United States.

The accreditation process is based on a system of regular surveys of the residency programs of each Canadian medical school on a six-year cycle. There are a number of steps in the survey process. The medical school first provides the pre-survey documentation for review. During the site survey the program is reviewed though interviews with the program director, teaching staff, residents, and with the residency program committee. The surveyors also tour the facilities and review the resources available to the program. After the site visit, each surveyor prepares a written report on each program surveyed. These are reviewed by the programs for factual correctness prior to review by the Accreditation Committee. The Accreditation Committee votes on the recommendations made in the report; this is an open process in which the Dean and Postgraduate Dean of the programs are invited to the meeting and can provide feedback on the process. The Accreditation Committee makes accreditation decisions, but the Council awards the final accreditation.

There are three categories of approval:

- New Approval: an acceptable application for accreditation of a program is granted new approval;
- Approval: for full six years;
- Provisional Approval: when a program is considered to have major weakness that require formal follow-up before the next scheduled survey. Review is usually internal but can also insist on an external review;
- Notice of Intent to Withdraw Accreditation: where very serious problems exist; onus is on the program to demonstrate why approval should not be withdrawn within 2 years;

- Withdrawal of Accreditation: a decision to withdraw accreditation becomes effective immediately unless there are residents enrolled in the program in which case it becomes effective at the end of the academic year in which the decision is taken.

The Accreditation Committee is responsible for the development and revision of standards with input from specialties/subspecialties committees of the RCPSC, CanMEDS, and other stakeholders. Standards are grouped into the following categories:

- Administration
- Goals and objectives
- Organization of program
- Resources
- Academic/scholarly components
- Evaluation[15]

These are viewed as guidelines for accreditation rather than as prescriptive. Descriptors have also been developed for each standard to clarify the guidelines and expectations for surveyors and for programs.

The development of the Canadian Medical Education Directions for Specialists 2000 Project (CanMEDS) framework and roles has been a central element for the revision and updating of standards for postgraduate medical education. Detailed guidelines within the above groups of standards refer to the CanMEDS roles of medical expert, communicator, collaborator, manager, health advocate, scholar, and professional. Accreditation standards are also linked to entry requirements for the profession; specialty and subspecialty committees take the revised standards and develop them into standards for admission to the specialty or subspecialty.

For the RCPSC, there is an accreditation committee which decides which changes will be made. Sometimes specific requests for changes/additions are made. Other times, the college will look at standards from other organizations, take a look at their standards and see how they have dealt with a certain area. After revisions are made, they go to staff at the College. There are several triggers that might occur, societal need, educational need, and practice changes. An example of this is "*changes in specialties, where new technology is being introduced, there is a need to look the evaluation of new training and teaching"*. It is usually 6-12 months before new standards are fully implemented for accreditation. There is a two step process. The College sends out extensive communication about the changes being made to make sure that each specialty has time to consider the new changes and can meet the new standard. A new standard is first implemented as a "should" i.e. *"should provide an opportunity for the resident to learn"*. After 1-2 years the standard is then implemented as a "must" i.e. *"must provide an opportunity for the resident to learn"*. This gives the program the opportunity to think about how to implement the standard.

[15] Complete standards are available online at http://rcpsc.medical.org/residency/accreditation/index.php

8.3 Nursing

The Canadian Association of Schools of Nursing (CASN) has been the accrediting body for nursing education programs since 1972, and has revised the accreditation program several times to respond to changing environments in health care and professional education. There has been a formal system of evaluation since 1987. CASN accredits undergraduate nursing programs (post-diploma and regular BN programs). Accreditation is a voluntary program; the school applies to be reviewed. Reviewers from a general CASN pool are assigned based on their compatibility with the needs and characteristics of the school being reviewed. For example, schools with collaborative BN training programs will have at least one reviewer who has experience with collaborative BN programming.

The accreditation process begins with an institutional self-study. The self-study process takes about one year following specific guidelines from CASN. The on-site review takes about four days and involves a review of the institutional self-study and on-site validation and interviews. The site visit team report is sent to the school for their response, and then both the site visit team report and the school response are forwarded to Accreditation Board members for review and discussion. A letter with the Board's decision is sent to the school, which has a 30 day period to appeal decisions. Appeals are based on the process of the review only, and go to an arms-length executive committee for feedback to the Accreditation Board for their final decision. Accreditation can be granted for the maximum term of seven years, for five years where identified weaknesses in compliance are sufficient, or denied. In both seven and five-year accreditations, the Board may also ask for an interim report on specific areas of concern.

The original accreditation program, including its standards and policies, was previously revised in 1995. The new 2005 accreditation program builds on more than 15 years of experience and evaluation of the previous programs. At the same time, this new program accommodates the many changes in nursing education, which include distance education, collaborative partnerships and new program models. The new program is the result of work undertaken by the Task Force on Accreditation (2000-2005) and also input from CASN members, review of the CASN existing program, identified trends, and the accreditation programs of other professional groups. While the 2005 program has a new framework and expanded standards, the original philosophy and approach to accreditation have endured since 1987.

The CASN accreditation process is divided into two sets of standards. One set related to the School of Nursing as the educational unit and the other to the nursing education program. The educational unit standards focus on the structure supporting program delivery. The nursing education program standards focus on the means for and achievement of outcomes through program delivery.

The standards for the educational unit are:[16]

- Leadership
- Partnerships
- Resources

[16] Completed standards available by requesting a copy at: http://www.casn.ca/content.php?sec=5

- Information Management Systems
- Environment
- Scholarship

The standards for each nursing education program are:

- Curriculum
  - Framework
  - Knowledge-based Practice
  - Professional Growth
- Evaluation

8.4 Pharmacy

Canadian Council for the Accreditation of Pharmacy Programs (CCAPP) was formed in 1993 with responsibility for the accreditation of pharmacy programs at both baccalaureate and doctoral levels. The CCAPP is composed of representatives appointed by the Association of Deans of Pharmacy of Canada, the Association of Faculties of Pharmacy of Canada, the Canadian Pharmacists Association, the Canadian Society of Hospital Pharmacists, the National Association of Pharmacy Regulatory Authorities and the Pharmacy Examining Board of Canada. A non-pharmacy member is also appointed to Council by CCAPP. Non-academic appointees form a majority of the Board of Directors which is responsible for establishing the Accreditation Standards, setting policy and managing the accreditation process.

CCAPP currently accredits 12 pharmacy academic programs offered at ten Canadian universities. A self-examination and site visit process is used for accreditation. Prior to the site visit a university provides information on personnel, budgets, enrolment, etc; conducts a comprehensive internal review; and develops a strategic plan. Site visit teams consist of a faculty member, an academic Dean, a member of the Board of CCAPP, and the Executive Director of CCAPP. During the site visit, the team seeks information to supplement the comprehensive internal review, assesses the feasibility of the strategic plan, and prepares a draft evaluation report. The Executive Director prepares the final evaluation report on the Faculty and a recommended accreditation status for consideration by the CCAPP board of directors. The Board then makes a decision on the appropriate accreditation status to be granted and determines the time period for the submission of the progress report and/or conditions to be associated wit the accreditation period. The university president and dean of the faculty are advised of the Board's decision and the accreditation status is published in the CCAPP Annual Report and Directory of Accredited Programs. Accreditation can be granted for up to six years (full accreditation).

The CCAPP received permission from the Accreditation Council of Pharmacy Education (ACPE) in the United States to use their accreditation documents and process as a starting point to develop Canadian standards and process. A major revision of standards took place in 1998 and another in 2006. The CCAPP is currently in the process of revising the standards again with a draft document released for comments from stakeholders in October 2007.

The accreditation standards are designed to reflect a linkage between entrance-to-practice competencies established by licensing authorities, educational outcomes developed by faculties of pharmacy, and accreditation of educational programs. The main categories of standards are:[17]

- Mission, planning, and evaluation - faculty mission, goals, and objectives, strategic planning, and evaluation of performance;
- Organization and administration - faculty–university relationships, relationships between university and affiliated health care facilities, faculty organization and administration, and responsibilities of faculty administrators;
- The academic program - the academic program in pharmacy, areas and content of the curricular core – knowledge and skills, areas and content of the curricular core – practice experiences, teaching and learning processes, assessment of student learning, academic program evaluation;
- Students - admission criteria, policies, and procedures, student services, student representation, and student/faculty relationships;
- Faculty and staff - quantitative factors, qualitative factors, and faculty assessment;
- Facilities and learning resources – library and learning resources, and physical facilities; and
- Financial resources.

The Standards and Guidelines Committee of the CCAPP Board recommends changes to the Board. The committee determines the action taken and will develop a draft of the new standards that address the changes. This draft is then circulated to the professional and education stakeholders. Once feedback is received it is reviewed by the committee and any revisions needed are made. The final standards are sent to the board for approval. Triggers for change may include any of the following: 1) standards are routinely reviewed in a 6-8 year cycle; 2) CCAPP likes to maintain comparability with the American Standards (ACPE); 3) development of new programs require new standards i.e. "*the doctor of pharmacy degree in Montreal – new standards are being developed for this new program"*; and 4) significant development in pharmacy education and professional development for pharmacy – "*watching the environment of professional practice and education"*. The programs are usually given 8-12 months after new standards are introduced before they have to use them for accreditation and self study.

8.5 Social Work

Responsibility for the accreditation of Social Work programs at the undergraduate level rests with the Canadian Association of Schools of Social Work (CASSW). The Association is a self-directed, voluntary organization of schools. Undergraduate programs are accredited by the CASSW Board of Accreditation which is a separate body relating with, but is at arms length from, the CASSW Board of Directors.

