INTERPROFESSIONAL EDUCATION AND PRACTICE (IPEP) REPORT
March 2015

1 INTRODUCTION

A Global Independent Commission (Frenk et al., 2010) recommends HPE delivers graduates that strive for health equity through patient-centred and community-based care. To realise this, instructional reform is required to facilitate transformative learning that equips students as agents of change. Institutional reform is also necessary to foster interdependence to promote interprofessional and transprofessional learning; breaking "down professional silos while enhancing collaborative and non-hierarchical relationships in effective teams" (Barr, 2011, p. 319).

The Commission advocates a system-based approach that starts by relating needs of the community to the competencies required from students. Barr (2011) envisions this as an "iterative process between education and practice, as it generates commitment and competence for collaborate practice" (p. 319). This echoes the WHO's call for interprofessional education (IPE) and collaborative practice (WHO, 2010) and its plea to maximize equity and solidarity in healthcare in response to people's needs (WHO, 2008).

1.1 BACKGROUND

In 2010/11 the IPEP strategy at the Faculty of Medicine and Health Sciences, Stellenbosch University (SU) (South Africa), was revised by a working group of representatives from all undergraduate programs (medicine, human nutrition, physiotherapy, occupational therapy and speech-language and hearing therapy), as well as postgraduate nursing. In keeping with findings of Frenk et al. (2010), the Institute of Medicine (2011), the Interprofessional Education Collaborative Expert Panel (2011), and the WHO (2010), the revised strategy considered the pivotal role IPEP can play in equipping students as agents of change to effectively address the health needs of individuals and populations.

By integrating IPEP rather than it being a loose-standing curriculum, the working group sought to develop health professionals as "competent collaborative patient-centred practitioners" (Oandasan & Reeves, 2005, p. 46) who can reform health systems. To institutionalise a culture of IPEP, **three focus** areas were identified (see Figure 1):

1. Development, integration and assessment of **core competencies** for interprofessional collaborative practice in curricula (Stephenson, Peloquin, Richmond, Hinman, & Christiansen. 2002), based on the CanMEDS Competency Framework (Frank, 2005) and the Canadian Interprofessional Health Collabotative's National Interprofessional Competency Framework (2010).
2. Promotion of an **interprofessional care and collaboration framework**, based on the **ICF** as common language between professions at individual, institutional and social levels (see Figure 2) (Allan, Campbell, Guptill, Stephenson, & Campbell, 2006; Cahill, O'Donnell, Warren, Taylor, & Gowan, 2013; Dufour & Lucy, 2010; Tempest & McIntyre, 2006; WHO, 2001).
3. **Cultivation of interdependence (harmonisation) between two key stakeholders in HPE: higher education (university) and service providers (provincial and district health departments** and community-based organisations). The aim was to develop trust relationships and build capacity among faculty and service providers in modelling interprofessional practice (Clark, 2004; Craddock, O'Halloran, McPherson, Hean, & Hammick, 2013; Global Consensus for Social Accountability of Medical Schools, 2010; Lawson, 2004; Steinert, 2005).

