



# **INTERPROFESSIONAL EDUCATION AND INTERPROFESSIONAL COLLABORATION**

## **IN HOME AND COMMUNITY CARE OF OLDER ADULTS AND THEIR FAMILIES**

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## **Purpose of this Report**

The Aging, Community and Health Research Unit (ACHRU) at McMaster University has allocated 25% of their research funds for the purpose of addressing a particular issue or need within Ontario's healthcare system. These funds are available to address the needs of older adults with multiple chronic conditions living in home and community. The Health Workforce Policy Branch of the Ministry of Health and Long-Term Care (MOHLTC) requested that ACHRU respond to an applied health research question (AHRQ) with regard to interprofessional education (IPE) and collaboration (IPC) opportunities in the care of older adults in community care settings. More specifically, the ACHRU was asked to:

- Outline and assess current geriatric/gerontological interprofessional Practice and Education in Ontario
- Document existing collaborative care models (e.g. education and practice) in older adult care in the community
- Investigate opportunities for further development of such models
- Document possibilities of integrating student and practitioner learning into these models
- Explore core competencies related to collaborative care with older adults living in the community
- Note any best practices by other provinces/territories, national or other key jurisdictions

## **Importance of AHRQ to Today's Issues**

Ontario's older adults are living longer<sup>1</sup>, with 14.6% of the province's population reaching 65 years of age and older.<sup>2</sup> As the baby boom generation ages, this demographic will increase exponentially over the foreseeable future, placing considerable demand on health and social services in the province. Although they will be healthier than their predecessors, many older adults will be dealing with at least one chronic condition and an increasing number will be facing multiple chronic conditions.<sup>1</sup> There is a need to plan, implement, and evaluate comprehensive programmes that will integrate primary health and social care of these individuals; address all the determinants of health; reduce premature institutionalization; and enhance quality of life, accessibility, and equity for services to the older adult population and their families in home and community.

Finding efficient and effective ways to care for the older adults has always been an important issue, but it is an issue of growing concern in Canada as the baby boom cohort ages. Until 2005, our healthcare system's central concern was acute care, that is, treatment of episodes of illness or injury for a short period of time. However, older adults often have multiple chronic conditions (MCC), requiring a variety of health and social support services to help them live well. In many cases, appropriate supports can allow people with chronic health issues to live in their own homes rather than in an institution, while avoiding the use of unnecessary hospital services. For those older adults who are fortunate enough to be in good health, it is essential that community-based primary health care and social services are available to support ongoing health promotion and disease prevention. But for care to be matched well to individual circumstances, a range of services may need to be coordinated or even, depending on the complexity of the need, "integrated" by pooling resources from multiple systems.

## **Process**

To respond to this question, ACHRU conducted an environmental scan which consisted of an in-depth literature review of the IPE and IPC literature and a review of provincial, national, and international policies and strategies implemented in the area of IPE and IPC, with a focus on best practices in home and community care for older adults and their families/caregivers (see Appendix A). To better understand the current operationalization of IPE and IPC, we conducted a series of key informant interviews with local, national, and international experts.

## **Community Context**

When considering IPE/IPC for older adults and their families and caregivers in the community, it is essential that we begin with a common understanding of the community context and what it entails. It differs greatly from the acute care sector where care is provided in a specific geographic space (the hospital) with all interprofessional healthcare providers housed in the same organization. Care of seniors in the community setting can take place in various settings including their homes, doctors' offices, and community-based clinics, with members of the interprofessional team located geographically across the community.<sup>4-6</sup> These differences pose major challenges to providing seamless and patient-focused care to these clients and have ramifications for interprofessional education and collaboration<sup>7-8</sup>, the most important of which is communication and co-ordination of care delivery.<sup>9,10</sup> More importantly, these differences have major implications for clients and their families in navigating such a complex system of services and providers.<sup>9-10</sup>

To better comprehend what is actually meant by community care, we have chosen the Canadian Institutes of Health Research (CIHR) definition of Community-Based Primary Healthcare<sup>11</sup> as outlined in the ACHRU team grant:

*“Community-based Primary Health Care (CBPHC) covers the broad range of primary prevention and primary care services within the community, including health promotion and disease prevention; treatment and management of chronic and episodic illness; and rehabilitation support. CBPHC involves the coordination and provision of integrated care provided by a range of health providers in a variety of community settings (e.g., people's homes, healthcare clinics, and physicians' offices). It is delivered in a way that is patient-centred and responsive to gender, cultural, social and economic differences.”*

Many papers in our literature review discuss the need for seamless transition from hospital to home and community.<sup>12-14</sup> It is recognized that without proper co-ordination, the transition can result in loss of important information, which can have detrimental effects on the care of the older adult once situated in the home and community.<sup>8,9,13,14</sup> Providing care for patients discharged from hospitals and delivering better community services has also become the focus of governments across the world.<sup>14,15</sup> Clearly, this bridge between acute and community care is essential in the delivery of integrated care to these clients. Further to this, it was evident in the literature that care of older adults and their families in the community requires more than interventions of health care providers. It is essential that social and community services providers be full partners in an integrated system of home and community care and that the patient, family and caregiver be key drivers of the interventions being delivered to these clients.

With these considerations in mind, the environmental scan was completed as outlined above.

## **Summary of Key Findings**

For more detailed discussion of each of these findings please see full discussion in Appendix B and c.

### *Interprofessional Education*

1. *Findings suggested collaborative education (CE) may be a more appropriate term than interprofessional education (IPE).*
2. A common operational definition of IPE is needed.
3. The definition of IPE should include the role of clients and their families, specifically older adults and their families.
4. Social care and community service providers should be included in IPE programmes.
5. The definition of IPE should use the term “providers” in lieu of “professionals”.

6. Learners should understand that clients and their families provide valuable input for IPE in home and community care.
7. Pre-licensure IPE theoretical learning in the classroom is essential, but clinically-based learning should also occur.
8. Post-licensure IPE education of collaborative teams should be driven by the team, customized and adaptable to each specific context<sup>16</sup>, in this case, the care of older adults and their families.
9. Innovative methods for post-licensure IPE need to be organized, to facilitate participation.<sup>17</sup>
10. All students and IP team practitioners should be taught the importance of reflective practice.<sup>16-19</sup>
11. Professional organizations should be invited to help plan a consistent IPE curriculum.<sup>20</sup>
12. IPE programmes specific to the care of older adults and their families should consider the inclusion of learning related to technological innovations.
13. For post-licensure IPE, alternative ways of learning through electronic classrooms, telemedicine, and videoconferencing should be more broadly explored, tested, implemented and evaluated.
14. The use of simulation technology should also be explored to its full extent.
15. Faculty teaching in IPE programmes should be champions in the care of older adults, IPE and IPC.<sup>17</sup>
16. Assess faculty's willingness and strength of conviction in the benefits of IPE.<sup>21</sup>
17. IPE educational opportunities, in particular coaching and mentoring skills, should be made available to faculty members.<sup>22</sup>
18. Faculty should be given protected time to teach IPE, as part of their teaching load.<sup>17</sup>
19. More research is required in the development, delivery, and evaluation of IPE.<sup>16,23-27</sup>

#### *Interprofessional Collaboration*

1. *Collaborative practice* (CP) may be a more appropriate term than *interprofessional collaboration*.
2. A common operational definition of IPC requires expansion of currently acceptable definitions when applied to older adults and their families.
3. Clients and their families, as well as key members of the geriatric IPC team, should be included in developing this definition.
4. Social care and community service providers, as well as unregulated caregivers, should be included in the definition of IPC for older adults and their families.
5. Patient-centeredness must be strongly encouraged particularly in the care of older adults and families.
6. Older adults and their families should be seen as key decision makers on the team.<sup>21,28-30</sup>
7. Older adults should have clear understanding of who is on the team and the role of each team member.



8. With the complexity of the community care system, older adults need support in understanding their role in prioritizing their needs.
9. A “system navigator” helps the older adult and families manoeuvre through the transition from hospital to home/community and through the complex community system networks.
10. Programme evaluation should be a key element built into IPC care models, with focus on team effectiveness and improved patient outcomes.
11. More randomized controlled trials (RCTs) are needed to study the effectiveness of IPC models.<sup>21,29,30</sup>
12. Qualitative studies are required to understand the experiences of older adults and their families with IPC models.
13. IPC should be based on improving patient outcomes and safety, with cost effectiveness being a secondary driver.
14. Organizational culture should support and value IPC.
15. Organizations that implement IPC should employ care providers with like values.
16. Partners should encourage technological innovation in IPC and provide the up-front funding.
17. IPC teams should have a strong information technology (IT) network.
18. More rigorous studies and observational research are required to fully understand the effectiveness of IPC specifically with older adults/families.<sup>3,30,31</sup>

## **Current Geriatric/Gerontological Interprofessional Practice and Education in Ontario**

### ***Background***

Over the past 10 years, educational institutions present a picture of Inter-professional Education (IPE) for health professionals at the undergraduate level (pre-licensure level) as a panacea for effective, continued Inter-professional Collaboration (IPC) in all sectors of the health care system. In a complex system where multiple professionals must practice collaboratively to provide the best possible care to clients, it is essential that these professionals be educated in a way that encourages integration of the concepts of teamwork, integration and collaboration across professional programs. Although the Ontario MOHLTC has provided funding for this to occur and educational institutions have responded in varying ways to the call for this kind of integration, the literature suggests that there is little coordination within and across institutions and collaboration in practice settings is not consistently occurring.

IPE programs vary across educational settings from an individual course to a one day seminar among health professionals with no integration of social and community providers and limited opportunities for clinical practice experience in clinical settings. This is particularly evident in the homecare and community sector and more specifically in the care of older adults with chronic multiple conditions. Although students enjoy the experience of learning and problem-solving simulated cases in the classroom setting, they have very little opportunity to practice this in real life, thereby forgetting what they have learned in an educational setting.

The lack of standardized curricula in IPC across institutional settings, the exclusion of important non-health related providers (i.e. social work students) from pertinent academic programs, the lack of dedicated teaching staff, inappropriate clinical settings and mentors and the perpetuation of professional silos remain stumbling blocks to achieving true IPC. Professionals who actually become involved in functioning IP teams in clinical practice attest to the need for integration of provider practice and are able to identify learning needs in order to make it happen, but continuing education opportunities in the post licensure period are very limited and mentors are either not available or unable to commit the time to mentoring new professionals. For effective collaboration in clinical practice new approaches are needed to enhance inter provider/professional education programs and a number of considerations derived from the literature and our interviews are articulated herein.

### ***Key Findings***

Literature suggests a need for an organized, co-ordinated approach to IPE, because evaluations of many IPE programmes presently in operation do not produce strong evidence of their effectiveness.<sup>17,23,25,43</sup>

**In Japan**, IPE is highly valued and promoted in universities across the country; however, it is not legislated. Ten Japanese universities that are engaged in health professions education established the Japan Inter Professional Working and Education Network (JIPWEN) in 2008. These schools (now eleven) implemented unique IPE programmes in response to concerns about quality of healthcare professions, and they were awarded Good Practices by the Japanese government with generous financial support.

JIPWEN discusses critical issues of IPE and presents plural models so that institutions interested in IPE programmes can adapt similar models. It plays a coordination and liaison role with the Japan Association for Interprofessional Education (JAIPE) members, WHO, international IPE networks, and international academic associations. It advocates the importance of IPE to the Japanese government and tries to strengthen the human resource for health (HRH) policy.

JIPWEN universities have their unique educational organizations, which play an important role in IPE management. There is strong leadership under the president or dean of the schools, such as 'The Planning and Evaluation Core Group' in Sapporo Medical University, 'Center of Planning and Coordination for Medical Education (PCME)' in University of Tsukuba, and 'Interprofessional Education Committee of Gunma University (IPEC-GU)' in Gunma University. These organizations have a number of responsibilities including preparing an annual plan, implementing faculty development, communicating with university hospitals and local facilities,

and evaluating and analyzing the achievements. Through these organizations, IPE is incorporated into diverse professions' curricula.

**In Denmark**, the public demand for interprofessional collaboration has led to a ministerial order of integrating interprofessional elements in the curricula of various educational programmes. An interprofessional element has been integrated in the Danish Bachelor programmes in Education, Social Work, and Health. The University Colleges are in the process of implementing the new legislation. Although the IPE elements may vary across disciplines, different IPE programmes share the same basic goals, which are to become qualified to cooperate with persons from other professions and to take innovative approaches in interprofessional work.<sup>93</sup> Patients/clients/family caregivers are included in IPE programmes, especially those focusing on home care and community care.<sup>53,55</sup> Projects to enhance IPC in educational institutes, healthcare settings, and communities were introduced nationwide. These projects conjoin the skills of various professions including social and healthcare assistants. Interprofessional training units (ITU) were established across the country, the first of which was in Holstebro in 2004. The Holstebro ITU consisted of eight beds in an orthopedic ward with 30 beds. Students from nursing, occupational therapy, physiotherapy, and medicine were placed for two weeks of clinical training. It has been shown that the placement at the ITU had a positive effect on students' attitudes and views of the other professions.<sup>53</sup> Recently, because of the incorporation of daily meetings of the interprofessional teams in the ITU, there was reduction of hospital stay for patients who had hip replacement.<sup>97</sup>

The trajectory of IPE from pre-licensure (IPE) at the undergraduate level, in both the classroom and the clinical practice setting, to post-licensure in the practice setting in the form of staff development and continuing education (CIPE) needs to be more clearly outlined and understood.<sup>22,34</sup>

#### ***Pre-licensure:***

IPE at the pre-licensure stage should take place at the undergraduate level, allowing students from different health and social programmes to learn together in special classes and in the clinical setting with well-functioning, interprofessional teams as their clinical mentors. This clinical practice component is particularly important in the care of older adults and their families in home and community.<sup>21</sup>

Since most current IPE models and frameworks vary across contexts and programmes, this diversity and lack of standardization makes them difficult to evaluate.<sup>17</sup>

#### ***Post-licensure:***

It is essential that input into and participation in the educational programming is sought from older adult clients and their families, who are fully functioning members of the team.<sup>21,44,45</sup>

Post-licensure, when these providers are practising collaboratively in an interprofessional model, continuing education and staff development programmes should be made available to the teams based on their stated educational requirements within the specific context of the team and after consultation with the older adults, families, and caregivers. This is essential to the continuing success of the team.<sup>21,34,46,47</sup>

Because of the variability across IPE programmes, they are difficult to evaluate. Aspects such as where they are being delivered, for how long, who the learners are, what the programme content is, and what the learning activities are contribute to the variability.<sup>16,17,21,24,26,27,61</sup>

More effort is required, particularly in pre-licensure, university-based programmes, to standardize core programmes and more clearly define the core content, thereby allowing for the development of programme standards and ease of programme evaluation.<sup>22,23</sup>

Specific desired outcomes of IPE must be defined with input from older adults and their families.

