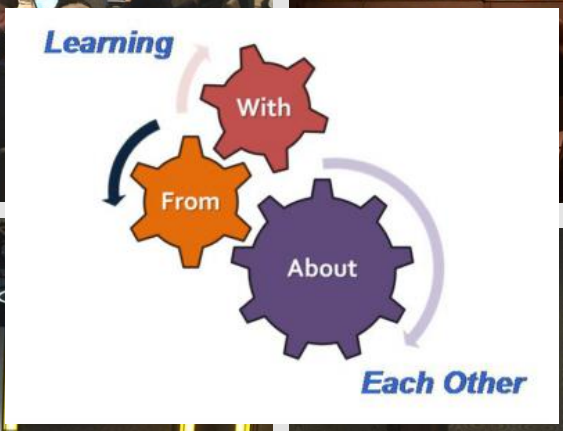
Workshop Report:

Collaborating for Patient Care – Interprofessional Learning for Interprofessional Practice

Tuesday 9 June 2015
Sofitel Melbourne On Collins; 25 Collins Street, Melbourne, Australia



Front cover diagram provided by workshop contributor Dr Lisa Nissen and colleague Dr Monica Moran. The diagram is inspired by the Centre For The Advancement Of Interprofessional Education (CAIPE) definition of interprofessional education, where ‘With’, ‘From’ and ‘About’ gears intermesh in the process of interprofessional learning.

This report has been prepared by the workshop planning group, comprised of the Australian Medical Council, the Council on Chiropractic Education Australia, the Australian Pharmacy Council and the Australian Nursing and Midwifery Accreditation Council.

Contents

Executive Summary

On 9 June 2015, the Australian Medical Council, in collaboration with the Australian Pharmacy Council, the Australian Nursing and Midwifery Accreditation Council, and the Council on Chiropractic Education Australasia, held a workshop with the aim of improving delivery of coordinated interprofessional education between health professions in Australia. The workshop was held with support and input from the Health Professions Accreditation Councils Forum (the Forum).

It brought together representatives of the regulated health professions' national boards and accreditation authorities, as well as representatives of the Australian Health Practitioner Regulation Agency (AHPRA), self-regulating health professions, education providers, government health departments, health service executives, collaborative groups for interprofessional education, and academics working in the field.

The workshop, titled "*Collaborating for Patient Care - Interprofessional Learning for Interprofessional Practice*" opened by looking at the health care changes driving the increasing need for team based care.

With this practical grounding as context, the workshop then stepped through three main parts:

- **PART 1 – *Identifying the Need for Interprofessional Practice and the Patients' Perspective***

  In Part 1, a presentation from the palliative care setting allowed participants to consider the importance of interprofessional practice for patient-centred care and the challenges in bringing together teams from several professions.

- **PART 2 – *Discussion of Interprofessional Education – "More Than Just Timetabling"***

  Following from examination of the skills required for professionals to work as part of an effective interprofessional team, the workshop considered interprofessional education and what is needed in education programs to underpin development of the required skill sets. This included examples of interprofessional programs from education providers, and consideration of interprofessional education models, the capabilities students should develop, as well as methods of evaluation and assessment.

- **PART 3 – *Role of Accreditation***

  The workshop then considered the current approach to accreditation and other possible ways accreditation bodies can support interprofessional education through their processes. This included a presentation by the Forum Chair, and small group deliberations, followed by examination through a panel discussion involving representatives of accreditation bodies, national boards, AHPRA, health services executives and representatives of jurisdictional health departments.

On 10 June 2015 the outcomes of the workshop were taken to a joint meeting of the regulated health professions' accreditation councils, national boards and AHPRA which discussed what the workshop outcomes could mean for accreditation processes. A closed meeting of the Forum then followed, where Members agreed immediate actions to be added to the Forum Work Plan to improve accreditation processes and better enable interprofessional education, while other more complex issues were highlighted for longer term focus.

Introduction and Context

What is interprofessional education and why is it needed?

According to the World Health Organization (WHO), "*Interprofessional education occurs when two or more professions learn about, from and with each other to enable effective collaboration and improve health outcomes*"[1]. While Workshop Facilitator Mr Kim Snowball recognised a number of alternative definitions exist that may be appropriate to different uses, he proposed and the participants accepted the WHO definition for the purposes of this workshop.

There is now sufficient evidence to indicate that interprofessional education enables effective collaborative practice[1], and it is gaining recognition as an important pedagogical approach for preparing students to work within collaborative interprofessional health care teams.

The contemporary health workforce is providing health services in the face of increasingly complex health issues, and health systems and patients alike are experiencing substandard outcomes as a result of fragmented patient care. Interprofessional health professions education for interprofessional collaborative practice is gaining prominence as a means to combat these problems but there is a concern that there is a widening gap between health professions education and current and future practice needs. The WHO *Framework for Action on Interprofessional Education & Collaborative Practice* details growing evidence of the need for effective collaborative team care by health care professionals to optimise outcomes for patients, and summarises the following research findings.

Collaborative practice can improve:

- access to and coordination of health services
- appropriate use of specialist clinical resources
- health outcomes for people with chronic diseases
- patient care and safety.

Collaborative practice can decrease:

- total patient complications
- length of hospital stay
- tension and conflict among caregivers
- staff turnover
- hospital admissions
- clinical error rates
- mortality rates.

In community mental health settings collaborative practice can:

- increase patient and carer satisfaction
- promote greater acceptance of treatment
- reduce duration of treatment
- reduce cost of care
- reduce incidence of suicide

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[1] World Health Organization, (2010) *Framework for action on interprofessional education and collaborative practice*. Geneva: WHO Press. Accessed 5 January 2016 at: http://www.who.int/hrh/resources/framework_action/en/

- increase treatment for psychiatric disorders
- reduce outpatient visits.

Australia's regulatory framework for health professionals

The National Registration and Accreditation Scheme (the National Scheme) came into law in 2010. It was enacted through the states and territories enacting the *Health Practitioner National Law Act 2009* (the National Law).

The National Scheme oversees the accreditation and registration of more than 619,500 health professionals from the 14 regulated health professions[2]. For each profession there is a national board with the main purpose of protecting the public by registering only suitability qualified, safe and competent practitioners.

The 14 professions included in the National Scheme are: Aboriginal and Torres Strait Islander health practice; Chinese medicine; chiropractic; dentistry; medicine; medical radiation practice; nursing and midwifery; occupational therapy; optometry; osteopathy; pharmacy; physiotherapy; podiatry and psychology.

Accreditation processes

Under the National Law, an accreditation authority has been appointed for each regulated health profession. Accreditation functions under the National Law include:

a) developing accreditation standards for approval by a national board; or
b) assessing programs of study, and the education providers that provide the programs of study, to determine whether the programs meet approved accreditation standards; or
c) assessing authorities in other countries who conduct examinations for registration in a health profession, or accredit programs of study relevant to registration in a health profession, to decide whether persons who successfully complete the examinations or programs of study conducted or accredited by the authorities have the knowledge, clinical skills and professional attributes necessary to practise the profession in Australia; or
d) overseeing the assessment of the knowledge, clinical skills and professional attributes of overseas qualified health practitioners who are seeking registration in a health profession under this Law and whose qualifications are not approved qualifications for the health profession; or
e) making recommendations and giving advice to a national board about a matter referred to in paragraph (a), (b), (c) or (d).

The National Law empowers the relevant national board to decide whether the accreditation functions will be carried out by an external accreditation entity, or a committee established by the board (section 43). Profession-specific accreditation committees have been established for three of the regulated health professions, namely Aboriginal and Torres Strait Islander health practice; Chinese medicine; and medical radiation practice.

For all of the other regulated health professions, external accreditation authorities have been assigned to undertake the accreditation function. In 2012, the national boards and the Australian

[2] Australian Health Ministers' Advisory Council, (2015). *Independent Review of the National Registration and Accreditation Scheme for health professionals.* Accessed 5 January 2016 at: http://www.coaghealthcouncil.gov.au/Projects/NRAS/ArtMID/524/ArticleID/68/The-Independent-Review-of-the-National-Registration-and-Accreditation-Scheme-for-health-professionals

Health Practitioner Regulation Agency (AHPRA) reviewed the performance of each of these accreditation authorities against the domains of the *Quality Framework for the Accreditation Function*[3] to inform the decisions on how to continue to implement the accreditation function under the National Law. Following this review process, all of the current profession-specific accreditation authorities were re-assigned responsibility for the accreditation function for their respective profession.

The Forum

The Health Professions Accreditation Councils' Forum ('the Forum') is a coalition of the independent accreditation entities (otherwise referred to as Accreditation Councils). The Forum comprises:

- Australian Dental Council
- Australian Medical Council
- Australian Nursing and Midwifery Accreditation Council
- Australian Pharmacy Council
- Australian Physiotherapy Council
- Australian Psychology Accreditation Council
- Australasian Osteopathic Accreditation Council
- Australian and New Zealand Podiatry Accreditation Council
- Council on Chiropractic Education Australasia
- Optometry Council of Australia and New Zealand
- Occupational Therapy Council (Australia and New Zealand) Ltd

The Forum has been meeting regularly since 2007 to consider matters of common interest, principally matters concerning the accreditation of education and training programs in the health professions.

Why hold a workshop?

Within the regulatory framework underpinning the Australian health system, interprofessional education is seen by many as an area where accreditation bodies have particular legitimacy and leverage to influence change and bring about improvements.

Reflecting this view, in 2012 when each accreditation authority was reassigned to a new term implementing the accreditation function for their profession, in addition to the objectives and guiding principles of the National Law they were also asked to consider:

1. opportunities to increase cross-profession collaboration and innovation and maximise efficiencies
2. opportunities to facilitate and support interprofessional learning
3. opportunities to encourage use of simulated learning environments where appropriate.

These considerations reflect issues identified by the Health Workforce Principal Committee and Health Workforce Australia in their response to the invitation to make submissions during the review of the accreditation arrangements for each profession.

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[3] Forum of Australian Health Professions Councils and Australian Health Practitioner Regulation Agency (2012) *Quality Framework for the Accreditation Function*. Accessed 18 July 2013 at: https://www.ahpra.gov.au/Publications/Accreditation-publications.aspx

At the time of the workshop the accreditation standards of many of the accreditation councils included standards and/or graduate outcome statements relating to interprofessional education. For example:

- The accreditation standards for pharmacy degree programs include the Learning Domain 5; Health care systems and the roles of professionals with an element describing interprofessional communication, teamwork and collaborative decision-making; and
- The accreditation standards for primary medical programs require:
    - As a graduate outcome: "Describe and respect the roles and expertise of other health care professionals, and demonstrate ability to learn and work effectively as a member of an interprofessional team or other professional group.", and
    - As a teaching and learning standard: "The medical program ensures that students work with, and learn from and about other health professionals, including experience working and learning in interprofessional teams."

Through the Forum, the accreditation authorities have discussed jointly their response to the interprofessional education issues. Beyond accreditation authorities amending the standards for their individual profession, it was thought it would be of value to further explore a common understanding of what is meant by interprofessional education, consider models for effective interprofessional education and assessment, and examine how accreditation authorities can enable interprofessional learning that supports interprofessional practice.

A workshop planning group, comprised of the Australian Medical Council, the Australian Pharmacy Council, the Australian Nursing and Midwifery Accreditation Council and the Council on Chiropractic Education Australasia agreed to develop plans for a workshop with input from Forum members and researchers in the interprofessional education field.

It was hoped the workshop would inform new strategies for furthering interprofessional education in Australia and articulate the possible role that accreditation can play in the process of improving the delivery of fit for purpose interprofessional health professional education and the assessment of the quality of that education.

Workshop Proceedings

Workshop scope

With the impetus for this workshop being the growing expectation that appropriate interprofessional education could be better enabled through accreditation processes, it was important to limit the primary focus to issues where accreditation has leverage and closely related matters, but leave more in-depth discussions of definitions and barriers upon which accreditation has no influence to one side.

While the legislated accreditation processes of the regulated health professions was at the centre of workshop discussions, given many health professions that are not regulated under the National Registration and Accreditation Scheme are vital in collaborative team health care centred on patient needs, the self-regulated health professions were included in the workshop.

Outcomes sought

The workshop's intent was to explore a common understanding of what is meant by interprofessional education, present and discuss examples of good interprofessional education and assessment, and examine any implications for accreditation functions, with the aim of improving delivery of coordinated interprofessional education between health professions in Australia.

Outcomes sought from the workshop included to:

- Support health profession collaboration for patient care through raised awareness of interprofessional practice and interprofessional health education in Australia;
- Consider learning outcomes of interprofessional education and what makes for success in interprofessional education;
- Explore how accreditation authorities can support interprofessional education;
- Improve understanding of contributing organisations' roles in delivery, standards setting and regulation of responsible, flexible and innovative health profession education;
- Contribute to improved collaboration on and coordination of interprofessional education through opportunities for networking and sharing good practice;
- Determine measurable goals and propose strategies for national boards, accreditation councils, education providers and health service providers to support interprofessional education (an interprofessional action plan).

Participants

The workshop brought together representatives of:

- Accreditation councils and committees
- National boards
- Australian Health Practitioner Regulation Agency
- Health education providers and Universities Australia
- National Alliance of Self-Regulating Health Professions
- Commonwealth, State and Territory health departments
- Health service executives

- The Interprofessional Curriculum Renewal Consortium, the Australasian Interprofessional Practice and Education Network, and the Australia and New Zealand Association for Health Professional Educators
- Academics working in the field of interprofessional education

The workshop was facilitated by Mr Kim Snowball of Healthfix Consulting.

Background material

A workshop webpage on the AMC website was published with supporting information prior to the workshop. The webpage provided background documents as suggested pre-reading. A list of these documents, (including some internet links), is provided at **Attachment 1**. Two of the background document central to the workshop discussions were also provided to participants in hard copy to refer to if needed during the workshop. These documents were:

- Accreditation Under The Health Practitioner Regulation National Law Act (2011); and
- Collaborating across boundaries - A framework for an integrated interprofessional curriculum (Mar 2015).

Workshop sessions

The workshop program can be found at **Attachment 2**. Biographies for the workshop facilitator and each of the presenters and panel members are at **Attachment 3**.

Following an introductory context setting session, the workshop was broken into three main Parts, which involved presentations and an opportunity for participants to examine the issues further and provide their insight through various forms of discursive activity, as described below.