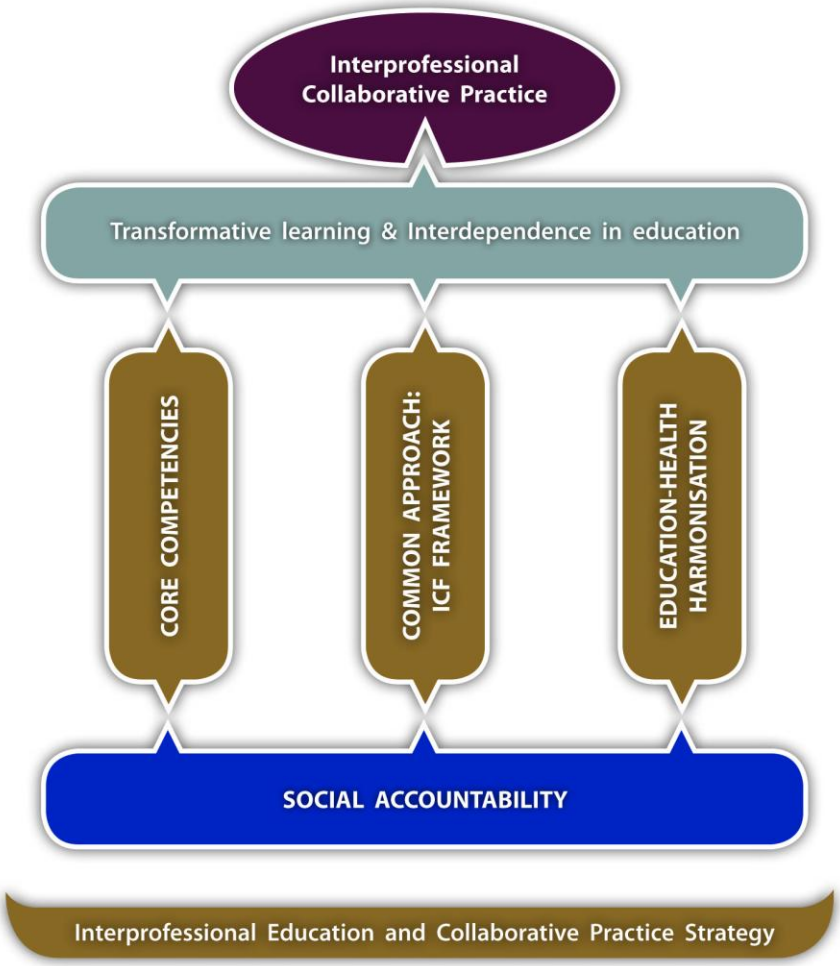

Figure 1. The IPEP strategy at the FMHS at SU.

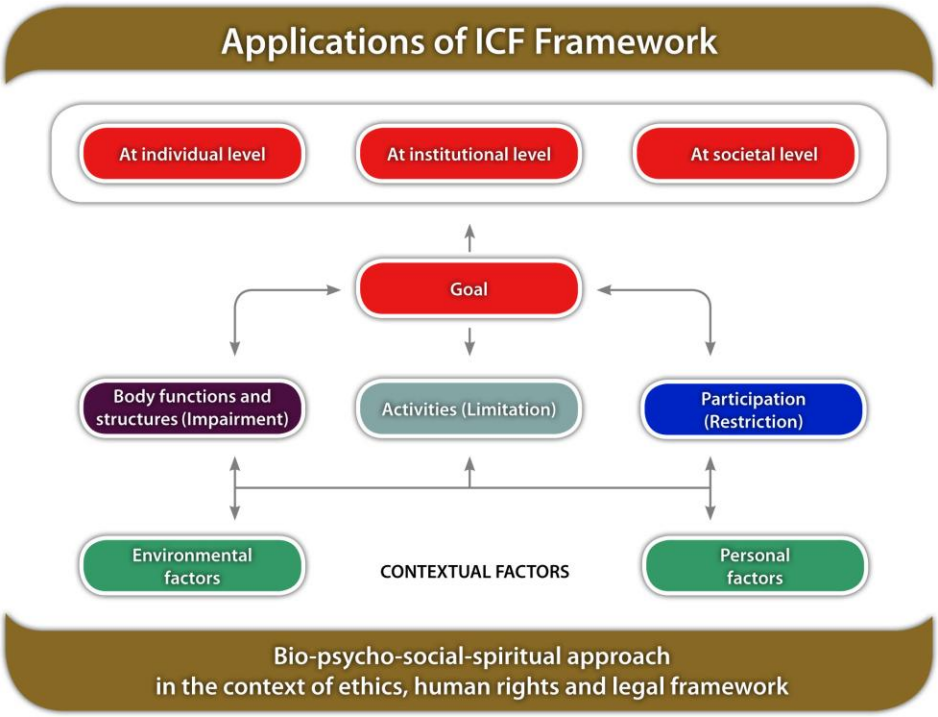

Figure 3. The framework of the World Health Organisation's International Classification of Functioning, Disability and Health (ICF) serves as common language and approach in the biopsychosocialspiritual approach to patients and communities.

The gradual implementation of this strategy commenced in the undergraduate community-based modules at SU's Ukwanda Rural Clinical School (see figure 3), where disciplinary silos were perceived to be less entrenched and where learning activities were being experienced as more flexible than in the tertiary environment and therefore open to creative innovation (Van Schalkwyk et al., 2012). Despite this, typical challenges of IPE were prominent, e.g. the short duration of rotations, shift incompatibility, issues of profession-specific supervision and claims that accreditation requirements by professional boards are not flexible enough to allow for IPEP (Freeth, Hammick, Reeves, Koppel, & Barr, 2005; Jacobs et al., 2013; Lawson, 2004; Oandasan & Reeves, 2005; Thibault, Schoenbaum, & Josiah Macy Jr. Foundation, 2013). There were logistic challenges; medical students were placed for a two-week rural clinical rotation in one of nine sites in a hundred and fifty kilometre radius from the medical school. Students from the other aforementioned undergraduate programs were only sporadically present at three of these sites. For these challenges to be solved through normal processes take significant time and so an alternative approach was adopted.

Facilitators were appointed at each site to facilitate IPEP between students and the various health professions and to build the capacity of local health professionals to model interprofessional collaboration and practice. During their rural rotation, medical students worked with these health professionals in managing their patients interprofessionally. A local interprofessional team assessed students as they presented their patients using the ICF framework. These assessments included peer discussions, where formative feedback was given.