**Health Workforce Australia (HWA)**, an initiative of the Council of Australian Governments (COAG), was established to address the challenges of providing a workforce that meets the needs of the community. The

latest HWA initiative is the Aged Care Workforce Reform (2012-2014) initiative, which involves redesigning jobs among aged-care workers, providing further education and training, increasing flexibility of job roles, and encouraging innovative team approaches to care ([www.hwa.gov.au/our-work/boost-productivity/aged-care-workforce-reform-program](http://www.hwa.gov.au/our-work/boost-productivity/aged-care-workforce-reform-program)).

In recognition of the growing burden of chronic disease, a national policy approach has been adopted to improve chronic disease prevention and care across Australia (National Health Priority Action Council (NHPAC), 2006).<sup>109</sup> The National Chronic Disease Strategy report<sup>109</sup> incorporated an IP approach to care, between individual practitioners as well as the various healthcare sectors; report available from [www.healthnetworks.health.wa.gov.au/modelsofcare/docs/Results\\_MOC\\_Survey.pdf](http://www.healthnetworks.health.wa.gov.au/modelsofcare/docs/Results_MOC_Survey.pdf).

Western Australia (WA) Health Networks was established in 2006 in response to the report, A Healthy Future for Western Australians (Department of Health Western Australia, 2004).<sup>110</sup> This report identified opportunities to overcome fragmentation and duplication across the WA health system through collaboration among public and private health service providers. By 2012, health networks existed and more than 60 models of care had been produced collaboratively. The “Model of care” document outlines the principles and directions for delivering the right care, in the right place, at the right time, by the right team (Department of Health Western Australia, 2007).<sup>111</sup> The “Patient First” model successfully linked hospitals and community-based healthcare services for the elderly. All stakeholders, including clients, were involved in the planning, implementation, and evaluation of the stages of the project. Patients who participated displayed a reduced demand for acute hospital services and hospital readmission.<sup>74</sup>

The importance of IPC has been strongly supported in the healthcare workplace **in Taiwan** especially when caring for the elderly. Although care managers assess clients’ needs and then coordinate service providers from multiple professional backgrounds, such as home care aids, nurses, physical therapists, occupational therapists, nutritionists and social workers, collaboration of providers has been determined as a necessity for successful coordination of services. Currently, home-based and institutional-based services have been universally provided throughout Taiwan, and community-based services are available in rural areas. Pilot sites offering community-based pharmaceutical services are being tested.<sup>114</sup>

In response to the need to develop a government-supported long-term care system, the Ministry of Health and Welfare of Taiwan launched a pilot plan for a long-term care system in 2000. However, the country’s first comprehensive care initiative started in 2008. In this 10-year plan, the Department of Health started to integrate and implement the resources of elderly health promotion based in regional care centers. Currently, the Taiwan Long-term Care Service Act and the Taiwan Long-term Care Insurance Plan have both been drafted<sup>115</sup> and await review to be legislated.<sup>116</sup> Under this legislation, “long-term care giving” will be recognized as a profession, and its quality enhanced through a certification, assessment and registration system.<sup>117</sup> Considering the developments in the long-term care system, the focus on high-quality patient-centered care, the increase of resources, and the prospect for forming high quality interprofessional collaborative long-term care are becoming a reality.<sup>116</sup>

#### **Future Considerations:**

1. In both pre- and post-licensure IPE programmes, it is essential that input at every level is sought from the older adult clients and their families in home and community care.
2. Pre-licensure IPE should be theoretically based and include consistent concepts and principles to address the complexity of older adults and their families and caregivers in their homes and communities. Theoretical learning in the classroom is essential, but clinically-based learning should take place with real-life functioning IPC teams within practice settings in the field; e.g., the Faculty of Health Sciences at McMaster University offers the Program for Interprofessional Practice, Education and Research [http://piper.mcmaster.ca/about\\_history.html](http://piper.mcmaster.ca/about_history.html)

3. Partners involved in the IPE initiative should explore the possibility of forming a consortium of interested post-secondary educational institutions in Ontario (capable of providing critical leadership support) to develop and deliver an undergraduate certificate programme in interprofessional collaborative practice, specifically in the seamless care of older adults and their families across sectors, including a built-in evaluation component. The present Japanese and Australia/New Zealand models are possible templates for such an approach.
4. This consortium, upon a successful evaluation, should explore an accountability framework through consistency and accreditation of these pre-licensure, post-secondary educational institution-based IPE programmes.
5. Post-licensure IPE programmes are context-specific and should be made available to healthcare provider teams (including patients and their families) by the organizations in which the teams work, based on their agreed-upon needs. The education of collaborative teams should be customized and adaptable to each specific context.<sup>16</sup> One example of a post-licensure program related to geriatric care is the Geriatric Certificate Program offered through the Department of Medicine, Division of Geriatric Medicine at McMaster University (<https://www.geriatriccp.ca/>). This program is open to a variety of health professionals.
6. Innovative methods for post-licensure IPE need to be organized to address the time and physical constraints of attending continuing education and staff development sessions.<sup>17</sup>
7. More research is required in development, delivery, and evaluation of IPE effectiveness in producing care providers capable of interprofessional collaboration at the point of care.<sup>16,23,24-27</sup>

“So we need to break down a lot of professional hierarchy and really truly respect a good skill set of all the health profession.” (Participant 12)

“I see it [IPE] across the continuum of learning. ... the focus has been more at the university/ college level and I think we’re only in the field starting to think about, how do you actually support lifelong learning and people who are already practicing? ... I see IPE starting when you’re a student in a health science programme, the pre-licensure, all the way through to, you know, mastery once you’re in a clinical or practice environment to continuing professional development, so very much learning across the lifespan as a healthcare professional”. (Participant 16)

“The vast majority of people are not working in a downtown, acute care hospital, and yet much of the training still happens in those big, traditional healthcare organizations. So there’d be huge value in ensuring that there is interprofessional learning both for students and for practicing clinicians in the home care context.... So if you can expose people and teams to home care and community settings you’d likely draw them to actually work there.... I think we should be focusing on placements that speak to where there is a need and where there is a growing population of, you know, our elderly folks. And so if you can get people there doing IPE you may be able to actually incent them to stay and work in those environments once they graduate. So I would see value from a quality of care perspective but also from a recruitment and retention perspective, yeah.” (Participant 16)

“We’ve just named IPE and collaborative education as something a little bit different but we really are talking about the same concepts. Interprofessional education or collaborative education is...it’s...it’s learners from pre-licensure to post-licensure. And could even *include* ...patients, clients, families, caregivers, if we were educating them, I would include them in that whole spectrum of learners about how to work within the health team more effectively. So...so it would be either, you know, communication, shared decision-making, respect, valuing, etc.” (Participant 06)

## Existing Collaborative Care Models (Education and Practice) In Older Adult Care in the Community and Opportunities for Further Development of these Models

### **Background**

"Collaboration among individual professionals is a first step in developing collaborative relationships among community constituents, agencies and professional groups (p.298)."<sup>67</sup> There is no one IPC model to fit every population of patients. The models vary significantly in focus and implementation among context-specific patient groups.<sup>21,28,30</sup>

Margaret MacAdam<sup>3</sup> at the Canadian Policy Research Network (CPRN) conducted a systematic review of the literature on efforts to provide integrated care for the elderly. The papers reviewed indicated that it is possible to design integrated programmes that redirect care away from institutional services (long-term care homes and hospitals) and achieve improved quality of life (QOL) and reduced caregiver burden. The specific features of successful models may vary, but typically include an interprofessional collaborative practice model; use of case management; and access to a wide range of social, health, and community supportive services. The strongest programmes also included *active* involvement of physicians, specifically geriatricians and general practitioners. Decision tools and common assessment and care planning instruments were integrated data systems frequently listed as infrastructure supports for integrated care. The key outcomes identified in this review included reduction in hospital, nursing home, and long-term care use; cost effectiveness and savings in the long term; and increased client satisfaction and quality of life.

There is a general consensus across the academic and grey literature that many general and context-specific IPC programmes in the care of older adults and their families in home and community have been implemented with varying outcomes. Some partial programme evaluation has been conducted but, although there is anecdotal evidence of their effectiveness in improving patient outcomes, little if any strong evidence of improvement in patient outcomes exists (Casimiro et al., 2011; Trivedi et al., 2013).

There has been some evidence in individual studies of positive organizational and system outcomes, such as improved team functioning, better client and caregiver satisfaction, reduced hospital and long-term care admissions, and better cost efficiency, to name a few, but more rigorous research is required to demonstrate strong evidence for IP team effectiveness and improved patient outcomes.

**Trivedi et al.**<sup>30</sup> point out, in a systematic review of 41 RCTs conducted worldwide and reporting user outcomes for IP care of community-dwelling older adults, that there is lack of evidence linking IP work to explicit outcomes for these clients. Further, it is not clear how different systems, contexts, professionals, agencies, roles, and services influence the effectiveness of IP work and collaboration. Based on this review, it is clear that the process of IPC is poorly documented and there is lack of evidence on the cost effectiveness of IPC. However, integrated models of care have the potential to improve the processes of care and reduce hospital or long-term care use. Further, the role of case/care management as an interprofessional related intervention needs further research.

**Markle-Reid, Browne and Gafni**<sup>86</sup> reported the results of 3 community-based RCTs in Southern Ontario, noting that nurse-led health promotion disease prevention (HPDP) strategies had statistically significant improvement in care for seniors in the home. They recommended multiple home visits, multidimensional assessments, IPC, and co-ordination of care by case managers with expertise in geriatrics. Further, they reported that interventions that engaged clients, family, and other healthcare providers were effective in improving the clients' overall quality of life scores (HRQOL), with no additional healthcare delivery costs, compared with the control group with usual home care service. There were insufficient data to generalize results beyond Southern Ontario but they do suggest the need for further research to determine which interventions were most successful, why they were successful, and how they should be incorporated into home care services given that HPDP strategies were incorporated with no extra cost to the system.

**A pilot study of an IPC model at Stonechurch Family Health Centre** in Southern Ontario used an IP shared-care model for seniors living in the community.<sup>21,87</sup> It was determined that this programme reduced referral times for seniors, provided easier access to services, and successfully allowed seniors to stay at home.

**Victorian Order of Nurses SMART In-Home Programme** provides one-on-one volunteer-facilitated exercise visits to help shift the balance away from potential frailty, empowering seniors to maintain their own wellness. This involves volunteer-facilitated functional fitness classes (1 hour/per week) brought to community-dwelling seniors who may otherwise not be able to participate or gain the benefits of appropriate physical activity. Twenty VON sites across Canada currently offer VON SMART programmes, with a long-term goal of having the programme in place in all sites. There is anecdotal evidence of excellent results and plans are underway for a full scale programme evaluation.

**Seniors Managing Independent Living Easily (SMILE) Programme** empowers seniors to live at home through access to individualized home support based upon their needs. This is an integrated programme in south-eastern Ontario that has a long wait list for services.<sup>88</sup> Through interaction with users of the model, it is apparent that access to community services for seniors partners well with prevention and early intervention programmes to support seniors who wish to continue living at home. Programme evaluation has not yet been conducted but anecdotal evidence suggests that is well received in the south-east Local Health Integration Network (LHIN) with other LHINs showing interest in implementing the programme.

A pilot study of a 6-month **interprofessional community-based intervention for older adults with diabetes and multiple chronic conditions** is being carried out in Guelph, Ontario (Markle-Reid et al, in progress). The intervention includes a series of home visits by a nurse and dietician from Diabetes Care Guelph (DCG) and a monthly group education programme offered by the Guelph Wellington Seniors Association (GWSA) in partnership with DCG. Interprofessional collaboration between interventionists from DCG and the GWSA is supported by monthly face-to-face case conferences. Preliminary feedback from the interventionists indicates that the case conferences have helped them function as a team, prepare for upcoming group sessions, and identify relevant community programmes and services to discuss with participants for health promotion and chronic disease management. Effects of the intervention on diabetes self-management will be evaluated.<sup>89</sup>

**Virtual Wards in the UK:** The new reform in the British healthcare system urged a collaborative approach by different care providers. Consequently, the government has issued a large number of policy documents promoting collaboration to improve efficiency and effectiveness. Pilot projects were conducted at sixteen sites across the country to examine innovative approaches to providing better integrated care. The pilots targeted a range of client groups, most commonly elderly people with multiple co-morbidities. Results from the projects revealed the importance of IPC in delivering integrated seamless care.<sup>99</sup>

An example of an IPC model that was first introduced in the UK in 2006 is the “Virtual Ward”. This model of care uses the staffing, systems, and daily routines of a hospital ward to deliver preventive care to patients in their own homes, with the aim of mitigating their risk of unplanned hospitalization. The goal was to reduce hospital readmissions by providing short-term transitional care to high-risk and complex patients recently discharged from hospital.<sup>71</sup>

The “Transforming Community Services” policy, which was launched in 2008 to move care closer to home, has succeeded in reducing lengths of stay in hospitals. However, because of the complexity of service provision patterns and the lack of effective collaboration between providers in hospitals and communities, there are still numerous barriers to change of community services.<sup>14</sup>

**Virtual Wards (An IPC model providing transitional care):** Virtual wards (VWs) foster collaboration, care integration, and effective transition. The aim was to reduce hospital readmissions by providing short-term transitional care to high-risk and complex patients in the community recently discharged from hospital.<sup>71,72</sup> Patients were provided home-based care by an IP team. In Canada, VWs were piloted in Toronto and Manitoba.<sup>72</sup> Teams varied in the different projects; however, they usually included a physician, a nurse, and a

care coordinator. Evaluation of programmes showed significant reduction of readmissions rates and VWs were well perceived by patients and providers.<sup>73</sup>

**Patient First model from Australia:** This model successfully linked hospitals and community-based healthcare services for the elderly. All stakeholders including clients were involved in the planning, implementation, and evaluation of the stages of the project. The overall results indicated patients who participated displayed a reduced demand for acute hospital services and hospital readmission.<sup>74</sup>

**Free-Choice Model in Denmark:** Helping the elderly to help themselves has been one of the basic principles in the Danish national legislation on the delivery of home care since the 1980s.<sup>95</sup> A “free-choice model” has been at work in Denmark since the beginning of 2003. According to this model, the elderly have free choice of care providers. However, the free choice model has changed the organisation of care provision as a whole and made interprofessional collaboration a necessity. The government wanted a more coherent service; consequently, it strengthened collaboration, coordination, and knowledge across the public sector.<sup>96</sup> The municipalities in Denmark shared the same expectations as the professionals about interdisciplinary and interprofessional problem-solving, and encouraged local authorities to: “Facilitate the possibilities for the professionals for getting to know each other’s competences and methods, create common development of competences and qualifications across professions and sectors and promote the development of common pedagogy and common tools” (The National Association of Local Authorities, October 12, 2007).