Opening and context setting

Mr Kim Snowball - Independent Reviewer of NRAS, and Ms Bronwyn Nardi – Health Workforce Principal Committee (HWPC)

The workshop opened with a combined presentation by workshop facilitator Mr Kim Snowball, who described relevant aspects of the recent Independent Review of the NRAS, and Ms Bronwyn Nardi who, as a Member of the Health Workforce Principal Committee, was able to describe how the changing landscape of the health system is increasing the need for team based care.

On the basis of stakeholder feedback received as part of the Independent Review Mr Snowball observed that the Australian health care system might be characterised as operating in silos, and that the professional divisions that currently exist can put patient interests second. He made the point that if health professionals continue to be educated and trained separately from one another, it is an unreasonable expectation that they will operate as an effective team when they graduate.

Mr Snowball and Ms Nardi discussed the nature of health care demand into the future. Considering Australia's aging population and resulting chronic illness burden there will be a heightened need for health professionals to work in teams to meet care expectations. An important message from Mr Snowball and Ms Nardi's discussion of evolving health sector needs was that workforce reform must involve all sectors involved in preparing and supporting future health professionals. Regulators, accreditors, educators, health services executives and government all need to recognise their collective responsibility for progress on the issue of interprofessional education. The slides from Mr Snowball and Ms Nardi's joint presentation are provided at **Attachment 4A**.

Part 1 – Identifying the Need for interprofessional practice and the patients' perspective

To ground the workshop in the realities of complex health care needs, Part 1 opened by looking at an example of interprofessional practice. Dr Peter Sherwen and Dr Di Clifton of St Vincent's Melbourne Palliative Care Services described their experience working in a multiprofession care team and the challenges encountered in bringing together teams from several professions. The team they work in involves doctors, ward nurses, psychiatrists, psychologists, physiotherapists, occupational therapists, pastoral care workers, social workers, research nurses, admissions triage nurses, and occasional attendees such as General Practitioners, music & art therapists and professional students.

Examples were given of individual patients with challenges very specific to their circumstances and their degree of acceptance of their terminal course, who required engagement with professions in accordance with their attitude at different stages of illness. Practical methods for keeping multi-profession teams engaged and informed were described, such as a weekly review of deaths and discharges, where reports are given by any team members about previously discharged patients. Also undertaken is a review of each current inpatient, that is chaired by a doctor but requires input from all disciplines who have involvement with that patient. Other methods used for teaching and learning from each other include:

- bed-side teaching involving medical students, junior doctors, pharmacists, and nurses;
- tutorials – junior doctors, medical students, nurses;
- staff reflection sessions around a theme; and
- interprofessional Grand Rounds, where all involved in the care of patients are welcome.

It was commented that the interprofessional nature of their team work is particularly important for ensuring coordinated patient care and to ensure that consistent messages are given to patients and families regarding the goals of care. It is also vital to use the opportunity to seek opinions, learn from other disciplines and make referrals to other disciplines and build a holistic view of the patient and their family. Dr Sherwen and Dr Clifton's presentation slides are available at **Attachment 4B**.

Plenary discussion

Mr Snowball led consideration of the presentations through a whole workshop discussion of the key principles required for successfully meeting patients' needs with a multiprofession care team, covering:

- the outcome of interprofessional practice and what it means for the patient;
- the patient's expectation of their health professionals;
- the role of the health care team, and understanding and recognising other members of the team;
- important skills for interprofessional practice and the particular challenges in bringing together teams from several professions;
- how well the current system is preparing practitioners for this team work environment, and what would be required in education programs to underpin development of the required skills.

This session provided workshop participants with an understanding of why interprofessional teams are important for delivering good care outcomes centred on the needs of individual patients, and set the scene for the workshop to consider what improvements might be required in education to give professionals the skillsets to underpin this key interprofessional work requirement. From discussions it was apparent there was general acceptance that, out of necessity, professionals need to work in teams to provide the expected level of care to their patients.

Part 2 – Discussion of interprofessional education – "more than just timetabling"

In Part 2 of the workshop there were presentations on evaluation frameworks, competencies and assessment of interprofessional education, followed by examples from institutions already offering interprofessional education as examples of recognised good practice.

Professor Maree O'Keefe, University of Adelaide

Internationally there are a number of sets of core competencies for health professions programs to prepare clinicians for interprofessional collaborative practice. Some go on to recommend learning experiences and educational strategies for achieving the competencies and related objectives.

Professor Maree O'Keefe, University of Adelaide, described her work completed in a National Teaching Fellowship, *Collaborating across boundaries: A framework for an integrated interprofessional curriculum*. This project included analysis of:

- Commonly used interprofessional education models;
- Evaluation of interprofessional learning models;
- Interprofessional learning competencies; and
- Challenges for delivering successful interprofessional education.

Professor O'Keefe has developed a series of interprofessional competencies as an extension to her March 2015 report[4], and these are presented in a final extension report[5]. The competencies were presented to the workshop for consideration, and are as follows.

On completion of their program of study, graduates of any professional entry level health care degree will be able to:

- ❖ *Explain interprofessional practice to patients, clients, families and other professionals*
- ❖ *Describe the areas of practice of other health professions*
- ❖ *Express professional opinions competently, confidently, and respectfully avoiding discipline specific language*
- ❖ *Plan patient/client care goals and priorities with involvement of other health professionals*
- ❖ *Identify opportunities to enhance the care of patients/clients through the involvement of other health professionals*
- ❖ *Recognise and resolve disagreements in relation to patient care that arise from different disciplinary perspectives*
- ❖ *Critically evaluate protocols and practices in relation to interprofessional practice*
- ❖ *Give timely, sensitive, instructive feedback to colleagues from other professions, and respond respectfully to feedback from these colleagues*

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[4] O'Keeffe, M. (2015) *Collaborating across boundaries - A framework for an integrated interprofessional curriculum.* Australian Government Office for Learning and Teaching. Accessed on 11 January 2016 at: https://digital.library.adelaide.edu.au/dspace/bitstream/2440/94298/3/hdl_94298.pdf

[5] O'Keefe, M., Henderson, A., and Chick, R. (2015) *Developing sustainable and embedded interprofessional education: threshold learning outcomes as a potential pathway.* National Teaching Fellowship, The University of Adelaide, Australia. Accessed on 15 January 2016 at: https://digital.library.adelaide.edu.au/dspace/bitstream/2440/94290/3/hdl_94290.pdf

Some of the major points to be garnered from Professor O'Keefe's presentation were that:

- there is a difference between teaching interprofessional competencies and simply teaching other curriculum aspects in an interprofessional setting;
- interprofessional education need not need be elaborate and expensive;
- most institutions are already doing some form of interprofessional education, but may not recognise it;
- there are evaluation frameworks and testable competencies already available to educators and accreditors that may be useful; and
- there needs to be a core set of interprofessional competencies for all health profession program graduates. For example as a member of a team, describe what the team does as opposed to what the individuals' role is. Professor O'Keefe's presentation can be found at **Attachment 4C**.

Professor Jill Thistlethwaite - Health Professions Education Consultant

As a logical next step from the points raised by Professor O'Keefe, Health Professions Education Consultant Professor Jill Thistlethwaite gave a presentation describing assessment of interprofessional learning. This elaborated on the purpose and particular challenges in assessment of interprofessional learning competencies. Professor Thistlethwaite discussed many of the major considerations relevant to educators in designing interprofessional education programs and for accreditors in assessing them, including:

- that in a large percentage of cases students are not currently assessed following interprofessional education activities in their coursework;
- the theory behind the utility of assessment;
- assessment formats and methods available to educators;
- the issue of individual vs team assessment; and
- the practical feasibility considerations that must be managed.

Professor Thistlethwaite's presentation slides can be found at **Attachment 4D**.

Examples of two existing interprofessional education programs followed, with presentations from the health education sector describing:

- program management and evaluation;
- challenges and approaches to overcome them; and
- interaction with accreditation authorities or health services.

Ms Maureen McDonald - Auckland University

Ms Maureen McDonald presented on Auckland University's extensive interprofessional health education program, covering their quality and safety workshop, Māori health intensive week, the ward simulation unit for clinical skills held in final year, and the rural health interprofessional immersion program. She outlined the many interprofessional activities within each of the program components and the particular challenges experienced, such as those related to scheduling and managing a large student body and the difficulties experienced in attracting adequate funding for these sorts of activities as compared to the more conventional course components. Ms McDonald's presentation slides can be viewed at **Attachment 6E**.

Professor Gary Rogers - Griffith University

A further impressive example of an innovative interprofessional education program was presented by Professor Gary Rogers of Griffith University. In his presentation Professor Rogers mentioned common arguments that can impact interprofessional education program design, such as whether it should occur early in the program, before students are acculturated within their own profession and possibly before they have adopted stereotype thinking regarding other professions, or if it should occur later so that students have a sense of their own professional identity and can make more sense of the interprofessional experiences.

Professor Rogers outlined the process followed in the development of Griffith's interprofessional education framework, its aims, the threshold learning outcomes they have devised, and he explained the program's 'three-phase pedagogy' - Phase I: Health professions literacy; Phase II: Simulated interprofessional practice experience; and Phase III: Real patient or client care interprofessional practice experience.

Professor Rogers' presentation also reflected on experience with accreditation assessments. These points, as listed below, were used for guiding further discussion later in the workshop:

- Accreditation requirements are often raised by Program Directors as a perceived barrier to involving their students in interprofessional learning activities – this discourse needs to change
- Transprofessional supervision within interprofessional placements appears to be discouraged by some accreditation bodies – leaves the impression of professional tribalism
- High quality simulation can provide experiential learning opportunities that are superior to traditional clinical placement in some ways and certainly complement it – some bodies need to adjust their placement requirements to recognise this
- Many professions have had standards about IPE for some time but these have been very variably enforced.

Professor Rogers' presentation slides can be viewed at **Attachment 4F**.

Part 3 – Role of Accreditation

Part 3 of the workshop considered the question, "With what we understand to be key requirements of good interprofessional education, how can accreditation processes promote interprofessional education?"

Professor Mike Morgan – Forum Chair

To better inform discussion, Health Professions Accreditation Councils' Forum Chair Professor Mike Morgan gave a brief introduction to explain the structure of the NRAS, the purpose of the Forum, and the role and existing processes of accreditation authorities.

He described how accreditation processes and standards currently approach interprofessional education, as well as the constraints on accreditation bodies, and their willingness to work with others to explore other options. Professor Morgan mentioned the continuing trend towards accreditation standards focussed on outcomes, not just process and inputs, and it was emphasised that accreditation certainly has a role in enabling interprofessional education but cannot in isolation drive improvements.

Professor Morgan raised some questions with regard to the role of accreditation standards, for further consideration in workshop deliberations, including:

- Should there be an accreditation standard for interprofessional education?
    - threshold levels for best practice?
    - what other areas of education should have a specific standard?

- Should the standard be common across accrediting councils?

Professor Morgan's presentation slides are at **Attachment 4G**.

Small group deliberations

Individual table groups were then asked to consider the roles of accreditation authorities, national boards and education providers in enabling good practice, and describe what they see as the three primary roles for each agency to support interprofessional education and practice through accreditation processes.

Opinions were also sought on how interprofessional competencies might be assessed and what accreditation authorities should be expecting and assessing in interprofessional education, using the program examples presented earlier as a basis for discussion.

In addition to these questions it was suggested that participants consider:

- whether they were in favour of accreditation authorities adopting a common definition of interprofessional education, such as that of the WHO;
- whether they were in favour of accreditation authorities adopting common interprofessional education competencies such as those presented by Professor O'Keefe; and
- the specific issues Professor Rogers raised from his experience with accreditation processes and make suggestions for addressing them.

For each table a scribe volunteered to record dot-points in relation to the issues discussed. The themes, action priorities and other issues discussed included:

Broad and general consensus to move towards planned and organised interprofessional practice and interprofessional education

- Tables all recognised interprofessional practice represents a key requirement of contemporary patient care and must become a part of standard practitioner training.

Support for agreed definition, standard and competencies

- Generally very supportive of developing a shared interprofessional education standard and competencies, and in-principle agreement to considering the WHO definition and the competencies presented to the workshop as a starting point for discussion.
- These factors are seen as important for clarity on what is core to interprofessional education and promote consistent expectations and understanding.
- Some participants suggested threshold standard/competencies only, believing anything beyond a 'hurdle' requirement would be impractical.
- There was some discussion of whether instead of an individual standard, an agreed interprofessional education principle could be integrated in all other standards.
- Accreditation standards and processes need buy-in from professions, to address tribalism and accreditation councils need to take the lead in working with professional groups to engage support.
- It was commented that interprofessional competencies are a subset of patient safety and quality guidelines.

Need for regulators to clearly signal their support for interprofessional practice and education

- Implementation should be supported by clear messages of support: from national boards to accreditation authorities, and in turn from accreditation authorities to education providers.
- Reinforce this message within accreditation teams and committees to ensure they reflect this leadership.
- This is necessary to provide permission to innovate.

- Early adopters/champions should be highlighted.

Outcome based standards, where appropriate

- The majority of participants agreed that outcome-focussed accreditation standards allow flexibility in delivery, including for interprofessional education, while others felt in certain instances there is a reasonable rationale for prescribing inputs.
- An outcome focus supports education providers' scope to innovate.
- Where prescriptive accreditation requirements have been developed with the professions and education providers, change will have to be done jointly and with their input and that of the national boards.
- Some differences between professions will continue to be needed.
- One size will not fit all - Complexities in different disciplines and universities' set-up mean delivering interprofessional education is complex but it is possible.
- Since national boards approve accreditation standards and develop registration standards, their input and cooperation is needed to move towards outcome focussed standards.

The health care practice 'test'

- Standards must work in rural and remote setting for them to be appropriate.
- Ensure education focus does not shift too far from the reality of practice and recognise that the scope of interprofessional practice is not limited to the hospital setting.
- Be mindful of the possible forms of cross-profession collaboration– email, phone, letters as well as face to face.

Cross-profession supervision

- Ensure standards allow for cross-profession supervision (and also within the health service) in appropriate circumstances.
- Cross-profession mentoring may also achieve the desired aims.

Continuum from undergraduate to postgraduate and later practice

- Interprofessional education is not effective if it is only a focus during undergraduate study - influencing new graduate practice is very important for delivering a real return.
- Barriers lie in the clinical placement setting and the workplace setting - education models are limited by placements currently available.
- Lifelong interprofessional education – Continuing Professional Development should also be a focus (and could be an issue for national boards where poor communication by and between practitioners lead to notifications).
- Interprofessional education should be included in health service Key Performance Indicators and reported against.
- Interprofessional practice is required to make education meaningful. NRAS encompasses postgraduates and continued learning and development.
- Placements involving another profession was suggested by many, including shadowing and pairing with other professions.
- Suggestion to aim for one placement for each graduate within another professional setting.
- There is a need to encourage close relationships between universities and clinical sites.
- Interaction in the field with other professions requires assessable outcomes.
- For many professions there is currently not a focus on quality through accreditation of postgraduate training. This should increase and include interprofessional education.