In 2001 the World Health Organization (WHO) launched the International Classification of Functioning, Disability and Health (ICF) as a comprehensive coding system for functioning and disability, a conceptual framework and a "common language between all professions" (WHO, 2001, p. 3). In its first decade the ICF was primarily used in international and national health and disability reporting, clinical and epidemiological use, and for impact, intervention and application research (WHO, 2013a). In undergraduate health professions education (HPE) the ICF has not been widely taught as a conceptual framework in approaching and managing patients (Allan et al., 2006; WHO, 2013b). Rather, students are often taught numerous, potentially contradicting, approaches to patients and communities, which can serve as a barrier to interprofessional communication and a bio-psycho-social-spiritual approach to patient-centred care (Fehrsen & Henbest, 1993). This tendency and other barriers to interprofessional education and practice (IPEP) are challenged as educators worldwide are searching for solutions to promote institutional reform that includes patient-centred interprofessional and transprofessional education (Barr, 2011; Frenk et al., 2010; Oandasan & Reeves, 2005; Thibault et al., 2013; WHO, 2010). Dufour and Lucy (2010) argue that solutions to these barriers necessitate moving away from the strong emphasis on biomedical aspects of disease, neglecting functional and contextual factors; and that "the ICF not only highlights the need for a diverse team of healthcare professionals, but also represents a paradigm shift in how to approach health and health care" (p. 668).

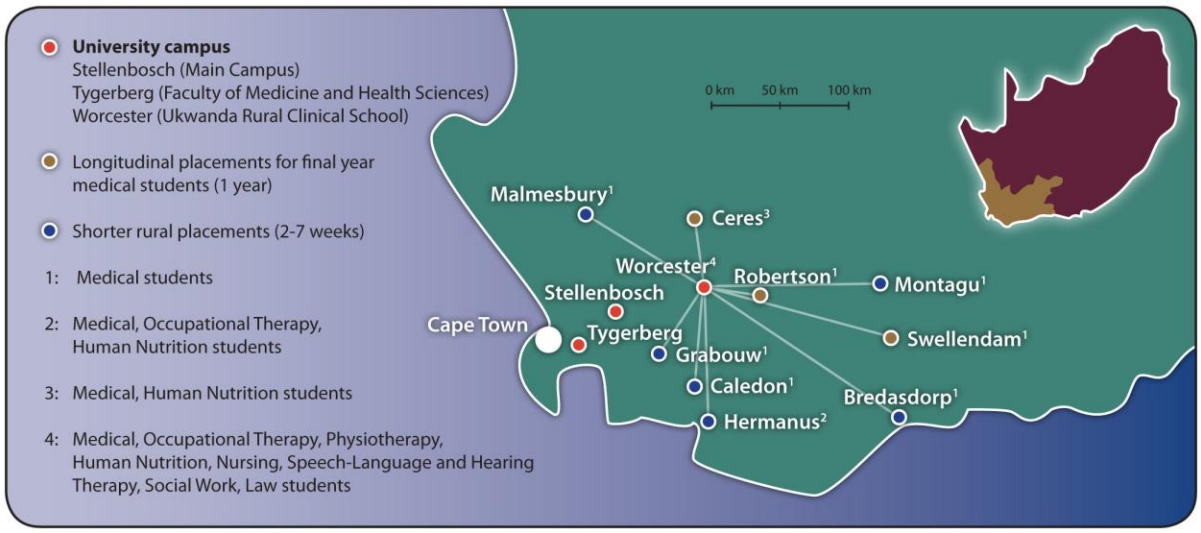

Figure 4. During the first two years (2012/13) the IPEP strategy was primarily piloted on the platform of the Ukwanda Rural Clinical School

2 PROGRESS MADE ON THE IMPLEMENTATION OF THE IPEP STRATEGY

2.1 CORE COMPETENCIES

One of the first activities that the IPEP working group embarked on in 2010 was a process to develop a set of core competencies (graduate attributes) that could represent the FMHS ideal graduate. In May 2012, a set of key and enabling competencies based on the CanMEDS model (Figure 2) were accepted by the Faculty Board. Integrating the graduate attributes into the various curricula, starting with the community-based programmes, is on-going. Dr Bridget Johnson was appointed in September 2012 to act as the manager facilitating the process to integrate the graduate attributes into the various curricula. She unfortunately moved with her family to George. Her scholarly contribution to the process and her supportive role to the various programmes will be missed dearly. The Graduate Attribute process has included a number of key activities:

- Faculty representatives participated in an initiative by the Medical and Dental Professions Board of the Health Professions Council of South Africa to develop a national core competency framework for doctors, dentists and clinical associates, adopted from and based on the CanMEDS framework. This provided further impetus to the FMHS initiative.

