Canadian Interprofessional Health Collaborative
Consortium pancanadien pour l'interprofessionnalisme en santé

# CIHC-CPIS SITUATIONAL ANALYSIS OF IPE IN CANADA, 2021

PRESENTED to the CIHC-CPIS BOARD
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## INTRODUCTION

The CIHC conducted a bilingual follow-up situational analysis (SA) to its 2008 Situational Analysis to better understand the state of interprofessional education (IPE) at selected post-secondary institutions in Canada. The purpose of this current SA was to identify the outputs of the Health Canada funding for IPE (2002-2004), and to understand the extent to which IPE[1] is supported and structured within and across Canadian post-secondary institutions (i.e., Universities, Colleges, and Institutes). Moreover, the SA wishes to show the interactions these post-secondary institutions have with health and social care systems to advance interprofessional education and collaborative patient-centered practice (IPECPCP) in both practice and learning environments. The CIHC will use data collected:

a) to advocate for policies that will foster IPECPCP across Canadian health and social care education and practice,
b) to advise and assist in the coherent and sustainable development of IPE programs,
**c)** to ground further development of IPECP in theory and data.

## BACKGROUND

Changing the way Canada educates and deploys health and social care providers is an important step towards strengthening the healthcare system. The 2003 First Ministers' Accord on Healthcare Renewal highlighted the need to improve the planning and management of health human resources in order to provide Canadians with better access to the health and social care (HASC) providers they need. The subsequent Pan-Canadian Health Human Resource Strategy (HHRS) responded to the Accord commitments by establishing a framework to secure and maintain a stable and optimal health workforce in Canada and support overall healthcare renewal. The HHRS was comprised of three initiatives:

- Pan-Canadian Health Human Resource Planning
- Interprofessional Education for Collaborative Patient-Centred Practice

[1] Interprofessional Education (IPE) is an "occasions when members or students of two or more professions learn with, from and about each other, to improve collaboration, and the quality of care and services." (CAIPE, 2018).

- Recruitment and Retention of Healthcare Providers/Professionals (including the Healthy Workplace Initiative)

In response to the 2003 First Ministers' Accord on Healthcare Renewal and the Pan-Canadian Health Human Resource Strategy (Source: 2003 First Ministers' Accord), in 2005 Health Canada launched two key initiatives: Interprofessional Education for Collaborative, Patient-Centred Practice (IECPCP) and the Healthy Workplace Initiative (HWI) (Source: Health Canada).

Collaborative patient-centred practice in interprofessional teams was identified in the HHRS as an area of focus for healthcare and health professional education now and in the future. How we educate health providers is key to ensuring that they have the necessary knowledge, skills, and attitudes to work effectively in interprofessional teams. The focus of the HWI was to support healthcare organizations in developing or enhancing programs and actions that would lead to improvements in work environments, the health and well-being of healthcare staff, and overall job satisfaction/quality of work life.

The goal of the IECPCP Initiative was to ensure healthcare providers could gain the necessary knowledge and skills needed to work effectively within interprofessional teams. In addition to two cycles of IECPCP learning projects funded through an allocation of $20M CAD over a five-year period, the initiative included a series of papers and meetings to explore issues around IPE. The specific goals of the learning projects were 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 perspective
- Increase the number of health professionals trained for collaborative patient-centred practice
- Stimulate networking and sharing of best educational approaches for collaborative patient-centred practice

(Source: *"Sustained and Measurable Outcomes and Impacts of the Interprofessional Education and Collaborative Patient-Centred Practice (IECPCP) and Healthy Workplace Initiatives (HWI) Projects"* Monkeytree Creative, Vancouver, 2013)

**The Purpose of the Situational Analysis**

With reference to the specific goals listed above, the *purpose* of this SA was to assess the 15-year downstream outcomes and lasting system changes of the IECPCP initiative at selected post-secondary Canadian institutions. Specifically, the CIHC SA sought to identify the outputs of the Health Canada funding for IPE (2002-2004), and to understand the extent to which IPE is supported and structured within and across Canadian post-secondary institutions (i.e., Universities, Colleges, and Institutes). Moreover, the SA wishes to show the interactions these post-secondary institutions have with health and social care systems to advance IPECP in both practice and learning environments. The CIHC will use data collected:

a) to advocate for policies that will foster IPECP across Canadian health and social care education and practice,
b) to advise and assist in the coherent and sustainable development of IPE programs,
**c)** to ground further development of IPECP in theory and data.