Simulation

- Broadly seen as offering increasing promise in new education environments, and was supported by virtually all groups.

Cross-profession assessment processes

- Accreditation teams could include other professions.
- The comment was made that six of the eight competencies presented to the workshop are behavioural rather than clinical and could be readily assessed by other professions.
- Cross profession dialogue is important and the Forum, its Accreditation Managers' Sub-Committee, and the Accreditation Liaison Group are possible vehicles.
- Accreditation authorities should consider accrediting interprofessionally where common university policies apply. We need to identify these areas and trust each other to be the lead reviewer on appropriate aspects of assessments.

Funding models

- Some barriers to interprofessional education and joint processes are built into the NRAS structure and legislature.
- Universities can experience difficulties initiating interprofessional education due to segmented funding structures between faculties.

Overseas trained practitioners

- Assessment of overseas trained practitioners does not currently consider interprofessional competencies. This should be considered jointly with accreditation processes.

Communication

- Establish and maintain a structure to advance interprofessional education issues, keep attendees informed of progress and an open dialogue with higher education.

Panel discussion

Following the small group deliberations and a break for continued informal discussions, a panel discussion to consider the current approach and other possible ways accreditation bodies can support interprofessional education through existing processes was held.

Panel members represented the various bodies relevant to this discussion as follows:

- Accreditation authorities /national boards /Australian Health Practitioner Regulation Agency
  - A/Associate Professor Debra Rowett PSM, President, Australian Pharmacy Council
  - Dr Fiona Joske, Medical Board of Australia
  - Dr Gerard Condon, Dental Board of Australia
  - Mr Martin Fletcher, Chief Executive Officer, Australian Health Practitioner Regulation Agency
- Education
  - Professor Lisa Nissen, Head of the School of Clinical Sciences, Queensland University of Technology
  - Associate Professor Christine Jorm, Associate Dean (Professionalism), Sydney Medical School, the University of Sydney
- Jurisdiction Health Department
  - Ms Bronwyn Nardi, Senior Director, Policy and Clinician Engagement, Queensland Health, and Member of the Health Workforce Principal Committee

- Health Service Executives
    - Mr Matthew Johnson, Director of Clinical Education, Cabrini Hospital

Each panel member was introduced and asked to address a number of questions, before broader discussion and questions from other workshop participants. The questions the panel addressed were:

1. ***From what we have heard today, is there 'enough consensus' for Australia to pursue interprofessional education and training as a basic principle in the design and delivery of health education and training programs?***

- Panel members were in general agreement that there is 'enough consensus' to pursue improved interprofessional education in training programs, with some stating that progressing this issue is a core rather that a discretionary agenda. A number of times it was commented that accreditation standards can be a leaver for positive change in this area.
- There was however debate as to where efforts should be best directed:
    - While some of the panel commented on the importance of early interprofessional education at university, others felt that resources would be better directed at influencing new graduate practice in the workplace, rather than primarily at the student experience.
    - It was commented that where interprofessional education exists at university level this often fails to be reflected in clinical placements and workplace settings, as there are insufficient placements that have appropriate models for delivering the desired education. Some of the panel felt universities are educating well but this learning was not being cemented in placements, which is where contextualising and role modelling occur. As such, it was suggested that accreditation authorities focus more on the clinical settings and postgraduate space.
    - Most agreed interprofessional education should be looked at as career continuum issue, from undergraduate, postgraduate and throughout clinical practice as part of continuing professional development.
- It was commented that grappling with these sorts of challenging cross-profession issues is central to the business of the NRAS, which provides a national platform for dialogue to take the workforce agenda forward. The Forum and ALG were seen as successful examples of cross profession dialogue.

2. ***What needs to change to support and promote interprofessional education and interprofessional practice? Members to consider this from the perspective of:***
    - ***Universities***
    - ***Boards***
    - ***Accreditation authorities***
    - ***Health service***
    - ***Professions***

- With reference to the discussion about whether interprofessional education is adequately reflected in graduate experience, the panel made some suggestions for changes including:
    - Providing greater flexibility to allow for cross-profession supervision in appropriate circumstances, requiring the cooperation of accreditation authorities, national boards, education providers and health services; and
    - Where possible, new graduates should be ensured at least one placement within another professional setting. For instance, physiotherapists could spend a week on wards 'shadowing' a nurse.

        - Where a shortage of appropriate clinical placements is seen as a barrier, one panel member suggested offering students international clinical placements to gain greater practical experience working in teams.
- An increase in the use of simulation was suggested by the panel as a mechanism that shows promise for enhancing interprofessional education and suggested it should be enabled through accreditation, beginning with identifying any standards that unnecessarily present barriers to its use and addressing these.
- The panel was supportive of continuing the move towards outcome focused accreditation standards so as to support for flexibility in education delivery.
- In terms of implementing change the point was made that the issues to consider should include capability (it is one thing to have a standard, but another thing to implement it), scalability (whether this can be taken to the scale required with the existing resource constraints) and transferability (taking this learning into health systems).
- Affording education providers permission to innovate through clear and consistent messaging and decision making by regulators was seen as important.

At this point, Professor Rogers was also asked for his views. He agreed that education providers are hesitant to attempt innovation if they are uncertain about how accreditation authorities will respond as universities risk losing existing accreditation if their programs change. He also mentioned difficulties and reluctance to attempt changing programs following past inflexible accreditation processes for some professions.

3. ***Would it be appropriate for accreditation authorities to support a single interprofessional education definition, for instance that of the WHO?; and***
4. ***Discuss what interprofessional skills graduates should have and whether there is agreement with adopting common competencies such as the eight presented and used at this workshop.***

- Panel members consistently indicated in principle agreement with adoption of the eight competencies and a common definition, with the primary question being how they are implemented and assessed to ensure they are achievable and manageable for educators.
- It was commented that all of the interprofessional competencies are a subset of the patient safety and quality guidelines which should already be applied.
- With regard to the adoption of competencies, any new standards and the other suggestions for change, the panel provided the overarching caution that any new process must also be able to work in a rural and remote setting.

Workshop Outcomes

Over 100 senior participants from the higher education sector, health services, State and national governments, national boards and accreditation authorities attended the workshop.

The contributions of workshop participants provided a good sense of interprofessional education and reflected a significant degree of consensus that interprofessional practice is a core expectation of patient-centered care.

It was apparent that in the contemporary Australian health care system, interprofessional education may need to be considered in a more organised and planned way than it has been previously. Workshop discussions identified some key opportunities also and barriers for the wider application of interprofessional education in the health and education sectors, noting that not all of these are the responsibilities of accreditation authorities or within the reach of their influence.

The key outcomes from the workshop and the tasks that may logically lead from these as follows:

Key workshop outcomes

1. The workshop acknowledged that health care delivery had historically operated in very strong professional and service silos and this was reflected in health professional education.
2. The participants acknowledged the central role of effective interprofessional practice in improved patient treatment and care in almost all contemporary health service delivery settings.
3. It is this collaborative feature of many existing and emerging models of clinical practice that is driving the need to educate and train future health professionals to work more collaboratively across professions at the earliest stage, in the interest of better patient safety and care.
4. There was broad and general consensus supporting a move towards a more planned and organised approach to interprofessional education as a basic principle underpinning the design and delivery of health professional education and training programs in Australia.
5. There was support for the World Health Organization definition of interprofessional education as a starting point.
6. The eight competencies presented by Professor Maree O'Keefe, Associate Dean, Learning and Teaching, Faculty of Health Sciences, University of Adelaide to reflect the content of interprofessional education were supported, while assessment of the competencies would require some further work.
7. There was a view expressed at the workshop for a closer relationship to be developed between the education and health sectors in both undergraduate and postgraduate programs. In particular the importance of communicating interprofessional practice into the design and delivery of education programs so students were better equipped to perform in an interprofessional practice environment.

The workshop had considered barriers to the future development of interprofessional education and what actions might need to be taken by the various agencies involved. Clearly, universities, national boards, accreditation authorities, health departments and the professions all have a role to play. The following action points describe those more immediate and those medium term actions that would assist the continued development of interprofessional education in Australia.

Key suggested actions for regulators

1. To support innovation and opportunities for interprofessional education, there was strong support for the focus on learning outcomes announced at the workshop by the accreditation authorities, and for a move away from detailed process and input standards, such as prescriptive contact hours and time in specific modes of education delivery, and in particular restrictions on simulated learning. .
2. There was a strong view that a clear and unambiguous signal by the national boards and accreditation authorities of support for interprofessional education would be of major benefit. It would indicate permission and support for innovation, while maintaining an accreditation standard for interprofessional education.
3. Some specific actions proposed included providing the regulatory means for cross professional supervision in appropriate circumstances and ensuring that early adopters and champions were recognised.
4. Investigate suggestions for a one week shadowing for students across all professions.
5. Examine whether national boards' continual professional development requirements might be used as a useful mechanism to drive interprofessional practice and education.
6. Investigate opportunities for cross-profession accreditation and/or for one accreditation authority to recognise the quality assurance and accreditation activities of other accreditation authorities.

In addition to these specific actions and issues it was apparent from the workshop that significant gaps in understanding of the respective roles and responsibilities of those represented existed.

All parties saw benefit in closer dialogue, particularly between the accreditation authorities and the higher education sector, in order to understand and address the barriers and opportunities to better organise and plan the delivery of interprofessional education in Australia.

The participants in the workshop were seen as a useful means of communicating developments and actions associated with interprofessional education.

Next steps

Regulators consideration of workshop outcomes

The key outcomes from the workshop were discussed the following day at a joint meeting attended by representatives of the national boards, accreditation authorities and AHPRA, and then immediately afterwards at a meeting only involving Forum Members. These meetings considered those matters that were within the brief and purview of the NRAS.

The Facilitator for the workshop, Mr Kim Snowball, reported to the joint meeting on the key outcomes and suggested actions to arise from the workshop.

The representatives at these meetings on 10 June concurred that participants involved in the workshop were positively focused and it was suggested they should continue to be utilised as this work progresses, after the outcomes have been circulated and a finalised workshop report conveyed to the group. It was also suggested the accreditation authorities, national boards and education providers should maintain continued dialogue so that all groups understand the issues and pressures within their respective processes for better collaboration and solutions.

Overall the workshop discussions were seen as very positive and it was thought there would be some clear, quick deliverables possible, and other issues within a broader agenda for continued focus which could form the basis of an ongoing work plan.

In relation to the issues identified in the workshop, AHPRA highlighted the three primary areas of its focus for moving forward, being:

- Supporting a cross professional approach within AHPRA itself, and specifically in the advice to boards in relation to cross-profession supervision;
- Demonstrate increased support for simulation as a viable teaching and learning tool; and
- Ensure the 'permission to innovate' message is clear, which can be achieved in a number of ways including through board processes, accreditation processes and AHPRA may be able to offer support.

To inform discussions regarding how best to take the workshop outcomes forward, the joint meeting first reflected on examples where an interprofessional education agenda has been done successfully, as well as other instances where it has not delivered to the extent it potentially could. One illustration looked at in detail was health professionals prescribing, for which a case example was given to examine the issues further.

Prescribing example

Bronwyn Clark, CEO of the Australian Pharmacy Council and Professor Lisa Nissen, Queensland University of Technology, described their experience with the Health Professionals Prescribing Pathway (HPPP), which is a Health Workforce Australia (HWA) initiative that seeks to deliver a national approach to prescribing by health professionals other than doctors. As part of this initiative, Professor Nissen has worked in an environment that encompasses interdisciplinary education and training, under an extended, expanded practice, whereby health professionals undertake a joint training program with a prescribing trainer. Many benefits have been observed through the joint training, including those completing it having developed a better understanding of various 'lenses' used by different professions to examine, interact and manage their patients.

Professor Lisa Nissen explained that this work on prescribing has moved ahead independent of the supporting structures of the NRAS. It was driven by Queensland Health which wanted training to match specific workforce needs, and provided a special legislative pathway for this purpose and scholarships to train professionals. More broadly frameworks such as this do not exist. She suggested that accreditation requirements should be looking to have common competencies to

match training with desired scope of practice for the workforce. This is difficult without national structures and agreed standards: It is hard for non-medical prescribers to know what appropriate training is, and also to know what prescribing could actually be currently occurring under existing training. In many cases professionals' full existing scope of practice is not being used.

Professor Nissen suggested there existed a barrier in that each profession felt they were unique and needed different training in prescribing, where as to her reckoning, to be a safe prescriber in a practical sense their training requirements are fundamentally the same. While they are worded differently, all of the competencies to be a safe prescriber are the same regardless of the profession, and it would be helpful to recognise this and work it through with the national boards and accreditation authorities.

Detailed consideration of the issues raised in the workshop

The joint meeting considered whether the bodies present could develop a structure to continue working interprofessionally to meaningfully advance the interprofessional education agenda, noting that this currently occurs to some extent within the accreditation councils.

As a starting point, those in the joint meeting discussed the issues identified in the workshop for reform, including detailed discussions of the complexities that need to be addressed. An overview of discussions in relation to the issues is provided below.

Outcomes-based standards

Taking a lead from the barriers identified in the prescribing example and the workshop message that moving to outcomes-based standards would better enable interprofessional education, the meeting discussed whether and the extent to which this is desirable from an accreditation authority standpoint, and if so, what changes were necessary and how such a transition might be achieved.

- It was recognised that most accreditation authorities had or were already moving in this direction.
- Some constraints that will continue to make the removal of some prescriptive requirements inappropriate or difficult were noted, for example where prescription is included to raise the standard.
    - The example was given of some professions' need to meet global professional standards or registration requirements, some of which include prescriptive standards.
    - Wide ranging stakeholder consultation is required on changes to standards. Whilst most authorities are already moving in this direction, it is necessary to recognise some stakeholders are pushing back and there must be an education processes to work changes through.
- The use of explanatory notes and evidence guides was discussed as a possible means of supporting a transition to outcome focused standards.
    - The accreditation authorities that use high-level outcome-based standards, but where appropriate, have accompanying explanatory notes or evidence guide that indicate possible models, give education providers room to innovate in meetings standards and delivering outcomes, but with guidance of equivalent methods of delivery that have been considered acceptable previously.
    - It was suggested this ensures recognition of generally accepted modes of delivery and also allows specification of externally driven requirements, such as those of global professional bodies.
- There was also discussion of analysing instances where outcome focused standards do not currently exist to see where changes might be possible. It was thought that stakeholders' complaints about prescriptive standards being barriers to innovation need to be specific, so that accreditation authorities and processes are not more broadly implicated, and so that such issues can be the subject of targeted consultation and review.