**The Invisible Chain Model in the Netherlands:** Like most other countries, the Netherlands are struggling with an ever increasing number of older adults either prone to or experiencing a plethora of chronic conditions or age-related complaints. Recognizing the real threat of increasing health care costs; there is a pressing need for an overhaul of the care for the chronically ill and vulnerable, older people in Dutch society.

They are focusing on:

1. A need for administrators of care educators, clients and policy makers to work together to improve the system.
2. The need for clients to have more control over their own health and illness
3. Improved quality, effectiveness, and safety of care of older adults
4. Collaboration and cooperation between professionals, clients, and caregivers across sectors to address the issues

To address these issues, the government of the Netherlands is exploring a seamless continuum model of care. An “invisible chain” model has been implemented which involves collaboration between a long term care (LTC) facility and a university on one end, where faculty from the university are cross-appointed to the LTC facility to work with administrators and staff to identify researchable questions and provide evidence for best practice. The LTC staff in turn spends time at the university to educate students in all disciplines involved in geriatric education. Further to this, the LTC facility partners with the community service home care providers to assist the clients through a “community gatekeeper” to identify the services they require while living at home. The “gatekeeper” can be any health or social service professional (usually a nurse or social worker) capable of coordinating home and community care. The model to date does not seem to address the link between acute care and discharge of the older adult to home and community, most likely due to the fact that not many older adults are discharged to home and community from acute care in the Netherlands. However, in Ontario, this happens fairly frequently, so it would need to be considered in any model such as this in order to achieve a true seamless continuum in the care of older adults.

**IPC in Sweden:** The healthcare systems in Sweden and the Netherlands are similar to that of Denmark. Sweden implemented laws requiring IPC in health care, especially for the elderly, in healthcare organizations and in community and home settings.<sup>82</sup> In Sweden, older people’s needs are often assessed in the context of care planning upon discharge from hospital, where professionals collaborate in teams planning the care, together with the older person. These professionals are assigned to carry out tasks where their specific expertise is needed. They enjoy various degrees of autonomy or discretionary power in judging the needs and rights of the



clients.<sup>82,94</sup> IP health teams in Sweden have transformational leadership, for instance, home planning teams (HPT) or discharge planning teams (DPT) for elderly patients. A registered nurse as case manager is the leader of the HPT, while a social worker is the leader of the DPT.<sup>82</sup>

**IPC in New Zealand:** In 2002, the Ministry of Health released the New Zealand Positive Aging Strategy and Health of Older People Strategy to provide better integrated, seamless care to older adults.<sup>104</sup> There have been many initiatives in the New Zealand healthcare system that aim to improve the care of older people. In terms of home care, local district health boards fund the support and care services to help the elderly be active in the community and be able to stay in their homes as long as possible. To reach this goal, there is collaboration between district health boards and aged-care providers in the community to help in building and maintaining a vital workforce towards care for the elderly.<sup>75</sup>

In 2014, the Ministry of Health released the 'Care closer to home' strategy with the aim of providing better, integrated health care closer to home for all New Zealanders.<sup>15</sup> To fulfill the Ministry's priority of "Care closer to home", health professionals are undertaking many initiatives. Doctors, nurses, midwives, pharmacists, physiotherapists, and other health professionals working in the community are focused on keeping patients healthy by identifying and treating health issues earlier, so patients do not end up in hospital. They are also collaborating to provide better support for patients who are discharged from hospital and reduce their risk of readmission. IPC is enhanced by using improvements in technology for a better flow of patient information between health services and for delivering better community-based services to help patients manage their long-term conditions at home. For example, the Enhanced Intermediate Care Assessment and Treatment Team (EICATT) programme began in 2012. The programme is helping older people return home earlier, after serious falls or injuries. The EICATT programme is designed for older people who are transferred from hospitals to a rehabilitation village before returning home. The team includes geriatricians, specialist nurses, physiotherapists, occupational therapists, and social workers who meet weekly. To date, the programme is well received by clients and providers.<sup>75</sup>

**IPC in Japan:** The Japanese government initiated mandatory public long-term care insurance (LTCI) in 2000, to help older people lead more independent lives and relieve the burdens of family carers. It is a user-oriented system where the elderly can use services by their own choice.<sup>92</sup> The basic principles are as follows:

- “(a) Elderly people should be entitled to utilize home care services and facility services in accordance with their own needs and desires without feeling a sense of reluctance, regardless of their income level and family situation.
  - (b) The second principle is to integrate the two existing systems for the elderly, the welfare system and the Health Service System for the Elderly.
  - (c) The third principle is to encourage diverse private sector.
  - (d) The fourth principle is to introduce the concept of “care management” in order to provide a variety of services in conjunction with one another to meet the desires of the elderly.”<sup>112</sup>
- [www.kaigo.gr.jp/JLClhp.htm](http://www.kaigo.gr.jp/JLClhp.htm)

The fourth principle was introduced because many elderly and their families were unaware of the type of service providers or care available. When providers were contacted, much negotiation was needed to receive services. The introduction of care management allowed the elderly to have a professional of their choice formulate a care plan and coordinate services (Raikhola & Kuoki, 2009).<sup>112</sup>

Care managers come from related occupations and must pass an exam and complete a training course. They are employed by a specialized agency or service provider; despite early worries about conflicts of interest, most care managers seem to serve the clients' interests well. Their main tasks are to coordinate with other providers (particularly family physicians and hospitals), manage service provision and reimbursement, and help recipients and carers make decisions.<sup>92</sup>

Despite the availability of a care manager, IPC represents a gap in the Japanese elderly care system. Coordination needs to be improved between the different sectors of long-term care and medical care. Both sectors are crucial for provision of good care, but cooperation is hard to achieve.<sup>92</sup>

**Northumberland PATH model:** Started in 2012, funded by the Change Foundation, the project involves a large group, including primary care providers, a technology partner, experts in geriatric care, and influential citizens. Patients and caregivers collaborate with providers across the community/system to co-design changes to improve healthcare transitions and experiences. The Foundation plans to present all that it learns from the Northumberland PATH, related research, and public engagement into a capstone Summit in 2015 that will result in key recommendations for change.<sup>76,77</sup>

**IMPACT model:** Project IMPACT (Interprofessional Model of Practice for Aging and Complex Treatments), initiated in 2008 at Sunnybrook Health Sciences Centre in Toronto, is a model of IP primary care for elderly patients with complex health care needs. The comprehensive team comprised family physicians, a community nurse, a pharmacist, a physiotherapist, an occupational therapist, a dietician, a community social worker, and trainees from each discipline. The main objective of IMPACT is to design and evaluate a new interprofessional team-based model of care for community-dwelling seniors with complex healthcare needs. Evaluation of the model so far has shown a better outcome for patients and positive feedback from patients, clinicians, and trainees.<sup>78</sup>

**PACE model:** The Program of All-inclusive Care for the Elderly (PACE) is an American long-term care delivery and financing innovation aimed at preventing unnecessary use of hospital and nursing home care and keeping seniors in their home and community longer. It has been implemented widely in cities and states across the USA, serving enrollees in day centres and clinics, their homes, hospitals, and communities. Enrollees must be 55 years of age or older, live in the geographic catchment area, and be referred by the state as eligible for the programme. Outcomes of the programme have been positive including good consumer satisfaction, reductions in institutional care, and controlled utilization of medical services, but start-up of the programme requires substantial time and capital.

**All-inclusive Care of the Elderly (ACE) Unit model:** Mt. Sinai Hospital in Toronto, Canada has implemented an ACE Unit for geriatric patients that is modelled partially on PACE but within the funding confines of the Canadian healthcare system. It is an integrated care model that uses multidisciplinary teams in the care of older adults and their families in a seamless system across the acute and community sectors. It is a relatively new programme but is already showing promising results (conversation with Dr. Samir Sinha).

**TAPESTRY project (EMS and community care):** TAPESTRY (Teams Advancing Patient Experience: Strengthening Quality) is a programme offered by the Department of Family Medicine in collaboration with the McMaster Family Health Team and other sites across Canada ([www.HealthTapestry.ca](http://www.HealthTapestry.ca)). Community volunteers make home visits to older patients to help them meet self-identified goals to stay healthier longer. Volunteers work in collaboration with the Family Health Team to help patients navigate the healthcare system. Patients can use their Personal Health Record to interact with and inform other members of their circle of care, such as community care nursing and family caregivers. The programme is in the early stages of evaluation. Drs. Jenny Ploeg and Ruta Valaitis from the ACHRU and McMaster School of Nursing are co-investigators.

**Toronto Central EMS project:** Ontario is investing 6 million dollars in the expansion of community paramedicine programmes to improve access to home care and community support services for seniors and other patients with chronic conditions. This will allow paramedics to apply their training and skills beyond the role of emergency response and can include home visits to seniors who frequently call EMS, educating seniors in their homes about chronic disease management, and helping refer patients to their local CCAC. Community paramedicine programmes will work with teams of health professionals, to co-ordinate care for individual patients with complex chronic conditions. These programmes will help seniors live independently, while helping reduce unnecessary emergency room visits and hospital admissions. A six-month study of this programme found that, when paramedics responding to emergency calls referred patients to community services, there

was a 50% decrease in the number of repeated 911 calls and a 65% decrease in the number of emergency department transports. (from MOHLTC website)

### **Key Findings**

IP work varies with context, intensity of need, workforce availability, and pragmatism<sup>68,69</sup> but there must be better understanding of how differences in context, systems, mix of professionals, agencies, roles, and services influence IP work and patient outcomes for community-dwelling older adults.<sup>21,28-30,70</sup>

There are a number of models in practice, including some good ones that, although not yet evaluated, do hold some promise.

Team effectiveness and patient outcomes are context-specific and there is no *strong* evidence that good team functioning improves patient outcomes.<sup>30</sup>

### **Future Considerations:**

1. Partners involved in planning and implementation of IPC care models in the home and community care of older adults and their families should plan for built-in programme evaluation, with a specific focus on team effectiveness and improved patient outcomes for the older adult population in the community. Committed partners in the model of care, including the clients, need to see the benefits of the programme.
2. There is a need for more randomized controlled trials (RCTs) to study the effectiveness of IPC models that focus on the care of older adults and their families, with particular emphasis on direct and indirect patient outcomes. Although research to date has provided some evidence for system and organizational outcomes, such as reduced hospital stays and nursing home use, better team functioning, improved community care, and increased patient and care provider satisfaction, more research is required to demonstrate team effectiveness and its relation to improved patient outcomes.<sup>21,29,30</sup>
3. While integrated care models theoretically may improve care in the community and reduce hospital stay and nursing home use, more rigorous studies and observational research are required to fully understand the effectiveness of IPC on targeted populations (Trivedi et al., 2013; Markle-Reid et al., 2013).
4. Descriptive observational and other qualitative studies are required to understand the experiences of older adults and their families with these particular models. These types of studies could further inform the findings of experimental studies.

“I really think that, for seniors especially, a healthcare team would be...and, you know, if you could put them sort of all in one place and I wouldn't have to drive to twelve different offices...I know that's not feasibly possible, but...there...you know, for seniors especially, they need the familiarity and that place to go to.”  
(Caregiver Quote-Study 1)

“I think probably the more major stumbling blocks are just the disconnection of home care, home and community care service providers from the rest of the system. So you think about... a client's journey from a hospital, for instance, so an elderly client is in a hospital, they have a suite of service providers that are caring for them in acute care. They are being planned for discharge. They get hooked up with the CCAC case manager, that case manager then connects them in some way to service providers in the home and community care sector once they get discharged from the hospital. So we, as home care providers, we never get to talk to the nurses that cared for that client in the hospital. We don't get to have a case conference with the physician, the primary physician, to understand their plan of care. It's all in writing and it's all referral based and it's all filtered through the CCAC case manager.....So we then take on the home care components of that directed by the

CCAC case manager, and I just think we're talking about interprofessional collaboration – from that perspective we're really missing a lot.... We don't get to talk to the physiotherapist that was doing rehab or with that client or other professionals in hospital. So there's a lot of missed opportunity from a professional, interprofessional collaboration perspective." (Participant 18)

"That's why we're blessed in this community because we're a tiny health team and we only have a catchment area of twenty-four thousand patients. We have twenty-eight doctors and we have then our family health team of dieticians, visiting nurses, geriatric specialists, diabetes specialists, congestive heart failure specialists...so we've got the whole gamut and our people can make house calls which is important for older adults." (Healthcare Provider Quote-Study 1)

"We have a terrible system filled with silos. Everybody keeps trying. The very best that I have seen so far is the Family Health Teams because we really collaborate. It is still a huge challenge working with outside agencies." (Healthcare Provider Quote-Study1)

"Swedish study, called Too Complex and Too Time-Consuming to Fit In (Geary and Shumacher, 2012). It's a study of why primary care providers' views of integrating older adults into treatment decision-making – it's too complex, too time-consuming to fit in. So...so patients can advocate for time and I think, really, across the board if we're going to call people complex it means there's no shortcut solution. It means there's no magic wand waving that's going to solve the problems. If we really want to own these problems, take them seriously and call it good quality of care, then we have to find the time." (Participant 12)

"I think we have under-explored the horizons that are represented by IPE and IP collaboration. So my recommendation is do more and evaluate what works. And in this field do it quickly . It truly needs to be supported, nurtured and championed. We just need to bite the bullet and fund a bunch of interprofessional centres for aging. Integrate social and medical care, throw away the disease model, you know. Buy into Mary Tinetti's *End of Disease Era*. Set up interprofessional assessment. Deal with patient's function and symptoms. You know, forget about their risk reduction if they're over 80 for their Lipitor." (Participant 12)

"I think one of the facilitators that we don't often talk about but is really part of the whole business model, that's a very influential factor, is that there is evidence that using collaborative team-based approaches can actually reduce the bottom line in the system. And I think because so many policy makers and so many health delivery decision-makers are so conscious of money and the unsustainability of the system, I think that's a real leverage point." (Participant 06)

"So we have...we run a model, SMILE ...so you're going to have to think about interprofessional collaboration in a different way because this is very much on the CSS side of things, so there's really very little professional designation in this model. But it is...it is very interprofessionally collaborative but with different people. The way that the programme runs is that elderly clients have a particular allocation of funds. We...we have a case manager, usually a professional so a social worker or a nurse, that works with the client to understand what their particular needs are from an IADL and ADL perspective, and we...we help the client. We match the client with those services..... it's things like, you know, driveway shovelling or wood cutting or taking an elderly person out to go grocery shopping, those kinds of things, to appointments and that kind of stuff. So it's not the medical model at all and when we think about interprofessional collaboration we think about that model....It is working very well!" (Participant 18)

## ***Possibilities of Integrating Student and Practitioner Learning Into these Models***

### ***Background***

Because the community is such a unique practice setting, where there is no one specific place where providers work as in the acute care sector, communication among providers, learners, the older adult, caregiver, and family can be problematic.