The Board of Accreditation authorizes four types of site visits according to the program's stage in the accreditation process: candidacy, first accreditation, re-accreditation, and supplementary visits to programs with limited accreditation. A formalized process of accreditation based on self-study and site visits is followed. A self-study report is prepared by the program in accordance with CASSW standards and Educational Policy Statements and

[17] Complete standards available online from, http://www.ccapp-accredit.ca/standards/.

submitted to the Board at least eight weeks before the Board meeting at which the program will be reviewed. The Board reviews the self-study and other relevant materials, including independent Reader's reports completed by two members of the Board, before finalizing the decision to proceed with a site assessment. A site team of at least two members, one of whom is a member of the Board, is appointed by the Board. Prior to the site visit the Board identifies aspects of the program which the team should focus its review upon. After the site visit, the team submits a report to the Board and a copy is forwarded to the school for comments. A decision on the accreditation status of the program is then made by the Board of Accreditation. Programs can be granted candidacy status for up to five years. Initial accreditation can be granted for seven years; four years, with a clear statement of conditions to be met; or two years, with a clear statement of conditions to be met. Re-accreditation can be granted for seven years; four years with a clear statement of conditions to be met; or two years, with specific recommendations to meet the standards.

Accreditation standards are established through CASSW by members of the Board of Accreditation. In particular, the Educational Policy Committee (EPC) has a close relationship with the Board of Accreditation in terms of standards. All internal subgroups in CASSW can provide input to the Board on accreditation issues. In addition, input on standards can come from professionals, such as members of site visit teams.

Standards were recently revised in June 2007. At that time, a lengthy review and revision of standards was completed. Although there is no set schedule for revision of the accreditation standards, they are kept current through the feedback mentioned above. The following categories of standards are utilized for accreditation:[18]

- Mission statements;
- Structure, administration, governance, and resources;
- Faculty and professional staff;
- Students;
- Standards for accreditation applicable to programs at the first university level (undergraduate social work degrees) and the second university level (programs requiring a previous social work or other undergraduate degree); and
- Field education standards for each of the above levels.

The Education Policy Committee (EPC) reviews policy in social work education. They propose new policies to the General Assembly at the Annual General Meetings. Once the new policies are adopted by the General Assembly they are forwarded to the Board of Accreditation. The Board then drafts new standards from these new education policies. These standards are then submitted to the General Assembly at the following AGM and if adopted are immediately made part of the standards manual and schools must start using them.

The Board of Accreditation can also identify new standards by identifying any gaps that exist. These would also go to the General Assembly for adoption. Schools may also refer matters to both the EPC and the Board of Accreditation. Special interest groups may also bring motions forward at the General Assembly. *"When site visits are made the reviewers may see some gaps or needs and bring these back to the Board of Accreditation as well".* There is also a systematic review of standards and how they match with the current curriculum. *"The EPC*

[18] Complete standards available online from, http://www.cassw-acess.ca/

reviews the curriculum and brings policies and standards into line with the current curriculum". It usually takes a full year for a policy to be adopted into a new standard.

8.6 Physiotherapy

Accreditation of Canadian schools of physiotherapy is the responsibility of the Accreditation Council for Canadian Physiotherapy Academic Programs (ACCPAP), which operates at arms length from the Canadian Physiotherapy Association (CPA). The accreditation cycle is very similar to the process for other academic accreditation bodies and professions in Canada. The normal cycle of accreditation is six years. Educational programs are required to indicate their intention to apply for accreditation approximately 12 months prior to the end of this period. A self-study report is prepared by the educational institution and forwarded to a peer review team who undertake the on-site review of the program. The peer review team conducts an on-site review which includes interviews with faculty, staff, students, graduates of the education program, university administrators, other faculty involved in teaching physiotherapy students, practitioners who provide clinical education placements, and employers of graduates. At the end of the site visit, members of the team meet with the Director/Chair of the program for an exit interview. Following the site visit, the peer review team submits their report for consideration and decision by the ACCPAP.

ACCPAP was incorporated in 2000 as the sole accrediting agency for physiotherapy programs in Canada. Because they are a new accrediting agency, ACCPAP was able to examine a number of existing models for the development of accreditation standards. A Standards Development Working Group representing different levels of expertise from across Canada reviewed existing models and prepared draft standards using the Pew Health Professions model. This "5 + 1" model incorporates five generic standards for health professions; the working group added a 6th standard which is specific to physiotherapy and draws on competency standards developed by the Canadian Physiotherapy Association. The resulting draft standards were discussed and feedback requested through a series of focus groups with educators, regulators, members of the public, professional associations, and physiotherapy professionals. After incorporating feedback from the focus groups, the revised standards were approved by ACCPAP and piloted in 2001/2002 with three existing physiotherapy education programs. The following standards, incorporating feedback from the pilots, were approved by ACCPAP and are currently in use:[19]

- The Program & Its Environment: The program has adequate resources and works closely with the university, practice community and the public to identify changing health needs and prepare a workforce that can respond to and meet community assets and needs;
- Faculty: The program has sufficient qualified faculty for effective program design and instruction, and provides appropriate, periodic and ongoing faculty development and evaluation;
- Students: The program prepares students with the skills, knowledge, and abilities relevant to physiotherapy practice and regularly assesses their competencies and achievements.
- Program Evaluation: The program maintains an effective process of continuous self-assessment, planning and improvement;

[19] Complete standards available online from, http://www.accpap.ca/AccreditationStandards.htm

- Accountability: The program accurately represents itself publicly and provides sufficient information to ensure accountability and consumer choice;
- Physiotherapy Competencies: The education program facilitates the achievement of student learning outcomes related to entry-level physiotherapy practice that reflect current physical therapy practice, emerging trends in the health system and advances in physical therapy theory and technology.

Specific criteria and examples of evidence are detailed within each of the six standards.

By the end of 2005, all programs participated in the accreditation process at least once. In 2006, the Standards Development Working Group (SDWG) was reconvened to generally review the standards, incorporate Essential Competencies in Standard 6 (a new essential competency profile for the profession was established in July 2004); incorporate Explanatory Notes for evaluation criteria; identify the evaluation criteria that should be outcomes based; and review criteria that should be identified as core/essential.

The draft accreditation standards developed by the SDWG are being reviewed by the Council following broad stakeholder input. It is anticipated that the revised accreditation standards document will be published in the spring 2008.

The process of reviewing and developing standards for physiotherapy is much like those of other health professions. Representatives from the different stakeholder groups are appointed to the SDWG. This group reviews and develops a draft of new standards. This draft is then reviewed by the Council. Once the draft standards are reviewed, they are sent out for broader stakeholder consultation. Once feedback has been received, changes are made by the working group. The final standards are then reviewed by the Council for final approval.

There are many different triggers for change that might occur over time including: 1) the development of the competency profile, standards would have to be revised to fit the competencies; 2) a national curriculum review may create the need for new standards for a new curriculum; 3) a response to changes in the environment; 4) changes in the regulatory practice; and 5) changes in the professional practice. Other sources of information may also trigger the need to review/revise standards. *"The interprofessional education movement across Canada is influencing the decision to review/revise standards".* New expectations and deliverables would strongly influence the review of standards, as would any powerful forces in the environment. *"The Council asks for feedback from the educators on the standards".* Any changes at the national level regarding process and documentation may be taken into consideration as well as any changes in the education curriculum. The programs are usually given 12 month after new standards are introduced before they have to use them for accreditation and self study.

8.7 Occupational Therapy

The Canadian Association of Occupational Therapists (CAOT) is the only academic accrediting agency in Canada for OT programs at the university level. As of 2008, CAOT will only accredit Masters entry-level programs. There are however, a few programs that were accredited for 7 years before the implementation of this new policy. These programs will therefore continue to offer the Bachelors entry-level program until approximately 2012. Once these awards have come due they must have transitioned to the new Masters entry-level in order to gain further accreditation. Some universities are studying the feasibility of also offering

professional entry-level Masters programs that can lead to a thesis-based Masters. Doctoral programs in OT do not currently exist in Canada; OT professionals with doctoral qualifications obtain these in related disciplines.

As with other health professional programs, the CAOT utilizes a self-study and site visit process for accreditation. Eighteen months in advance of expiry of awarded accreditation, the university program is contacted to begin their accreditation process following the standards.[20] A self-study and associated documents are submitted to CAOT seven months prior to the site visit. An off-site team reviews these documents and prepares a report on compliance with standards. The report is forwarded to the on-site team and to the university program prior to the site visit. Terms of reference for the site visit are provided to the review teams and the university programs. Based on the on-site team's report, the Academic Credentialing Council makes a recommendation on the accreditation award to the CAOT Board of Directors, which makes the final decision on the accreditation to be awarded to the program. Accreditation can be awarded for a maximum of seven years, and accreditation for five or no years can also be awarded if considerable non-compliance is present.

The CAOT accreditation program has several distinguishing features. Standards address the outcomes of the educational programs. The self-study guide addresses the strengths of the program and areas for continuous improvement. The process is designed to be user-friendly for both the educational program and the accreditor. In addition, the accreditation process has the capacity to be adapted for other professional/occupational programs.

The CAOT Academic Credentialing Council (ACC) develops standards in cooperation with two groups: (1) Association of OT Regulatory Organizations (ACOTRO) – regulatory group; and the (2) Association of Canadian OT University Programs (ACOTUP) – educational group. Development has various stages including a cycle of development and evaluation. The most recent criteria were completed in 1998. Recently developed indicators for standards were published in March 2003; a working group for ACC and other members of CAOT and the university occupational therapy programs worked with an external consultant to develop, revise, and field test the indicators. The CAOT Academic Accreditation Standards were revised in 2005.