Prescribed hours of clinical placements in accreditation standards

There was discussion around whether prescribed hours are in themselves a major problem, or whether tight stipulation of what sort of supervision or activities can take place in the hours is what is constraining innovation and restricting interprofessional activities.

- Some felt there would always be a minimum number of hours of clinical experience required to demonstrate competency.
- It was commented that outcomes versus hours is not a black and white issue, and nor should it be seen as a question of having just one or the other.
- The opposing viewpoint was that effective outcome-based accreditation standards and processes would guard against unacceptably minimal hours where the standard was not met. The proponents of this view point thought that not stipulating hours would merely allow for flexibility in the evidence base presented to prove the outcome has been met, which one would expect would always include experience attained through clinical hours.

Cross-profession supervision, shadowing and simulation

Participants at the joint meeting recognised the workshop's support of innovative methods of interprofessional learning such as shared simulation activities, and cross-profession supervision and shadowing. They recognised where used appropriately, each of these offer significant opportunities for valuable experience, particularly in resource stretched environments.

It was, however, noted that the term 'supervise' may have different meanings for different professions and contexts, so the intent of such activities will require elaboration to avoid being contentious. The appropriateness of any form of supervision will depend on the type of placement and outcome sought.

Interprofessional education definition and competencies

There was in principle agreement to adopting one definition, and to the WHO definition of interprofessional education, and for the eight competencies presented by Professor Maree O'Keefe, Associate Dean, Learning and Teaching, Faculty of Health Sciences, University of Adelaide. Pending referral to each of the accreditation authorities, those present felt the definition and competencies could be adopted across the professions.

Process for taking workshop outcomes forward

The meeting discussed the option of adopting a common approach to develop and also possibly consult on new accreditation arrangements to enable interprofessional education, possibly through the Forum and the ALG. While the ALG is not a decision making group, meaning it would need to be an opt-in agreement to adopt common interprofessional education elements, it was felt that the ALG could bring about effective collaboration. The ALG Chair, Dr Joanna Flynn AM, agreed that it would be appropriate for the ALG to be involved with the Forum in taking this work forward.

There was discussion about the difficulties in changing standards in the National Scheme, given the need for consultation, and the need for national Boards to approve standards for their profession. Many felt it might be overly complicated and ambitious to undertake development and consultation within a single process. There was broad agreement that it would instead be easier for each council and board to undertake their own process, but following a common work plan coordinated through the Forum and ALG.

Meeting participants broadly recognised that interprofessional education and interprofessional practice are happening, and they will be implemented regardless of whether national structures and processes keep pace and evolve to reflect this reality. It will be necessary to adopt a collective view on interprofessional education and reflect it within each profession's processes, including individually by looking at barriers within the standards. Participants affirmed the need to remain

focused on protection of the public. Multi-morbidity is increasing the need for interprofessional practice and demands students and clinicians to have these higher capabilities.

Report of the workshop and meeting, and work-plan for implementation

Meeting participants agreed to Mr Snowball's suggestion that he reflect the day's discussions in the report of the workshop, including providing recognition of some of the realities constraining immediate delivery of the workshop outcomes. Based on this, the report can then elevate those aspects where progress is to be delivered more immediately within the current scheme and structures, and those for longer-term focus.

The meeting agreed to Professor Mike Morgan's suggestion that this work be taken back to the Forum to identify issues that it thinks should be taken forward in this area, which would then need ALG support as part of medium-term work plan to be developed and implemented by the Forum and ALG.

It was suggested that the work-plan includes a piece of work to undertake a systematic analysis of where accreditation may be a barrier to interprofessional education and how this might be changed.

Another suggestion was that a case study on prescribing be included in the work-plan. The Australian Pharmacy Council offered to take a lead on this case-study work, if this is something the group decides to progress as part of the work plan.

Resourcing ongoing cross-profession work on interprofessional education

Meeting participants considered that if implementation of an ongoing work plan on interprofessional education is to be progressed there needs to be a more considered, structured process for resourcing and undertaking joint work.

The meeting discussed the process for obtaining funding for cross profession collaboration in the National Scheme, when each board is funded by registration fees from a specific profession. It was thought there might be scope to fund implementation of a joint work plan on interprofessional education through discretionary funding available to encourage innovation, so it was agreed a proposal would be prepared for the national boards' consideration.

Forum Work Plan

Following the meeting with the national boards, accreditation committees and AHPRA, Forum Members held a short meeting to continue discussions of accreditation-specific issues. Actions that can be implemented immediately to take forward workshop outcomes were determined and added to the Forum's existing work plan. Other issues that require further exploration and attention were also highlighted for ongoing work. As this was a closed meeting, only the agreed actions are summarised in this report, as listed below.

1. Communique

Members congratulated the Forum working group on the previous day's workshop, *Collaborating for Patient care- Interprofessional Learning for Interprofessional Practice,* as a successful event. A communique will be drafted and circulated.

2. Interprofessional education competencies

Members discussed the outcomes of Professor Maree O'Keefe's, Associate Dean, Learning and Teaching in the Faculty of Health Sciences at the University of Adelaide, work undertaken in a National Teaching Fellowship – *Developing Sustainable, Embedded Interprofessional Learning*.

Members agreed to present the eight competencies to each of their perspective Councils with the view of adopting them as an explanatory note, or a reference document. Once feedback from Councils is received it was suggested that a position statement of endorsement in relation to the document be drafted to go on the Forum website.

Members suggested that a short document adding evidence to support achievement of the eight competencies", could be written to assist in evaluating the competencies.

3. Position statements

Develop a series of Forum position statements on important areas of policy consensus. These position statements will reference the relevant literature, supporting evidence and significant developmental events. Position statements will be made available on the Forum website and circulated to relevant stakeholders.

A position statement on interprofessional education will be used as a means of developing a process for signing off on subsequent statements on other issues. Sub-groups will be tasked with developing draft statements which will subsequently be reviewed, amended if necessary, and signed off by the Forum.

The meeting proposed a number of position statements be developed. Those of relevance to interprofessional education are as follows:

- **Interprofessional education**
    - This position statement was developed and agreed by the Forum on 30 November 2015. It can be found at **Attachment 5** and is also available on the Forum's website at the following link: http://www.healthprofessionscouncils.org.au/files/ced02785690f608cfb04da6528cc2849caae7129_original.pdf
- **Simulation**
- **Outcome-focused standards**

4. Funding proposal

A proposal will be prepared for AHPRA and the national boards for funding to undertake collaborative cross-profession work on interprofessional education.

5. Sharing of good practice

Councils agreed it would be worthwhile to flag good examples of interprofessional education from their accreditation reports and share these with the Forum at future meetings, as appropriate, but the difficulty of deciding what is good practice was noted.

Attachments

Attachment 1 - List of background documents circulated to participants

- The Interprofessional Curriculum Renewal Consortium, (2013). *Curriculum Renewal for Interprofessional Education in Health*. Centre for Research in Learning and Change, University of Technology, Sydney, Australia
- The Canadian Interprofessional Health Collaborative, (2010). *A National Interprofessional Competency Framework*. College of Health Disciplines, University of British Columbia, Vancouver, Canada.
- Nicol, P. (2013). *Interprofessional education for health professionals in Western Australia*. Centre for Research in Learning and Change, Faculty of Arts and Social Sciences, University of Technology, Sydney
- Interprofessional Education Collaborative Expert Panel, (2011). *Core competencies for interprofessional collaborative practice: Report of an expert panel.* Washington, D.C.: Interprofessional Education Collaborative.
- Lee, A., Steketee, C., Rogers, G., Moran, M. (2013). *Towards a theoretical framework for curriculum development in health professional education.* Focus on Health Professional Education: A Multi-Disciplinary Journal: Vol 14, No. 3.
- O'Keeffe, M., (2015) M. *Collaborating across boundaries - A framework for an integrated interprofessional curriculum*. National Teaching Fellowship, The University of Adelaide, Australia. Accessed on 11 January 2016 at: https://digital.library.adelaide.edu.au/dspace/bitstream/2440/94298/3/hdl_94298.pdf
- J.E, Thistlethwaite., Forman, D., Matthews, L.R., Rogers, G.D., Steketee, C., and Yassine, T. (2014). *Competencies and Frameworks in Interprofessional Education: A Comparative Analysis.* Academic Medicine: Vol. 89, No. 6.
- Thistlethwaite, J. (2012). *Interprofessional education: A review of context, learning and the research agenda*. Medical Education: Vol. 46, Pg. 58–70.
- World Health Organization, (2010). Framework for action on interprofessional education and collaborative practice. Geneva: WHO Press. Accessed 5 January 2016 at: http://www.who.int/hrh/resources/framework_action/en/
- Forum of Australian Health Professions Councils and Australian Health Practitioner Regulation Agency, (2012). *Accreditation under the Health Practitioner Regulation National Law Act (the National Law).* Accessed 5 January 2016 at: http://www.ahpra.gov.au/Legislation-and-Publications/AHPRA-Publications.aspx#accreditation.

Attachment 2 - Workshop program

WORKSHOP OVERVIEW	
PART 1 – *Identifying the Need for interprofessional practice and the patients' perspective*	
• Workshop facilitator Mr Kim Snowball welcomes participants, outlines the aims of this workshop, and together with Ms Bronwyn Nardi, Queensland Member of the Health Workforce Principal Committee, discusses the health care changes driving team based care.	**9.30–10.00**
• Examples of interprofessional practice in a palliative care team - Dr Peter Sherwen and Dr Di Clifton of St Vincent's Melbourne Palliative Care Services ○ Setting standards for patient-centered interprofessional practice ○ Meeting patients' needs with a multiprofession care team ○ Challenges in bringing together teams from several professions.	**10.00–10.30**
• Workshop facilitator Mr Kim Snowball leads workshop discussion of key principles required for successful interprofessional practice and optimal patient care ○ Role of the health care team, and understanding and recognising other members of the team ○ Important skills for interprofessional practice ○ How well we are preparing practitioners for this environment, and what would be required in education programs to underpin development of these skills.	**10.30–11.00**
Morning Tea Break	**11.00–11.30**
PART 2 – *Discussion of Interprofessional Education – "more than just timetabling"*	
• Workshop facilitator Mr Kim Snowball introduces Part 2	**11.30-11.55**
• Professor Maree O'Keefe, University of Adelaide, describes work completed in an National Teaching Fellowship, *Collaborating across boundaries: A framework for an integrated interprofessional curriculum*, including: ○ Commonly used interprofessional education models ○ Evaluation of interprofessional learning models ○ Interprofessional learning competencies ○ Challenges for delivering successful interprofessional education.	
• Professor Jill Thistlethwaite, Health Professions Education Consultant, describes assessment of interprofessional learning and competencies	**11.55-12.05** **12.05-12.45**
• Presentations from education providers, Ms Maureen McDonald, University of Auckland, and Professor Gary D Rogers, Griffith University, provide examples of existing interprofessional education programs, including: ○ Program management and evaluation ○ Challenges and approaches to overcoming them ○ Reporting to accreditation authorities and feedback from accreditation authorities or health services.	**12.45-13.00**
• Questions for session presenters and Professor O'Keefe to wrap-up the session.	
Lunch Break (13:00 – 13.45)	**13:00-13.45**

PART 3 – *Role of Accreditation*	
• Workshop facilitator Mr Kim Snowball introduces Part 3. This will lead into discussion of the question, "With what we understand to be key requirements of good interprofessional education, how can accreditation processes promote interprofessional education?"	**13.45-13.50**
• Health Professions Accreditation Councils' Forum Chair Professor Mike Morgan discusses what accreditation bodies do and how accreditation processes and standards approach interprofessional education. • Individual tables to deliberate on the role accreditation authorities, national boards, and education providers in enabling of good practice through accreditation standards and accreditation processes. o What should accreditation authorities be expecting and assessing in interprofessional education? o Consider the examples presented earlier and how interprofessional competencies might be assessed.	**13.50-14.20** **14.20-15.10**
Afternoon Tea Break	**15.10-15.30**
• Panel discussion to consider the current approach and other possible ways accreditation bodies can support interprofessional education through existing processes, followed by whole workshop discussion. Panel to include: o Accreditation authorities / national boards /Australian Health Practitioner Regulation Agency ▪ A/Associate Professor Debra Rowett PSM, President, Australian Pharmacy Council ▪ Dr Fiona Joske, Medical Board of Australia ▪ Dr Gerard Condon, Dental Board of Australia ▪ Mr Martin Fletcher, Chief Executive Officer, Australian Health Practitioner Regulation Agency o Education ▪ Professor Lisa Nissen, Head of the School of Clinical Sciences, Queensland University of Technology ▪ Associate Professor Christine Jorm, Associate Dean (Professionalism), Sydney Medical School, the University of Sydney o Jurisdiction Health Department ▪ Ms Bronwyn Nardi, Senior Director, Policy and Clinician Engagement, Queensland Health, and Member of the Health Workforce Principal Committee o Health Service Executives ▪ Mr Matthew Johnson, Director of Clinical Education, Cabrini Hospital	**15.30-16.40**
• Workshop facilitator Mr Kim Snowball to wrap up the day's outcomes	**16.40-17.00**

Attachment 3 – Workshop Biographies

Facilitator

Mr Kim Snowball, Director, Healthfix Consulting

Since his retirement as Director General of Health in Western Australia in 2013, Mr Snowball has joined with his wife, Dr Felicity Jefferies, to form a new consulting company, Healthfix Consulting. Through this vehicle Mr Snowball conducted an independent review of the National Registration and Accreditation Scheme for health professionals for the Australian Health Ministers. The review commenced in April 2014 and involved widespread consultation nationally, over 230 written submissions and a consultation paper released in September, 2014. A final report was submitted to Health Ministers through the Australian Health Ministers Advisory Council in April 2015. A response to the Report from the Health Ministers is expected in August 2015.

Other projects conducted by Healthfix Consulting have included an independent report on medical workforce needs in Western Australia and on a proposal by Curtin University for a new medical school.