Education and practice of providers in the field requires organizational and IT planning that centres around learner, practitioner, and patient-related processes to manage the older adult and family in home and community.<sup>21</sup>

### ***Key Findings***

There is a need for mobile technology and processes between agencies to enhance IP communication and documentation for seniors care in the home. This mobile technology and interagency processes should consider and accept the varying role-related responsibilities among caregivers.<sup>9</sup>

Literature suggests faculty teaching in the IPE programmes must have:

- leadership support and a strong commitment to IPE/IPC.<sup>16,23</sup>
- a positive attitude for teamwork with other health and social professionals.<sup>22</sup>
- appropriate preparation in teaching content within the IP programme<sup>17</sup>, which is not necessarily core content within their own professional programme.
- workloads in their core professional programmes should reflect their involvement in the IPE programme.<sup>17</sup>

IPE should be valued by universities and legislated by governments.

**The UK** is a pioneer in the area of IPE, with many initiatives to promote IPE since the 1950's and the establishment of the Centre of Advanced Interprofessional Education (CAIPE). CAIPE is a national and international authoritative voice on IPE in both universities and the workplace. The government first focused on continuing professional development in its workforce strategy for health and social care.<sup>62</sup> The government then shifted its emphasis abruptly to pre-licensure IPE with the turn of the millennium.<sup>63</sup> Recent national policy documents have linked health workforce reform to changes in the way healthcare professionals are educated and trained. The 2010 UK Department of Health consultation paper clearly linked workforce planning with the need to take a stronger multiprofessional approach to education and training of healthcare professionals (Department of Health, 2010).<sup>100</sup>

As an important aspect of the new reform, the National Health System (NHS) stressed the importance of collaboration between the NHS, higher education providers, and regulatory bodies to make IPE basic training more flexible. This training should come after incorporating IPE in a core curriculum for common foundation programmes to promote partnership at all levels and ensure a seamless service of patient-centred care including communications skills and NHS principles.

The shift in the governmental preferences led to a shift of funding towards pre-licensure IPE, hence, more focus on IPE in universities and colleges. National initiatives have included the establishment and funding of four leading edge IPE sites in 2003: North-East, Sheffield, Southampton, and King's College London.<sup>101</sup> These were followed by the formation of the Creating an Interprofessional Workforce (CIPW) framework.<sup>102</sup> This framework has been credited with providing direction and guidance to those involved in developing IPE programmes and enhancing wider individual and organizational interest in IPE.<sup>103</sup>

In 1996, Linköping University was the first in **Sweden** to implement an interprofessional training ward (IPTW) at the department of orthopedics, to help undergraduate students become proficient in teamwork.<sup>54</sup> Students

from medicine, nursing, physiotherapy, and occupational therapy perform the care, treatment, and rehabilitation of patients in the IPTW. Other IPTWs were established in Sweden based on this model. In Orebro, an IPTW was established in municipal care for older adults, including students from occupational therapy, nursing, and social work.<sup>55</sup> Reports on experiences with IPTW at the University of Linköping and other Swedish universities have been published.<sup>53,56,57</sup> It has been shown that the placement at the IPTWs had a positive effect on students' attitudes and views of the other professions.<sup>98</sup> Learning from the interprofessional training unit (ITU) model in Høstebro, Denmark<sup>53</sup>, Karolinska Institutet in Sweden introduced ITU at two geriatric wards.<sup>58</sup>

**In New Zealand**, interprofessional education is provided at the Universities of Auckland and Otago. Several reports from the government highlighted that the quality of healthcare services depends on staff that can work well with all healthcare professionals, respect each others' contribution, and together provide quality patient care. Consequently, the New Zealand National Centre for Interprofessional Education and Collaborative Practice (NCIECP), based at the Auckland University of Technology, was established. It was the first of its kind in New Zealand, with a mandate to develop interprofessional educational programmes, both within the classroom and in the clinical environment. The centre also supports research and organizes conferences related to interprofessional education at the undergraduate and postgraduate levels.

**In Australia**, several government policy documents and independent reports have advocated for the inclusion of IPE in health professional education programmes.<sup>105,106</sup> A recent cross-sectional survey found that, while 80% of Australian and New Zealand universities claimed to offer IPE experiences to their students, the majority of these did not fit the accepted definition of IPE. Rather, they involved passive learning from other professions in lectures or tutorials (29%). IPE opportunities on clinical placement accounted for 17% of IPE efforts; however, most of these occurred without structured opportunities for interaction between students and staff from different health professions.<sup>107</sup>

One example of IPE in Australia is a six-bed student training ward (STW) which was established in 2010. The STW operates within a 26-bed general medical ward at Royal Perth Hospital. Final year students from medicine, nursing, occupational therapy, pharmacy, and physiotherapy undertake all ward duties as an interprofessional team. Facilitated group learning sessions and reflective practice complement profession-specific and generic tasks. Curtin University is the leading partner in this STW. Partners include four other Western Australian universities, Country Health Service, and Health Consumers Council, reinforcing the concept that collaboration across the health and education sectors is necessary for the implementation of large scale IPE projects (Brewer & Franklin, 2010).<sup>108</sup>

Universities across Australia and New Zealand established the Australian Interprofessional Practice & Education Network (AIPPEN), which is a platform for individuals, groups, institutions, and organizations committed to researching, delivering, promoting, and supporting IP learning to advocate and promote IP education and practice.

**In Japan**, IPE is highly valued by the government and promoted in universities across the country. However, it is not legislated. IPE initiatives have been implemented for undergraduate students in several universities, which receive generous financial support from the Japanese government. The programmes vary in content and are diverse in their goals, methods, and students. Through IPE, students are expected to value community health care, deepen their understanding of the community, and develop a sense of mission and commitment to community health care.<sup>59</sup>

Ten Japanese universities engaged in health professions education established the Japan Inter Professional Working and Education Network (JIPWEN) in 2008. JIPWEN discusses critical issues of IPE and presents plural models to help other institutions adopt similar IPE programmes. It plays a coordination and liaison role with the Japan Association for Interprofessional Education (JAPE), WHO, international IPE networks, and international academic associations. It also advocates the importance of IPE to the Japanese government and tries to strengthen the Human Resource for Health (HRH) policy. JIPWEN universities have unique educational

organizations, which play an important role in IPE, including preparing an annual plan, implementing faculty development, communicating with university hospitals and local facilities, and evaluating and analyzing the achievements. Through these organizations, IPE is incorporated into the curricula of diverse professions.

There has been a focus on IPE and IPC in caring for the elderly in **Taiwan** since the end of the past century, in response to the growing aging population. Concerning IPE, changes in education policy were made at both the undergraduate and postgraduate levels. At the undergraduate level, the Ministry of Education funded a project to build consensus on core curricula for social workers, nurses, physical therapists, and occupational therapists to prepare students in the fields of geriatrics and long-term care.<sup>113</sup> Amongst the core competencies required in all professions is teamwork.

In support of education at the post-professional level, the Ministry of Health and Welfare has organized Long-term Care Personnel Training programmes, which are fundamental to the success of implementing long-term care. Seventy-four hours of post-professional training are required for each professional health worker in long-term care. To prepare trainees for adequate interprofessional practice in the workplace some courses emphasize interprofessional learning.<sup>114</sup>

In addition to the support to IPE from the government of Taiwan, universities and different associations advocate for IPE. For instance, Fu-Jen Catholic University in Taipei, which offers a Master's program in Transdisciplinary Long-term Care hosted a conference on Interprofessional Collaboration in Long-term Care in September 2013 in collaboration with the Taiwan Long-term Care Professional Association (TLTCPA). The conference focused on exploring the role and contribution of interprofessional collaboration in the delivery of effective long-term care. This conference was informed by the workshops on Interprofessional Education and Faculty Development held earlier in the year by the Consulting Office of the Ministry of Education.<sup>114</sup>

### **Future Considerations**

1. IPE programmes should consider the inclusion of learning related to technological innovations such as mobile technology, electronic documentation, and electronic communication systems for older clients and their families and caregivers in home and community.
2. Because IPE involves many different providers in many different venues in the community, scheduling face-to-face class time for post-licensure programmes can be problematic. Alternative ways of learning through electronic classrooms, telemedicine, and videoconferencing should be explored.
3. The use of simulation technology should also be explored to the full extent of its capabilities in teaching interprofessional collaboration and practice in the care of older adults and their families in the community.
4. Faculty teaching in IPE programmes should be champions of IPE and IPC.<sup>17</sup>
5. Assess faculty's willingness and strength of conviction in the benefits of IPE and the development and utility of IP collaboration, especially in the care of older adults and their families in home and community.<sup>21</sup>
6. IPE educational opportunities, in particular coaching and mentoring skills, should be made available for faculty members showing interest and commitment to teaching in IPE programmes.<sup>22</sup>
7. Faculty who are recruited to teach in IP programmes from their core programmes should be given protected time to teach IPE and this should be considered as part of their teaching load.<sup>17</sup>

"The Federation of Healthcare Professionals, and I was part of that, we just developed about a year and a half ago e-learning tools for healthcare professionals and it deals with frequently asked questions. There's a

website. And they created a milestone model where you could put in a scenario, a patient scenario, and it prompts you so that you can be aware of who the key players need to be or who the key healthcare professionals need to be, so that the client, if they move from the community to the hospital and back to the community, so it's sort of a tool, a tool that you can use online to sort of learn in an interprofessional way, and it's on the website, who the key players are and what information needs to be gathered, I guess, from...in terms of taking care of the client." (Participant 17)

"You should note that down, because not all faculty here believe in the concept of IPE. It's often regarded as the soft and fluffy, touchy feely, be nice to one another and respectful. And they don't understand that one of the ultimate goals of IPE is patient safety." (Participant 11)

"Well, funding, faculty involvement, teachers, and flexibility in healthcare delivery models (*are important for sustainability*)." (Participant 11)

"You know, to support good interprofessional models of practice, I think one needs to actually have strong leadership that recognizes the value of that. And you have to have a team commitment." (Participant 26)



## Core Competencies Related to Collaborative Care with Older Adults Living in the Community

### Background

With the increasing complexity of our health and social systems, flexibility within the systems is critical to their future functioning. Accepting the inevitability of change as a constant mandates a need for flexibility. Focusing on capabilities of practitioners, as opposed to competencies, should be considered, because practitioner and team capabilities can change based on the needs of the older adult and family within a changing environment. Competencies are procedural skills that are far less flexible.<sup>25</sup>

### Key Findings

IPE programmes should incorporate as a basic tenet a clear **Patient/Client-Focus to Practice**. In fact, patients/clients and family caregivers should be included in the development and delivery of programmes.<sup>16,34,37</sup>

**Relational Capabilities** are essential for interprofessional collaborative practice. They focus greater attention on the often-referred to *softer skills* or qualities of compassion, empathy, respect, and trust in relationships with patients, families, and other teams.<sup>21,27,48-51</sup>

IPE programmes should encourage **Ethical Practice**, which encourages students/practitioners to understand their own value system and that of others, as well as the possible interactions between these, in order to enter into successful interprofessional collaboration that is patient/client-focused.<sup>17,19,25,42</sup>

It is felt that there should be **Sound Professional Practice (knowledge and skill)** within each discipline, delivered in conjunction with IPE knowledge and skill.<sup>17, 21,22</sup>

Literature suggests the content of interprofessional (IPE) should include:

- relational capabilities
- professional socialization<sup>16,17,23, 34,38</sup>
- collaborative knowledge and skill (respect and trust of others, understanding of roles and overlap, communication/negotiation skills)
- conflict resolution skills<sup>42</sup>
- transformational leadership skills<sup>19, 21,42</sup>
- setting shared goals and shared decision-making strategies<sup>45,52</sup>
- inclusion of patient and family as key decision-makers in the planning of care
- content related to the co-morbidities and complexities of older adults living independently in the community through case studies and small group learning, where groups consist of all healthcare providers, clients, and families that are involved in the team<sup>21</sup>
- Clinical placements are important to incorporate into practice settings and should correlate with classroom learning. More focus needs to be placed on real-life clinical experience
- Clients and families should be consulted in curriculum development and content and included in the learning where possible in the post-licensure phase

**In Denmark**, the public demand for interprofessional collaboration has led to a ministerial order of integrating interprofessional elements in the curricula of various educational programmes. An interprofessional element has been integrated in the Danish Bachelor programmes in Education, Social Work, and Health. The University Colleges are in the process of implementing the new legislation. Although the IPE elements may vary across disciplines, different IPE programmes share the same basic goals, which are to become qualified to cooperate with persons from other professions and to take innovative approaches in interprofessional work.