There has been a process of development since 1995 for the 1998 standards, and the plan to develop indicators began in 2001. There will be an evaluation of the whole process in 2008. There is a 5 to 7 year cycle of review. There is an accreditation credentialing council, and as new issues arise CAOT is notified. New standards are drafted and these are reviewed at the General Board meeting. Triggers for review may include: 1) new programs starting need new standards; 2) there may be shifts in practice; and 3) issues may occur that change practice. Different types of information may be considered when revising accreditation standards including input received from the programs about the standards. Literature reviews and environmental scans may also be conducted. It usually takes two years depending on how substantial the changes are. *"Changes have to be phased in during the two years it takes schools to go through the accreditation process".*

[20] Available online from, http://www.caot.ca/default.asp?pageid=42

9.0 Canadian Academic Accreditation Standards/Criteria Related to IPE

As mentioned in the previous section, a systematic review of the pre-licensure academic accreditation process of each accrediting body for the various professions comprising the AIPHE project was undertaken. This review included interviews with key informants and a review of documentation describing the accreditation process and related standards for each profession.

The general consensus across all key informant interviews was that IPE was an important element in current and future practice for respective professions. However, even with recent changes to accreditation standards for some professions, most accreditation bodies were currently demonstrating relatively few, if any, specific standards or criteria related to IPE. With the exception of the accreditation standards for Pharmacy, accreditation standards did not specifically address IPE. The standards neither encouraged nor presented specific barriers to IPE and were largely silent about it.

Academic accreditation standards for the professions of medicine, social work, physiotherapy, and occupational therapy exhibited standards related to interprofessional collaboration rather than specific reference to IPE in the curriculum. In these instances, the importance of interprofessional collaborative work with other professions was emphasized as a key element of professional practice. Accreditation standards for pharmacy make direct reference to IPE and emphasize the need for programs to offer interprofessional learning opportunities for students in collaboration with other health sciences programs. Appendix E summarizes the findings of the systematic review of accreditation standards.

9.1 Medicine

The academic accreditation system for undergraduate medical education did not specifically recognize IPE, although several accreditation criteria were indirectly related to interprofessional practice (Appendix E). The key informants felt that none of the standards explicitly described IPE, although there is *"is an implication in some of the standards"*. Programs must provide educational opportunities in multidisciplinary content areas, such as emergency medicine and geriatrics and in support disciplines such as diagnostic imaging and clinical pathology, that can include exposure to the concept of interprofessional teamwork. The curriculum must also introduce the basic principles of clinical and translational research - this includes patient focused courses. The key informants noted that there are a number of standards that deal with effective communication between disciplines. Programs are also required to provide specific instruction in communication skills with patients, families, colleagues and other health professionals. The value of IPE was also recognized. One key informant felt that IPE, collaborative care or collaborative patient-centered practice is not necessarily the language that is currently used in the standards.

> "*We have been more inclusive in modifying some of the standards around the learning environment to embrace other professions but it is more in terms of the of the impact they have on the students in a clinical setting than explicitly calling for interprofessional training or curriculum initiatives in that regard*".

This key informant also commented that there is an institutional setting standard which makes reference for the need of an interprofessional environment. The informant interpreted this

standard to mean that *"you can't have a free standing medical school that's not linked up with graduate programs, nursing programs, the interprofessional environment"*. The informant referred to Standard IS-12:

> *"A medical school should be a component of a university offering other graduate and professional degree programs that contribute to the academic environment of the medical school"*.

A new standard has been implemented over the last year around *"service-learning."* IS-14A states that:

> *"Medical schools should make available sufficient opportunities for medical students to participate in service-learning activities, and should be encouraged and support student participation"*.

There are also educational content standards that focus on communication skills, opportunities in multidisciplinary content areas and patient-focused courses. In the area of education curriculum management, standard ED-36 refers to having:

> *"…support and services for the efforts of the curriculum management body and for any interdisciplinary teaching efforts that are not supported at a departmental level"*.

The key informants from both the RCPSC and CFPC felt that IPE operates at a resident level. Within the accreditation standards for the CFPC, collaboration is mentioned within the principles of family medicine, but only in passing. The standards for accreditation of training programs in family medicine are based on the following four principles of family medicine:

- The family physician is a skilled clinician;
- Family medicine is community-based;
- The family physician is a resource to a defined practice population;
- The doctor-patient relationship is central to the role of the family physician.

These four key principles for accreditation standards highlight the importance of family medicine being intrinsically community-based and that family physicians must be skilled in working with other professionals to deliver patient-centered care. One of the standards makes reference to the fact that:

> *"Residents are expected to work in a number of different settings and in context where they are going to encounter delivery of care on a team based means"*.

Another standard indicates that residents must have:

> *"... knowledge of and willing to draw upon the community's resources, such as medical consultants, other health professionals, and community agencies"*.

The key informant of the CFPC provided examples of "palliative medicine" and "care of the elderly" as areas that are deeply involved in interprofessional work for patient-centered care. There are standards relating to elder care that state that residents:

> *"…should learn to be effective team members by participating in multidisciplinary geriatric teams".*

The key informant of the RCPSC stressed that IPE was very much valued and recognized within the accreditation process for RCPSC accredited medical specialties and subspecialties. Interprofessional collaboration is a key theme for the CanMEDS roles that make up the CanMEDS Framework. Examples of the inclusion of the theme of collaboration within these roles include:

Medical Expert

- seek appropriate consultation from other health professionals, recognizing the limits of their expertise.

Communicator

- develop rapport, trust and ethical therapeutic relationships with patients and families;
- accurately elicit and synthesize relevant information and perspectives of patients and families, colleagues and other professionals;
- accurately convey relevant information and explanations to patients and families, colleagues and other professionals;
- develop a common understanding on issues, problems and plans with patients and families, colleagues and other professionals to develop a shared plan of care.

Collaborator

- participate effectively and appropriately in an interprofessional health care team;
- effectively work with other health professionals to prevent, negotiate, and resolve interprofessional conflict.

Scholar

- facilitate the learning of patients, families, students, residents, other health professionals, the public, and others, as appropriate.

9.2 Nursing

The current academic accreditation process for the nursing profession did not exhibit specific standards related to IPE. Although no specific standards were exhibited in the accreditation guidelines, several indicators relevant to interprofessional collaborative practice were observed. The standard pertaining to partnership deals with a number of criteria around the development of formal and informal partnerships, relationships and teams. This standard also has criteria that stipulate the need for *"trust, mutual respect, shared leadership and open communication support to support partnerships, relationships and teams".* There is also a standard for knowledge-based practice with a criteria that states *"learners develop functional working relationships".*

The key informant stressed that IPE is important for nursing and that CASN is involved in a number of projects in this area. Although there are currently no standards specific to IPE, it was noted that:

> *"…a taskforce on interprofessional education is currently drafting a position statement on interprofessional education in nursing".*

9.3 Pharmacy

Canadian Council for the Accreditation of Pharmacy Programs (CCAPP) is a member of the Canadian Association of Accrediting Agencies (CAAA). One key informant for pharmacy accreditation stated that IPE is discussed in the preface of the Canadian accreditation standards and guidelines documentation. CCAPP:[21]

> *"…believes in the preparation of competent graduates who have the ability to practice pharmaceutical care and, together with other health care providers, can contribute to the making of decisions to ensure that services are effective and that the community is involved in improving the health of its residents. Pharmacists must practice with compassion, empathy and integrity and they must be able to work in interdisciplinary teams and be adaptable enough to work in a variety of settings".*

Both the goals and standards highlight and reference IPE. With the current emphasis on interprofessional collaboration in the health system, the CCAPP considers IPE a major area of importance for the pharmacy profession. Academic accreditation standards for undergraduate education programs in Pharmacy do specifically address IPE. There are two areas in the 2006 standards which do this. Guideline 4.5:

> *"The University should facilitate interprofessional health science education. Pharmacy students should benefit from collaboration with students in other health science programs in activities such as practice experiences and integrated small learning activities."*

Standard 10 – Curriculum Core – Practice Experiences has a guideline with focuses on teamwork and communication, Guideline 10.2:

> *"…practice experiences should enhance teamwork and communication with patients, colleagues, and other professionals."*

The key informants noted that current standards will be maintained and that there will be a move to provide greater clarity and specificity. One respondent commented that:

> *"The standards have always been drafted solely from the input from Pharmacy professionals. Now is the time to start merging and working with other health professionals to develop IPE standards".*

[21] Canadian Council for the Accreditation of Pharmacy Programs. (2006). Accreditation Standards and Guidelines for the Baccalaureate Degree Program in Pharmacy. http://www.ccapp-accredit.ca

The key informants also noted that IPE was one of the most prominent areas of deficiency which was revealed in recent accreditation standard reviews. It is anticipated that this will remain one of their most important areas of emphasis in the development of new standards. *"There has been overall acceptance of the site visits, documentation and self studies by the institutions, but the uptake of the interprofessional education is low."*

9.4 Social Work

The accreditation standards for social work programs contained multiple references to the value and importance of collaboration with other professionals in the community. Criteria related to interprofessional collaboration were exhibited across all levels of accreditation and standards, although these were not specifically identified as criteria for IPE. One key informant commented that the Canadian Association of Schools of Social Work (CASSW) standards do *"not address interprofessional education well at all."*

> *"The practice is leading the accreditation standards in this area. There are components to the programs around interprofessional education but these are not currently reflected in the standards. There are standards that refer to working with other professionals in general, nothing specific to the health disciplines."*

Guideline SB 1.10 states that social work programs "*shall contribute to the advancement of the social work profession and social welfare. This may include… collaborative research"*.

Guideline SB 2.14 states that a school "*shall establish and maintain collaborative relationships with professionals and professional associations relevant to its program*".

Guideline SB 3.8 states that a school "*shall promote and support productive working relationships between members of the faculty and other bodies internal and external to the university*".