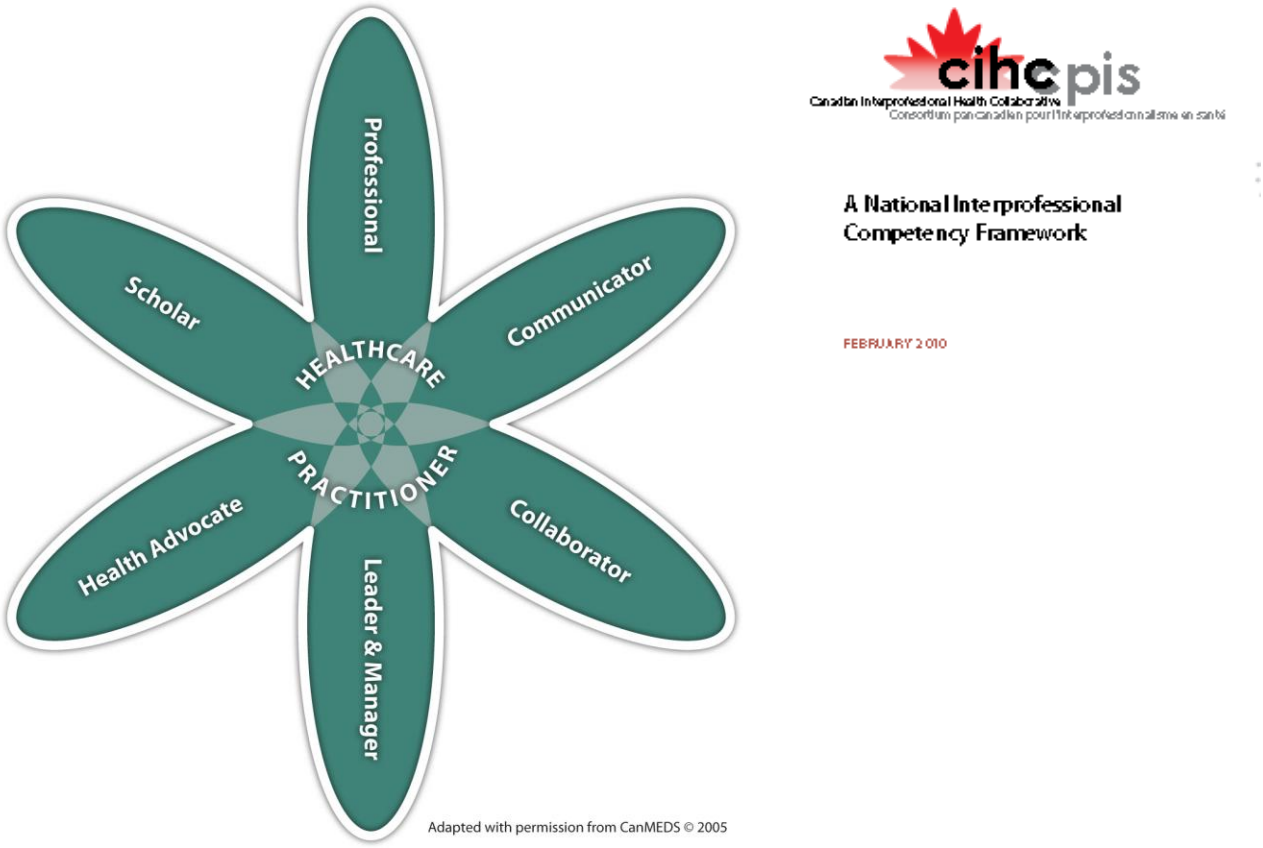

Figure 2. The development of core competencies for IPEP were adapted from the CanMEDS framework[1] and the Core Competencies for Interprofessional Collaborative Practice

- Institutionally there is a renewed focus to embed graduate attributes into curricula with the FMHS playing a prominent role.

[1] *Aadapted from the CanMEDS Physician Competency Framework with permission of the Royal College of Physicians and Surgeons of Canada. Copyright © 2005*

- Community-based interprofessional activities in CBE were promoted and encouraged. This form of learning lends itself not only to sound academic learning, but also to meaningful and relevant interprofessional service, reflection, personal development and the cultivation of active citizenship.
- Research projects were initiated to determine to what extent (a) to determine the "gap" relating to graduate attributes in the various curricula and (b) to study the introduction of an ePortfolio. These project we put on hold when Mrs Johnson left our service.
- Dr Stefanus Snyman was also invited to as member to the International Advisory Council of CanMEDS 2015 and to participate in the activities of the In-2-Theory Global Think tank on research and theory in interprofessional education and collaborative practice.
- We partnered with the Department of industrial Psychology and started to develop training and assessment packages based on the competency framework.
- Together with SAAHE, we invited Dr Jason Frank of CanMEDS to South Africa in June 2014, where we spent three days workshop to further refine our strategy.

2.1.1 GRADUATE ATTRIBUTES: PLANS FOR 2014-2016

See separate report regarding the current draft strategic plan.

2.2 ICF AS CATALYST FOR IPEP

2.2.1 EVALUATION OF HOW USING THE ICF IN IPEP WAS EXPERIENCED BY MEDICAL STUDENTS, PRECEPTORS (STUDENT PLACEMENT SUPERVISORS) AND PATIENTS

In a recent evaluation of the strategy it was sought to establish how using the ICF in IPEP was experienced by medical students, preceptors (student placement supervisors) and patients.