In addition to changes in curricula, projects to enhance IPE and IPC were introduced nationwide in Denmark. Interprofessional training units (ITU) were established across the country, the first of which was in Holstebro in

2004. The Holstebro ITU consisted of eight beds in an orthopedic ward with 30 beds. Students from nursing, occupational therapy, physiotherapy, and medicine were placed for two weeks of clinical training. It has been shown that placement at the ITU had a positive effect on students' attitudes and views of the other professions.<sup>53</sup>

In **Sweden**, educational institutes are required by law to include IPE elements in their curricula and training. In 1996, Linköping University was the first to implement an interprofessional training ward (IPTW) at the department of orthopedics, to help undergraduate students become proficient in teamwork.<sup>54</sup> Students from medicine, nursing, physiotherapy, and occupational therapy perform the care, treatment, and rehabilitation of patients in the IPTW. Other IPTWs were established in Sweden based on this model. In Orebro, an IPTW was established in municipal care for older adults, including students from occupational therapy, nursing, and social work.<sup>55</sup> Reports on experiences with IPTW at the University of Linköping and other Swedish universities have been published.<sup>53,56,57</sup> Learning from the above-mentioned ITU model in Hølstebro, Denmark<sup>53</sup> Karolinska Institutet in Sweden introduced ITUs at two geriatric wards.<sup>58</sup>

In **Sweden and Denmark**, patients/clients and family caregivers are included in IPE programmes, especially those focusing on home and community care.<sup>53,55</sup>

In Hokkaido Prefecture of **Japan**, in response to concerns about community health care, an IPE programme was introduced. The programme is meant to systemize several practical experience-training programmes and restructure them into one joint curriculum for community health care. The programme also provides students with an opportunity to interact with not only medical professionals, but also patients and their families and healthcare staff. Through IPE, students are expected to value community health care, deepen their understanding of the community, and develop a sense of mission and commitment to community health care.<sup>59</sup>

In 2006, the **Ontario** government created the Interprofessional Care Steering Committee with the purpose of preparing a blueprint to guide government, educators, health caregivers, organizational leaders, regulators, and patients in how to make the adoption of IPC a reality. Four main pillars of the blueprint include 1) building a strong foundation upon which to implement and sustain IP activities; 2) sharing responsibilities for implementation of IP strategies among interested parties; 3) implementing system enablers for the IP to be taught, practised, and organized in a systematic way; and 4) leading sustainable change that recognizes the collaborative nature of IP care and embraces it in the health and education sectors in Ontario.<sup>60</sup>

## Future Considerations

1. All students and IP team practitioners should be taught the importance of and how to engage in Reflective Practice<sup>16-19</sup>
2. Professional Organizations should be invited to engage in dialogue and planning for a standardized IPE curriculum<sup>20</sup>

"You know we need to be assessing students' interprofessional capabilities and those of our staff.....capabilities go a little beyond competence because they're about the application of those competencies – the ability to adapt them and react to different contextuals... So it's not that you take the list of competencies...capability is about adapting that into all sorts of different situations. But can you adapt your communication (as a competency) to working with older people, younger people, people with cognitive impairment, and people from a different culture, and those sorts of things." (Participant 20)

"I mean, I can point to some work that I know of focused on a programme called the Health Mentor Programme where – now this is at the student level – where students work with a "health mentor," someone living with a chronic illness in the community. And this is...this is qualitative work that's been done at the University of Toronto and we're seeing that what these kind of longitudinal experiences, where interprofessional groups of students are actually embedded more in the community with a health mentor, they

really open their eyes to what does safety mean in a community context. And, again, because the predominant lens is the hospital, I really truly believe that in terms of how we socialize most of our healthcare professionals, they really start to think about, ok, safety might look a little bit different in a home environment or in a community environment than it might in a hospital environment. So I think these kinds of experiences, the impact is it extends a student's or a practicing professional's worldview and it really helps them to understand, like, what is it really like for someone out there living with these chronic illnesses in their community. We don't get that kind of exposure. And I think those are perspectives that students and practicing clinicians can bring back to wherever they choose to work in the future". (Participant 16)

"If one believes that, at the end of the day, this is all about relational-centred care, then you have to have ways to build those relationships. So, you know, it could be once a year that the whole team gets together and the focus of that time together is about setting common goals for the team or the organization. People have to see, I think, themselves in the work over time and finding those face-to-face moments, I do think, is really important. Our students at the pre-licensure level, we think of them as the most technological savvy cohort of people ever on this planet, right? And when...when they survey themselves, so they lead a survey about the IPE curriculum at U of T and they are very honest, they tell us what's working and what's not working, and they ask themselves questions about what are the most meaningful types of pedagogies and experiences. It's not the technology. We're busy developing more online stuff, they talk about the face-to-face small group with real patients/clients and practicing clinicians. So that, to me, gives some evidence for what people value even in a technological environment. Does it make a difference at the end of the day? I don't know. We don't have the evidence for that yet. But I do think there has to be some element of face-to-face, for sure, yeah. Yeah." (Participant 16)

"So core competencies would include things like conflict resolution, being able to communicate, being able to listen, using client-centred services, coordinating care. What are... the seven principles of...Oh, you know what? One model that I can think about is Way and Jones, we did a lot of work". (Participant 17)

"And I could actually argue that, because in the community and in primary care I've seen some beautiful examples like in Memory Clinics or in the Fall Clinic or the Heart Failure Clinic that I'm in now, there's beautiful interprofessional practice there, that people really understand how and why they need to collaborate. I don't see students graduating with that kind of integrated collaborative thinking and especially not in care for older adults.....they don't realize that if everybody just does what they are trained for, then you have massive gaps, especially with older people." (Participant 10)

"I think part of it is that we have to...you know, it's hard to do IPC if groups aren't resourced to do IPC...So partly you've got to resource and make sure that those team members are supported to be a part of the team in order to actually have a team to do interprofessional collaborative practice together. I think once you actually have those teams, you create great learning environments where different professional learners can come and learn together and be mentored." (Participant 26)

## Best Practices by Other Provinces/Territories, National or Other Key Jurisdictions

### **Background**

Best practices vary across programmes and few, if any, are universal, making evaluation difficult. Best practices must be modified to individual programmes and client characteristics.

### **Key Findings**

Because of the complexity of providing interprofessional care for older adults and their families in home and community as outlined throughout this report, appropriate and thorough communication among care providers, caregivers, and clients, as well as across sectors, is essential in the co-ordination of this care. The majority of academic papers and grey literature address the need for technological innovations for collaborative practice in the community. It has been lauded as one of the key elements in supporting the success of integrated models of care for older adults and families across the system and specifically in home and community.<sup>3,21,29,30</sup>

Common assessment and care planning instruments and integrated data systems are commonly listed infrastructure supports for integrated care<sup>3</sup>, both across the system and, more importantly, in the community sector where services are widely spread out and team communication is more difficult because of time and geographical challenges.

Although there is presently much work occurring with better communication systems among care providers and clients in the community, such as electronic documentation that can be shared across the system, many issues remain to be addressed to render the system workable. Emailing, teleconferencing, and video-conferencing are applications that are now readily available for virtual team meetings across sites that have the potential to improve time management and negate the geographical issues. Handheld devices and PDAs serve a functional purpose in keeping participants connected across sites and applications (apps) to improve client care are continually being developed and tested. More work is required in these areas.

The designing and building of a mobile health (mHealth) solution to support community health providers in providing evidence-informed care to older adults with multiple chronic conditions who have experienced a stroke. **Markle-Reid..., Ploeg, J., Gafni, A., Valaitis, R.**<sup>85</sup>: The MOHLTC has funded a qualitative descriptive study where end users will be engaged in the design of the mHealth application. This app will be web-based with a mobile phone platform. The app will include the following functions: a communication tool for all care providers in the circle of care; the Stroke Management Protocol embedded within a safety framework; a safety checklist based on best practices with alerts to relevant professionals, including primary care practitioners; and trending of client status/progress over time. This information will be accessible by health team members and will provide key metrics, statistics, and summary information in the form of standardized reports to the interprofessional team as needed. This innovative technology has great potential to improve evidence-informed care for older adults with multiple chronic conditions and their caregivers. It is presently under development.

“The EMR, it’s a fantastic tool for collaboration and efficiency.” (Care provider-Study 1)

### **Future Considerations**

1. Technological innovation can go a long way in facilitating IPC and IPE in the care of older adults and families, as well as facilitating interprofessional communication across sectors and the community. Partners should encourage innovation in this area and provide the up-front funding for the innovative technologies that promise long-term efficiency and effectiveness in care delivery.
2. IPC teams across the sectors and particularly in the community should have a strong information technology (IT) network with common medical records and charting systems to prevent duplication of efforts and facilitate interdisciplinary communication.

## Summary of Facilitation and Sustainability of IPE in Home and Community Care for Older Adults and their Families

In order for IPE to be most effective and sustainable, it requires:

- Strong patient and family focus
- Strong government and organizational support with the primary focus more that of patient well-being, with cost-effectiveness, although important, being a secondary concern
- Organizational support translated into policy
- Investment in human resources and capital
- Interministerial and interorganizational cooperation and planning
- Institutional and government support (including financial, physical and human resources)
- Individual practitioners with values, attitudes, and commitment to the care of older adults and their families, willing to work together in teams across the care continuum in a seamless fashion
- Consistent core curricula, facilitating more effective programme evaluation
- Committed, competent faculty
- Relevant learning experiences, with an emphasis on clinical placements within well-functioning IPC teams who can act as role models for learners and provide real life experiences
- Non-threatening learning environments
- Role understanding and mutual respect for competency/capability
- Trust
- Good leadership and communication skills
- Reflective and ethical practitioners with a genuine interest in and commitment to the care of older adults
- For pre-licensure IPE programmes, an accountability structure and quality standards may play an important role
- Post-licensure education that is context-specific and ongoing, with content defined by individual teams engaged in IP. This is particularly important in the care of older adults with complex comorbidities living in the home and community.
- Consideration of consortium models of interested post-secondary educational institutions, as implemented in Japan and other countries.

The IPE models presented from Japan, Denmark, and Sweden indicate that government and institutional support and collaboration of efforts are crucial for the development and sustainability of IPE programmes.

Government/Organizational support plays an important role in IPE. For instance, in England, the government first focused on continuing professional development in its workforce strategy for health and social care.<sup>62</sup> The government then shifted its emphasis abruptly to pre-licensure IPE with the turn of the millennium.<sup>63</sup> The shift in the governmental preferences led to a shift of funding towards pre-licensure IPE, hence, more focus on IPE in universities and colleges.

“But, our challenge is, it’s easy to get all the healthcare professionals to the table for the training except the physicians.” (Participant 19)

“Public engagement...for the sustainability and also flexibility in the community setting, you need actually to prime and prompt and engage the public or the client or, you know, people to ask for it... you know the bottom-up, top-down approach, you need to have the bottom-up. You need the clients, the community asking for it. You need tell them so they can see it, recognize it, and actually attach a value to it, what we also mentioned to you they don’t see because they have no way of knowing that it’s happening”. (Participant 19)

## Summary of Facilitators/Sustainability of IPC in Home and Community Care for Older Adults and their Families

### Key Considerations for Successful Collaborative Practice

- Teams should have common goals and values, willingness to persevere with the programme, and mutual reliance and respect.
- Teams should have a defined geographical area and a common home base to facilitate communication.
- Teams should have a strong IT network with common medical records and charting systems to prevent duplication of efforts and facilitate interdisciplinary communication.
- Teams should develop an adaptable practice that allows for flexibility and facilitation of outreach activities.
- Relationship building is essential and will allow for capacity building initiatives, encourage support of people outside the team, and enhance a mutual respect for the importance of time.
- There is a need for transformational leadership within interprofessional teams.<sup>30, 80</sup>
- Government and organizational support, adequate funding, and common influences and values of stakeholders can also facilitate team collaboration.<sup>90</sup>

In countries where IPC is endorsed, resources (i.e., financial, human, or technical) played a central role in the development or regression of collaborative practice. For example, in England, pressure on healthcare resources has led to a reduction of technical and financial resources directed toward training and education.<sup>91</sup>

Scarcity of human resources can also be an obstacle to IPC. For instance, in Japan, more care workers are needed every year but they are difficult to recruit and retain because of the lower pay, more difficult working conditions, and lower chances of promotion compared with other specialties.<sup>92</sup>

In some Scandinavian countries, such as Sweden and Denmark, where financial and technical resources are available, IPC is incorporated in healthcare systems and legislated.<sup>82,93</sup>

In Sweden, older people's needs are often assessed in the context of care planning upon discharge from hospital, where professionals collaborate in teams planning the care, together with the older person. These professionals are assigned to carry out tasks where their specific expertise is needed. They enjoy various degrees of autonomy or discretionary power in judging the needs and rights of the clients.<sup>82,94</sup>

Transformational leadership within IP teams is incorporated in Sweden health teams, such as home planning teams (HPT) or discharge planning teams (DPT) for elderly patients. A registered nurse as case manager is the leader of the HPT, while a social worker is the leader of the DPT.<sup>82</sup>

## Appendix A: Country Summaries of Policies and Strategies for the Care of Older Adults and Families

### Denmark

#### IPC Policies in Denmark

##### Nationally

Helping the elderly to help themselves has been one of the basic principles in the Danish national legislation on the delivery of home care since the 1980s.<sup>95</sup> A “free-choice model” has been at work in Denmark since the beginning of 2003. According to this model, the elderly have free choice of care providers. However, the free choice model has changed the organisation of care provision as a whole and made interprofessional collaboration a necessity. The government wanted a more coherent service; consequently, it strengthened collaboration, coordination, and knowledge across the public sector.<sup>96</sup>

##### Municipally

The municipalities in Denmark shared the same expectations as the professionals about interdisciplinary and interprofessional problem-solving, and encouraged local authorities to:

“Facilitate the possibilities for the professionals for getting to know each other’s competences and methods  
Create common development of competences and qualifications across professions and sectors  
Promote the development of common pedagogy and common tools”  
(The National Association of Local Authorities, October 12, 2007)

#### Strategies to Enhance IPE and IPC

The public demand for interprofessional collaboration has led to a ministerial order of integrating interprofessional elements in the curricula of various educational programmes. An interprofessional element has been integrated in the Danish Bachelor programmes in Education, Social Work, and Health. The University Colleges are in the process of implementing the new legislation. Although the IPE elements may vary across disciplines, different IPE programmes share the same basic goals, which are to become qualified to cooperate with persons from other professions and to take innovative approaches in interprofessional work.<sup>93</sup> Patients/clients/family caregivers are included in IPE programmes, especially those focusing on home care and community care.<sup>53,55</sup>

Projects to enhance IPC in educational institutes, healthcare settings, and communities were introduced nationwide. These projects conjoin the skills of various professions including social and healthcare assistants. Interprofessional training units (ITU) were established across the country, the first of which was in Holstebro in 2004. The Holstebro ITU consisted of eight beds in an orthopedic ward with 30 beds. Students from nursing, occupational therapy, physiotherapy, and medicine were placed for two weeks of clinical training. It has been shown that the placement at the ITU had a positive effect on students’ attitudes and views of the other professions.<sup>53</sup> Recently, because of the incorporation of daily meetings of the interprofessional teams in the ITU, there was reduction of hospital stay for patients who had hip replacement.<sup>97</sup>

## The Netherlands

Like most other countries, the Netherlands are struggling with an ever increasing number of older adults either prone to or experiencing a plethora of chronic conditions or age-related complaints. Recognizing the real threat of increasing health care costs; there is a pressing need for an overhaul of the care for the chronically ill and vulnerable, older people in Dutch society.