In broader national roles, Mr Snowball was appointed Chair of the Australian Health Ministers' Advisory Council (AHMAC) a body providing advice and support to Health Ministers and the Australian Health Workforce Ministerial Council (AHWMC). This included a key focus on the implementation of the National Law in relation to the regulation and registration of Australian health professionals and governance and support in respect to the key national agencies involved. Mr Snowball was also a member of the National E-Health Transition Authority.

Under his leadership in Western Australia a package of reforms were implemented including:

- Introduction of Activity Based Funding of hospitals and health services.
- Full implementation of the four hour rule program across the states hospitals, with independent research showing the program saved up to 267 lives annually through reduced overcrowding in WA Tertiary hospitals (a program that was subsequently adopted nationally).
- Introduction of public/private partnerships both infrastructure and service delivery to drive efficiency into the public health system. This involved private contracts for the delivery of public services at Joondalup and Midland and the state's largest private contract with Serco to deliver non clinical services at Fiona Stanley Hospital.
- Introduction of planning forums in partnership with the Aboriginal Community Controlled Sector and doubling of the level of employment of Aboriginal people within the public health system.
- Redesigned the States approach to investment in health and medical research. During his leadership of the hospital system, Western Australia went from amongst the poorest performers in Elective Surgery waiting times and emergency department access block to the best performed hospitals in Australia in Emergency Department waiting times and the second best nationally in elective surgery wait times in just three years. Mortality rates in the state's major hospitals fell and a major focus was placed on safety and quality reform.

Presenters

Dr Di Clifton, Psychiatrist, Psycho-oncologist, Coordinator of Education, Psychosocial Cancer Care, St Vincent's Health Melbourne

Dr Dianne Clifton is a psychiatrist who has worked in psycho-oncology and palliative care for the past 20 years; both in private practice and the public hospital system. She has also previously

been Director of Emergency Psychiatric Services, providing services for acutely psychiatrically unwell patients in the hospital and community.

Dr Clifton was appointed as an Honorary Clinical Senior Lecturer in the Department of Psychiatry and Department of Medicine at The University of Melbourne. When working as a senior consultant psychiatrist and Medical Director of Psychosocial Cancer Care at St Vincent's Hospital and Caritas Christi, Dr Clifton also saw the development of statewide education and training of staff from different disciplines in the delivery of psychosocial cancer care, clinical service delivery to St Vincent's Hospital, and staff support programmes.

Dr Clifton is currently working in psychosocial cancer care and as Coordinator of Education at St Vincent's, Melbourne. In her private practice Dr Clifton sees patients with cancer and their families through all stages of their illness and treatment experience.

Ms Maureen McDonald, Professional Teaching Fellow, School of Pharmacy, Faculty of Medical and Health Sciences, University of Auckland

Ms Maureen McDonald is a practicing pharmacist. She has been registered for 32yrs and has worked mostly in community pharmacy. Maureen is also a Professional Teaching Fellow at the University of Auckland in the Pharmacy Practice Team. Maureen recently completed a Post-Graduate Diploma in Clinical Education.

Professor Mike Morgan, President, Australian Dental Council, Chair, Health Professions Accreditation Councils' Forum

Professor Mike Morgan has been involved in dental education and research both in Australia and internationally. He is currently the Head of the Melbourne Dental School at The University of Melbourne and holds the Chair of Population Oral Health in the Faculty of Medicine, Dentistry and Health Sciences. Mike is the President of the Australian Dental Council Governing Board, Chairs the Health Professions Accreditation Councils' Forum and is a board member of VicHealth.

Mike's principal teaching responsibility is in population oral health, focusing on oral disease causation in relation to common risk factors and disease prevention at a population level - with an emphasis on community water fluoridation. He has research interests in oral health economics and clinical trials of preventive agents.

Ms Bronwyn Nardi, Queensland representative, Health Workforce Principal Committee

Ms Bronwyn Nardi has worked in a range of senior roles in health. Currently she is the Senior Director, Policy and Clinician Engagement in the Queensland Department of health. This is a portfolio covering Strategic Policy, Health Legislation, Clinical Workforce Policy, and Clinical Leadership. Bronwyn is Queensland's representative on the Health Workforce Principal Committee and the Practitioner Regulation Subcommittee; Community Care and Population Heath Principal Committee and the Greater Northern Australia Regional Training Network. She is a Board Member of the Community and Health Services Industry Skills Council.

Bronwyn is a Registered Nurse and Midwife. In addition, she holds a Master of Business Administration and is a Graduate of the Australian Institute of Company Directors.

Professor Maree O'Keefe, Associate Dean, Learning and Teaching, Faculty of Health Sciences, University of Adelaide

Professor Maree O'Keefe is the Associate Dean, Learning and Teaching in the Faculty of Health Sciences at the University of Adelaide. She is a qualified paediatric medical specialist and holds a PhD in medical education. She is currently the deputy chair of the University Academic Board. In addition to her academic roles, through her work with the Office of Learning and Teaching and the

Australian Learning and Teaching Council, she has provided national leadership in health professional education.

Maree has over 20 years' experience of teaching and curriculum innovation. She has won a number of institutional and national grants and awards, and held appointments to national committees and councils. Her research interests include interdisciplinary collaboration, interprofessional learning and developing quality experiential learning environments. She continues her clinical practice as a paediatrician.

Professor Gary D. Rogers, Professor of Medical Education and Deputy Head of School (Learning & Teaching), Griffith University School of Medicine

Professor Gary D. Rogers is currently Professor of Medical Education and Deputy Head of School (Learning & Teaching) at the Griffith University School of Medicine, in addition to a role as Program Lead in Interprofessional and Simulation-Based Learning for the Griffith Health Institute for the Development of Education and Scholarship (Health IDEAS) and clinical work as an HIV physician at Gold Coast University Hospital. He is Immediate Past President of the Australian and New Zealand Association for Health Professional Educators and chairs the Association's Fellowship Committee, as well as serving on the Executive Committee of AMEE, the International Association for Medical Education. In 2012 he was joint winner of the Griffith University Award for Excellence in Teaching in Health.

Gary was a member of the leadership team for the major national Curriculum Renewal for Interprofessional Education in Health project, jointly funded by the Office of Learning and Teaching, Health Workforce Australia and the Government of WA. He is currently a Chief Investigator for an Office of Learning and Teaching Extension Grant relating to the project.

Dr Peter Sherwen, Palliative Care Doctor, Caritas Christi Hospice and Epworth Hospital

Dr Peter Sherwen is a Palliative Care doctor working at Caritas Christi Hospice, Eastern Palliative Care (community service), and at Epworth Hospital.

Professor Jill Thistlethwaite, Health professions education consultant

Professor Jill Thistlethwaite is an Adjunct Professor in Medical and Health Professional Education at the University of Technology Sydney (UTS). Since qualifying as a general practitioner in the U.K, she has been involved in health professional education with a strong focus on interprofessional education (IPE) and collaborative practice for health professionals.

Jill has been a partner on several Australian Learning and Teaching Council/ Office of Learning and Teaching grant focusing on IPE, most recently in relation to the work-based assessment of interprofessional teamwork. She was a Fulbright senior scholar in 2014 and spent four months at the National Center for Interprofessional Practice and Education in Minneapolis during which time she was invited to speak on the evidence for IPE by the Institute of Medicine in Washington DC. Jill has written and co-edited several books about IPE and collaborative practice, as well as numerous papers, and was part of a study group with the World Health Organization on IPE in 2009-2010.

Panel Members

Dr Gerard Condon, Practitioner Member, Dental Board of Australia

Dr Gerard Condon is a Member of the Dental Board of Australia and a part-time Clinical Demonstrator, Melbourne Dental School, Examiner Australian Dental Council, Melbourne Dental School, LaTrobe University, Former Private Practitioner, Former President, Dental Practice Board of Victoria, Former President, Australian Dental Council, Former President, Australian Dental

Association, Victorian Branch, Former Chair, Infection Control Committee, Australian Dental Association (Inc).

Mr Martin Fletcher, Chief Executive Officer, Australian Health Practitioner Regulation Agency

Mr Martin Fletcher started with AHPRA in December 2009 as the inaugural chief executive officer and has 15 years' experience in patient safety in Australia, the United Kingdom and internationally. Before joining AHPRA, Martin was chief executive of the National Patient Safety Agency, the leading National Health Service body for patient safety in England and Wales. From 2004 to 2007 Martin worked with the World Health Organization in Geneva to establish a global program of work on patient safety. From 2000 to 2002, he worked with the Australian Council for Safety and Quality in Health Care to establish the first national program of work on patient safety in Australia.

Martin holds a Master of Management degree in public sector management, an Honours degree in behavioural sciences and an undergraduate degree in social studies.

Associate Professor Christine Jorm, Associate Professor – Special Projects (DVC Education Portfolio), Associate Dean (Professionalism), Sydney Medical School, University of Sydney

Associate Professor Christine Jorm is Associate Dean Professionalism at Sydney Medical School. Christine practiced as an anesthetist for more than 15 years before her interest in quality assurance led to full time work in patient safety and quality. A/Prof Jorm has doctorates in neuropharmacology and sociology. Her PhD resulted in a book ‘Reconstructing Medical Practice - Engagement, Professionalism and Critical Relationships in Health Care’ which examines why doctors have limited ability to admit to error or engage with the system. She was recruited as a foundation staff member to the Australian Commission on Safety and Quality in Health Care in 2006 and was responsible for providing specialist safety and quality advice on all aspects of the Commission's work - with special responsibility for Open Disclosure and Clinical Handover - until moving to Sydney University in January 2010. She remains passionate about finding ways to enable the doctors of the future to better engage with and influence the health care system.

She has broad interests, with publications and/or on-going research in such areas as: medical culture, organisational culture, safety and quality, clinical handover, root cause analysis, open disclosure, narrative in education, health information literacy, use of smart phones in health care, peer assessment, professionalism, rules and regulation, simulation meaningful measurement of health care quality and use of health care data to improve care, infection control practice and interprofessional education and practice (and is currently working on a major project in this area for Sydney University).

Mr Matthew Johnson, Director of Clinical Education, Cabrini Health

Mr Matthew Johnson has been an Intensive Care Paramedic for Ambulance Victoria since 1998. In 2009 he left his full-time clinical role to coordinate units on clinical communication and cardiac care for first year undergraduate nursing and paramedic students at Monash University. In 2010 Matt was appointed the Coordinator of Post Graduate Studies for the School of Primary Health Care at Monash and was responsible for the education of Intensive Care Paramedics, Flight Paramedics and Retrieval physicians. He is the editor of the textbook "Clinical Reasoning in Emergency Health Care" and in November 2013 was appointed as Simulation Manager at Cabrini Health in Melbourne. In August 2014 he took on the role of Director of Clinical Education at Cabrini.

Dr Fiona Joske, Practitioner Member, Medical Board of Australia

Dr Fiona Joske is a general practitioner and a principal in a rural group practice in Longford, Tasmania, where she has worked since 1999. Her previous practice was at Smithton in North West

Tasmania. The current practice is a teaching practice which hosts medical students, nursing students, GP registrars, and international medical graduates.

Fiona was appointed to the Medical Board of Australia in August 2009 and was a member of the Medical Council of Tasmania from 2000. She is now also a member of the Tasmanian Board of the Medical Board of Australia.

Fiona is an examiner for the Royal Australian College of General Practitioners and for the University of Tasmania School of Medicine. Her past positions include member of the Medical School Accreditation Committee of the Australian Medical Council, Chair of General Practice Workforce Tasmania, Medical Advisor to Rural Workforce Support Tasmania, Chair of the Tasmania Faculty of the Royal Australian College of General Practitioners, a National Coordinator of the RACGP Exams, GP Consultant to the Health Insurance Commission and Council Member of the University of Tasmania.

Professor Lisa Nissen, Professor and Head, School of Clinical Sciences at Queensland University of Technology

Professor Lisa Nissen is an experienced pharmacy practitioner, researcher and educator. She has worked in both hospital and community pharmacy in metropolitan and rural areas. Her focus is on improving the Quality Use of Medicines in the wider community, across the health care continuum, with a focus on professional service development for pharmacists and the factors which influence prescribing of medicines.

Lisa is a strong believer in the benefits of multidisciplinary health care teams in the care of patients in the community. Lisa brings this passion for multidisciplinary care into the classroom with a commitment to the development and implementation of innovative multiprofessional education. She is a co-founder and director of the Healthfusion Team Challenge, an exciting and dynamic competition designed to educate tomorrow's health care professionals in collaborative client care.

Lisa represents the pharmacy profession and provides advice to local, national and international groups on the role of pharmacists in health care and the quality use of medicines. This includes work with organisations such as the Commonwealth Department of Health and Aging, the International Pharmacy Federation, and the World Health Organisation. She also actively contributes to the Pharmacy profession in many ways including presenting lectures at continuing education events and writing regular articles for Australian Pharmacist.

A/Associate Professor Debra Rowett PSM, President, Australian Pharmacy Council

A/Associate Professor Debra Rowett is President of the Australian Pharmacy Council and also the Chair of the Accreditation Committee of the Australian Pharmacy Council. Her particular areas of current practice are in research, training and service delivery in primary care. Debra has a particular interest in aged care, palliative care, pharmacoepidemiology and pharmacovigilance. She also has strong interest in health policy and workforce development. She is the Director, Drug and Therapeutics Information Service at the Repatriation General Hospital, South Australia.

Attachment 4 - Presentation Slides

A - Mr Snowball and Ms Nardi

Collaborating for Patient Care – Interprofessional Learning for Interprofessional Practice

The purpose of today's workshop is to consider Inter-professional Learning and Inter-professional Practice in the Australian Health Care systems.

We will be going through three main steps to consider this issue –

Part 1: Identifying the need for inter-professional practice and the patients' perspective

Part 2: Discussion of inter-professional education – more than just timetabling.

Part 3: The role of accreditation

During the course of the day there will be several opportunities to get your input and discussion.

Collaborating for Patient Care – Interprofessional Learning for Interprofessional Practice

The three stages will culminate at the end of the day, with two key questions –

1. From what you have heard today is there enough consensus and support for Australia to pursue inter-professional education and training as a basic principle in the design and delivery of health professional education and training programs?
2. What needs to change to support and promote inter-professional education and inter-professional Practice in Australia?
   - Universities
   - Boards
   - Professions
   - Health Departments
   - Accreditation Authorities

Collaborating for Patient Care – Interprofessional Learning for Interprofessional Practice

Some observations from the Independent Review of NRAS –

- Australian Health Care system is best characterised as a system that operates in silos
- Professional divisions can put patient interests second.
- If we educate and train our health professionals separately from one another, how do we expect them to operate as a team when they graduate.
- Workforce reform must involve all sectors involved in preparing and supporting our future health professionals.
- All graduates must be ready to work in patient centred and collaborative health professional teams. Otherwise we are short changing good patient treatment and care.
- No-one can change the current system except you.