This report presents the findings of a situational analysis about the Canadian experience of initiating and sustaining IPE to support and enlighten local and global IPECP initiatives. This SA did not address IPE or IPC in practice settings, integration of IPE, or challenges of the IPE-IPC continuum, did not survey knowledge end-users (students/practitioners), nor did it have an observational component. These aspects are partially covered in Azzam et all. paper (Source: Azzam et al, 2021)

## METHOD

The survey posed 19 two-level questions (close-ended in the form of "yes-no-unsure" and related open-ended questions asking to "describe/indicate/explain") about structures, processes, and metrics of IPE programs and faculty, student and patients' involvement in IPE. The questions are presented in Appendix B.

Institutions were eligible for this study if they received funding through either cycle 1 or 2 of the Health Canada IECPCP Initiative and if they were known at the time of the SA to have structured health and social care (HASC) IPE programs, as determined through a web-based search as well as through discussions with IPE champions and the CIHC Board. The

web-based, bilingual survey was sent to a convenience sample of pan-Canadian key informants (n=34) between November 2020 and February 2021. Three email reminders were sent to all participants at 15 days intervals (Appendix A).

Once collected, quantitative data were tabulated, and qualitative data were analyzed using an inductive emergent thematic approach.

## RESULTS

### Quantitative data

Nineteen responses were received, representing a response rate of 56%. Responses spanned every Canadian province and participants responded in either French or English. Statistics for individual anonymous survey answers are presented in Table 1.

Table 1: Survey responses to the close-ended responses

| N = 19 surveys analyzed (completed responses) | Yes | Unsure | No | N/A |
|---|---|---|---|---|
| Does your institution support a specific program of IPE? | 79% | 5% | 16% | 0% |
| Does your program of IPE have a publicly accessible, designated IPE Website? | 63% | 5% | 32% | 0% |
| Does your program of IPE use Social Media to communicate with faculty and/or students from all health programs? | 37% | 21% | 42% | 0% |
| Has your program of IPE developed Webinars and/or asynchronous virtual teaching material about IPE/CP for students, faculty, or practice settings in the past five years? | 84% | 5% | 11% | 0% |
| Has your program of IPE ever held Meetings with senior policy advisors in government? | 47% | 26% | 26% | 1% |
| Has your program of IPE sought the support of health and social care professional associations to advance IPE in your institution? | 21% | 47% | 21% | 11% |
| Does your program of IPE have a specific funding line in the operating budget of your educational institution? | 53% | 11% | 26% | 10% |
| Including clinical facilitators, does your program of IPE have faculty and staff associated with / assigned to your IPE programs? | 63% | 11% | 16% | 10% |

| | Yes | Unsure | No | N/A |
|---|---|---|---|---|
| Do the formally assigned faculty to your IPE program have a designated workload / protected time to do so? | 37% | 11% | 21% | 31% |
| Are facilitators and faculty involved in IPE activities in your program educationally prepared to do so? | 53% | 11% | 5% | 31% |
| Does your program of IPE have Student participation in its IPE curriculum development? | 53% | 21% | 16% | 10% |
| Does your program of IPE have patient / client participation / involvement in its IPE curriculum development? | 32% | 26% | 32% | 10% |
| Does your program of IPE occupy its own educational and administrative space (including teaching space)? | 32% | 0% | 58% | 10% |
| Has your program of IPE developed curricular online materials via e.g. Zoom, MS Teams for asynchronous IP learning by facilitators, including in Covid 19 times? | 63% | 5% | 21% | 11% |
| Has your program of IPE developed Webinars or face to face IPE Workshops for the instruction of IPE facilitators? | 53% | 16% | 21% | 10% |
| Does your program of IPE collect quantitative data? | 47% | 26% | 16% | 11% |
| Does your program of IPE collect qualitative data? | 58% | 21% | 11% | 10% |
| Excluding the accreditation process, has your program of IPE been through an external review as required by your institution? | 26% | 21% | 42% | 11% |
| Does your program of IPE use outcome measures of any kind to understand patient participation in your programme? | 11% | 32% | 47% | 10% |