They are focusing on:

5. A need for administrators of care educators, clients and policy makers to work together to improve the system.
6. The need for clients to have more control over their own health and illness
7. Improved quality, effectiveness, and safety of care of older adults
8. Collaboration and cooperation between professionals, clients, and caregivers across sectors to address the issues

To address these issues, the government of the Netherlands is exploring a seamless continuum model of care. An “invisible chain” model has been implemented which involves collaboration between a long term care (LTC) facility and a university on one end, where faculty from the university are cross-appointed to the LTC facility to work with administrators and staff to identify researchable questions and provide evidence for best practice. The LTC staff in turn spends time at the university to educate students in all disciplines involved in geriatric education. Further to this, the LTC facility partners with the community service home care providers to assist the clients through a “community gatekeeper” to identify the services they require while living at home. The “gatekeeper” can be any health or social service professional (usually a nurse or social worker) capable of coordinating home and community care. The model to date does not seem to address the link between acute care and discharge of the older adult to home and community, most likely due to the fact that not many older adults are discharged to home and community from acute care in the Netherlands. However, in Ontario, this happens fairly frequently, so it would need to be considered in any model such as this in order to achieve a true seamless continuum in the care of older adults.



## Sweden

### **Policies and Strategies related to IPC**

The healthcare systems in Sweden and the Netherlands are similar to that of Denmark. Sweden implemented laws requiring IPC in health care, especially for the elderly, in healthcare organizations and in community and home settings.<sup>82</sup> In Sweden, older people's needs are often assessed in the context of care planning upon discharge from hospital, where professionals collaborate in teams planning the care, together with the older person. These professionals are assigned to carry out tasks where their specific expertise is needed. They enjoy various degrees of autonomy or discretionary power in judging the needs and rights of the clients.<sup>82,94</sup> IP health teams in Sweden have transformational leadership, for instance, home planning teams (HPT) or discharge planning teams (DPT) for elderly patients. A registered nurse as case manager is the leader of the HPT, while a social worker is the leader of the DPT.<sup>82</sup>

### **Policies and Strategies related to IPE**

In 1996, Linköping University was the first in Sweden to implement an interprofessional training ward (IPTW) at the department of orthopedics, to help undergraduate students become proficient in teamwork.<sup>54</sup> Students from medicine, nursing, physiotherapy, and occupational therapy perform the care, treatment, and rehabilitation of patients in the IPTW. Other IPTWs were established in Sweden based on this model. In Örebro, an IPTW was established in municipal care for older adults, including students from occupational therapy, nursing, and social work.<sup>55</sup> Reports on experiences with IPTW at the University of Linköping and other Swedish universities have been published.<sup>53,56,57</sup> It has been shown that the placement at the IPTWs had a positive effect on students' attitudes and views of the other professions.<sup>98</sup> Learning from the interprofessional training unit (ITU) model in Høstebro, Denmark<sup>53</sup>, Karolinska Institutet in Sweden introduced ITU at two geriatric wards.<sup>58</sup>

## United Kingdom

### Policies and Strategies related to IPC

The new reform in the British healthcare system urged a collaborative approach by different care providers. Consequently, the government has issued a large number of policy documents promoting collaboration to improve efficiency and effectiveness. Pilot projects were conducted at sixteen sites across the country to examine innovative approaches to providing better integrated care. The pilots targeted a range of client groups, most commonly elderly people with multiple co-morbidities. Results from the projects revealed the importance of IPC in delivering integrated seamless care.<sup>99</sup>

An example of an IPC model that was first introduced in the UK in 2006 is the “Virtual Ward”. This model of care uses the staffing, systems, and daily routines of a hospital ward to deliver preventive care to patients in their own homes, with the aim of mitigating their risk of unplanned hospitalization. The goal was to reduce hospital readmissions by providing short-term transitional care to high-risk and complex patients recently discharged from hospital.<sup>71</sup>

The “Transforming Community Services” policy, which was launched in 2008 to move care closer to home, has succeeded in reducing lengths of stay in hospitals. However, because of the complexity of service provision patterns and the lack of effective collaboration between providers in hospitals and communities, there are still numerous barriers to change of community services.<sup>14</sup>

### Policies and Strategies related to IPE

The UK is a pioneer in the area of IPE, with many initiatives to promote IPE since the 1950’s and the establishment of the Centre of Advanced Interprofessional Education (CAIPE). CAIPE is a national and international authoritative voice on IPE in both universities and the workplace. The government first focused on continuing professional development in its workforce strategy for health and social care.<sup>62</sup> The government then shifted its emphasis abruptly to pre-licensure IPE with the turn of the millennium.<sup>63</sup> Recent national policy documents have linked health workforce reform to changes in the way healthcare professionals are educated and trained. The 2010 UK Department of Health consultation paper clearly linked workforce planning with the need to take a stronger multiprofessional approach to education and training of healthcare professionals (Department of Health, 2010).<sup>100</sup>

As an important aspect of the new reform, the National Health System (NHS) stressed the importance of collaboration between the NHS, higher education providers, and regulatory bodies to make IPE basic training more flexible. This training should come after incorporating IPE in a core curriculum for common foundation programmes to promote partnership at all levels and ensure a seamless service of patient-centred care including communications skills and NHS principles.

The shift in the governmental preferences led to a shift of funding towards pre-licensure IPE, hence, more focus on IPE in universities and colleges. National initiatives have included the establishment and funding of four leading edge IPE sites in 2003: North-East, Sheffield, Southampton, and King’s College London.<sup>101</sup> These were followed by the formation of the Creating an Interprofessional Workforce (CIPW) framework.<sup>102</sup> This framework has been credited with providing direction and guidance to those involved in developing IPE programmes and enhancing wider individual and organizational interest in IPE.<sup>103</sup>

## **New Zealand**

### **Policies and Strategies related to IPC**

In 2002, the Ministry of Health released the New Zealand Positive Aging Strategy and Health of Older People Strategy to provide better integrated, seamless care to older adults.<sup>104</sup> There have been many initiatives in the New Zealand healthcare system that aim to improve the care of older people. In terms of home care, local district health boards fund the support and care services to help the elderly be active in the community and be able to stay in their homes as long as possible. To reach this goal, there is collaboration between district health boards and aged-care providers in the community to help in building and maintaining a vital workforce towards care for the elderly.<sup>75</sup>

In 2014, the Ministry of Health released the 'Care closer to home' strategy with the aim of providing better, integrated health care closer to home for all New Zealanders.<sup>15</sup> To fulfill the Ministry's priority of "Care closer to home", health professionals are undertaking many initiatives. Doctors, nurses, midwives, pharmacists, physiotherapists, and other health professionals working in the community are focused on keeping patients healthy by identifying and treating health issues earlier, so patients do not end up in hospital. They are also collaborating to provide better support for patients who are discharged from hospital and reduce their risk of readmission. IPC is enhanced by using improvements in technology for a better flow of patient information between health services and for delivering better community-based services to help patients manage their long-term conditions at home.

### **Strategies related to IPE**

Interprofessional education is provided at the Universities of Auckland and Otago. Several reports from the government highlighted that the quality of healthcare services depends on staff that can work well with all healthcare professionals, respect each others' contribution, and together provide quality patient care. Consequently, the New Zealand National Centre for Interprofessional Education and Collaborative Practice (NCIECP), based at the Auckland University of Technology, was established. It was the first of its kind in New Zealand, with a mandate to develop interprofessional educational programmes, both within the classroom and in the clinical environment. The centre also supports research and organizes conferences related to interprofessional education at the undergraduate and postgraduate levels.

## Australia

### Strategies related to IPE

In Australia, several government policy documents and independent reports have advocated for the inclusion of IPE in health professional education programmes.<sup>105,106</sup> A recent cross-sectional survey found that, while 80% of Australian and New Zealand universities claimed to offer IPE experiences to their students, the majority of these did not fit the accepted definition of IPE. Rather, they involved passive learning from other professions in lectures or tutorials (29%). IPE opportunities on clinical placement accounted for 17% of IPE efforts; however, most of these occurred without structured opportunities for interaction between students and staff from different health professions.<sup>107</sup>

One example of IPE in Australia is a six-bed student training ward (STW) which was established in 2010. The STW operates within a 26-bed general medical ward at Royal Perth Hospital. Final year students from medicine, nursing, occupational therapy, pharmacy, and physiotherapy undertake all ward duties as an interprofessional team. Facilitated group learning sessions and reflective practice complement profession-specific and generic tasks. Curtin University is the leading partner in this STW. Partners include four other Western Australian universities, Country Health Service, and Health Consumers Council, reinforcing the concept that collaboration across the health and education sectors is necessary for the implementation of large scale IPE projects (Brewer & Franklin, 2010).<sup>108</sup>

Universities across Australia and New Zealand established the Australian Interprofessional Practice & Education Network (AIPPEN), which is a platform for individuals, groups, institutions, and organizations committed to researching, delivering, promoting, and supporting IP learning to advocate and promote IP education and practice.

### Strategies related to IPC

Health Workforce Australia (HWA), an initiative of the Council of Australian Governments (COAG), was established to address the challenges of providing a workforce that meets the needs of the community. The latest HWA initiative is the Aged Care Workforce Reform (2012-2014) initiative, which involves redesigning jobs among aged-care workers, providing further education and training, increasing flexibility of job roles, and encouraging innovative team approaches to care ([www.hwa.gov.au/our-work/boost-productivity/aged-care-workforce-reform-program](http://www.hwa.gov.au/our-work/boost-productivity/aged-care-workforce-reform-program)).

In recognition of the growing burden of chronic disease, a national policy approach has been adopted to improve chronic disease prevention and care across Australia (National Health Priority Action Council (NHPAC), 2006).<sup>109</sup> The National Chronic Disease Strategy report<sup>109</sup> incorporated an IP approach to care, between individual practitioners as well as the various healthcare sectors ([www.healthnetworks.health.wa.gov.au/modelsofcare/docs/Results\\_MOC\\_Survey.pdf](http://www.healthnetworks.health.wa.gov.au/modelsofcare/docs/Results_MOC_Survey.pdf)).

Western Australia (WA) Health Networks was established in 2006 in response to the report, A Healthy Future for Western Australians (Department of Health Western Australia, 2004).<sup>110</sup> This report identified opportunities to overcome fragmentation and duplication across the WA health system through collaboration among public and private health service providers. By 2012, health networks existed and more than 60 models of care had been produced collaboratively. The “Model of care” document outlines the principles and directions for delivering the right care, in the right place, at the right time, by the right team (Department of Health Western Australia, 2007).<sup>111</sup> The “Patient First” model successfully linked hospitals and community-based healthcare services for the elderly. All stakeholders, including clients, were involved in the planning, implementation, and evaluation of the stages of the project. Patients who participated displayed a reduced demand for acute hospital services and hospital readmission.<sup>74</sup>

## Japan

### Policy and Strategy related to IPC

The Japanese government initiated mandatory public long-term care insurance (LTCI) in 2000, to help older people lead more independent lives and relieve the burdens of family carers. It is a user-oriented system where the elderly can use services by their own choice.<sup>92</sup> The basic principles are as follows:

- “(a) Elderly people should be entitled to utilize home care services and facility services in accordance with their own needs and desires without feeling a sense of reluctance, regardless of their income level and family situation.
  - (b) The second principle is to integrate the two existing systems for the elderly, the welfare system and the Health Service System for the Elderly.
  - (c) The third principle is to encourage diverse private sector.
  - (d) The fourth principle is to introduce the concept of “care management” in order to provide a variety of services in conjunction with one another to meet the desires of the elderly.”<sup>112</sup>
- ([www.kaigo.gr.jp/JLClhp.htm](http://www.kaigo.gr.jp/JLClhp.htm))

The fourth principle was introduced because many elderly and their families were unaware of the type of service providers or care available. When providers were contacted, much negotiation was needed to receive services. The introduction of care management allowed the elderly to have a professional of their choice formulate a care plan and coordinate services (Raikhola & Kuoki, 2009).<sup>112</sup>

Care managers come from related occupations and must pass an exam and complete a training course. They are employed by a specialized agency or service provider; despite early worries about conflicts of interest, most care managers seem to serve the clients’ interests well. Their main tasks are to coordinate with other providers (particularly family physicians and hospitals), manage service provision and reimbursement, and help recipients and carers make decisions.<sup>92</sup>

Despite the availability of a care manager, IPC represents a gap in the Japanese elderly care system. Coordination needs to be improved between the different sectors of long-term care and medical care. Both sectors are crucial for provision of good care, but cooperation is hard to achieve.<sup>92</sup>

### Policy and Strategy related to IPE

In Japan, IPE is highly valued by the government and promoted in universities across the country. However, it is not legislated. IPE initiatives have been implemented for undergraduate students in several universities, which receive generous financial support from the Japanese government. The programmes vary in content and are diverse in their goals, methods, and students. Through IPE, students are expected to value community health care, deepen their understanding of the community, and develop a sense of mission and commitment to community health care.<sup>59</sup>

Ten Japanese universities engaged in health professions education established the Japan Inter Professional Working and Education Network (JIPWEN) in 2008. JIPWEN discusses critical issues of IPE and presents plural models to help other institutions adopt similar IPE programmes. It plays a coordination and liaison role with the Japan Association for Interprofessional Education (JAPE), WHO, international IPE networks, and international academic associations. It also advocates the importance of IPE to the Japanese government and tries to strengthen the Human Resource for Health (HRH) policy.

JIPWEN universities have unique educational organizations, which play an important role in IPE, including preparing an annual plan, implementing faculty development, communicating with university hospitals and local facilities, and evaluating and analyzing the achievements. Through these organizations, IPE is incorporated into the curricula of diverse professions.