Two key themes emerged: using the ICF framework as an interprofessional approach to manage patients and the experience of IPEP as a result of promoting the ICF.

Using the ICF framework as an interprofessional approach to manage patients

The ICF is known to facilitate more effective interventions and improved patient outcomes by improving the level of functioning and quality of life (WHO, 2013b). Most students were positive about using the ICF, reporting a better understanding of applying the framework in clinical practice. Preceptors felt some students still struggled to apply the ICF framework in approaching a patient and in developing an interprofessional management plan.

Students found, as did Allan et al. (2006), the ICF framework comprehensive and beneficial in obtaining effective and holistic insight into patient needs and context. This helped most students recognise the complexity of health and that healthcare is not only curative and biomedical.

Mirroring the findings of Tempest and McIntyre (2006), some students experienced the ICF too time-consuming, unnecessarily detailed and not always practical given the clinical workload. They were under the impression they should utilize the main volume of the ICF. However Üstün, Chatterji and Kostanjsek (2004) found only a fraction of the categories is needed for any single patient. Students desired more teaching and exposure in clinical settings on using the ICF framework.

All preceptors responded consistent with the findings of Cahill et al. (2013) that the ICF enabled a more comprehensive and holistic understanding of patients. This was especially experienced by preceptors during the interprofessional assessment of students presenting their patient management plans.

Students' case presentations impacted positively on healthcare facilities, creating awareness, promoting teamwork, collaboration, communication and respect amongst staff, resulting in better patient care and improving patient outcomes. Although not situated in the context of the formative and summative assessment of students, other studies reported similar encouraging outcomes when the ICF is applied (Allan et al., 2006; Pryor, Forbes, & Hall-Pullin, 2004; Steiner et al., 2002).

Preceptors indicated that their involvement with these students challenged them to develop both as professionals and as educators:

> *Using the ICF reduced my tendency to work in the silos of healthcare.*
>
> *The ICF improved my practice especially regarding referral, health promotion, discharge and post-discharge planning.*
>
> *It has definitely made me a better doctor.*

Aligned with the findings of Dufour & Lucy (2010), Lawson (2004), Hammick, Olckers and Campion-Smith (2009), and Tempest and McIntyre (2006) preceptors also reported using the ICF in their own clinical practice, reduced the traditional hierarchy and professional silos prominent in their healthcare teams. Furthermore it enhanced respect, collaborative leadership, job satisfaction, trust relationships and accountability between team members, as well as a culture of on-going learning.

Even with inconsistent use, preceptors reported that the ICF framework provided comprehensive and holistic insight, which stimulated clinical reasoning resulting in better patient outcomes, best practice and improvements in the functioning of the local health system. Using the ICF as approach lead to "more input, less missed detail, better overall result" and the "patient feels more attended to". This is consistent with the findings of Allan et al. (2006), Dufour and Lucy (2010) and Tempest and McIntyre (2006).

Experience of IPEP as a result of promoting of ICF

Students reported that prior to this rural placement they had little exposure to IPEP, having been primarily exposed to a curative biomedical model of care. Interprofessional collaboration, as also reported by Cahill et al. (2013) and Hammick et al. (2009), enhanced students' understanding of the importance and benefits of working as a team. Students and preceptors reported excellent relationships with nursing staff, suggesting nurses be more involved in interprofessional teams. They were of the opinion that IPEP activities during the rural rotation contributed "significantly to the students' development as future healthcare professionals". This supports MacKenzie and Merrit's (2013) finding that IPE facilitates rich learning. In addition medical students felt valued by patients, believing they had made a constructive contribution.

In the light of the challenges for IPEP described earlier, both students and preceptors agreed that teamwork is "difficult to implement", but "worth the effort".

Response by patients and their carers

Mirroring the findings of Hallin, Henriksson, Dalén and Kiessling (2011), patients and carers felt valued by the students and the health system, experiencing improved quality of care when treated by an interprofessional team. They recognised a change in their interaction with students and the benefit thereof:

> *The student sensed my frustration and dealt with it.*
>
> *I'm a month here [in the hospital] waiting for information – the students explained better to me why I've been here for so long.*
>
> *Once you're a doctor you just run through things, but these students thought broader.*
>
> *Doctors will be more useful . . . if they ask me the questions these students did.*

Students influenced me how I can improve my health and what I must do to achieve it.

While visiting patients' homes, students used the environmental factors (physical, social and attitudinal) of the ICF to assess the context influencing the health of patients and how these impacted on patients' activity limitations and participation restrictions. Patients and carers experienced these home visits positively, feeling respected, listened to and that their needs were taken seriously by medical students who really care. This provided an opportunity to clarify aspects of their condition, functioning, environment and treatment. One patient commented that the student's "humanness was very helpful for me and my parents", lamenting that these visits only take place during training. Patients made valuable recommendations as to how healthcare professionals could gain their confidence by being courteous, respecting their time and introducing themselves in a culturally acceptable manner.