## Qualitative data: emergent themes

All open-ended responses were translated and analyzed. Three main themes, with associated sub-themes, emerged from the qualitative analysis of the open-ended survey questions: macro-structure and organization; microstructure and teachers/facilitators/learners involvement; external influences and participation (students, patients) and accreditation.

### Macro-structure and Organization

#### *Administrative organization*

The organizational structure of IPE across Canada was not standardized or uniform. Some respondents indicated that their 'program' of IPE was more informal in nature holding no

specific title, such as a Centre of IPE. Rather they provided a description of the program as a surrogate to a formal designation.

> *"The 'program' is rather in the form of courses offered to future health workers (nursing sciences, rehabilitation sciences, nutritional sciences, medicine, education). For our academic programs offered in both official languages, these courses are also available in English."*

Despite not formalizing a specific Office or Centre of IPE, administrative space was often dedicated to IPE programming. On the other hand, teaching space was rarely formally designated, but more commonly the result of arrangements made with hospitals or schools and space was often shared with others.

> *"office space only- teaching space we utilize campus space and rooms"*

> *"Teaching rooms and offices designated for interprofessional collaboration. The environment is conference room type and includes all the necessary equipment to broadcast the activities. Coordinator's office"*

### *Funding*

Most respondents did not report funding in the qualitative responses. It is possible that participants lack knowledge to answer the questions or that respondents may not have wished to answer the questions. For those who did report specific IPE funding, they also indicated that a loss of dedicated funding created an unclear future for participants.

> *"There has been a very recent change at our university with the organizational support for IPE. […]. Before Jan 2021 there was a dedicated budget line and space for IPE. At this point, there is no centralized funding, however programs will still offer IPE, its just unclear exactly what that looks like going forward."*

There was an expressed belief that increased research funding would improve IPE programs.

*"Lobbying for dedicated IPE/CP research funding is essential in order to advance the science."*

### *Organizational relationships and partnerships*

At an organizational level, there was an expressed need for better policies to guide practice-academic interactions. Most academic-practice relationships involved partnership with regional authorities. However, some respondents indicated collaborating or interacting with provincial health authorities (e.g., Ministries of Health).

*"Discussions between our staff and policy directors at the provincial government department level occurred […] The purpose of the meeting was to describe the provincial curriculum framework developed as part of this project and to explore areas of overlap and alignment between government, regional health authorities and [the] University."*

These meetings allowed IPE programs and stakeholders to have an enhanced understanding of one another. However, participants emphasized the paucity of institutional policies to support, for example, programs and facilitators.

*"We need more policy related to guiding the interaction between post-secondary and health care (practice education)."*

There was a general lack of partnership with professional associations to advance IPE. Reported encounters were either for the purpose of identifying profession-specific needs in relation to IPE and IPC or for facilitator recruitment.

*"We request support from professional associations when recruiting small group facilitators to join pre-licensure learners for each IPE activity in our calendar. Additional discussions with professional associations centre around understanding the needs of registered professionals, identifying opportunities to deliver professional development in interprofessional collaborative care, and to consult on emerging scope of practice issues in the province."*

### *Organizational communications*

Most respondents used social media (e.g., Facebook and/or Twitter) to communicate with students about IPE. Although most included academic centers have a website, respondents did not identify the website as a mode of communication with students. There was no mention of the use of newer social media programs such as TikTok or Instagram.