Guideline 5.10.12 is the only guideline which makes any specific reference to interprofessional collaboration. It states that:

> "*The curriculum shall ensure that the student will have knowledge of other related occupations and professions sufficient to facilitate interprofessional collaboration and teamwork."*

Interprofessional work and collaborative patient-centered practice is seen as integral to the social work profession. One informant commented:

> *"There is currently IPE in the practice of teaching and standards do evolve from practice, so new policy may develop in the future. Given the nature of social work, social workers already work in various environments and interact with many different professions."*

9.5 Physiotherapy

The accreditation standards for physiotherapy programs in Canada make reference to *"interdisciplinary collaboration"*, although there are no specific references to IPE as a standard for curriculum or program delivery. The 2004 standards do have the standard 6.5 *"Communication and Interdisciplinary Practice"*, although none of the core criteria refer directly to IPE. One key informant noted that with this and other standards *"there are widely varying degrees of interpretation and administration. The standards currently lack consistency and programs find it hard to understand the definition of IPE and how to implement it"*.

Standard 6.5 states: *"Physiotherapy students, upon graduation, will communicate with clients, relevant others and health team members to achieve interdisciplinary collaboration and service coordination through their knowledge and skills…"*

The Accreditation Council for Canadian Physiotherapy Academic Programs (ACCPAP) is currently undergoing a review of the standards and new standards are expected in spring 2008.

> *"There has been a lot of talk about interprofessional education and it is the focus of the revisions. The new standards will be more explicit in the wording and are based on the Essential Competency Profiles of physiotherapy professionals."*

In 2004 a document entitled Essential Competency Profiles[22] was developed with agreement and participation from the profession. There are seven dimensions of Essential Competencies. One of these is the dimension of Communication and Collaboration which states that the physiotherapist "*communicates with clients and professionals in other disciplines to collaborate and coordinate services*". This dimension has two elements: "*1) establishes and maintains effective communication with clients, relevant others, and professional colleagues; and 2) demonstrates effective collaboration and interprofessional teamwork"*. This document is a driving force in the current revision process now underway. Standards are currently being revised to match the competencies in this document. These new standards will be much more explicit in their reference to interprofessional relationships.

> "*The 2004 standards are now undergoing their first revision and this will bring increased focus on interprofessional education."*

9.6 Occupational Therapy

The Canadian Association of Occupational Therapists (CAOT) views the value of IPE from a historical perspective of collaborative practice, but also recognizes a need to detail this more carefully in accreditation standards. However, specific standards or criteria for IPE are not currently detailed in the accreditation process. Standards are not seen as prescriptive.

[22] Accreditation Council for Canadian Physiotherapy Academic Programs. (2004). Essential Competency Profile for Physiotherapists in Canada.
http://www.collegept.org/college/content/pdf/en/guide07/III.A.2.Essential_Competency_Profile.pdf

"The programs informally acknowledge client centered practice, but not interprofessional education directly. CAOT has just recently developed new key competencies which include the role of collaborator. Interprofessional education is on the agenda for the annual meeting of the board in June 2008."

New professional profiles in practice were released in January 2008.[23] The roles in the profile include that of collaborator. There are two collaborator competencies: "*E3.1 – Work effectively in interprofessional and intraprofessional teams; and E3.2 – Effectively work with teams to manage and resolve conflict*". The CAOT refer to the new professional profiles to ensure that program content and the product of the educational process reflects the competencies identified in the profile.

"The new profile of practice which is centered on client centered practice and the new collaborator role will help to implement interprofessional teamwork."

The Canadian Guidelines for Fieldwork Education in Occupational Therapy have criteria which focus on the expectations that students will learn to work with service delivery teams and understand the roles and functions of other team members. These criteria state that students are expected to:

- Increase their understanding of and respect the roles and functions of other team members;
- Learn how occupational therapists contribute to the service delivery team;
- Increase their understanding of the systems in which occupational therapists practice.

[23] Canadian Association of Occupational Therapists. (2007). Profile of Occupational Therapy Practice in Canada. http://www.caot.ca/pdfs/otprofile.pdf

10.0 Key Informant Interview Findings

Key informants were asked to identify and discuss key issues/concerns, challenges/barriers and supports/enablers that they felt the Steering Committee for the Accreditation of Interprofessional Health (AIPHE) project should be aware of as they work to develop common principles for the accreditation of IPE. In terms of issues/concerns, the main themes which emerged pertained to: level of understanding by academic programs of IPE and what it is; the diversity of specialty perspectives; the addition of greater complexity to current accreditation processes; and how current university infrastructure may hinder the implementation of new IPE standards. The main themes which emerged pertaining to challenges/barriers that accrediting bodies might encounter in developing and/or introducing new accreditation standards relevant to IPE included: logistics; lack of knowledge about other professions and their roles on interprofessional teams; time constraints; regulatory and jurisdictional issues; the value and support given to IPE; and understanding what IPE is. Themes related to supports/enablers which key informants believed would be helpful in enacting changes/modifications or introducing new standards related to IPE included: the timing of this project; a collaborative approach to IPE; the development of new training resources for reviewers; implementation tools; and effective communication.

10.1 Medicine

One concern key informants raised was around communication to schools about changes to standards and accreditation processes. Allowing time for effective communication of changes to programs would allow for better buy-in and a smoother implementation of new standards. "*Communicating what they are planning to do is very important, it allows feedback*". Linked to this issue is the use of language. Respondents commented that when the AIPHE committee is developing these common principles it is important that the type of language used is taken into consideration. The committee needs to *"ensure that language is generalizable, that it builds upon what currently exists and helps to illuminate what is there"*. The informants felt that all things associated with accreditation, especially the expectations, need to be made more explicit. One informant gave the example of the CanMEDS competency of *"Health Advocate"*. "*Some physicians are still struggling with what does Health Advocate mean?"* This informant suggested that rather than just giving them the competency or standard, they also receive something to help them understand what it is, what the expectation is, and how they might implement it.

Another suggestion provided by one of the respondents was that there needed to be a full understanding of the complexity of the accreditation process involved. Due to the joint administration of the accreditation process by both the AFMC and the LCME, any changes to the accreditation standards for medical schools would require the entire North American environment to agree. *"Changes must be accepted by all schools in North America"*.

The interprofessional perspectives of specialties and professions may also need to be considered. A respondent suggested that one way of meeting this challenge would be to have champions in the different specialties and in the different areas of the country promoting the cause. The positions of programs on IPE are also quite diverse. "*Some schools are much further ahead in interprofessional education than others"*. One informant also felt that the definition of the role of the physician needs to be made quite clear. *"Is the role appropriate, how do all the*

professionals work together and how are the physician's skills best utilized?" are all questions that this informant felt need to be considered.

A cautionary note was added by one of the key informants that there will be a concern that the responsibility for accreditation not be taken away from each of the accrediting bodies and given to an umbrella organization. This informant advised that *"each accrediting body needs to have input, agree on the principles, the pedagogy, and be given the responsibility to implement any new interprofessional education standards".*

The key informants felt that the current infrastructure of universities works against IPE. In some cases the professional schools are not housed in a common location making the scheduling of IPE sessions challenging. Even when they are in the same building, curricula is developed and scheduled in isolation of other programs, causing further scheduling problems. *"Timetabling would be a challenge, getting students together".*

Whether or not physicians are comfortable with their role on the team was posed as another possible barrier. One respondent commented that if physicians are comfortable with their role, "*…then there aren't any barriers, but for those who are not, barriers will exist".* One informant also mentioned that getting the faculty members within academic programs on side could prove to be a challenge. Given the complexity of the process surrounding the development of new standards or changes in existing ones, the benefits of IPE need to be demonstrated to all committees that approve new standards within an accrediting body. This is particularly true of the CACMS/LCME accreditation process. *"The committees must see the benefits very clearly".*

Another challenging area may be the educational curve that is involved in introducing something new, letting schools know what the concept of IPE means. Clarifying expectations around standards needs to be clearly articulated so that programs understand how they can integrate these into their programs. "*We need to make it easy to understand, use and implement the standards".* Following from this is the issue of assessment and evaluation of the standards. *"How will we know if a program truly is meeting the standard?"* Informants felt that certain measures will be needed. Communication was considered to be another challenge; the programs need to understand what is happening and the purpose behind it.

Several key informants felt that the timing of this project was good. There are currently people in key decision making roles that are strong supporters of the IPE movement. They feel the key is to identify the champions in academic programs and accrediting bodies and make sure that they are comfortable with what is coming. As one respondent stated, "*most are currently aware of this move toward interprofessional education, which makes it much easier to develop and implement".* One respondent felt that it was a great way to encourage interprofessional teamwork and education by *"putting the accreditation processes of each body in front of each one another".*

Another key informant noted that using a collaborative approach which involves educators, practitioners, accreditors and member of the university community would support the enacting of changes/modifications or introducing new standards related to IPE. "*This would help to develop a common view as to what the standards would look like".*

One key informant suggested that "*some educational supports, compelling pieces of literature, anything that illustrates the merits and benefits to the health of the community and makes links to interprofessional education"* will help move the process along. The development of tools that help to explain the expectations of a standard would also go a long way to implementing the standard. *"Making things simple and being very clear as to what each expectation is".*

10.2 Nursing

This key informant felt that the committee would need to consider the importance of not making the implementation of new interprofessional standards and guidelines as part of the accreditation process more onerous for both the reviewers and the schools. The reviewers and schools already feel it is a lot of work, and adding more standards would be hard to *"operationalize"*. "*We would have to definitely look at reducing duplication and streamlining the standards"*.

The translation of new standards was also an area of concern raised by this informant. Providing any new standards and guidelines that have already been translated and approved would be something to consider as *"translation of materials has always been an issue especially around the amount of time it takes and the costs involved"*. This key informant commented that the development of new resources or formats for training the reviewers would be an enabler to implementing new standards. All the reviewers and schools would need to be trained in order to make sure they are aware of the new standards and expectations that come with these standards. "*Implementing new interprofessional standards would require sufficient exploration on how to address and meet the new expectations"*. Conducting some training by teleconferencing and adding online resources were methods suggested. "*There is a new online training tool provided by the National Nursing Accreditation Body, adding a complementary piece around interprofessional education would certainly enable the process"*. Providing tools which could be used to explain the expectations of new standards would be useful and clarity of the expectation of each standard needs to be provided so that programs understand how they can integrate them into their programs. "*We need to make it easy to understand, use, and implement the standards"*.