Collaborating for Patient Care – Interprofessional Learning for Interprofessional Practice

Some observations from a State Health Department and the Health Workforce Principal Committee –

- What is driving the need for inter-professional practice and in turn inter-professional education?
- What is the nature of health demand into the future and why is it so critical for health professionals to work in teams to meet these health demands?
- What does HWPC and government expect of those involved in education of our future health workforce?

B - Dr Sherwen and Dr Clifton

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Interprofessional care in practice

St Vincent's Palliative Care Services
St Vincent's Hospitals & Caritas Christi, Melbourne

StV CENTRE for PALLIATIVE CARE

Part of St Vincent's Hospital and a Collaborative Centre of The University of Melbourne

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Clinical Services
- Inpatient Palliative Care Services – CCH Kew 28 beds, CCH Fitzroy 8 beds. Both have full interprofessional team

Consultation Services
- Inpatients across 2 public and 2 private hospitals
- Outpatient clinics - 2 specialist palliative care clinics, 3 non-malignant clinics, 1 psych-oncology clinic and daily day oncology
- Attend 8 out of 11 tumour stream multidisciplinary meetings

Regional/Rural outreach
- Hume region, Victoria – specialist medical outreach
- Senior consultant clinics in Wangaratta and Shepparton monthly + telehealth In hours for and after hours triage
- After hours community palliative care triage service – 4 health regions, 1/3 Victoria
- Decision Assist 24 hour palliative care call centre
- Psychosocial secondary consultation/supervision by videoconference to Barwon Health, face to face with Eastern Palliative Care, Eastern Health

Academic Centre – Centre for Palliative Care
- Integration with St V clinical services – research, tools and projects, education
- State wide education and training, research
- State wide coordination of palliative care medical and NP training
- University of Melbourne post graduate courses

Interprofessional Care Team Meeting for Inpatient Services

- Doctors
- Ward Nurses
- Psychiatrist
- Psychologist
- Physiotherapist
- Occupational therapist
- Pastoral Care worker
- Social Worker
- Research Nurse
- Admissions triage nurse

Occasional Attendees: -
- GPs, Medical, Music & Art therapists and other professional students

Format

- Review of deaths and discharges for previous week – usually 7-10 out of 28 patients
- Report by any team members about any previously discharged patients
- Individual review of each current inpatient
- Chaired by doctor – with input from all disciplines who have involvement with that patient

Focus

- Some background is given for each patient but focus is on dealing with current medical and psychosocial issues
- A lot of work is done on establishing the goals of care and aligning them with those of the patient and family

Goals
- End of Life Care
- Symptom Management
- Discharge Planning
- Restorative/Respite Care

Benefits 1 - General

- Coordinated patient care – consistent message given to patient, families *re* the goals of care
- Opportunity to seek opinions and learn from other disciplines and make referrals to other disciplines
- Building a holistic view of the patient and family
- Opportunity to set meeting times, discharge dates *etc*.
- Debriefing/ Sharing the burden
- Adjunct for daily clinical handover – all team members can attend
- Occasion for family meeting planning
- Mentoring for professional students *eg* medical, nursing, occupational therapy, physiotherapy, social work

Benefits 2 – Education (informal)

- Informal knowledge exchange between professions at meetings leads to understanding about how others operate and think, contributes to each professional's knowledge, to the benefit of patient care.
- *Examples*
  - commencing preferred drugs used by psychiatry team if psych review not immediately available
  - learning not to set discharge date before OT review
  - making sense of emotional responses and behaviours on the ward after learning of the patient's history of trauma, loss and other earlier experience
  - learning of specific family dynamics which may be problematic
  - modifying interactions and expectations according to the degree and pattern of cognitive deficits

Benefits 3 – Education (structured)

Methods used include

- Bed-side teaching – medical students, junior doctors, pharmacist, nurses
- Tutorials – junior doctors, medical students, nurses
- Staff reflection sessions around a theme
- Grand Rounds – interprofessional, all welcome

Benefits 4 - Education (structured)

Generally the formal teaching is *received* by one professional group but may be *given* by one of their own or by a member of another group.

eg medical students receive teaching from medical, allied health and psychosocial professionals

It is less common for a range of professional groups to receive education at the one session. Grand rounds and university short courses and certificates would be an exception to this pattern. Generally sessions to a broad group of professions would be on a topic of interest to all – perhaps a topical ethical issue

Useful adjuncts

1. Handover sheet – updated daily and used by all groups. Includes demographic data, diagnosis, phase of care, mental state, goal of care and physical performance status. Clinicians hand-write on the sheets additional information of relevance to them conveyed in the handover
2. Morning handover meeting– attended by most disciplines Monday to Friday
3. PCOC – updated at each MDT and reviewed to determine trends in progress

Downside/Risks

- Not all patients want to be seen by all professional groups
- It is important that decisions are made by professionals who have actually seen and assessed the patient and not by people who attend the meetings and make judgments based on what is documented and discussed

eg the 'withdrawn' patient may be depressed, experiencing a hypoactive delirium or dying

the 'abusive' patient may be delirious, in pain, highly anxious about dying or being dependent and helpless

Final Comment

Palliative Care is less formula-driven than many other areas of medicine. Input from a range of appropriately trained health professionals as well as patients and families is therefore very helpful for decision making. Good interprofessional team work is also very important for goal setting and conveying a consistent message to patients and their carers.

In palliative care, we consciously work at creating a culture of professionals working collaboratively and learning from each other to nurture best clinical practice. We value and practise good communication skills and involvement of patients and carers in treatment planning.

Case Discussion – 'Sonia'

'Sonia' - 1

- Late 30's, married, 2 children under school age
- Diagnosed 15/12 ago with metastatic leiomyosarcoma (pelvis, lung, liver) 3/7 after delivery of her 2nd child
- 4 years of symptoms attributed to her pregnancies
- Chemotherapy ⟹ partial response
- 8/12 ago ⟹ progression

Staff involved

- Senior and junior palliative care doctors
- Nurses
- Pastoral care worker*
- Psychiatrist
- Psychologist
- Physiotherapist
- Occupational therapist
- Massage therapist
- Art therapist
- Music therapist

'Sonia' - 2

- 6/12 ago radioRx → liver, pelvis
- 2/12 ago chemo → failed to respond
- referral to psychiatrist – anxiety
- rapid functional decline → admission to CCH 4/52 ago
- Symptom Mx
  - pain (liver capsule, hip, leg)
  - anxiety
  - lymphoedema

'Sonia' - 4

- Re-admitted after 6/7
  - ↑ confusion
  - falls
  - anxiety
  - hiccoughs
  - pain
  - nausea
  - unable to be safely cared for at home

'Sonia' - 5

- Issues during admission
  - Wanting optimal alertness *vs* adequate management of pain, anxiety and hiccoughs
  - Wanting to retain control, make decisions *re* each medication – yet cognitively only intermittently lucid
  - Difficult to have the 'dying' conversation
    - no legacy work possible
    - impact on instituting comfort measures
  - Died on day 4

'Sonia' - 3

- Issues during 2/52 admission
  - ↑ cognitive decline
  - death anxiety/death denial
  - loathing of body
  - feeling detached from children
  - missing Hb – caring for young children
  - some difficulty engaging with staff
  - wanting to return home but terrified
- Discharged

Issues for staff

- Young patient, young children
- High degree of anxiety and denial
- Degree of loathing of her body
- Underlying anger and mistrust
- Detachment from her children
- Difficulty in providing adequate symptom relief because of her need to feel in control

→ staff reflection session

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- Sonia's past history of emotional neglect, criticism and bullying over her body made her especially sensitive to body image problems with her cancer
- Not being listened to and the disastrous consequences of a missed diagnosis influenced the way she related to staff
- Sonia's terminal care did not 'follow the book' because of the respect paid to her wish to be in control of the process.

C - Professor O'Keefe

Collaborating for Patient Care

Developing sustainable, embedded interprofessional learning

Melbourne 9 June 2015

Maree O'Keefe

Australian Government Office for Learning and Teaching (OLT)/ALTC

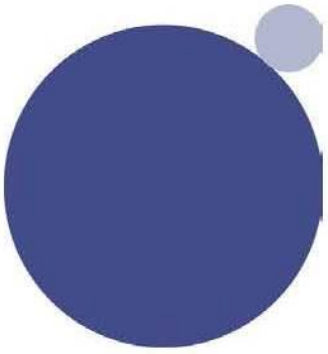
Has provide key support through:

- Learning and Teaching Academic Standards project 2010
- Harmonising project 2011
- Collaborating across boundaries (National Teaching Fellowship) 2013

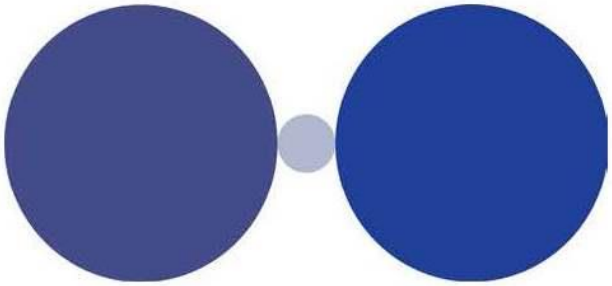
IPL Why is it so hard?

- It is ill defined
  - What exactly do we want students to learn?
- Ongoing tension regarding delivery
  - Structured classroom or authentic experiential
- Leadership hot potato (who leads)
  - Who is leading/addressing challenges
- Unrealistic expectations
- Allow opt-outs

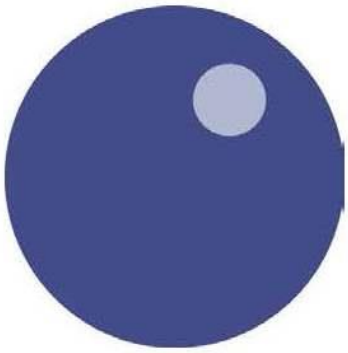
Uni-disciplinary IPL activities



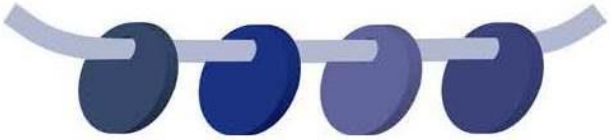
Multidisciplinary IPL activities



Embedded uni-disciplinary IPL

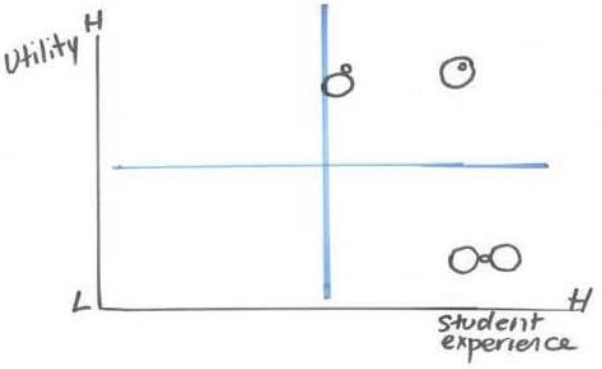


Embedded and connected IPL



Evaluation Framework

Institutional workshop example



IPL: are we talking competencies or teaching approaches?

6 national and international IPL frameworks

165 IPL competencies

Authoring body	State-ments
National Interprofessional Competency Framework (CIHC) Canada	39
Core Competencies for Interprofessional Collaborative Practice (IPEC) USA	38
Interprofessional Capability Framework (Combined Universities Interprofessional Learning Unit, Sheffield) UK	44
An Implementation Framework for Interprofessional Learning at Griffith University, Australia	10
Curtin University Interprofessional Capability Framework, Australia.	24
IPE and Collaborative Practice Curriculum Framework, University of Western Australia	12

Authoring body	State-ments
CanMEDS Framework (Royal College of Physicians and Surgeons of Canada)	126
HWA National Common Health Capability Resource: shared activities and behaviours in the Australian health workforce	120

IPL Competencies by TLOs (not including CanMeds or HWA competencies*)

1. Professionalism	45
2. Clinical practice	8
3. Promoting health	5
4. Evidence based	6
5. Collaboration	83
6. Life long learning	18

* Not specifically IPL

IPL competencies

On completion of their program of study, graduates of any professional entry level healthcare degree will be able to:

- Explain interprofessional practice to patients, clients, families and other professionals
- Describe the areas of practice of other health professions
- Express professional opinions competently, confidently, and respectfully avoiding discipline specific language
- Plan patient/client care goals and priorities with involvement of other health professionals
- Identify opportunities to enhance the care of patients/clients through the involvement of other health professionals
- Recognise and resolve disagreements in relation to patient care that arise from different disciplinary perspectives
- Critically evaluate protocols and practices in relation to interprofessional practice
- Give timely, sensitive, instructive feedback to colleagues from other professions, and respond respectfully to feedback from these colleagues

Questions

- Pick a competency and decide how could be taught/learned.
  - Which of the models could be effective?
  - How could it be assessed?
  - What evidence could be provided to professional accreditation bodies?
- Which IPL competencies are currently being taught/learned and assessed?

Threshold Learning Outcomes (Health)

Upon completion of their program of study, health graduates at professional entry level* will be able to:

- Demonstrate professional behaviours
- Assess individual and population health status and, where necessary, formulate and implement management plans in consultation with patients/clients/carers/animal owners
- Promote and optimise the health and welfare of patients/clients and populations
- Retrieve, critically evaluate, and apply evidence in the performance of health care activities
- **Deliver safe and effective collaborative health care**
- Reflect on current skills, knowledge and attitudes, and plan ongoing personal and professional development activities

(*as defined by individual disciplines)

TLO 1 Demonstrate professional behaviours

Size

TLO 2 Assess individual and population health status and, where necessary, formulate and implement management plans in consultation with patients/clients/carers/animal owners

Size

TLO 3 Promote and optimise the health and welfare of patients/clients and populations

s the words centre around)

TLO 4 Retrieve, critically evaluate, and apply evidence in the performance of health care activities

s the words centre around)

TLO 5 Deliver safe and effective collaborative health care

Number of words: 100 / 100 (100%)

where the words centre around)

TLO 6 Reflect on current skills, knowledge and attitudes, and plan ongoing personal and professional development activities

lumber of words: 100 / 100 (100%)

e words centre around)

(1 : 0.33)

D - Professor Thistlethwaite

IPE WORKSHOP 9 JUNE 2015: ASSESSMENT

- Professor Jill Thistlethwaite

The purpose of assessment

Why do we assess?