Additional findings

This evaluation also found that students requested greater exposure to IPEP and that they be required to collaborate with other healthcare students and/or professionals during earlier years of study and in all clinical placements. A frequent request was for clear guidelines on when, and to which profession, patients should be referred.

Preceptors felt that professional jealousy, shortage of personnel and logistical constraints are obstacles to IPEP and that successful implementation is largely dependent on individuals.

2.2.2 LESSONS LEARNT FROM IPEP STRATEGY EVALUATION

As demonstrated in the evaluation, the ICF – when situated in an authentic learning experience as offered on the rural platform – can be introduced successfully at undergraduate level as common language and interprofessional collaboration framework in approaching and managing patients. Fourth year medical students demonstrated the ability to deliver patient-centred and community-based care as part of an interprofessional team using the ICF.

As in the case of Orchard, Curran and Kabene (2005) and Steiner et al. (2002), students realised that doctors cannot solve health problems alone. "Just writing referral letters" don't have the desired outcomes, necessitating an interprofessional approach for common goal setting by using the ICF.

This evaluation confirmed the value of the ICF to facilitate clinical reasoning, to elicit the non-linear complexity of health and to serve as framework in the iterative "juggling" during patient interactions. These findings are consistent with other studies (Allan et al., 2006; Jelsma & Scott, 2011; Tempest & McIntyre, 2006). As suggested by the WHO (2013b), the ICF provided a systematic, though non-mechanical means of engaging with patients, carers and members of the interprofessional team

Students unknowingly served as agents of change, primarily because they modelled a patient-centred approach and engaged with other professionals to develop interprofessional management plans presented for assessment. This highlights the transformative power of interprofessional learning in creating change and facilitating a cultural shift in practice (Cooper, 2010). The interprofessional formative and summative assessment of students positively changed the interprofessional practice of preceptors affecting the local health system. Preceptors also acquired new skills to guide and support students.

The value of the ICF was highlighted as a catalyst in strengthening the interdependence between the university and service providers (preceptors and health managers at the various placement sites). For example, the university was requested to train all health professionals in one health district to use the ICF in the management of their patients, enhancing collaboration in order that patients experience improved services.

The research team, which was closely involved with the implementation of the ICF, noted that the hierarchal relationships within the health structure were flattened, almost by default as a result of using the ICF framework. This affected mutual cooperation and respect, entrenching the understanding of what each profession can contribute to the health status of the patient, deflate the hierarchical system where one profession is regarded of greater value than another, and enable medical practitioners to know when and to which profession to refer, as well as which

professional should lead each case (Allan et al., 2006; Cahill et al., 2013; Dufour & Lucy, 2010; Tempest & McIntyre, 2006).

The need for instructional and institutional reform to facilitate IPEP and system-based learning – advocated by Barr (2011), Frenk et al. (2010), the Interprofessional Education Collaborative Expert Panel (2011), Thibault et al. (2013) and the WHO (2010) – was confirmed as students requested the synchronisation of time tables and placements of the various courses, earlier exposure to IPEP and the ICF, modelling of IPEP in all clinical rotations and longer placements in community-based settings. The traditional way in which health services are organised in silos remains a barrier to IPEP.

This evaluation contributed to our understanding of integrating interprofessional education as an authentic learning experience in clinical and community environments and the potential use of the ICF as a unique and efficient catalyst in pushing boundaries for change. The assessment of students presenting their patients using the ICF to an interprofessional team of health professionals, demonstrated the ICF's potential not only to drive learning, but also to drive interprofessional practice.

The ICF served as catalyst to facilitate interdependence, improving inter professional collaboration and practice in a clinical setting, and strengthening relationships between health profession educators and preceptors in the health service.

These positive attitudes towards the ICF were experienced during rural community-based rotations of medical students. The nature of this evaluation was self-reported behaviour and perceptions, which "must be regarded as a weak approach to measuring behavioural change" (Hammick et al, 2007, p. 747).

2.3 PROGRESS MADE WITH THE IMPLEMENTATION OF THE ICF AS IPEP APPROACH TO PATIENTS AND COMMUNITIES

The following progress in the ICF strategy was made during 2013/14:

