

Opinions

Interprofessional Education: A College Perspective

Much has been written over the past few years on interprofessional education (IPE) and the need for team-based care. In addition, a number of provincial and federal initiatives have been put in place to support its promotion and implementation. For example, a recent article in *HealthcarePapers* by Clements, Dault and Priest (2007) summarizing the findings gathered by a research team funded by the Canadian Health Services Research Foundation overwhelmingly supported the need for effective teamwork to improve healthcare delivery, adding that it is more than desirable, “it is a basic prerequisite [that patients] often assume to be in place” (p. 27).

On the federal level, the 2004 Health Canada Initiative on Interprofessional Education for Collaborative Patient-Centred Practice (IECPCP) recognized the need to change the way health sciences students are educated. The specific objectives of IECPCP are to promote and demonstrate the benefits of IPE for collaborative patient-centred practice and to increase the number of health professionals trained before and after entry to practice.

Until recently, colleges had not been formally involved in the discussions regarding IPE; yet, colleges are major players in healthcare education. A 2004 position paper titled *Beyond the Stethoscope: Ontario's Human Resource Requirements in a Reformed Health Care System* by Colleges Ontario (formerly the Association of Colleges of Applied Arts and Technology of Ontario) stated that 70% of healthcare professionals are educated and trained in the college system. This includes those in nursing, health information, prosthetics and orthotics, dental hygiene, medical imaging, laboratory technology and radiation therapy (approximately 36 named professions). This is a significant number and an important support to the healthcare system.

Traditionally, the primary research focus of the healthcare team has been the doctor-nurse relationship. The initial requirement for the first round of IECPCP research projects included this dyad. However, not surprisingly, many of the approved research projects involved other university-educated health professions, such as physiotherapy, occupational therapy, speech-language pathology, pharmacy, nutrition and social work. It should be noted that in the second round of approved projects, more colleges were involved as partners and Centennial College in Toronto is a project lead.

We know that the patient requires the input and support of many professionals who may or may not be directly at the bedside or working in an institutional setting. Therefore, if we truly want to look at improving teamwork and collaborative practice in the healthcare system, we need to look at addressing

IPE in the college system and develop stronger ties with university-trained professionals.

This link between universities and colleges is not new. Many colleges already have relationships with targeted faculties such as nursing. However, what is new is linking universities and colleges more systematically around collaborative patient-centred practice.

The support and timing for working together has never been better. In Ontario, the Health Human Resource goal is to ensure the healthcare system has the right number and mix of appropriately prepared healthcare providers, where and when they are needed. In addition, Healthforce Ontario recently released *Interprofessional Care: The Blueprint for Action* document, which outlines action-oriented priorities that will facilitate the implementation of interprofessional care within the healthcare and education systems. Federally, the Health Council of Canada summit report (2005) emphasized the need to build a workforce skilled in working together. There was even a recommendation to expand IPE, with colleges and universities identified as leads. However, two years ago, the college system was not ready to support a recommended 2008 commitment.

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Moving forward, colleges have many advantages in implementing IPE. With many different professional programs reporting to one academic lead (dean or director), there is greater flexibility to respond quickly and to get different faculty to work together. Second, colleges are experts in applied learning, and it is this major focus of college education that can facilitate the development of clinical skills. Third, colleges often have a large number of part-time diploma courses and certificate programs that help to address gaps in the system.

George Brown College (GBC) in Toronto has been a big supporter of IPE for more than four years. The college is one of the largest in Ontario, with more than 14,500 full-time students. The Centre for Health Sciences has approximately 2,500 full-time students enrolled in four schools – Nursing, Health and Wellness, Dental Health and Health Services Management. In all, GBC offers over 90 full-time and part-time programs and courses.

During the past four years, there have been many new initiatives to ensure that IPE becomes a major focus. The Centre for Health Sciences IPE agenda has included a reorganization of the program clusters and governance model, the development of an IPE curriculum framework, the creation of a professional devel-

opment strategy, the renovation of the college's 59-chair dental clinic to an Interprofessional Learning Clinic (ILC) that will accommodate other services and students from other programs, and the renovation of the Nursing Resource Centre (a 51-bed in-patient environment) as a Simulated Practice Centre (SPC). The ILC and SPC are helping to address some of the current challenges facing IPE integration: the need to be able to link the theoretical elements with the practical application of good teamwork, the ability to appraise the relationship between one's own profession and the background of others and the understanding that collaboration supports better patient outcomes.

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Although several clinical and community-based settings may be talking the talk, few are walking the walk at the present. Therefore, GBC has enhanced its own clinical and laboratory settings to become controlled applied learning environments (CALEs) where some of this integration of theory with practice can take place. The expanded use of these CALEs will be developed and evaluated over the next few years and are seen as an important adjunct to clinical practice and not meant to replace placements in external clinics and environments. The ILC was cited as an example of an IPE initiative in the 2005 Health Council summit report.