## Taiwan

### **Policies and Strategies related to IPE**

There has been a focus on IPE and IPC in caring for the elderly in Taiwan since the end of the past century, in response to the growing aging population. Concerning IPE, changes in education policy were made at both the undergraduate and postgraduate levels. At the undergraduate level, the Ministry of Education funded a project to build consensus on core curricula for social workers, nurses, physical therapists, and occupational therapists to prepare students in the fields of geriatrics and long-term care.<sup>113</sup> Amongst the core competencies required in all professions is teamwork.

In support of education at the post-professional level, the Ministry of Health and Welfare has organized Long-term Care Personnel Training programmes, which are fundamental to the success of implementing long-term care. Seventy-four hours of post-professional training are required for each professional health worker in long-term care. To prepare trainees for adequate interprofessional practice in the workplace some courses emphasize interprofessional learning.<sup>114</sup>

In addition to the support to IPE from the government of Taiwan, universities and different associations advocate for IPE. For instance, Fu-Jen Catholic University in Taipei, which offers a Master's program in Transdisciplinary Long-term Care hosted a conference on Interprofessional Collaboration in Long-term Care in September 2013 in collaboration with the Taiwan Long-term Care Professional Association (TLTCPA). The conference focused on exploring the role and contribution of interprofessional collaboration in the delivery of effective long-term care. This conference was informed by the workshops on Interprofessional Education and Faculty Development held earlier in the year by the Consulting Office of the Ministry of Education.<sup>114</sup>

### **Policies and Strategies related to IPC:**

The importance of IPC has been strongly supported in the healthcare workplace in Taiwan especially when caring for the elderly. Although care managers assess clients' needs and then coordinate service providers from multiple professional backgrounds, such as home care aids, nurses, physical therapists, occupational therapists, nutritionists and social workers, collaboration of providers has been determined as a necessity for successful coordination of services. Currently, home-based and institutional-based services have been universally provided throughout Taiwan, and community-based services are available in rural areas. Pilot sites offering community-based pharmaceutical services are being tested.<sup>114</sup>

In response to the need to develop a government-supported long-term care system, the Ministry of Health and Welfare of Taiwan launched a pilot plan for a long-term care system in 2000. However, the country's first comprehensive care initiative started in 2008. In this 10-year plan, the Department of Health started to integrate and implement the resources of elderly health promotion based in regional care centers. Currently, the Taiwan Long-term Care Service Act and the Taiwan Long-term Care Insurance Plan have both been drafted<sup>115</sup> and await review to be legislated.<sup>116</sup> Under this legislation, "long-term care giving" will be recognized as a profession, and its quality enhanced through a certification, assessment and registration system.<sup>117</sup> Considering the developments in the long-term care system, the focus on high-quality patient-centered care, the increase of resources, and the prospect for forming high quality interprofessional collaborative long-term care are becoming a reality.<sup>116</sup>

## Appendix B

### Common Operational Definition: What is IPE and what does IPE entail for older adults and their families?

#### Principles

A social movement to prevent and discourage ageism and enhance respect for older persons is growing around the world as part of a larger initiative to build and sustain an accessible, equitable, and just society for all. Older adults have a wealth of knowledge and experience to offer communities. A major consideration for older adults is their health and their ability to remain in their home and community as long as they possibly can. They deserve a voice in their future health care and the right to be trusted, respected, and heard.

The current definitions are general to all contexts and not specific to any one group of clients. When applied to older adults in the home and community, we are referring to clients with multiple co-morbidities, navigating a very complex system with only minimal help. Many are confused about the meaning of interprofessional education and collaboration and the role they play in facilitating this. Consequently, operational definitions require more precision and must be clear to all participants.

The definition most commonly used in the literature for IPE is:

**“IPE occurs when 2 or more professionals learn with, from and about each other to improve collaboration (IPC) and quality care of patients and their families (IPP).”<sup>16,25,32-34</sup>**

However, this definition requires further elaboration and needs further discussion and debate among all stakeholders including educators, learners, practitioners, and older adults and their families in the community.<sup>16,21,22,34</sup>

In any organization that implements systematic programmes of IPE, top leadership support has been critical.<sup>35</sup>

Because not all members of the team are regulated professionals, the definition should use the term “providers” in lieu of “professionals”.

Networks such as the International Association for Interprofessional Education and Collaborative Practice (Inter-Ed), the Centre of Advanced Interprofessional Education (CAIPE), and the Canadian Interprofessional Health Collaborative (CIHC) provide a platform for advocates of IPE to communicate and transfer knowledge and experience across health professions.

The World Health Organization’s (WHO) Framework for Action on IPE and Collaborative Practice<sup>36</sup> provides direction for embedding IPE within national health systems and highlights case studies that show exemplary practice in both developed and developing countries.

#### Future Considerations

1. Based on input from our interviews with experts and review of the literature, it became apparent that the terms *interprofessional education* and *interprofessional collaboration* may be misnomers. Because present definitions do not include the client and family as key members of the process, nor do they take into consideration social care providers and unregulated providers, we suggest that a more appropriate term for the process is *collaborative education* (CE) in lieu of IPE.
2. There should be an agreed-upon, common operational definition of IPE that is inherent to all educational programmes, but more specifically to programmes that are focused on the home and community care of older adults and their families and caregivers.

3. The definition of IPE should be explicit in outlining the role of the older adult clients and their families in providing educational experiences for learners within an IPE programme
4. There is a need to consider inclusion of social care and community service providers in IPE programmes, where possible, particularly in the care of older adults and their families in the community.

“I think it’s (*IPE*) two things for me: it’s training people how to collaborate by using the competency framework or some framework to work through what does this actually mean, and secondly, I think it means bringing people together around areas of common interest for professional development. So, for example, rather than teaching... or rather than having people go off and do courses in chronic disease management, then why not have those courses focused on chronic disease management and all those professions that actually are involved in chronic disease management come to the same programme of study on chronic disease management.” (Participant 2)

“IPE is not a product, it’s not a content area, it’s a process. So it’s a process by which we train people to...to work collaboratively. I consider interprofessional collaboration as the endpoint.” (Participant 2)

“The interprofessional approach is going to be an interprofessional education approach as well as collaboration approach all at once. What I’m saying is they’re kind of like Russian dolls, they’re all embedded with each other and trying to figure out which...which dolls on the outside are on the inside is often not the question...rather where they intersect.” (Participant 12)

“In Alberta we dropped interprofessional from IPE and talk about collaborative education instead of interprofessional education, and again we’re really using I think it’s the CAIPE definition when two or more health programmes or disciplines learn about, from, and with each other to enable effective collaboration and improve health outcomes. So we’re not going outside the boundaries and keeping it inclusive. Pretty standard stuff.” (Participant 3)

“Interprofessional practice for us is the actual doing of that, the actual enacting of the interprofessional capabilities that the staff and students have learned about in education actually working in an interprofessional way out in practice.” (Participant 20)

## **Interprofessional Education (IPE) Theory**

### **Principles**

Most IPE programmes are atheoretical but some use theoretical pluralism as their basis, borrowing from psycho-social, educational, and leadership theories. Complexity theory, which examines the complexity of our health and social systems, may have an important role to play in the development of an IPE theory.<sup>17,19,21,34,37-40</sup>

Theory informed education models are as important as non-theory informed models and enhance programme implementation.<sup>41</sup>

IPE differs from most traditional education programmes, because it is largely socially created through interactions with others and involves unique collaborative skills, perceptions, and attitudes, particularly in the care of older adults in home and community.<sup>17,22,30,38</sup>

Theories and frameworks related to professionalism and stereotyping, communities of practice, patient-centeredness, relational capabilities, change, ethics, and reflective and transformative learning should be central to and guide IPE.<sup>19,42</sup>



## Common Operational Definitions of IPC

### Principles

With the complexity of providing IP collaborative care in home and community, it is essential that older adults, as participants in these IPC models, understand what interprofessional collaboration means, who the members of the team are, what their role is on the team, and what the roles of the different team players are. In an environmental scan conducted in the Ottawa region in 2008 by Casimiro et al.<sup>29</sup> it became clear that clients and families are not always well-informed on these issues. For these models to be successful in the clinical realm, a common operational definition, understandable by all participants, is fundamental.

The most commonly used definition of interprofessional collaboration was proposed by the Canadian Interprofessional Health Collaborative (CIHC) in June 2007. It aligns with the definitions proposed in a number of other important studies in the area, albeit with some expansion of ideas.<sup>30,34,64</sup>

**“Interprofessional collaboration is a partnership between a team of health care providers in a participatory, collaborative and coordinated approach to shared decision making around health and social issues”.**

There are varied definitions used in the field; however, they are expanded versions of the CIHC’s definition. The CIHC’s definition of IPC is the definition used in governmental and organizational documents in Canada and all over the world.<sup>36, 60, 65</sup>

The Journal of Interprofessional Care and two biennial international conferences in interprofessional collaboration are examples of platforms for dialogues and discussions involving definitions, concepts, and models of IPC.

### Future Considerations

1. Based on input from our interviews with experts and review of the literature, it became apparent that the terms *interprofessional education* and *interprofessional collaboration* may be misnomers. Because present definitions do not include the client and family as key members of the process, nor do they take into consideration social care providers and unregulated providers, we suggest that a more appropriate terms for the process is *collaborative practice* (CP) in lieu of IPC.
2. A common operational definition of IPC requires more dialogue and agreement around the expansion of currently acceptable definitions.
3. Clients, families and caregivers should be included as active members of these discussions, as well as key members of the geriatric IPC team and this should be implicit in the definition.
4. Social care and community service providers, as well as unregulated caregivers, should be included in the definition of IPC in any integrated, community-based, older adult/family collaborative care model.

“We intentionally, much to some people’s chagrin, dropped interprofessional (*from our definition of IPC*) because we wanted to make sure that there was more of a sense of inclusivity, not just regulated professions, not even just including non-regulated health providers, but also individuals, families, and caregivers. So really collaborative practice assumes all the players ...assumes all the players who are involved in some sort of a health encounter.” (Participant 6)

“What I usually see in teams is they...they will either cooperate well or they coordinate well. They just don’t partner well. And so that’s where the partnership piece and the inclusion of the patient and caregiver is usually where they...the weaknesses are and that’s really the crux of collaborative practice.” (Participant 01)

“The health care system in Canada is wonderful. However, they can’t do everything. They are so specialized, that no one person is going to see your loved one the same way that you do. I discovered the only person who has the whole picture is the caregiver.” (Caregiver quote – Study 1)

“Yeah. And so maybe that’s involving people from social services. So if I think about the community, it’s sometimes hard to differentiate when you’re thinking about the social determinants of health. Is this a healthcare person involved with this client, patient, elder? Or is it a social service person? We artificially divide those from a governmental perspective. But yeah, I think it needs to be much more inclusive, for sure, yeah.” (Participant 16)

“I mean, I have PSWs I work with, they have a PSW certificate, but their experience and knowledge is amazing. And then you have physicians that have just graduated from med school, their knowledge might be amazing in a certain area but they have zero expertise. And so having the two put together that’s where the learning is going to happen and that’s where they’re going to understand each other’s role in trying to address the person’s needs in the community. To have the time to do that and to build those strong teams, that’s not happening either.” (Participant 11)

“If all those sectors, *acute, primary care, and community* are better integrated, you’re going to get better care. And I think that collaborative practice, or IPP, offers an opportunity to de-fragment, better integrate, increase outcomes, reduce risks.” (Participant 06)

## **Client and Family-centred Focus and Understanding of Who Constitutes the Team**

### **Principles**

Given the nature of home and community IP collaborative practice, where the delivery of care often occurs within the confines of the client’s home and where multiple care providers are dispersed in a large geographical space within the community, the nature of the provision of home and community care for older adults and their families differs considerably from acute care delivery.

The concept of being a contributing member of an IPC team, where the older adult and family set the goals for care in collaboration with the team, may be foreign to many older clients and to some care providers. Many older adults have been conditioned to believe that the care providers are in the driver’s seat when it comes to deciding the best approaches in care. Indeed, some care providers may also believe this to be true. Putting the clients at the centre of care and seeking their input in decision-making is a shift in thinking for both clients and care providers.<sup>21,29,30</sup>

There is a need for inclusion and integration of health, social, and community services across all sectors to adequately address comprehensive, yet targeted, care of older adults living in the community.<sup>21,29,30</sup>

### **Future Considerations**

1. Patient-centeredness must be strongly encouraged in collaborative practice models and integrated IPC teams should strive to include patients and their families as key decision makers on the team.
2. Older adults and their families should be seen as key decision makers and equal members of the team.<sup>21, 28-30</sup>
3. Older adults should have clear understanding of who is on the team and the roles of each team member and what services they can provide vis-à-vis the specific role of the older adult client and family.
4. With the complexity of the community care system and the difficulty older adults experience with the navigation through this system, it is essential that they learn their role in identifying their priorities, their

needs and how, with the help of the IPC team, they can get their needs met. More work is required to achieve this important goal.

5. The role of a “system navigator” should be re-examined for possible inclusion in any integrated care model from acute and community sectors as a bridge to helping the client and family manoeuvre through the transition from hospital to home/community and through the complex community system networks.

“Basically, it doesn’t matter where you go but there’s still this perception that the patients or the clients we deal with are empty vessels and we have to help them to get all the knowledge into their heads. In other words, we situate ourselves in this power relationship with them that just ignores that these people are real people and they have, especially those with chronic diseases they’ve been living with them for a long time, they have so much they can teach us and it’s us giving up this attitude that, you know, you be quiet, we’ll tell you what to do. And to me that’s absolutely critical. And I think there’s a whole lot of perception that as people get older, you know, they get more infirm and incapable of doing this and my experience is that’s not the case. But we don’t give them an opportunity; so, therefore, why should they participate with us?” (Participant 01)

“I’m not a part of any decision-making really, the doctor tells me what’s wrong and what I need to do.” (Client Quote-Study 1)

“It’s frustrating because I have separate people who deal with my problems separately...but, we’re all...everything’s interconnected, everything is me.” (Client Quote-Study 1)

“It’s exhausting but it needs to be done so what I’m learning is, I need to get extra help in addition to my family so the...working with the CCAC has.....learning how to work with professionals has been very useful in reducing my stress level and knowing how to properly manage him.” (Caregiver Quote-Study 1)

“At the palliative stage, the teams are beautiful, the assessments...the...the care coordinators are thorough, the communication is very clear to the other healthcare providers that come in. Up until then, it’s very disjointed so I...and people just do piecemeal approach and not a holistic approach. I...I really, strongly feel that if we could do that...that kind of integrated, interprofessional communication and collaborative care earlier, people would be much healthier for a longer term and we would put the resources where we could have that optimal health in aging earlier and we wouldn’t be at that palliative stage so soon.” (Caregiver Quote-Study 1)

“If there’s anything that caregivers need it would be much more psychological support and counselling. As a caregiver, there are multilevel roles you are playing, so you really do need counselling support to help you advocate.” (Caregiver quote – Study 1)

## **Care Provider, Organizational, and Government Support**

### **Principles**

There is government commitment across the globe to closer working between professionals to improve health but this is poorly understood by users/clients/ patients.<sup>29,30</sup>

Care provider and organizational, as well as government, support is required to sustain successful collaborative practice.