1. 892 undergraduate health professions students at SU and UWC were trained during 2013/2014 to apply the ICF framework as interprofessional approach to patient care and public health.
2. An article for publication was submitted to an international peer-reviewed journal. The unfolding findings of the study were presented at the annual conferences of the South African Association of Health Educationalists (SAAHE) (Durban), the Association of Medical Educators in Europe (AMEE) (Prague), the WHO-FIC conference (Brasilia), a plenary at the Council for Social Work Educators (CSWE) (Dalas) and the IOM's Global Forum on Innovation in health Professions Education (Washington DC).
3. As a result of this project a chapter on the value of the ICF in IPEP and community-based education was published in two different WHO publications:
    - World Health Organisation. 2013. *How to use the ICF: A practical manual for using the International Classification of Functioning, Disability and Health (ICF). Exposure draft for comment. October 2013. Chapter 3.* Geneva: World Health Organisation.
    - Talaat, W. & Ladhani, Z. 2014. *Community Based Education in Health Professions: Global Perspectives. Chapter 8.* Cairo: WHO Regional Office for the Eastern Mediterranean
4. The University of KwaZulu-Natal and the Northwest University indicated that they want to join our collaborative with UWC regarding our ICF initiative. Further negotiations were conducted during the first semester of 2014.
5. After a very successful pilot in 2013, Stellenbosch University and the University of the Western Cape will held regular IPE World Café in 2014 involving medicine, physiotherapy, occupational therapy, speech-language and hearing therapy, social work, natural medicine, pharmacy, dental hygiene, dentistry and nursing. Ethical clearance for a more comprehensive study on the application of the ICF in IPEP was obtained. The first round of data was collected and is currently being analysed.
6. Our ICF initiative to use the ICF as a catalyst for IPEP was presented to the WHO and lead to the Functioning and Disability Reference Group of the WHO to develop a mobile application (mICF) for using the ICF as catalyst for interprofessional collaboration and practice. The concept was a poster winner at the WHO's Family of International

Classifications annual meeting and conference in Beijing (October 2013) and we were subsequently ask to present the project to a joint sitting. 193 international collaborators from 38 countries signed up to participate in this project. Stefanus Snyman is the principal investigator.

The relevance of the ICF has been demonstrated in community-based rehabilitation (CBR) and community-oriented primary care (COPC) and interprofessional education and practice (IPEP). However, the pivotal role of data on functioning and context are often overlooked in mobile applications designed to capture patient information.

Currently, no mobile applications incorporate the ICF. It is envisaged that the mICF, in providing a means to collect and transfer ICF-related information, could support continuity of care.

The aim of this project is to develop an ICF mobile application (mICF) to:

- ensure accurate and efficient capture of functional status and contextual information
- convey information securely between service providers in different service settings consistent with ethical and privacy principles in relation to data sharing, e.g. among health professionals
- facilitate clinical decision-making by making person-centred data readily available
- facilitate administration and reporting through data aggregation
- minimise the need for repeat data collection.

The mICF could:

- Provide a means to collect and transfer ICF-related information
- Add value to interprofessional collaborative practice
- Improve continuity of care
- Contribute to more efficient and cost effective health systems

For more information go to: http://tiny.cc/icfmobile.

2.3.1 ICF: THE ROAD AHEAD

An ICF curriculum has been developed and we will continue to present it to preceptors and students. In the same way the mICF collaborative will hopefully be piloted in the Western Cape by 2016.

The next step will be to determine if and how the promotion of the ICF can facilitate improved IPEP and patient-centred care in secondary and tertiary teaching hospitals as well as facilitate improved continuity of care at community level, especially as increasingly health professions students are trained in community-based settings, working closely with nurses and community care workers (Frenk et al., 2010; The Training for Health Equity Network, 2011).

2.4 EDUCATION HEALTH HARMONISATION

The third pillar of the IPEP strategy to harmonise the education-health divide allowing for students to be placed in community-based settings and to develop role models of interprofessional collaboration and practices.

The future of HPE is community-based teaching and learning (Frank et al., 2010; WHO, 2010). This offers the urgent challenge to harmonise the divide between Education (FMHS) and Health (provincial, local and NGOs). A two throng approach is needed to bridge this divide. On the one side there are the political and bureaucratic negotiations at the top and from the top, for example the work that is being done by the FMHS's Deputy Dean: Community Interaction and the Division of Community Interaction's Director: Sustainable Rural Development. On the other hand there is the building of trust relationships on grassroots level with service providers and communities, the fostering of a mutual concern locally to improve patient outcomes, the encouragement to the strengthening of health systems and cultivating and supporting the desire to equip students as agents of change to address the health needs in the 21st century.

Over the past 2 years we made the following progress in an effort to advocate interprofessional collaborative practice to service providers and role models for our students

1. The IPEP facilitators did a marvellous job over the past 30 months to build trust relationships on grassroots level. The development of the ICF initiative in the Cape Winelands and Overberg Districts serves as proof, where we are requested to assist health professionals to acquire the competencies for interprofessional collaboration and practice. 172 health professionals (doctors, psychologists, social workers, dental assistants, physiotherapists, occupational therapists, nurses, speech therapists and dieticians) were trained in using the ICF as approach to IPP in the Cape Winelands District Municipality and the Cape Metro (Cape Town)
2. MEPI invited Dr Snyman to training faculty and nurses at eThekwini (Durban) Municipality and the University of KwaZulu-Natal
3. The Western Cape Provincial Health Department incorporated parts of the ICF as part of its discharge summary in hospitals.
4. The enormous value of the IPEP facilitators are becoming more and more evident as they slowly but surely build trust relationships and render support on grassroots level. For the past 30 months on the rural platform and for the past 18 months in the urban settings, facilitators are slowly but surely "preparing the ground" as "harmonisers". They are but a small cog in the wheel; though an amazingly dedicated interprofessional team of change agents. The challenge is how to harmonise and utilise this "bottom-up" process with similar and other "top-down" initiatives.
5. A full day pre-conference workshop was held at the 5th International Service-learning Symposium exploring how the pedagogy of service-learning (in combination with the IPEP) can facilitate transformative learning in health professions education.