### *Metrics*

In terms of program evaluation metrics, participants mentioned that student and facilitator evaluations were often solicited but these solicitations were identified as being predominantly linked to research. In the context of these research mandate, qualitative data were collected via focus groups as well as with open-ended questions/narratives on surveys. IPE outcome measures were most commonly focused on student satisfaction.

Data from evaluations were used to inform program revision, accreditation, and assessment of higher-order learning. It was not clear whether evaluation data was used for quality assurance/improvement purposes.

### *Accreditation of IPE programs*

Most external accreditation reviews were not specific to or focused on the IPE program but were, instead, part of a broader program evaluation of health and social care professional curricula. IPE specific recommendations received from accreditation review bodies were related to leadership (e.g., need for greater research, in-practice involvement) or to the structure of IPE (funding, patient inclusion). External reviews specific to IPE and a more formalized IPE accreditation process were viewed as critical to advancement and investment in IPE programs.

> *"External review was critical to the advancement of our IPE program and resulted in the investment of significant resources that enabled the expansion of the program."*

> *"A formalized accreditation process to ensure the appropriate funding and quality of IPE education is critical to ensuring the advancement of the initiative in Canada."*

## Microstructure and Teachers/Facilitators/Learners Involvement

### *Teaching, learning models, teaching mode, assessment*

When asked to describe the IPE program, some respondents only provided the "name" of the program as opposed to an actual description. There were a variety of teaching and learning modalities employed across Canada, from IPE champions to more formal structured teaching with clearly stated IP objectives.

> *"My institution has no such program, making it difficult to answer the questions (there is no N/A option). IPE exists, but on the backs of individual faculty champions, and in their classes only."*

CIHC Competency Framework domains were not used consistently or uniformly in IPE offerings in Canadian programs nor were these programs always informed by theoretically grounded IPE-specific teaching approaches. For example, respondents reported IPE offerings that were integrated into another activity, while others reported stand-alone IPE.

> *"IPE at my institution relies on individual champions who teach IPE in their classes. They may run workshops, simulations, etc."*

Many IPE sessions were online or blended, involving both online and in-person activities. Although the pandemic changed much in academia, in regard to IPE respondents reported that online teaching was offered synchronously and asynchronously before and during COVID. It was noted that transition of IPE from face-to-face to online learning was supported either by manuals, in-house guidelines, or workshops. Various platforms (e.g., Zoom, Microsoft Teams, etc.) were reported as media used to deliver virtual IPE programs.

Finally, a variety of quantitative survey tools were used in IPE to assess students and evaluate facilitators within the programs, the most popular being the Interprofessional Collaborative Competencies Attainment Survey (ICCAS), Interprofessional Facilitation Scale (IPFS), Interprofessional Collaborator Assessment Rubric (ICAR), and Interprofessional Attitudes Scale (IPAS). The ICAR has also been modified for team self-assessment ("Team-ICAR") to assess the functioning of interprofessional student teams.

*"Most recently, we have developed focus group discussion guides to engage students in group discussion about their own professional group's perception of the meaning of interprofessional education and collaborative practice."*

### *IPE faculty*

When teaching HASC students/learners, respondents appeared to use the terms IPE 'teacher' and 'facilitator' interchangeably, as clarity around the roles of each was not explicitly provided. That being said, the most commonly reported role of participants was that of a facilitator. The number of IPE personnel and hours of participation per person were quite varied across academic institutions. IPE programs were mostly built and sustained by volunteer faculty or champions. Respondents referred to IPE being "built on the 'backs' of faculty"

In responses given, IPE facilitators/teachers were from a broad representation of HASC professions and academic programs (see Table 3)