A final element of GBC's IPE strategy has been the development of significant partnerships with other educational institutions, including Ryerson, the University of Toronto's Office of IPE, The Michener Institute and Centennial College as well as hospitals and a private provider of long-term care facilities. The scope of these partnerships is still forming. However, they are critical to the success of IPE as the students educated in the college system will need to have opportunities to learn with and about the professions educated in the university system in order to "hit the system running." An exciting relationship with St. Michael's Hospital will involve medical students working alongside students from GBC in the Community Learning Centre for Healthy Living, which is located in the ILC.

I agree with authors Clements et al. (2007) when they state, "It is vital to bring educators together to determine core competencies and curricula, while building on the existing initiatives such as the IECPCP" (p. 32). The future of IPE is still evolving, and the college system is ready for the ride.

References

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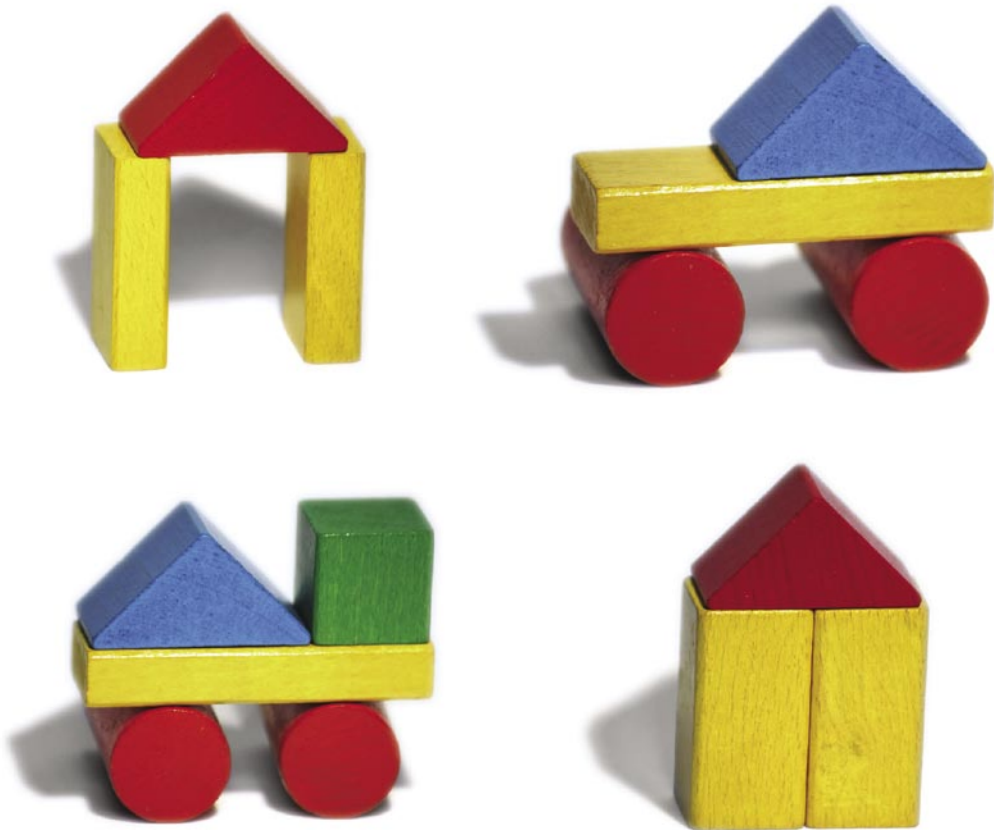
Celebrating 10 Years

Top Ten Health Policy Mistakes Since Medicare

1. Moving too late and too timidly on a national pharmaceutical strategy, and overvaluing the presence of having a branch-plant R & D presence in Canada (see: New Zealand).
2. Giving doctors too much power in setting fee schedules and determining the relative incomes of family practitioners and specialists (see: cataractologists vs. geriatricians).
3. Allowing the College of Dental Surgeons to kill off the school-based Children's Dental Health program in Saskatchewan – one of the most successful primary health care programs in Canadian history.
4. Allowing professions to increase their entry-to-practice credentials without producing evidence that doing so would improve the system, and basing scope of practice on credentials rather than demonstrated competencies.
5. Failure to build a Canada-wide, comprehensive health information system useful at the clinical, managerial and governance levels to enhance quality, efficiency, and accountability.
6. Retaining fee-for-service remuneration beyond its useful life span.
7. Failure to translate demonstration projects into system-wide policy (see: primary health care stuck in neutral).
8. Failure to develop a cooperative framework that unites the federal and provincial/territorial governments and aligns goals, funding, and accountability.
9. Governments have ceded too much of the policy agenda and discourse to interest groups.
10. Governments have been too aggressive in telling regional health authorities how to do their work and not aggressive enough in setting goals, and developing incentives to accelerate improved performance.

— Steven Lewis, Saskatchewan

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