2.4.1 THE ROAD AHEAD 2014-2016: EDUCATION HEALTH HARMONISATION

Our IPEP strategy will not be sustainable if we cannot facilitate a culture change for interprofessional collaborative practice. If students don't see it modelled in the clinical area, it may be regarded as a futile exercise. That is why our biggest focus over the next two years will be to develop preceptors as IPEP role models on our training platforms.

The role out of this initiative will kick off as soon as we've registered our short course and got the support from faculty management and the Department of Health.

3 FOCUS FOR 2014-2016

In June 2013 an IPEP strategic workshop was conducted in the FMHS to evaluate the progress made in the implementation of the IPEP strategy and to propose how to take the implementation of the strategy forward. The outcomes of the workshop is summarised here.

3.1 VISION FOR IPEP

To enable all health professionals to learn from and about each other, working together at all levels of care to achieve optimal health for individuals and communities.

3.2 OBJECTIVES

1. Implement a philosophy of IPEP across all levels of care.
2. Structure curricula to achieve interprofessional practice as an outcome.
3. Capacitate health professionals to act as IPEP role models.
4. Impact positively on individuals and the community.
5. Ensure that all interventions and programs are evidence based.

3.3 THE ROLE OF IPEP FACILITATORS TO IMPLEMENT THE PLAN

3.3.1 THE MAIN ACTIVITIES OF FACILITATORS ARE TO:

- Imbed IPEP in clinical practice by building the capacity of preceptors in interprofessional collaborative practice
- Facilitate students to practice IPEP by using the ICF as framework
- Engage management of facilities (once it has been cleared by the FMHS and the Dept of Health) gaining permission to present a short course in interprofessional collaborative practice. This course involves developing core competencies for interprofessional collaborative practice and includes, i.e. case discussions with students and colleagues; reflective practice; using the ICF; continuity of care.
- Attend IP ward rounds and case discussions

3.3.2 THE OUTPUTS REQUIRED FROM FACILITATORS ARE TO:

- Establish good reciprocal trust relationships with management and clinicians at the various sites
- Use a practical training guide to train service providers, preceptors and students in developing the core competencies for interprofessional collaborative practice
- Foster the integration of IPEP core competencies in learning activities and clinical practice at various sites
- Evaluate the progress made

3.3.3 THE OUTCOMES DESIRED AS A RESULT OF THE FACILITATORS' INVOLVEMENT AT THE VARIOUS SITES ARE:

- Management and health practitioners embracing IPEP as part of the solution to address health needs of individuals and communities;
- Graduates and preceptors competent in interprofessional collaborative practice in order to improve patient outcomes and to strengthen healthcare systems
- Opportunities for interprofessional collaborative practice in the holistic management of patients are utilised or created
- Preceptors complete the short course demonstrating competence
- Interdependence between university and placement sites are strengthened and not strained
- Quality improvement cycle for IPEP at the various sites are practiced

3.3.4 THE FOLLOWING INDICATORS WILL ASSIST US TO EVALUATE OUR PROGRESS

- Student assessment reflecting competency in holistic patient care within an IPEP framework;
- Preceptors demonstrating competence to work interprofessionally
- Health services embracing interprofessional collaborative practice
- Students and preceptors demonstrating the competence in holistic patient-centred care with full support of management
- Clinical training sites apply principles of interprofessional collaborative practice and modify their traditional modus operandi accordingly
- High performance teamwork between facilitators and sites

3.3.5 THE FOLLOWING SOURCES OF EVIDENCE WILL BE USED TO EVALUATE THE PROGRESS MADE IN IPEP

- Assessment of student and preceptor IPEP competence (including attitudes, relationships, etc.)
- Improved patient care and outcomes attributed to IPEP
- Support from management;
- Improved health system as result of IPC and IPP.

3.4 IMPLEMENTATION OF THE PLAN

The implementation of the subsequent plans that were developed at and as a result of the 2013 FMHS IPEP strategic workshop is hanging in the balance due to budget constraints and the training sites that are multiplying.

The main aim of each of the current facilitators is to work themselves out of a job by 2016, when their sites should

We will hopefully be able to secure funding to implement these plans.

4 RECOMMENDATIONS TO THE UNDERGRADUATE EDUCATION COMMITTEE

See separate proposal.

5 REFERENCES

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