Table 3: Number of times (N) a profession was identified/named as an IPE facilitator by participant

| **Profession as IPE Facilitator** | N |
|---|---|
| **Oral health** | |
| Dentistry | 5 |
| Dental hygiene | 2 |
| **Physical and functional** | |
| Medicine | 10 |
| Nursing | 10 |
| Occupational Therapy | 10 |
| Physical Therapy | 9 |
| Pharmacy | 6 |
| Kinesiology | 6 |
| Nutrition/Dietetics | 5 |
| Speech Language Pathology | 5 |
| Respiratory therapy | 3 |
| Radiation Therapy sciences | 2 |
| Physician assistant | 2 |
| Med lab sciences | 1 |
| Midwifery | 1 |
| Prosthetics | 1 |

| | |
|---|---|
| Diagnostic ultrasound | 1 |
| **Mental and social health (including pop health)** | |
| Social Work | 6 |
| Psychology and psychoeducation | 3 |
| Sociology | 3 |
| Health management/admin | 2 |
| Genetics counselling | 1 |
| Music therapy | 1 |
| Population health | 1 |
| **Ocular health** | |
| Optometry | 1 |

Although IPE facilitators/ teachers had access to IPE specific training and courses, the format of the faculty development and frequency/timing varied across academic institutions. Also, respondents reported using various training strategies for student learning experience and for facilitator training (e.g., in-person, simulation, synchronous and/or asynchronous). Online learning faculty development was highly influenced by the CIHC Competency Framework with respondents noting a range of faculty development themes:

- Roles
- Communication
- Conflict
- Team functioning
- Collaborative mental health
- Debriefing
- Giving/receiving feedback
- IPE/IPC foundations
- IPE facilitation
- Managing difficult conversations
- Patient safety
- Indigenous cultural training

Many respondents also reported utilizing the University of Toronto Educating Health Professionals for Interprofessional Care (ehpic™) course to prepare faculty/facilitators/teachers for their role in IPE (Source: ehpic™, UofT).

## External influence and participation (students, patients)

### *Student involvement*

Respondents provided a range of IPE programming activities that engaged students. For example, students were represented on IPE standing committees or interest groups, involved in orientation programs, and engaged in curricular decisions. Some IPE programs involved students as IP facilitators.

> *"We have student representation on our curriculum committee. They attend all meetings and participate in all discussions regarding development of new courses, review the drafts of course outlines and teaching materials, and also review the course evaluation data. In addition, we pilot new initiatives with a group of volunteer students and their feedback is valued and considered in the final revision of the materials."*

Some respondents reported the existence of student led IPE associations/organizations. However, funding emerged as a significant challenge to long-term sustainability of these associations/organizations.

### *Patients influence and involvement*

Many respondents recognized the value of patient partners in IPE programs. However, most viewed it as an innovation yet to be implemented. The primary role for patient engagement was serving as a patient sharing perspectives in an IPE activity. Less often, patients were involved in IPE curriculum development and governance. No participant specifically described involvement by diverse and equity-deserving groups, including Indigenous, Black or People of Color or at-risk populations (e.g., homeless and marginalized populations), although the absence of description does not mean to indicate

absence of participation. Further, there was no mention of compensation for patient involvement in IPE.

> *"Patient partners are included in all stages of training development. They participate in educational, evaluation and research committees. They are involved in the governance of the program"*

> *"Patient partners participate in a training workshop on the IPE curriculum and receive activity-specific training. Some of our patient partners facilitate (additional training) and also lead activities (additional engagement through working group participation)."*

## DISCUSSION

The findings of this survey suggest that since the 2002 Romanow Report (Source: Romanow Report), the Health Canada funded IECPCP Initiative in 2005 (cycle 1) and 2006 (cycle 2) and the 2008 CIHC Situational Analysis (Source: CIHC reports), Canadian academic institutions have made tremendous progress in advancing IECPCP and in addressing the four goals of the Health Canada IECPCP funding. The findings of our 2021 CIHC Situational Analysis also align with the nine principles noted to influence/support successful implementation of IPE initiatives identified in the 2008 CIHC Situational Analysis (Source: CIHC IPE in Canada Situational Analysis. April 28, 2008). We use these goals and principles to orient our discussion.