10.3 Pharmacy

The key informant felt that the committee needs to consider that there may be some issues around *"buy-in"* from pharmacy professionals of the IPE approach. The committee needs to be aware that "*there are many supporters for IPE and the team approach within the pharmacy regulatory bodies, and the academic and education communities. However, the development of true collaborative practice settings that include pharmacists has been very slow."*

The respondent also commented that there is a prevailing perspective that health care providers still work in isolation. Interprofessional collaboration or team work is not really visible. Team meetings happen, but often without the patient. "*Even the patient doesn't understand what team care involves; they don't see the professionals working together*".

The key informant felt there may be systemic/professional barriers. There may be inconsistent or a general lack of expectations from professional regulatory bodies regarding the demonstration of collaborative or interprofessional competencies in practice. Differences between remuneration models between health providers may also provide little incentive to change practices. The respondent felt that because many traditional primary care practice settings are "*uni-professional in design, e.g. physician's offices, community pharmacies, physiotherapy practices"*; it may be difficult to implement IPE standards. Another barrier which may exist is the fact that "*many clinical instructors for pharmacy schools are not involved in well-established collaborative patient centred care practices"*.

The respondent also put forward several university and program issues to consider. The respondent felt that there is great diversity in requirements for interprofessional experiences defined by the accreditation standards for different health profession programs. Current university reward systems, structures (e.g. calendars, timetabling, and curriculum rigidity), and resource allocation methods often do not foster IPE.

> *"[The] complicated logistics of the more 'centrally positioned' health programs (like medicine and nursing) in coordinating interprofessional education experiences involving their students with students from many other programs".*

The key informant felt that a significant enabler will be the outcome of this project. "*By beginning to develop a common message to accreditation bodies that we will no longer be working in isolation, but have a new integrated approach. That would be very significant".* The development of a similar dialogue between the regulatory authorities in each province was suggested as another possible enabler. The respondent commented that by encouraging these bodies to incorporate team-based care and collaborative practice into the skills and competencies *"we would further close the circle".*

The informant also suggested that if more concrete examples of collaborative patient-centered practice were occurring in front-line care, "*we could see collaborative patient-centered practice (CPCP) occurring in the real world"*, then these real-world models would enhance the ability to incorporate it into the accreditation standards.

10.4 Social Work

Both key informants wanted to raise the awareness that social workers currently work with many different disciplines. The main challenge brought forward by these informants was how broadly or narrowly interprofessional collaboration is addressed. They felt that IPE is an issue for health professionals practicing in formal health care settings and also an issue for collaboration beyond these setting. It is an issue in community-based services. Social workers in the community work with other professions besides health care, i.e. teacher, lawyers, police. Anyone developing new guidelines needs to take into account that social work practice occurs in a variety of settings, not just within the health environment.

> *"[The committee] needs to consider that collaboration is needed across community based services, in other fields of social work practice, not just in health care settings".*

One of the respondents also suggested that requests for changes to accreditation criteria are often put forward by *"groups which define themselves oppressed or marginalized"*. This informant proposed that the challenge lies in including the *"people who need the health services"* in the development of new standards that will implement changes toward *"better education"*.

One key informant suggested that having some guidelines or models of wording of an IPE standard would be helpful. Being provided with some "*best practice"* examples would provide support to the development and implementation of the standards. This informant also felt that this initiative is also very useful. "*It will help accrediting bodies in looking at the general principles involved in interprofessional education and collaboration"*. Another key

informant suggested that it would be helpful to the process if there was collaboration and buy-in of all the professional associations, accrediting bodies, schools, and service organizations. In order for this to work well, "*we need to consider how to work with all these different bodies in a collaborative way".*

10.5 Physiotherapy

The key informants felt that there would need to be clarification regarding what is meant by the nature of IPE. Schools need to be clear of the intent of the standards. For example, would they require *"mandatory content or an elective learning experience?"* What qualifies as IPE? *"Are the students from different disciplines just sitting in a lecture hall together, or is it something more interactive?"* Guidelines need to be explicit about what IPE means and how it could be put into practice. They felt that examples of IPE experiences that would meet the criteria would need to be provided to the programs. Interactions between disciplines could be significantly different at the early stages of their education compared to the middle and end of their education. One respondent commented that different kinds of interprofessional learning take place at different times in the programs. *"Does it matter whether the students are at the beginning, middle or end of their program when interprofessional education occurs?"* One respondent also commented that it would be a challenge to implement interprofessional standards if the process was not collaborative. *"One discipline cannot move forward with interprofessional education if the other disciplines are not interested".*

One of the key informants commented that communication is a strong enabler when it comes to implementing any type of new standard. *"Programs need to be forewarned about the process, about the major steps along the way".* This informant suggested that educating potential users about why new standards or processes are being developed and what they entail would facilitate both the development and implementation of new standards.

Another key informant felt a strong enabler to the development and implementation of new IPE standards will be the consistency of standards between programs and disciplines, *"common interprofessional education criterion for all of the eight accreditation bodies".* Providing tools that will allow for the clarity of what is meant by IPE was again suggested by this informant as providing support to the process. The informant suggested that by providing *"definitions, examples and resources, schools will have a better understanding of what is expected".*

10.6 Occupational Therapy

This key informant felt that the logistics involved with implementing new IPE standards would be one of the main issues to keep in mind. There are several different barriers within a university setting. Different disciplines have students at different levels; some are undergraduate programs while others are at the graduate level. How to schedule IPE would be an important consideration as well. "*It is very difficult to have students from different disciplines come together at the same time".* The respondent commented that flexibility needs to be built in the programs if IPE is to take hold.

Resources were another area of concern for this respondent. There needs to be time within the curriculum and funding for the programs to develop and implement new IPE standards. *"Faculty need time to develop new offerings in the programs".* The respondent also

spoke about concerns that currently exist about liability issues when someone from one discipline is supervising the field work of someone in another discipline. "*They don't always feel that they have the necessary knowledge and skill set to supervise a different discipline"*.

Logistics was again one area that this key informant suggested may act as a barrier in implementing IPE standards. "*Getting students together from different disciplines is difficult"*. This respondent also felt that the licensing bodies would also have to incorporate IPE criteria into their licensing skills. "*If interprofessional education is not on the list of needs to be certified, then the programs will not pursue it"*.

This key informant also commented that a useful enabler would be to make the process as collaborative as possible. Implementation would be far more successful if all the accreditation and regulatory bodies have to move through this together, system wide. *"Interprofessional education has to be a collaborative effort. You can't be 'interprofessional' on your own"*. The respondent felt that if all programs are pressing forward with IPE, this would also allow for more buy-in from the universities.

The respondent also suggested that funding and resources for program development specific to IPE would also be a good enabler. A final comment by this informant was that *"this project is acting as a strong supporter/motivator for the movement across the country toward interprofessional education"*.

11.0 Conclusion

Accreditation has typically been defined in terms of evaluating a program's compliance with a minimum set of acceptable standards based on professional and educational criteria. Accreditation has an important role in sustaining and enhancing quality. First, accreditation serves as a gatekeeper for assuring a threshold level of quality. Achieving and maintaining accreditation requires, at the most basic level, that an institution meets a set of defined minimum standards of educational quality. Second, it provides a strong incentive for quality improvement. Accreditation processes and agencies link institutions and key individuals with an interest in improving the quality of higher education. The participation of representatives from the practice setting and academic setting in educational accreditation activities ensures relevancy and facilitates peer-review at the same time. This can be viewed as one of the fundamental cornerstones of the accreditation system.

Accreditation processes and agencies have been identified as potential avenues and agents for leading and encouraging educational change. Cooperation and collaboration between accreditation agencies, professional associations, and educational programs in the interests of patient care are key factors in positioning accreditation as a force for change in health professional education. It has been suggested that accreditation systems need to be responsive to societal needs and the needs of the health services system. The accreditation oversight process of health professional education has been identified as a key force for fostering and sustaining change involving IPE.

In the United States a significant level of work has taken place regarding academic accreditation and IPE. The Institute of Medicine's (2003) recommendations have pinpointed accreditation and other oversight processes as major forces for change in health professional education, including the need for education and training to improve interdisciplinary teamwork competencies. In Canada, federal and provincial funding activities have fostered significant growth and development of IPE in post-secondary institutions across the country. The Canadian Interprofessional Health Collaborative (CIHC) has been established as a network of faculty and other stakeholders with an interest in IPE. The National Health Sciences Students Association (NaHSSA) has been established to foster and promote interest at the student level and to develop future champions. The recent Primary Health Care Transition Fund (PHCTF) has also served to foster and promote interprofessional collaboration as a fundamental pillar of the primary health care system across Canada. Primary health care teams or collaboratives have been established and are serving as model learning sites for IPE. The Canadian Patient Safety Institute (CPSI) and the Royal College of Physicians and Surgeons of Canada (RCPSC) have also articulated interprofessional team/collaborator competencies for guiding education and training of future and current practitioners in the Canadian health system. Significant activity is occurring across Canada in the area of IPE at the governmental, educational and professional levels.

The findings from the environmental scan indicate that aspects of the accrediting process in Canada for pre-licensure health professional education are similar across most professions, including: establishment of standards and criteria; site visits to an institution or program by peer reviewers to determine whether the institution or program meets the accreditation standards or criteria; and periodic reviews to ascertain whether the accredited institution or program continues to meet the standards or criteria. All accreditation processes also demonstrate a process for recommending, reviewing and approving additions to accreditation standards. These processes

include stakeholder consultations and review by appropriate sub-committees through the accrediting organization.