REASONS…

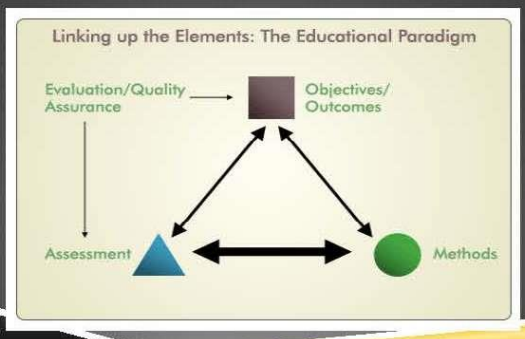
- To ensure learners are fit to practise (collaboratively/interprofessionally)
- And are safe
- The public expect it
- To give feedback (formative)
- To drive learning (assessment for learning)
- To improve standards
- To make sure students learn/know/are competent – with respect to what we have taught them (assessment of learning)
- (To rank students/award prizes)

ASSESSMENT: PROJECT FINDINGS

Q21. Is the IPE Activity assessed (i.e. learner/ student performance)?

4

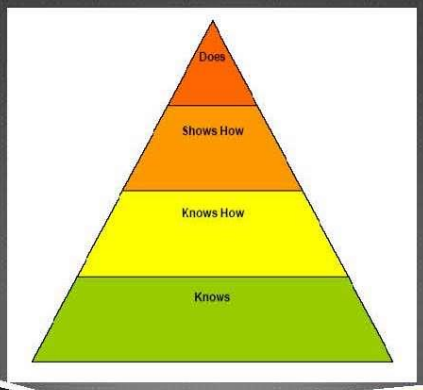
From the London Deanery: Curriculum alignment



THE UTILITY OF ASSESSMENT

- Utility = educational impact x reliability x validity x cost effectiveness x acceptability x feasibility

Van der Vleuten, 1990



Miller's pyramid

Miller G. The assessment of clinical skills/competence/performance. Academic Medicine 1990;65:S63-S67

COMPETENCE V PERFORMANCE

- **Competence:** The ability to do the job. Assessed in end-point examinations usually under examination conditions.
- **Performance:** The ability to do the job well. Assessed 'on the job' in clinical practice. Relates continuing quality improvement.

ASSESSMENT – OF DEFINED LEARNING OUTCOMES

- Teamwork (collaborative practice) Complex competence – shows how, does
- Knowledge of roles and responsibilities Knows
- Communication Skill - Shows how, does
- Respect Attitude/behaviour, does

OBSERVABLE BEHAVIOURS

- Treats other professionals with respect (chiropracters)
- Demonstrate by listening, sharing and responding, the ability to communicate clearly, sensitively and effectively with patients, their families/carers, doctors and other health professionals (medicine – observable but very broad)
- Demonstrates effective communication with midwives, health care providers and other professionals (midwifery)

BROAD OUTCOMES

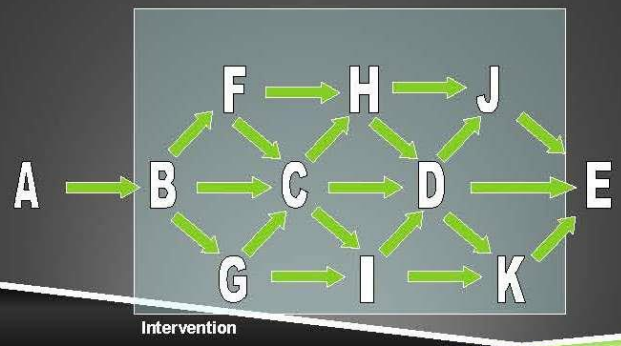
- Contributes to team of health care practitioners in delivering care in a cooperative, collaborative and integrative manner (dentistry)
- Collaborates with the health care team to inform policy and guideline development (nursing)

ASSESSMENT FORMATS

- Knows…MCQ (multiple choice) and written tests
- Knows how…written tests asking for more than knowledge recall - reasoning
- Shows how…OSCE (objective structured clinical examination), team OSCE, team project
- Does…WBA, observation, multisource feedback (multiple professions)

ASSESSMENT OF TEAMWORK SKILLS?

DIVERSITY OF EXPERIENCE



INDIVIDUAL VERSUS TEAM ASSESSMENT

- Driven by professional accreditation or university regulations
- Usually of the individual within a team rather than the team itself
- Who assesses? Can one profession assess another?

ASSESSMENT METHODS

- Team project: assessment of content and process; include peer and self assessment? Align with learning outcomes?
- Clinical interaction: authentic? Over what time frame? Who assesses?
- Simulation of clinical team based activity: eg diabetes clinic; CPR (but newly formed team)

Work-Based Assessment

For assessing the 'does' of Miller's pyramid – ie performance on the job

Wide range of sources of data and evidence

Good validity but often poor reliability and feasibility

Requires teamwork in action…but for students often new teams

TEAMWORK INSTRUMENTS

- More formative than summative?
- For individual 'interprofessional' behaviour
- Who assesses and how often?
- Remediation?

IP PORTFOLIO, PASSPORT…

- Students provide evidence of meeting outcomes
- Menu of activities with different 'credits'…

STANDARD SETTING

- If summative need to consider the 'pass mark' and whether pass/fail or grades.
- All professions involved must have same stakes in the assessment

COMPETENCE

- Competence v not competent v incompetent
- What should we expect at each level of training?

FEASIBILITY

- Large numbers of students
- Different schools and time tables
- Currently no consensus on learning outcomes
- Observation required
- Define behaviours
- Who assesses?
- How often?
- What does 'competence' look like?

E - Ms McDonald

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FACULTY OF MEDICAL AND HEALTH SCIENCES

Inter-professional Learning

Maureen McDonald

RegPharmNZ, PGDip Clin Ed
Professional Teaching Fellow

School of Pharmacy
Faculty of Medical and Health Sciences
The University of Auckland

THE UNIVERSITY OF AUCKLAND
FACULTY OF MEDICAL AND HEALTH SCIENCES

IPE at the University of Auckland

THE UNIVERSITY OF AUCKLAND
FACULTY OF MEDICAL AND HEALTH SCIENCES

N= 2225

MMI

1 Years 3 4 6

Common year

B Nurs (100)

B Pharm (100)
B Optom (45)

MB ChB (298)

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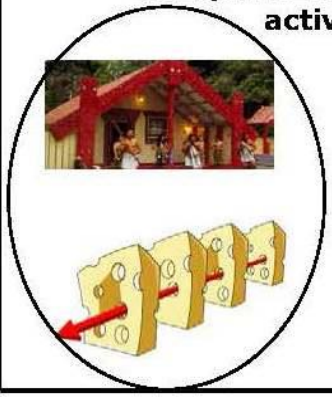
FACULTY OF MEDICAL AND HEALTH SCIENCES

Interprofessional learning activities



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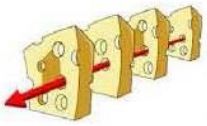
Interprofessional learning activities

All students at Year 2



All students except Optom at Year 3 level

All students at Final Year

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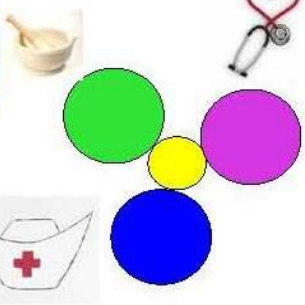
Māori Health Intensive Week



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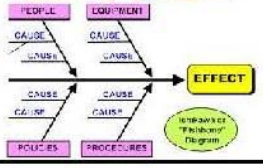
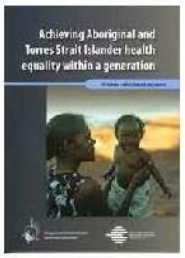
Outcomes





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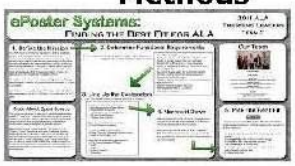
Methods




THE UNIVERSITY OF AUCKLAND
FACULTY OF MEDICAL AND HEALTH SCIENCES
Challenges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Quality and Safety Workshop


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FACULTY OF MEDICAL AND HEALTH SCIENCES
Outcomes
Speak Up for Patient Safety
See it
Say it
Fix it
CONFIDENTIAL


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FACULTY OF MEDICAL AND HEALTH SCIENCES
Methods


THE UNIVERSITY OF AUCKLAND
FACULTY OF MEDICAL AND HEALTH SCIENCES
Challenges
Staff Training


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All students at final year
All students at final year

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Challenges

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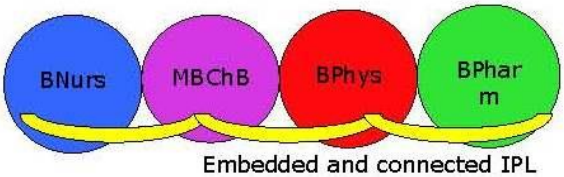
Rural Health Interprofessional Immersion programme



Embedded and connected IPL

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Outcomes

- Understand roles and capabilities of each other
- Contributions of each to patient safety
- Communication strategies between groups
- Importance of patient confidentiality
- Overcome different ideologies

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Methods

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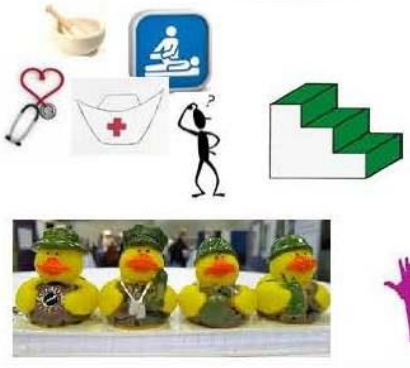
Challenges



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Conclusions

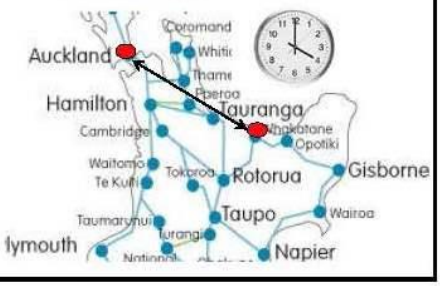
In the Loop

Newsletter of the Pharmacy Curriculum Group
February 2014

Acknowledgements

- Organisers of all four IPL courses
- All of the staff involved in IPL courses
- UoA students – Medicine, Pharmacy, Nursing and Optometry

Methods



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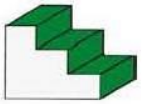

Conclusions

In the Loop

Newsletter of the Pharmacy Curriculum Group

February 2014

F - Professor Rogers

Health IDEAS
Griffith Health Institute for the Development of Education and Scholarship

Programmatic interprofessional education: The Griffith three-phase pedagogy

Gary D. Rogers
Professor of Medical Education and Deputy Head of School (Learning & Teaching), School of Medicine
Program Lead for Interprofessional and Simulation-Based Learning,
Health Institute for the Development of Education and Scholarship (Health IDEAS)

Griffith University, Queensland, Australia

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Griffith University Health Group

- >9000 health students across 8 schools and 5 campuses
  - Medicine
  - Nursing
  - Dentistry
  - Dental technology
  - Environmental health
  - Exercise physiology
  - Health services management
  - Medical laboratory science
  - Midwifery
  - Nutrition and dietetics
  - Occupational therapy
  - Pharmacy
  - Physiotherapy
  - Psychology
  - Public health
  - Rehabilitation counselling
  - Speech pathology
  - Social work
  - Paramedicine (from 2016)

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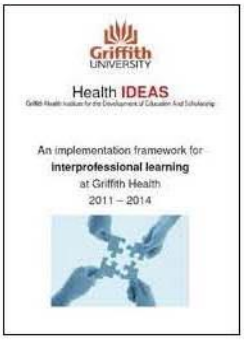
Griffith Health IPL Framework



- Devised in 2010/11 through an interprofessional collaborative process
- Aims to have all health professional graduates from Griffith University competent for interprofessional collaborative practice
- 10 threshold learning outcomes that all health professional graduates need to meet
- 3-phase pedagogy …

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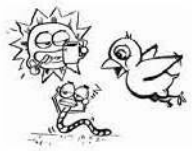
Timing of IPE activities

- Two opposing arguments:
  - **Should occur early in the program, before students are acculturated to tribal perspectives and stereotypes of other professions from within their profession**[1]
  - **Should occur later, so that students have a sense of their own professional identity and so can make more sense of the IPE encounter**[2]



1. Horder J. The Centre for the Advancement of Interprofessional Education. *Education for Health* 9(3):397-400, 1996.
2. Pirrie A, et al. Multiprofessionalism or multidisciplinarity? Part 2 – promoting collegiate practice in health care. *Medical Teacher* 20(5):413-416, 1998

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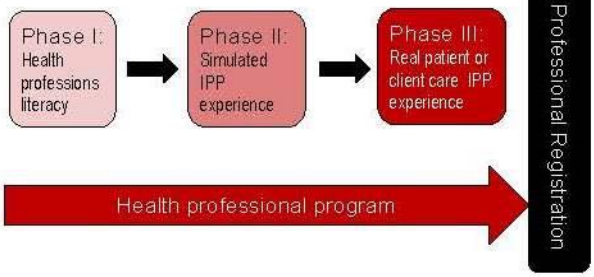
3-phase pedagogy



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CAIPE definition of IPE

Interprofessional Education occurs when two or more professions learn with, from and about each other to improve collaboration and the quality of care

- Critical that stand-alone IPE activities meet this definition to be effective, but …
- Within a **program** aimed at achieving IPL outcomes does **every** activity need to meet the definition?
- Can the effectiveness of (difficult and expensive) 'CAIPE-compliant' activities be enhanced by other activities earlier or later in the program?

3. Centre for the Advancement of Interprofessional Education, 2002

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Phase I

- Aimed at students gaining foundational 'health professions literacy'
  - = *an understanding of the history, theoretical underpinnings, philosophy, roles and contributions of the major health professions, including participants' own*
- Need not be learnt interprofessionally – though ideally would be
- Can be learnt through video/online presentations, augmented by large or small group interactive discussion

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Learning for health professions literacy

- *It takes a team* – phase I activity with video-based online learning package
- Narrative story about a man with many health risk factors who has a car accident and starts to encounter health professionals for the first time
- Interview with each practitioner about their profession
- High production values to engage Gen Y learners
- Assessed through pre- and post- scenario-based MCQs
- Prospective study has confirmed enhanced health professions literacy immediately after utilisation[4]

4. Morrissey S, Rogers GD, Chan PC, Kerkow EJ, Bezborowa S. Establishing 'health professions literacy': Evaluation of a video-based learning package in a three-phase curriculum. Oral presentation no 182 at the All Together Better Health VII conference, Pittsburg, USA, June, 2014.