### Health Canada IECPCP Goal #1: Increase the number of health professionals trained for collaborative patient-centred practice.

With a majority of respondents reporting the existence of a program of IPE and offering IPE webinars and/or asynchronous virtual learning, it is safe to say that the number of health professionals trained for collaborative patient-centred practice is increasing. Based on responses to the SA, it seems that IPE is now part of the general curricula of HASC professionals across Canada; this is possibly due to the introduction of accreditation standards related to IPE in many HASC professions (Source: Ruby Grymonpre et al, 2021).

### Health Canada IECPCP Goal #2: Stimulate networking and sharing of best educational approaches for collaborative patient-centred practice.

Data also supports that networking and sharing of best practices is occurring at the sites included in the SA. The IPE programs showcased across Canada are diverse both in terms of organization, structure, and professions involved. Important themes that emerged from our qualitative analysis emphasized the array of teaching and learning models necessary to foster sustainable and scalable efforts to increase the number of HASC professionals who participate in IPE. This clearly underlines the principle of "one size does not fit all", allowing programs to learn from each other.

Regarding communication, 63% of respondents reported having a designated website and other forms of communication. Communication, external relations, and politics emerged as themes in our qualitative analysis. Most communication about IPE occurred via social media platforms suggesting that it was not solely internal or student-oriented. An impressive 47% of respondents reported meeting with senior policy advisors in government. Awareness and commitment from government, responsible for funding and policy development, are essential for sustainability and growth of IPE and IPC. Communication and networking with policymakers and other stakeholders helps to align IPE/IPC with government priorities, promote sustainability of IPE programs and can be viewed as an important strategy to promote the benefits of IPE/IPC Moreover, 53% of respondents reported student and patient participation in IPE curriculum development, showing a diversified and inclusive view of important stakeholders, allowing programs to build stronger IPE initiatives.

Fifty three percent (53%) of respondents reported a specific line of funding for IPE, showing financial support and institutional commitment to IPE suggesting commitment to long-term sustainability. With continued financial support and institutional commitment, IPE may be regarded as a relevant and permanent aspect of the curricula, with limited resources being attributed to IPE accordingly.

## Health Canada IECPCP Goal #3: Promote and demonstrate the benefits of interprofessional education for collaborative patient-centred practice

A number of programs reported collecting both quantitative and qualitative evaluative data to assess student learning and to inform program evaluation/quality improvement. Some programs noted use of the data to improve IP learning.

The findings/potential influence of external reviews were of interest as their evaluations identified the need for/importance of academic leadership, administrative re-structuring, funding, practice-based IP learning, inclusion of patients, and optimized research methods. However, concerns arise from limited funding that is dedicated to IPE research that may hinder faculty promotion, faculty retention, and scientific demonstration of IPE benefits for the Canadian population.

### Health Canada IECPCP Goal #4: Increase the number of educators prepared to teach from an interprofessional perspective

Sixty-three percent of faculty/staff were assigned IPE responsibilities; however, only 37% had protected time to do so. Involvement in IPE without protected time may encroach on faculty service/administrative capacity and thus be detrimental to their promotion and/or retention.

Fifty-three percent of respondents reported having faculty development in IPE. The primary focus was on how to facilitate IPE, giving/receiving feedback, and understanding IP competency domains. Managing conflict was not cited specifically as an IPE facilitator training topic, although but it is recognized as an important skill for the IPE facilitators. Facilitator training strategies included face-to-face and online sessions, a full day workshop, and webinars. Some training sessions were context specific (e.g., patient safety, population health, substance use and addictions). COVID appears to have impacted the delivery of IPE faculty development in a positive way, increasing its availability and utilization because of the transition to online forums.