Most accreditation processes currently demonstrate relatively few, if any, specific standards or criteria related to IPE. With the exception of the accreditation standards for Pharmacy, accreditation standards did not specifically address IPE. The standards neither encourage nor present specific barriers to IPE and are largely silent about it. Many could be expanded to more specifically address IPE issues. Academic accreditation standards for the professions of medicine, social work, physiotherapy, and occupational therapy exhibited standards related to interprofessional collaboration rather than specific reference to IPE in the curriculum. In these instances, the importance of interprofessional collaborative work with other professions was emphasized as a key element of professional practice. Silence in standards and curriculum policy statements may make it difficult to move from externally funded pilot programs to a second generation of institutionalized interprofessional efforts. A lack of specific reference to IPE may marginalize rather than support development of these programs.

Key informants representing the various professions affiliated with the AIPHE project reported a high level of support for the project and the concept of collaboration between the various accrediting bodies in developing principles and standards for IPE across the professions. The fact that the accrediting bodies were collaborating on the AIPHE project together meant greater potential for system-wide change. Key themes emerging from the interviews with key informants were:

- Need for promotional strategies which highlight the rationale and need for accreditation standards which specifically promote IPE;

- Having IPE champions - profession-specific, specialty-specific and in some instances sub-specialty-specific;

- Effective strategies for consulting with academic, professional (e.g. professional associations, regulatory bodies) and public stakeholder groups concerning the need for the addition/revision of accreditation standards, as well as subsequent communications regarding impending changes;

- Having a common language which would be clearly understood across professions;

- Specific definition, description and guidelines to accompany any new standards and associated criteria related to IPE;

- Need for support for academic programs in adopting and applying new standards related to IPE;

- Need for evaluation of the impact of new standards on academic programs;

- Ensure the addition of new standards does not complicate or make the accreditation process more onerous - new standards related to IPE need to be flexible;

- Interprofessional collaboration occurs in community-based settings and health settings - accreditation standards need to reflect and acknowledge this diversity.

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Appendix A: Key Informant Interview Script

Key Informant Interview Script

Background

The *Accreditation of Interprofessional Health Education (AIPHE)* project, funded by Health Canada, brings together a partnership of 8 national organizations that accredit pre-licensure[24] education for 6 Canadian health professions: physiotherapy, occupational therapy, pharmacy, social work, nursing and medicine. The long-term vision of the AIPHE project is that all students in health-related fields will develop the knowledge, attitudes and skills needed for collaborative, patient-centred practice as a result of interprofessional education in health professional education programs. The overarching project goals are to develop common principles for the accreditation of interprofessional education in six health professions and to educate a wider audience about the value of interprofessional education.

Main project activities include an environmental scan (literature review, key stakeholder interviews and a background paper) and a national consultation process to create and implement draft core principles/guidelines via two face-to-face joint Steering Committee - Advisory Group meetings and a national forum on Accreditation of Interprofessional Education for stakeholders from the 6 participating disciplines. Project documents and the website will be widely promoted through meetings, conferences and partner networks. Products include a background paper, joint core accreditation principles/guidelines, a resource on accreditation review processes (best practices) and a forum report. The Association of Faculties of Medicine of Canada (AFMC) is the Secretariat for the project.

Definitions of Interprofessional Education and Collaborative Patient-Centred Practice

The following are some key definitions in interprofessional education and collaborative practice:

Interprofessional Education: "occasions when two or more professions learn from and about each other to improve collaboration and the quality of care." (CAIPE, 1997 revised)

Pre-licensure education: "occurs while a student is in their formal years of learning, before receiving a license to practice independently." (Oandasan & Reeves, 2005)

Collaboration: "an interprofessional process of communication and decision making that enables the separate and shared knowledge and skills of health care providers to synergistically influence the client/patient care provided." (Way & Jones, 2000)

Collaborative Patient-Centred Practice: "is designed to promote the active participation of each discipline in patient care. It enhances patient and family centred goals and values, provides mechanisms for continuous communication among care givers, optimizes staff participation in clinical decision making within and across disciplines and fosters respect for disciplinary contributions of all professionals." (Health Canada, 2003)

[24] Pre-licensure: entry to practice.

Pre-Licensure Education Accreditation and Interprofessional Education

1. Does the pre-licensure academic accreditation system for your profession recognize and/or place value on interprofessional education for collaborative patient-centred practice? If so, how? Please describe.

2. Are specific standards and/or criteria related to interprofessional education for collaborative patient-centred practice included in your pre-licensure accreditation guidelines at present?

    2(a) If yes, please describe the nature of these specific standards and/or criteria? (examples may include: the requirement for clinical learning experiences that include interprofessional teams; courses dealing with skills for working with interprofessional teams; or interprofessional team teaching)
    2(b) Are there plans to incorporate such standards in the future?
    2(c) Has your accrediting body attempted such new standards in the past? If so, what was the outcome?

3. How does your pre-licensure accrediting body determine or identify the need for revision/change/updating of accreditation standards?

    3(a) What is the process?
    3(b) What might be the triggers for change?
    3(c) What information is usually considered?
    3(d) What is the time period required for proposals of new standards and the implementation of these new standards?

4. From the perspective of your pre-licensure academic accrediting body, what issues/concerns should the Steering – Advisory Committee for the *Accreditation of Interprofessional Health Education (AIPHE)* project be aware of as they work to develop common principles for the accreditation of interprofessional education?

5. What might be some of the challenges/barriers which your accrediting body might encounter in developing and/or introducing new accreditation standards for interprofessional education for collaborative patient-centred practice at a pre-licensure education level?

6. What supports/enablers would be helpful to your accrediting body in enacting changes/modifications or introducing new standards related to interprofessional education for collaborative patient-centred practice at a pre-licensure education level?

Appendix B: List of Key Informant Interview Participants

Key Informants

List of Key Informant Interview Participants

Health Profession	Level	Organization	Key Informant
Medicine	Undergraduate	Association of Faculties of Medicine in Canada (AFMC) www.afmc.ca	Dr. Nick Busing Executive Director Phone: (613) 730-0687 Ext 222 Fax: (613) 730-1196 nbusing@afmc.ca Nicole Flanagan Executive Assistant nflanagan@afmc.ca
		AFMC Committee on Accreditation of Canadian Medical Schools (CACMS) in cooperation with the Liaison Committee for Medical Education (LCME)	Dr. Robert Woollard Committee Member Tel: (604) 225-2551 Fax: (604) 225-2557 woollard@familymed.ubc.ca
	Graduate/Postgraduate Family Medicine	The College of Family Physicians of Canada (CFPC) www.cfpc.ca	Dr. Ivy Oandasan Chair – CFPC's Section of Teachers University of Toronto Phone: 416-603-5800 ext 2577 Fax: 416-603-5580 i.oandasan@utoronto.ca Assistant: Belinda Vilhena Belinda.Vilhena@uhn.on.ca Dr. Paul Rainsberry Associate Executive Director

Health Profession	Level	Organization	Key Informant
			Academic Family Medicine CFPC Phone: 1-800-387-6197 ext 400 pnr@cfpc.ca
	Graduate/Postgraduate Specialty Programs	Royal College of Physicians and Surgeons of Canada (RCPSC) www.rcpsc.medical.org	Ms. Margaret Kennedy Manager, Educational Standards Unit Phone: 613-730-6202 mkennedy@rcpsc.edu
Nursing	Undergraduate	Canadian Association of Schools of Nursing (CASN) www.casn.ca	Ms. Andrea Perrier Manager, Accreditation Phone: (613) 235-3150 Ext. 24 Fax: (613) 235-4476 aperrier@casn.ca Ms. Sarah Anderson Past Interim Manger, Accreditation Phone: 613-235-3150 Ext. 22 Fax 613-235-4476 sanderson@casn.ca
Pharmacy	Undergraduate	Canadian Council for the Accreditation of Pharmacy Programs (CCAPP) www.ccapp-accredit.ca	Dr. David S. Hill Executive Director Canadian Council for the Accreditation of Pharmacy Programs (CCAPP) Phone: 604-676-4230 Fax: 604-676-4231 dhillccapp@shaw.ca
Social Work	Undergraduate	Canadian Association of Schools of Social Work (CASSW) Board of Accreditation www.cassw-acess.ca	Dr. Brad McKenzie Co-Chair (Anglophone) Phone: (204) 474-8767 Fax: (204) 474-7594

Health Profession	Level	Organization	Key Informant
			mcknzie@cc.umanitoba.ca Dr. Jocelyn Lindsay Board Member Phone: 418-656-2131 ext. 7868 Jocelyn.Lindsay@svs.ulaval.ca
Physiotherapy	Undergraduate	Accreditation Council for Canadian Physiotherapy Academic Programs (ACCPAP) www.accpap.ca	Ms. Cathryn Beggs Executive Director Phone: (519) 641-6883 Fax: (519) 472-3119 cathryn.beggs@accpap.ca Ms. Peggy Proctor School of Physiotherapy University of Saskatchewan Phone: 306-966-6574 peggy.proctor@usask.ca
Occupational Therapy	Undergraduate	Canadian Association of Occupational Therapists www.caot.ca	Ms. Sandra Hobson Chair, CAOT Academic Credentialing Council Faculty of Occupational Therapy University of Western Ontario Phone: 519-661-2111 ext. 88957 shobson@uwo.ca

Appendix C: Web sites Reviewed

Web sites Reviewed

Health Profession	Organization	Website URL
Medicine	Association of Faculties of Medicine in Canada (AFMC) Liaison Committee for Medical Education (LCME) College of Family Physicians of Canada (CFPC) Royal College of Physicians and Surgeons of Canada (RCPSC)	www.afmc.ca www.lcme.org www.cfpc.ca rcpsc.medical.org
Nursing	Canadian Association of Schools of Nursing (CASN)	www.casn.ca
Pharmacy	Canadian Council for the Accreditation of Pharmacy Programs (CCAPP)	www.ccapp-accredit.ca
Social Work	Canadian Association of Schools of Social Work (CASSW)	www.cassw-acess.ca
Physiotherapy	Accreditation Council for Canadian Physiotherapy Academic Programs (ACCPAP)	www.accpap.ca
Occupational Therapy	Canadian Association of Occupational Therapists (CAOT)	www.caot.ca

Appendix D: Statement of Common Purpose for Subject Benchmark Statements for the Health and Social Care Professions

Statement of Common Purpose for Subject Benchmark Statements for the Health and Social Care Professions

1.1.1 Introduction

This new statement of common purpose builds on and replaces the emerging framework and, like the emerging framework, is designed to be associated with subject-specific benchmark statements in health and social care. It is set out under three main headings:

1 Values in health and social care practice

2 The practice of health and social care

3 Knowledge and understanding for health and social care practice.

The statement places the focus of students' learning on meeting the needs of clients and patients within an environment that requires effective team, interprofessional and inter-agency working and communication, as well as expert care. Its aims to encourage shared learning by students from a range of health and social care disciplines, both in practice and in classroom-based activities. Higher education institutions, in partnership with service providers, will make informed curriculum choices about the construction of shared learning experiences which promote improved collaborative practice and this statement is an important consideration in making those choices. It should not, however, be regarded as a national curriculum for shared learning in health and social care.