Presentation Video

Health IDEAS
Griffith Health Institute for the Development of Education and Scholarship

Phase II

- Simulated interprofessional practice experience with learning supported by critical reflection
- Can be as simple as a shared paper PBL case …
- … or more sophisticated, like the CLEIMS program[5] in place at Griffith where medical students undertake an extended simulated patient care experience over a week and are joined at realistic points in the story by students from other professions
- Narrative contrivances and guided reflection to enhance fulfilment of interprofessional learning outcomes
- Fully 'CAIPE-compliant'

5. Rogers GD, McConnell MW, Jones de Roy N, Blem F, Lombard M. A randomised controlled trial of extended immersion/mini-clinical continuing simulation to prepare senior medical students for practice as junior doctors. *BMC Med Educ* 14:50, 2014

Presentation Video

Health IDEAS
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Phase III

- Real patient or client care IPP experience
- Best learnt from working in an interprofessional **student service team** (per Linköping model) …
- … but very difficult to achieve **at scale** (for all students)
- Some of the famous centres are revising and re-thinking this approach
- Can **all** health professional students meet or enhance some IPE learning outcomes through (routine) placement in an interprofessional **practitioner healthcare teams** (with guided reflection and supervision on IPP)?

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Interaction with accreditation bodies

- AMC Report on accreditation of Griffith University School of Medicine, February 2015:

  The team commends the progress made by the School in enabling students to work with and learn from and about other health professionals.

  The Griffith Health Institute for the Development of Education and Scholarship (Health IDEAS) has developed an implementation framework for interprofessional learning at Griffith Health. Now in its third year, much has been achieved…

  The CLEIMS program involves an intensive school week where students are taken through a series of simulations involving patient journeys. The students assess and manage patients and the initiative allows students from several health-related disciplines to work together. Members of other professions are skilfully incorporated into the scenarios adding authenticity and enhancing learning. This is an innovative and effective way to learn how to be an effective member of an interprofessional team to improve patient care and continued research is encouraged.

- IPL team have also had input into recent accreditation visits for other programs

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Interaction with accreditation bodies

Issues to consider from our experience

- Accreditation requirements are often raised by Program Directors as a perceived ***barrier*** to involving their students in interprofessional learning activities – this discourse needs to change
- Transprofessional supervision within interprofessional placements appears to be discouraged by some accreditation bodies – leaves the impression of professional tribalism
- High quality simulation can provide experiential learning opportunities that are **superior** to traditional clinical placement in some ways and certainly complement it – some bodies need to adjust their placement requirements to recognise this
- Many professions have had standards about IPE for some time but these have been very variably enforced

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Conclusions

- Implementation of the Griffith Framework is generally proceeding well
- A programmatic approach to IPE may not require that **all** activities be fully 'CAIPE-compliant'
- Learning from expensive and difficult to arrange 'CAIPE-compliant' activities may be optimised by simpler activities earlier and later in programs
- Further work needed to study impact of phase I & III 'augmenting' activities on the quality and persistence of learning from ('CAIPE-compliant') phase II

Phase I: Health professions literacy → **Phase II:** Simulated IPP experience → **Phase III:** Real patient or client care IPP experience

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OTTAWA Conference 2016
Assessment in medicine and the healthcare professions
Perth Western Australia 19-23 March

ANZAHPE
Australian & New Zealand Association for Health Professional Educators

Two conferences for the price of one!
www.ottawa2016.com

g.rogers@griffith.edu.au

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Griffith Health IPL TLOs

Upon graduation, Griffith-trained health professionals will be able to:

1. articulate the purpose for effective interprofessional practice in relation to optimisation of the quality, effectiveness and person-centredness of health and social services, in order to assist patients and clients to maximise their health and wellbeing
2. work effectively in a team, both in the role of team member and of team leader
3. describe the potential barriers to effective teamwork and strategies through which they may be overcome
4. describe the roles, responsibilities, practices and expertise of effective members of their own profession
5. describe the roles, practices and expertise of effective members of each of the other major health professions
6. recognise and challenge stereotypical views in relation to the roles, practices and expertise of particular health professions in their own thinking and in the communication of others
7. express their professional opinions competently, confidently and respectfully to colleagues in any health profession
8. listen to the opinions of other health professionals effectively and respectfully, valuing each contribution in relation to its usefulness for the patient, client or community concerned, rather than on the basis of the professional background of its contributor
9. for individual level care:
   - synthesise the input of multiple professional colleagues, together with the beliefs, priorities and wishes of the patient or client and their significant others, to reach consensus on optimal treatment, care and support and how it should be provided,

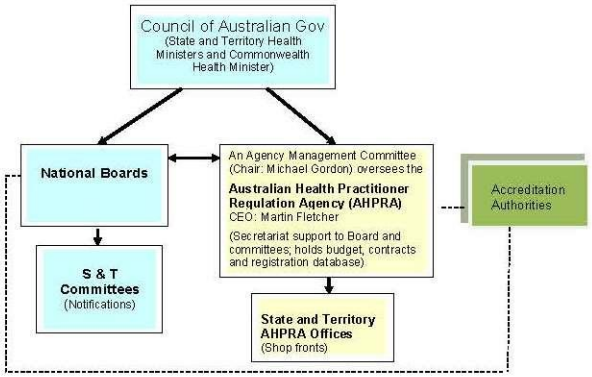
   while for community level health activity:
   - synthesise the input of multiple professional colleagues, together with the values and priorities of the community concerned, to reach consensus on optimal interventions and how they should be implemented
10. reflect critically and creatively on their own performance in health professional team settings.

G - Professor Morgan

The role of accreditation in interprofessional education (IPE)

Professor Mike Morgan
Chair, Health Professions Accreditation Councils Forum

Structure of National Registration and Accreditation Scheme (NRAS)



HEALTH PROFESSIONS UNDER THE NRAS

- Australasia and New Zealand Podiatry Accreditation Council
- Australian Dental Council
- Australian Medical Council
- Australian Nursing and Midwifery Accreditation Council
- Australasian Osteopathic Accreditation Council
- Australian Pharmacy Council
- Council on Chiropractic Education Australasia
- Optometry Council of Australia and New Zealand
- Australian Psychology Accreditation Council
- Australian Physiotherapy Council
- Occupational Therapy Council (from July 2012)

<u>From 1 July 2012 Accreditation Committees</u>

- Aboriginal and Torres Strait Islander Health Practice
- Chinese Medicine
- Medical Radiation Practice

Health Professions Accreditation Councils Forum

Who we are:

- Members are independent legal entities appointed by the National Board
- Forum member Councils contribute individually and collectively

The purpose of the Forum is:

- to work together on issues of national importance
- to identify areas of common interest and concern
- to work toward a position of consensus
- to take joint action in areas of importance
- to develop joint position statements

A good reason to implement IPE

IPE - where are we?

- We all think IPE is a 'good thing'
- Definitions of what is meant by IPE differ – it means different things to different people
  - students all in together … IPE?
- It varies across the educational sector
  - acknowledge that standards may be applied variously
- It is less common than we might think it should be, despite many "wishing to engage more"
- IPE does exist already:
  - Central Queensland University (CQU) – Allied Health Clinic

The Current situation

- The concept of IPE is starting to appear in Australian accreditation standards e.g.
  - ADC Standard 3, Criterion 3.6 '*Principles of inter-professional learning and practice are embedded in the curriculum*'
  - Identical criterion (3.5) in draft OCANZ 'Entry Level Accreditation Standards for Optometry Programs in Australia and New Zealand'
  - The AMC's Draft Revised Standards for Assessment and Accreditation of Specialist Medical Education Programs and Professional Development Programs – Standard 4.2.5 '*The specialist medical program ensures that trainees experience working and learning in inter professional teams.*'
- *But,* this is yet to be tested in a widespread way
- The international evidence indicates a similar picture

Example - CQU

- CQU's on-campus Allied Health Clinic offers IPE opportunities for nursing, BOH, social work, podiatry, speech therapy, physiotherapy and exercise science students
- Local GPs refer patients (normally with chronic disease) to the clinic for an inter-professional examination
- Clinic holds weekly student case conferences – 2 cases presented to all students for group discussion

The Challenges

- What exactly do we want graduates to have?
  - acknowledge the 8 competencies that grads should have
- Assessment
- Location
  - Proximity to other healthcare students
  - Types of patients available to students
  - Timetables
  - Facilities
- General trend – pressure on student clinical placements
  - Increasing student numbers – difficulty in finding sufficient clinical placements
- Students are still trying to learn their own discipline
- Making sense of the 'language' of other disciplines
- Health politics

Example - Melbourne

- School of Health Sciences
- 10 interdisciplinary simulation case studies
  - Currently being implemented
- Developed a Supervisor and Tutor Education Program (STEP)

Example - Dental

- While not inter-professional in the truest form:
  - Dentist education and Oral Health Therapy
  - Closer than most in discipline but no closer to IPE

The role of Standards - some questions

- Should there be an accreditation standard for inter-professional education?
  - threshold levels *cf.* best practice
  - what other areas of education should have a specific standard?
- Should it be common across accrediting councils?
- Would that have any chance of working?

The role of accreditation

- Standards are focusing on outcomes
- No specification of: how to do it / what it looks like / number of hours
- The main focus of accreditation standards is discipline specific
- Not define codes of practice or competencies
- Should reflect, not define, educational practice
- Accreditation can encourage IPE
- For it to be a positive experience for students, all stakeholders have to support /assess/evaluate it
  - The education provider
  - The clinical placement provider
  - Supervisors
  - The accrediting councils

Accreditation

- Does not want to be, or perceived to be, a barrier
  - often used, not by accreditors, to prevent change
- Is becoming more outcome focussed
- Cannot lead on scopes of practice or direct education principles
- Will work with educators, legislators and governments to reduce barriers

Attachment 5 – Forum Position Statement

Health Professions Accreditation Councils' *Forum*

A coalition of the accreditation Councils of the regulated health professions.

Position Statement

Interprofessional learning

The members of the Health Professions Accreditation Councils' Forum (the Forum) acknowledge that multidisciplinary team care is a key feature of contemporary models of health care and that effective teams improve patient care. It is this collaborative feature of many existing and emerging models of clinical practice that is driving the need to educate and train future health professionals to work more collaboratively across professions in the interest of better patient safety and care.

An interprofessional education (IPE) workshop (June 2015) considered the health service drivers of interprofessional practice, examples of interprofessional education, and the role of accreditation standards and processes in enabling good interprofessional education.

The Forum members have agreed to the outcomes of that workshop with the following actions.

Commitment to support good practice interprofessional education

Commitment is shown through the accreditation councils' roles in setting standards and assessing programs of study and providers for accreditation, and through the assessment of overseas-trained health professionals.

A shared definition of interprofessional education

The Forum members endorse the World Health Organization's definition of interprofessional education:

Interprofessional education *occurs when two or more professions learn about, from and with each other to enable effective collaboration and improve health outcomes.*

- *Professional is an all-encompassing term that includes individuals with the knowledge and/or skills to contribute to the physical, mental and social well-being of a community.*

Collaborative practice *in health-care occurs when multiple health workers from different professional backgrounds provide comprehensive services by working with patients, their families, carers and communities to deliver the highest quality of care across settings.*

- *Practice includes both clinical and non-clinical health-related work, such as diagnosis, treatment, surveillance, health communications, management and sanitation engineering.*'[1]

Interprofessional competencies

The Forum members adopt the following statement and interprofessional learning competencies as a reference point (i.e. guidance only) for use in their processes for accreditation of health profession programs. These competencies and the statement have been developed through

---

[1] World Health Organization: Health Professions Networks Nursing & Midwifery Human Resources for Health, *Framework for Action on Interprofessional Education & Collaborative Practice,* 2010, http://www.who.int/hrh/nursing_midwifery/en/

The Secretary, Health Professions Accreditation Councils' *Forum* PO Box 4810 KINGSTON ACT 2604
TELEPHONE: 0400 546 765 FACSIMILE: (02) 6270 9799
e-mail:**info@healthprofessionscouncils.org.au** Website:**http://healthprofessionscouncils.org.au**

research and consultation led by Professor Maree O'Keefe in an Office for Learning and Teaching National Teaching Fellowship. [2, 3]

Interprofessional learning
The principles of interprofessional learning encompass understanding, valuing and respecting individual discipline roles in health care. Interprofessional practice places the interests of patients and populations at the centre of healthcare delivery. A key element of interprofessional practice is the recognition and use of the skills of other health professionals in healthcare delivery. It is supported by interactions that clarify perspectives, and enable insights and learning from other health professions.

Interprofessional learning competencies
On completion of their program of study, graduates of any professional entry level healthcare degree will be able to:

- *explain interprofessional practice to patients, clients, families and other professionals*
- *describe the areas of practice of other health professions*
- *express professional opinions competently, confidently, and respectfully avoiding discipline specific language*
- *plan patient/client care goals and priorities with involvement of other health professionals*
- *identify opportunities to enhance the care of patients/clients through the involvement of other health professionals*
- *recognise and resolve disagreements in relation to patient care that arise from different disciplinary perspectives*
- *critically evaluate protocols and practices in relation to interprofessional practice*
- *give timely, sensitive, instructive feedback to colleagues from other professions, and respond respectfully to feedback from these colleagues.*

Supporting innovation and evolution of health profession education

The Forum members support innovation in the education and training of health professionals and recognise that education and training must evolve in response to changing models of care, community need and educational developments.

As interprofessional education itself also continues to develop and evolve, the Forum members have agreed to adopt the statement and the IPL competencies as reference material and recognise that education providers will continue to review and develop their own learning outcomes, curriculum content, learning and teaching approaches and assessment methods.

Supporting relevant cross profession accreditation activities

The Forum members are working together to ensure accreditation processes are efficient, and streamlined, building on each other's processes and those of other regulators where relevant.

Adopted
30 November, 2015

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[2] O'Keefe M. Collaborating across boundaries: A framework for an integrated interprofessional curriculum, Australian Government Office for Learning & Teaching 2015, http://www.olt.gov.au/resource-collaborating-across-boundaries-framework-integrated-interprofessional-curriculum-2015

[3] O'Keefe M, Henderson A, Chick R. Developing sustainable and embedded interprofessional education: threshold learning outcomes as a potential pathway. Australian Government Office for Learning and Teaching 2015 http://www.olt.gov.au/resources