## LIMITATIONS OF THIS SITUATIONAL ANALYSIS

This survey only catches a glimpse of IPE actually occurring in Canada because a substantial number of HASC students are trained in colleges and non-university institutions

which were not included in the SA. It is assumed that there are a large number of individuals across Canada involved in different IPE learning processes, programs, and curricula. When all these types of training institutions are included, our convenience sample might underrepresent the broad Canadian perspective on IPE.

Of concern are the number of ‘unsure’ responses throughout the survey, indicating that those leading IPE may not be well informed to do so and may negatively impact long-term planning and sustainability. There is limited data in terms of IECPCP outside of the traditional learning environments, for instance in practice environments. As noted above, a future major challenge will be to uncover whether there is congruence between what is taught and what is modelled in practice.

Although student IP learning environments may be more and more robust, data are limited and a clear picture not available. For example, many questions are left unanswered such as, how many student-run clinics are there in Canada? How do different institutions in the same geographic location collaborate to foster IPE and include more HASC professionals?

## PLAN TO ACTION / FOR THE FUTURE

As shown by this situational analysis, IPE in Canada is robust, but it is also fragile. These areas and themes should concern CIHC for the future sustainability of IECPCP in Canada. The following recommendations and strategies are offered to help mitigate the challenges identified in the SA:

1. Facilitate collaboration through strategic and innovative partnerships
2. Develop strategic plans for sustainability by promoting resource allocation
3. Fund interprofessional incentives and rewards in health and education
4. Focus on programs and integration by developing and supporting leadership
5. Implement policy change at government and organizational levels
6. Demonstrate and promote the benefits of interprofessional education
7. Support knowledge dissemination and best practice exchange – to IPE leaders and the concerned community
8. Disseminate information that expands interest in IPE to a wider audience
9. Articulate, advance, and advocate a comprehensive agenda for future research and evaluation

To transform these recommendations into actions and actualize each of the above-mentioned recommendations and associated strategies, it will be imperative that:

1. Interprofessional leaders engage with the education and practice communities
2. Collaborative learning environments be created
3. Structures must be modified to support collaboration
4. Non-human (e.g., built environments) and human resources are available and/or created
5. Curricula changes are implemented to create shared IP learning opportunities for HASC learners
6. Institutional structures must be modified to support collaboration (e.g., administrative support, clinical care, leadership)

7. IPE should be embedded in the academic and healthcare systems
8. Consideration that one size does not fit all and therefore IPE will be structured to support the system in which it sits
9. Evidence makes the best case for IPE; therefore, IPECP research must be methodologically sound and theory-driven

## CONCLUSIONS

This SA report presents the current state of the IECPCP in Canada, 15 years after the Health Canada initiative. Canadian institutions have made strides to improve access to and quality of IPE program since the launch of the first initiative; however, there are still some challenges to address that will ensure sustainability of IPE programs in Canada.

**APPENDIX A**
**LETTER TO IPE Key Contacts**

CIHC Situational Analysis (SA) of IPE in Canada 2002

Dear colleagues,

CIHC has developed a Situational Analysis (SA) to better understand the state of interprofessional education (IPE) at selected post-secondary institutions in Canada. Interprofessional Education (IPE) is an interactive educational approach in which learners from two or more different occupations learn with, from and about each other to improve collaboration, and the quality of care and services (CAIPE, 2018). This CIHC SA complements a CIHC survey of accreditation, and a Situational Analysis developed by Interprofessional.Global.

The purpose of this CIHC SA is to understand the extent to which IPE is supported and structured within and across Canadian selected post-secondary institutions, and their interactions with health and social care system. Data acquired through the SA will allow CIHC to develop policy initiatives that will inform and foster IPE across Canadian health and social care education and practice and assist the growth of IPE programs across Canada. A major challenge for this SA will be to uncover whether there is congruence between what is learned in pre-licensure years, and what is modelled in practice. Data collected will be used to inform future strategic analyses of a broad range of post-secondary institutions, and of interprofessional collaborative practice in a variety of community settings.