1.1.2 1 Values in health and social care practice

Health and social care professionals are personally accountable for their actions and must be able to explain and justify their decisions. They work in many different settings and practices and have to make difficult decisions about complex human situations which require the application of ethical principles. They seek to improve the quality of life for their patients and clients. All hold a duty to protect and promote the needs of their clients and patients and, in so doing, take into account any associated risks for the public.

1.1 Respect for clients' and patients' rights, individuality, dignity and privacy

Health and social care staff should:

- be open and honest with their clients and patients
- listen to clients and patients
- keep information about clients and patients confidential within the limits of duty of care
- ensure that their own beliefs do not prejudice the care of their clients and patients
- recognise and value cultural and social diversity
- ensure individualised care and treatment to combat discrimination and social exclusion.

1.2 Clients' and patients' right to be involved in decisions about their health and social care

Health and social care staff should:

- provide information about clients' and patients' health and social care options in a manner in which the clients and patients can understand
- gain appropriate consent before giving care and treatment
- enable clients and patients to make informed choices about care, including cases where those choices may result in adverse outcomes for the individual
- provide clients and patients with proper access to their health and social care records.

1.3 Justify public trust and confidence

Health and social care staff should:

- be honest and trustworthy at all times
- act with integrity and never abuse their professional standing
- never ask for or accept any inducement, gift, hospitality or referral which may affect, or be considered to affect, their professional judgement
- always declare any personal interests to those who may be affected.

1.4 High standards of practice

Health and social care staff should:

- recognise and work within the limits of their knowledge, skills and experience

- maintain and improve their professional knowledge, skills and performance
- be committed to enhancing standards of practice in health and social care
- make prompt, relevant, clear, legible and proper records
- must deliver the highest standards of integrity and competence.

1.5 Protection from risk of harm

Health and social care staff should:

- act properly to protect clients, patients, the public and colleagues from the risk of harm
- ensure that their own or their colleagues' health, conduct or performance does not place clients and patients at risk
- protect clients and patients from risks of infection or other dangers in the environment.

1.6 Cooperation and collaboration with colleagues

Health and social care staff should:

- respect and encourage the skills and contributions which colleagues in both their own profession and other professions bring to the care of clients and patients
- within their work environment, support colleagues to develop their professional knowledge, skills and performance
- not require colleagues to take on responsibilities that are beyond their level of knowledge, skills and experience.

1.7 Education

Health and social care staff should, where appropriate:

- contribute to the education of students, colleagues, clients and patients, and the wider public
- develop skills of responsible and proper supervision.

1.1.3 2 The practice of health and social care

Health and social care are applied academic subjects, where practice is underpinned by theoretical learning. In their practice, health and social care professionals draw from the values, knowledge and skills of their own discipline. This knowledge and understanding

forms the basis for making decisions and judgements in a variety of contexts, often against a backdrop of uncertainty. Partnership working is essential to promote the wellbeing of individuals, groups and communities. Professional practice is essentially a process of problem solving. It can be characterised by four major phases:

- the identification and assessment of health and social care needs in the context of individual interaction with their environment
- the development of focussed intervention to meet these needs
- implementation of these plans
- critical evaluation of the impact of professional and service interventions on patients and clients.

2.1 Identification and assessment of health and social care needs

Health and social care staff should be able to:

- obtain relevant information from a wide range of sources, using a variety of appropriate assessment methods
- adopt systematic approaches to evaluating information collected
- communicate their evaluations effectively to their clients, patients and other members of the health and social care team.

2.2 The development of plans to meet health and social care needs

Health and social care staff should be able to use knowledge, understanding and experience to:

- work with clients and patients to consider the range of activities that are appropriate
- plan care, and do so holistically
- record judgements and decisions clearly.

2.3 Implementation of health and social care plans

Health and social care staff should be able to:

- conduct appropriate activities skilfully and in accordance with good practice
- assign priorities to the work to be done effectively
- maintain accurate records
- use opportunities provided by practice to educate others.

2.4 Evaluation of the health and social care plans implemented

Health and social care staff should be able to:

- assess and document the outcomes of their practice
- involve clients and patients in assessing the effectiveness of the care given
- learn from their practice to improve the care given in the particular case
- learn from the experience to improve their future practice
- participate in audit and other quality assurance procedures to contribute to effective risk management and good clinical governance
- use the outcomes of evaluation to develop health and social care policy and practice.

2.5 Communication

Health and social care staff should be able to:

- make active, effective and purposeful contact with individuals and organisations utilising appropriate means such as verbal, paper-based and electronic communication
- build and sustain relationships with individuals, groups and organisations
- work with others to effect positive change and deliver professional and service accountability.

1.1.4 3 Knowledge and understanding for health and social care practice

The education and training of health and social care professionals draws from a range of academic disciplines which provide the underpinning knowledge and understanding for sound practice. Each profession has an identifiable body of knowledge and will draw from this as appropriate. However, there are areas of knowledge and understanding that are common to all health and social care professionals, which include;

- ethical principles, values and moral concepts inherent in health and social care practice
- legislation and professional and statutory codes of conduct relevant to their practice, and understanding of health and social care delivery configurations
- research and evidence-based concepts and explanations from law, psychology, social policy and sociology
- physical and psychological human growth and development.

In addition, and to an extent determined by the nature of their practice, health and social professionals will be familiar with:

- the structure, function and dysfunction of the human body
- public health principles
- health education in their practice.

1.2 Annex A - List of NHS benchmark statements

Arts therapy
Audiology
Clinical psychology
Clinical sciences
Dental care professions
Dietetics
Health visiting
Midwifery
Nursing
Occupational therapy
Operating department practice
Orthoptics
Paramedic science
Physiotherapy
Podiatry
Prosthetics and orthotics
Radiography
Speech and language therapy

Appendix E: Standards/Criteria Relevant to IPE in Pre-Licensure Education Accreditation Systems

Standards/Criteria Relevant to IPE in Pre-Licensure Education Accreditation Systems

Health Profession	Accrediting Body	Standards Relevant to IECPCP
Medicine	Association of Faculties of Medicine in Canada (AFMC)/Liaison Committee on Medical Education (LCME)	ED-17. Educational opportunities must be available in multidisciplinary content areas, such as emergency medicine and geriatrics, and in the disciplines that support general medical practice, such as diagnostic imaging and clinical pathology. ED-17A. The curriculum must introduce the basic principles of clinical and translational research, including how such research is conducted, evaluated, explained to patients and applied to patient care - There are several ways in which programs can meet the requirements of this standard……patient focused courses…… ED-19. There must be specific instruction in communication skills as they relate to physician responsibilities, including communication with patients, families, colleagues, and other health professionals. ED-36. The chief academic must have sufficient resources and authority to fulfill the responsibility for the management and evaluation of the curriculum - Support and services for the efforts of the curriculum management body and for any interdisciplinary teaching efforts that are not supported at a departmental level.
	The College of Family Physicians of Canada (CFPC)	GENERAL STANDARDS PRINCIPLES OF FAMILY MEDICINE *Family medicine is community-based.* Family medicine is based in the community and is significantly influenced by community factors. As a member of the community, the family physician is able to respond to people's changing needs, to adapt quickly to changing circumstances, and to mobilize appropriate resources to address patients' needs.

Health Profession	Accrediting Body	Standards Relevant to IECPCP
		The family physician may care for patients in the office; the hospital, including the emergency department; other health care facilities; or the home. Family physicians see themselves as part of a community network of health care providers and are skilled at collaborating as team members or team leaders. They use referral to specialists and community resources judiciously. STANDARDS FOR FAMILY MEDICINE CURRICULUM (*general guidelines)* 2. Programs **must** demonstrate that effective experiential learning of continuity of patient care occurs within the program. ….. Residents **must** learn the skills of coordinating the interprofessional care of patients with multisystem illness, including the maintenance and use of high-quality health care records and other forms of communication. ….. *Curriculum guidelines related to " the family physician is an effective clinician"* **Care of the elderly** Residents should learn to be effective team members by participating in a multidisciplinary geriatric team. **Behavioral medicine** Programs may wish to integrate other appropriate health care workers in a complementary role in the teaching of residents, however, family physicians must provide and coordinate core teaching. *Curriculum guidelines related to "family medicine is community based"* Residents **must** have knowledge of and be willing to draw upon the community's resources, such as medical consultants, other health professionals, and community agencies.