To participate, just click on this link to go to the survey:

https://www.research.net/r/CIHC-CPIS_survey

We thank you in advance for your help with this important interprofessional initiative. **We will follow up with a reminder in two weeks.**

The Canadian Interprofessional Health Collaborative

## APPENDIX B: Questions asked in the survey

*(Y-U-N: yes-unsure no)*
*(OE: open-ended question)*

1. Does your institution support a specific program of IPE? (Y-U-N)
    a. Please give the name of the IPE program (OE)
2. Does your program of IPE have a publicly accessible, designated IPE Website? (Y-U-N)
    a. Please give all the relevant URL(s) (OE)
3. * Does your program of IPE use Social Media to communicate with faculty and/or students from all health programs? (Y-U-N)
    a. Please name all the platforms your program use to communicate with students or the public (OE)
4. Has your program of IPE developed Webinars and/or asynchronous virtual teaching material about IPE/CP for students, faculty or practice settings in the past five years? (Y-U-N)
    a. Please list titles of presentations, webinars or teaching material used for students, faculty or practice settings. (OE)
5. Has your program of IPE ever held Meetings with senior policy advisors in government? (Y-U-N)
    a. Please indicate at what level in government. (OE)
6. Has your program of IPE sought the support of health and social care professional associations to advance IPE in your institution? (Y-U-N)
    a. Please indicate what form of support (OE)
7. Does your program of IPE have a specific funding line in the operating budget of your educational institution? (Y-U-N)
    a. Please indicate approximate CAD$ funding (OE)
8. Including clinical facilitators, does your program of IPE have faculty and staff associated with / assigned to your IPE programs? (Y-U-N)

a. Approximately how many faculty and staff, including facilitators, are associated with and formally assigned as IPE faculty? (OE)
b. From what professions? (OE)
c. Faculty and staff average of hours per WEEK? (OE)
d. Facilitators average of hours per YEAR? (OE)

e. How many hours (on average) faculty and staff participate / facilitate IPE activities? (OE)

9. Do the formally assigned faculty to your IPE program have a designated workload / protected time to do so? (Y-U-N)

10. Are facilitators and faculty involved in IPE activities in your program educationally prepared to do so? (Y-U-N)

    a. Please explain the type of professional development faculty and facilitators have received (OE)

11. Does your program of IPE have Student participation in its IPE curriculum development? (Y-U-N)

    a. Please describe how this is organized and the nature of their involvement (OE)

12. Does your program of IPE have patient / client participation / involvement in its IPE curriculum development? (Y-U-N)

    a. Please describe how they are trained, and their participation is organized and integrated in the curriculum (OE)

13. Does your program of IPE occupy its own educational and administrative space (including teaching space)? (Y-U-N)

    a. Please describe this teaching and administrative environment (OE)

14. Has your program of IPE developed curricular online materials via e.g. Zoom, MS Teams for asynchronous IP learning by facilitators, including in Covid 19 times? (Y-U-N)

    a. Please describe (OE)

15. * Has your program of IPE developed Webinars or face to face IPE Workshops for the instruction of IPE facilitators? (Y-U-N)

    a. On what topics? (OE)

16. Does your program of IPE collect quantitative data? (Y-U-N)

    a. Please describe any instrument used (OE)

    b. Please describe how this information is used (OE)

17. Does your program of IPE collect qualitative data? (Y-U-N)

    a. Please describe any collection process or instrument that your program has developed and used (OE)

18. Excluding the accreditation process, has your program of IPE been through an external review as required by your institution? (Y-U-N)

    a. What broad recommendations were made by the reviewers? (OE)

19. * Does your program of IPE use outcome measures of any kind to understand patient participation in your programme? (Y-U-N)

    a. Please describe (OE)

    DO YOU HAVE ANY OTHER INFORMATION TO SHARE THAT YOU CONSIDER WOULD HELP THE CIHC FURTHER DEVELOP IPE POLICY INITIATIVES? (OE)

(A French version followed)




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