Health Profession	Accrediting Body	Standards Relevant to IECPCP
		STANDARDS FOR FAMILY MEDICINE/ EMERGENCY MEDICINE CURRICULUM *Family medicine is community-based* An EM resident **must** acquire the knowledge and skills to: 1. understand the principles of the development and implementation of support emergency services in the community for pre hospital care, (i.e., paramedics, ambulance service, communication systems, first aid programs, poison control, public education, organization of emergency medical services, and disaster planning) *The doctor-patient relationship is central to the role of the family physician.* An EM resident **must** acquire the knowledge and skills to: 2. demonstrate effective communication skills with patients, families, and co-workers RESOURCES *Clinical teaching resources* The training program **must** provide: 5. Interdisciplinary experience with social workers, nursing staff and other health professionals, focusing on their role in the comprehensive delivery of health care services in the emergency department setting. STANDARDS FOR PROGRAMS IN CARE OF THE ELDERLY CURRICULUM

Health Profession	Accrediting Body	Standards Relevant to IECPCP
		Family medicine is community-based The resident must actively use and interact with community resources to enhance patient management. RESOURCES FACULTY RESOURCES Qualified teaching staff, some with appointments in the department of family medicine, will be appointed to supervise and to provide teaching. These will include: 4. Faculty from other health care professions. STANDARDS FOR FAMILY PRACTICE – ANESTHESIA (FP-A) CURRICULUM *The doctor-patient relationship is central to the role of the family physician.* A FP-A resident must acquire the knowledge and skills to: …..demonstrate effective communication skills with patients, families and co-workers….. RESOURCES CLINICAL TEACHING RESOURCES The training program must provide: -Interdisciplinary experience, focusing on the role of the FPA in the comprehensive delivery of health care services.

Health Profession	Accrediting Body	Standards Relevant to IECPCP
		STANDARDS FOR PALLIATIVE CARE Note: Accreditation for residency programs in this area is shared between the CFPC and RCPSC *General Objective 5* *(Principle #2 - Effective Clinician)* The resident will be able to collaborate as an effective member of an interdisciplinary team. Specific Objectives The resident will be able to: 5.1 describe the roles of other disciplines in providing palliative care; 5.2 participate in interdisciplinary care of patients, including family conferences; 5.3 communicate effectively with other team members; 5.4 demonstrate adequate skills in educating and in learning from members of the interdisciplinary team; *V Content and Organization of the Program* 2. Program Requirements: One year of palliative medicine. This program must include: …..interprofessional care and teaching. *VI Resources* 3. Interdisciplinary faculty including: …..experienced teachers from other medical specialties and other disciplines such as nursing, social work and theology…..

Health Profession	Accrediting Body	Standards Relevant to IECPCP
		4. Support Services …..palliative care counselling resources such as social workers, psychiatrists or psychologists with special expertise in caring for dying patients and their families…..
	Royal College of Physicians and Surgeons of Canada (RCPSC)	STANDARD A.2: SITES FOR POSTGRADUATE MEDICAL EDUCATION Affiliated teaching hospitals and other education sites participating in residency programs must have a major commitment to education and quality of patient care. Interpretation 3. It is important that residency programs be supported by active teaching services in other disciplines related to the specialty or subspecialty. Details of these relationships will be found in the specific standards of accreditation for programs in each specialty or subspecialty. 4. All participating sites **must** be actively involved in a formal quality assurance/improvement program, including regular reviews of deaths and complications. Quality assurance activities should be part of an integrated program that allows interaction between all members of the patient-centered health care team. The quality of patient care and the use of diagnostic procedures on the teaching services whether medical, surgical, or laboratory should be under continuous review. STANDARD B.2: GOALS AND OBJECTIVES There must be a clearly worded statement outlining the goals of the residency program and the educational objectives of the residents. Interpretation 2. Goals and objectives **must** be structured to reflect the CanMEDS competencies. (See Standard B.5). Clearly defined educational objectives for

Health Profession	Accrediting Body	Standards Relevant to IECPCP
		teaching each of these competencies and mechanisms of formal assessment **must** be in place. Medical Expert: - seek appropriate consultation from other health professionals, recognizing the limits of their expertise. Communicator: - develop rapport, trust and ethical therapeutic relationships with patients and families - accurately elicit and synthesize relevant information and perspectives of patients and families, colleagues and other professionals - accurately convey relevant information and explanations to patients and families, colleagues and other professionals - develop a common understanding on issues, problems and plans with patients and families, colleagues and other professionals to develop a shared plan of care Collaborator: - participate effectively and appropriately in an interprofessional health care team - effectively work with other health professionals to prevent, negotiate, and resolve interprofessional conflict Scholar: - facilitate the learning of patients, families, students, residents, other health professionals, the public, and others, as appropriate. STANDARD B.5: CLINICAL, ACADEMIC AND SCHOLARLY CONTENT OF THE PROGRAM The clinical, academic and scholarly content of the program must be appropriate for university postgraduate education and adequately prepare residents to fulfill all of the Roles of the specialist. The quality of scholarship in the program will, in part, be demonstrated by a spirit of enquiry during clinical discussions, at the

Health Profession	Accrediting Body	Standards Relevant to IECPCP
		bedside and in clinics, in seminars, rounds, and conferences. Scholarship implies an in-depth understanding of basic mechanisms of normal and abnormal states and the application of current knowledge to practice. Interpretation 1. Medical Expert 1.2 There **must** be an effective teaching program in place to ensure that residents learn to consult with other physician and health care professionals to provide optimal care of patients. 2. Communicator 2.1 The program **must** ensure that there is adequate teaching in communication skills to enable residents to effectively: 2.1.1 interact with patients and their families, colleagues, students, and co-workers from other disciplines to develop a shared care plan; 3. Collaborator 3.1 The program **must** ensure that there is effective teaching and development of collaborative skills to enable residents: 3.1.1 to work effectively with all members of the interprofessional health care team; 3.1.2 to manage conflict. STANDARD B.6: EVALUATION OF RESIDENT PERFORMANCE There must be mechanisms in place to ensure the systematic collection and interpretation of evaluation data on each resident enrolled in the program. Interpretation 2.5 Collaborating abilities, including interpersonal skills in working with all

Health Profession	Accrediting Body	Standards Relevant to IECPCP
		members of the interprofessional team, **must** be assessed.
Nursing	Canadian Association of Schools of Nursing (CASN)	<u>Partnership</u>: The educational unit has strategic partnerships that support quality nursing education and scholarship 1. The strategic plan guides the development of informal and formal partnerships, relationships, and teams of the achievement of mutual goals 2. Strategic goals are achieved by teams within partnerships and relationships consistent with the concept of shared leadership 3. Trust, mutual respect, shared leadership and open communication support partnerships, relationships, and teams 5. Benefits of the teams, partnerships, and relationships are evident 6. The teams, partnerships, and relationships create new opportunities, innovations, and synergy <u>Knowledge-based Practice</u>: Learners have opportunities to engage in effective, knowledge-based practice that is safe and ethical 8. Learners develop functional working relationships
Pharmacy	Canadian Council for the Accreditation of Pharmacy Programs (CCAPP)	Guideline 1.3: "The mission statement of a Faculty should acknowledge pharmaceutical care as the contemporary mode of pharmacy practice in which the pharmacist, in partnership with patients and other health providers, determines the patient's desired health outcomes, assists in identifying their drug related needs and establishes the mutual responsibility of each participant. The professional program in pharmacy should proved educational preparedness so as to enable the pharmacist to collaborate with other health professionals and to share in the responsibility for the outcomes of drug and related therapy in patients."

Health Profession	Accrediting Body	Standards Relevant to IECPCP
		Guideline 4.4: "The University should promote and the Faculty should develop relationships among health profession Faculties." Guideline 4.5: "The University should facilitate inter-professional health science education. Pharmacy students should benefit from collaboration with students in other health science programs in activities such as practice experiences and integrated small learning activities." Guideline 9.3: "….The behavioural, social and administrative pharmacy sciences area should attend to the knowledge, skills, and abilities necessary to the efficient and effective management of patient-centered practice." Guideline 10.2: "…Practice experiences should enhance teamwork and communication skills with patients, colleagues and other professionals." Guideline 10.3: "...Practice experiences should develop pharmaceutical care capabilities in …, and interdisciplinary environments…" Guideline 11.2: "…The curricular areas of pharmacy practice and the practice experiences should serve as the mainstay for the application and further development of interpersonal and inter-professional communicative and collaborative skills necessary to the rendering of pharmaceutical care."
Social Work	Canadian Association of Schools of Social Work (CASSW) Board of Accreditation	SB 5.10.12: The curriculum shall ensure that the student will have knowledge of other related occupations and professions sufficient to facilitate interprofessional collaboration and team work.
Physiotherapy	Accreditation Council for Canadian Physiotherapy Academic Programs (ACCPAP)	6.3.4.5 Collaboration with clients, family members or other care-givers, and members of the health team. 6.4.2 Providing education for clients and consulting with other professionals as

Health Profession	Accrediting Body	Standards Relevant to IECPCP
		required. 6.4.5 Discharge planning and follow-up care including referral to other health care team members or community resources as indicated. 6.5 Communication and Interdisciplinary Practice: Physiotherapy students, upon graduation, will communicate with clients, relevant others and health team members to achieve interdisciplinary collaboration and service coordination through their knowledge and skills in: 6.5.1 Documenting relevant aspects of client history, assessment, planning, intervention, discharge and follow-up 6.5.2 Effective written, verbal and non-verbal communication skills 6.5.3 Responsibility to refer to other physiotherapists and members of the health team when required 6.5.4 Providing education for clients and colleagues using pedagogical principles 6.5.5 Consulting and collaborating with individuals, other professionals, and community-based organizations to facilitate delivery of services 6.5.6 Informed consent and participatory decision-making
Occupational Therapy	Canadian Association of Occupational Therapists (CAOT)	Canadian Guidelines for Fieldwork Education in Occupational Therapy Students are expected to: • Increase their understanding of and respect the roles and functions of other team members;

Health Profession	Accrediting Body	Standards Relevant to IECPCP
		• Learn how occupational therapists contribute to the service delivery team; • Increase their understanding of the systems in which occupational therapists practice.