The concept of interprofessional collaboration in the seamless care of older adults and their families should be embedded in organizational culture and values and should, in turn, be strongly supported and valued by care providers either in or affiliated with that organization.<sup>80</sup>

Our review suggested that the organizational and government support for IPC is often driven by health economics, patient safety, and quality healthcare outcomes, in that order. Although health economics is an essential driver,

patient safety and healthcare outcomes should be the priority and would be more likely to engage clients, families, and healthcare providers.<sup>30</sup>

Countries around the globe have realized that health requires a community focus, an “all-policies” focus, a focus on prevention and wellness, and an IP focus facilitated through teamwork in learning and practice. Despite strong organizational and government support, policies have not been fully issued to implement IPC in most health systems.

Health Canada’s initiative of Interprofessional Education For Collaborative Patient-Centred Practice (ECPCP) in its “Pan-Canadian Health Human Resource Strategy”<sup>81</sup> promoted collaborative practice amongst disciplines and optimized clinical decision-making by including patients and their families. However, many years after this initiative was introduced, it is still not translated into policy or legislation.

Some Scandinavian countries, such as Sweden, implemented laws requiring IPC in health care, especially for the elderly, in healthcare organizations and in community and home settings.<sup>82</sup>

In England, a policy called Transforming Community Services was launched in 2008 to shift more health care from hospitals to settings closer to people’s homes, but it was mostly concerned with structural changes rather than with how services could be changed.<sup>83</sup> The King’s Fund convened a working group of community providers to explore the steps that are required to change community services in ways that will help create the transformation promised in that policy. A key step is to build multidisciplinary teams for people with complex needs, including social care, mental health, and other services.<sup>14</sup>

In late 2007, immediately after the release of Interprofessional Care: A Blueprint for Action in Ontario<sup>60</sup> the Ontario Ministry of Health and Long-Term Care (MOHLTC) convened a multidisciplinary, cross-sectoral, Interprofessional Care Strategic Implementation Committee, with individuals from academic institutions and professional associations, as well as caregivers and regulators. The goal of the committee was to work with the health and education sectors to implement the IPE/IPC recommendations of the blueprint at the system, organizational, education, practice, and policy levels. The final report of this committee was tabled in May 2010 (Implementing Professional Care in Ontario, May 2010).<sup>84</sup> Over the next four years, IPE programmes were initiated in academic institutions and IPC collaborative practice teams were implemented in many areas of the healthcare system. Partners responsible for excellence in care for all Ontario have demonstrated a strong commitment to IPE and IPC as a platform for providing that care including, academic educators, healthcare organizations, regulators, individual healthcare providers, patients, and government. Much work has been done to date but more remains to be done.

### **Future Considerations**

1. Interprofessional collaboration should be based on the need for improved patient outcomes and safety with cost effectiveness being a secondary driver.<sup>31</sup>
2. Organizational culture should support and value interprofessional collaboration in the seamless, intersectoral care of older adults and their families, if they are to implement it in a successful manner.
3. Organizations that implement IPC programmes to provide this kind of care should employ care providers with like values.

<b><i>INTERPROFESSIONAL EDUCATION</i></b> <b>IPE THEMES/PRINCIPLES/FUTURE CONSIDERATIONS</b>	<b>Examples of Strategies &amp; Policies</b>	<b>Interview Feedback</b>
<p><b>Theme 1 - Common Operational Definition: What is IPE and what does IPE entail for older adults and their families?</b></p> <p><b>Principles</b> A social movement to prevent and discourage ageism and enhance respect for older persons is growing around the world as part of a larger initiative to build and sustain an accessible, equitable, and just society for all. Older adults have a wealth of knowledge and experience to offer communities. A major consideration for older adults is their health and their ability to remain in their home and community as long as they possibly can. They deserve a voice in their future health care and the right to be trusted, respected, and heard.</p> <p>The current definitions are general to all contexts and not specific to any one group of clients. When applied to older adults in the home and community, we are referring to clients with multiple co-morbidities, navigating a very complex system with only minimal help. Many are confused about the meaning of interprofessional education and collaboration and the role they play in facilitating this. Consequently, operational definitions require more precision and must be clear to all participants.</p> <p>The definition most commonly used in the literature for IPE is: “IPE occurs when 2 or more professionals learn with, from and about each other to improve collaboration <b>(IPC)</b> and quality care of patients and their families <b>(IPP)</b>.”<sup>16,25,32-34</sup></p>	<p>Networks such as the International Association for Interprofessional Education and Collaborative Practice (Inter-Ed), the Centre of Advanced Interprofessional Education (CAIPE), and the Canadian Interprofessional Health Collaborative (CIHC) provide a platform for advocates of IPE to communicate and transfer knowledge and experience across health professions.</p> <p>The World Health Organization’s (WHO) Framework for Action on IPE and Collaborative Practice<sup>36</sup> provides direction for embedding IPE within national health systems and highlights case studies that show exemplary practice in both developed and developing countries.</p>	<p>“I think it’s (<i>IPE</i>) two things for me: it’s training people how to collaborate by using the competency framework or some framework to work through what does this actually mean, and secondly, I think it means bringing people together around areas of common interest for professional development. So, for example, rather than teaching... or rather than having people go off and do courses in chronic disease management, then why not have those courses focused on chronic disease management and all those professions that actually are involved in chronic disease management come to the same programme of study on chronic disease management.” (Participant 2)</p> <p>“IPE is not a product, it’s not a content area, it’s a process. So it’s a process by which we train people to...to work collaboratively. I consider interprofessional collaboration as the endpoint.” (Participant 2)</p> <p>“The interprofessional approach is going to be an interprofessional education approach as well as collaboration approach all at once. What I’m saying is they’re kind of like Russian dolls, they’re all embedded with each other and trying to figure out which...which dolls on the outside are on the inside is often not the question...rather where they intersect.” (Participant 12)</p> <p>“In Alberta we dropped interprofessional from IPE and talk about collaborative education instead of interprofessional education, and again</p>

<p>However, this definition requires further elaboration and needs further discussion and debate among all stakeholders including educators, learners, practitioners, and older adults and their families in the community.<sup>16,21,22,34</sup></p> <p>In any organization that implements systematic programmes of IPE, top leadership support has been critical.<sup>35</sup></p> <p><b>Future Considerations</b></p> <p>5. Based on input from our interviews with experts and review of the literature, it became apparent that the terms <i>interprofessional education</i> and <i>interprofessional collaboration</i> may be misnomers. Because present definitions do not include the client and family as key members of the process, nor do they take into consideration social care providers and unregulated providers, we suggest that a more appropriate term for the process is <i>collaborative education</i> (CE) in lieu of IPE.</p> <p>6. There should be an agreed-upon, common operational definition of IPE that is inherent to all educational programmes, but more specifically to programmes that are focused on the home and community care of older adults and their families and caregivers.</p> <p>7. The definition of IPE should be explicit in outlining the role of the older adult clients and their families in providing educational experiences for learners within an IPE programme</p>		<p>we're really using I think it's the CAIPE definition when two or more health programmes or disciplines learn about, from, and with each other to enable effective collaboration and improve health outcomes. So we're not going outside the boundaries and keeping it inclusive. Pretty standard stuff." (Participant 3)</p> <p>"Interprofessional practice for us is the actual doing of that, the actual enacting of the interprofessional capabilities that the staff and students have learned about in education actually working in an interprofessional way out in practice." (Participant 20)</p>
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<p>8. There is a need to consider inclusion of social care and community service providers in IPE programmes, where possible, particularly in the care of older adults and their families in the community.</p> <p>9. Because not all members of the team are regulated professionals, the definition should use the term “providers” in lieu of “professionals”.</p>		
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IPE THEMES/PRINCIPLES/FUTURE CONSIDERATIONS	Examples of Strategies & Policies	Interview Feedback
<p><b>Theme 2 - Interprofessional Education (IPE) Theory</b></p> <p><b>Principles</b>  Most IPE programmes are atheoretical but some use theoretical pluralism as their basis, borrowing from psycho-social, educational, and leadership theories. Complexity theory, which examines the complexity of our health and social systems, may have an important role to play in the development of an IPE theory.<sup>17,19,21,34,37-40</sup></p> <p>Theory informed education models are as important as non-theory informed models and enhance programme implementation.<sup>41</sup></p> <p>IPE differs from most traditional education programmes, because it is largely socially created through interactions with others and involves unique collaborative skills, perceptions, and attitudes, particularly in the care of older adults in home and community.<sup>17,22,30,38</sup></p> <p>Theories and frameworks related to professionalism and stereotyping, communities of practice, patient-centeredness, relational capabilities, change, ethics, and reflective and transformative learning should be central to and guide IPE.<sup>19,42</sup></p> <p>Literature suggests a need for an organized, co-ordinated approach to IPE, because evaluations of many IPE programmes presently in operation do not produce strong evidence of their effectiveness.<sup>17,23,25,43</sup></p>	<p>In Japan, IPE is highly valued and promoted in universities across the country; however, it is not legislated. Ten Japanese universities that are engaged in health professions education established the Japan Inter Professional Working and Education Network (JIPWEN) in 2008. These schools (now eleven) implemented unique IPE programmes in response to concerns about quality of healthcare professions, and they were awarded Good Practices by the Japanese government with generous financial support.</p> <p>JIPWEN discusses critical issues of IPE and presents plural models so that institutions interested in IPE programmes can adapt similar models. It plays a coordination and liaison role with the Japan Association for Interprofessional Education (JAPE) members, WHO, international IPE networks, and international academic associations.</p> <p>It advocates the importance of IPE to the Japanese government and tries to strengthen the human resource for health (HRH) policy.</p> <p>JIPWEN universities have their unique educational organizations, which play an important role in IPE management. There is strong leadership under the president or dean of the schools, such as ‘The Planning and Evaluation Core Group’ in Sapporo Medical University, ‘Center of Planning and Coordination for Medical Education (PCME)’ in University of Tsukuba, and ‘Interprofessional Education Committee of</p>	<p>“So we need to break down a lot of professional hierarchy and really truly respect a good skill set of all the health profession.” (Participant 12)</p> <p>“I see it [IPE] across the continuum of learning. ... the focus has been more at the university/ college level and I think we’re only in the field starting to think about, how do you actually support lifelong learning and people who are already practicing? ... I see IPE starting when you’re a student in a health science programme, the pre-licensure, all the way through to, you know, mastery once you’re in a clinical or practice environment to continuing professional development, so very much learning across the lifespan as a healthcare professional”. (Participant 16)</p> <p>“The vast majority of people are not working in a downtown, acute care hospital, and yet much of the training still happens in those big, traditional healthcare organizations. So there’d be huge value in ensuring that there is interprofessional learning both for students and for practicing clinicians in the home care context.... So if you can expose people and teams to home care and community settings you’d likely draw them to actually work there.... I think we should be focusing on placements that speak to where there is a need and where there is a growing population of, you know, our elderly folks. And so if you can get people there doing IPE you may be able to actually incent them to stay and work in</p>



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<p>The trajectory of IPE from pre-licensure (IPE) at the undergraduate level, in both the classroom and the clinical practice setting, to post-licensure in the practice setting in the form of staff development and continuing education (CIPE) needs to be more clearly outlined and understood.<sup>22,34</sup></p> <p><i>Pre-licensure:</i> IPE at the pre-licensure stage should take place at the undergraduate level, allowing students from different health and social programmes to learn together in special classes and in the clinical setting with well-functioning, interprofessional teams as their clinical mentors. This clinical practice component is particularly important in the care of older adults and their families in home and community.<sup>21</sup></p> <p>Since most current IPE models and frameworks vary across contexts and programmes, this diversity and lack of standardization makes them difficult to evaluate.<sup>17</sup></p> <p><i>Post-licensure:</i> It is essential that input into and participation in the educational programming is sought from older adult clients and their families, who are fully functioning members of the team.<sup>21,44,45</sup></p> <p>Post-licensure, when these providers are practising collaboratively in an interprofessional model, continuing education and staff development programmes should be made available to the teams based on their stated educational requirements within the specific context of the team and after</p>	<p>Gunma University (IPEC-GU) in Gunma University. These organizations have a number of responsibilities including preparing an annual plan, implementing faculty development, communicating with university hospitals and local facilities, and evaluating and analyzing the achievements. Through these organizations, IPE is incorporated into diverse professions' curricula.</p>	<p>those environments once they graduate. So I would see value from a quality of care perspective but also from a recruitment and retention perspective, yeah." (Participant 16)</p> <p>"We've just named IPE and collaborative education as something a little bit different but we really are talking about the same concepts. Interprofessional education or collaborative education is...it's...it's learners from pre-licensure to post-licensure. And could even <i>include</i> ...patients, clients, families, caregivers, if we were educating them, I would include them in that whole spectrum of learners about how to work within the health team more effectively. So...so it would be either, you know, communication, shared decision-making, respect, valuing, etc." (Participant 06)</p>

IPE THEMES/PRINCIPLES/FUTURE CONSIDERATIONS	Examples of Strategies & Policies	Interview Feedback
<p>consultation with the older adults, families, and caregivers. This is essential to the continuing success of the team.<sup>21,34,46,47</sup></p> <p><b>Future Considerations</b></p> <p>10. In both pre- and post-licensure IPE programmes, it is essential that input at every level is sought from the older adult clients and their families in home and community care.</p> <p>11. Pre-licensure IPE should be theoretically based and include consistent concepts and principles to address the complexity of older adults and their families and caregivers in their homes and communities. Theoretical learning in the classroom is essential, but clinically-based learning should take place with real-life functioning IPC teams within practice settings in the field.</p> <p>12. Partners involved in the IPE initiative should explore the possibility of forming a consortium of interested post-secondary educational institutions in Ontario (capable of providing critical leadership support) to develop and deliver an undergraduate certificate programme in interprofessional collaborative practice, specifically in the seamless care of older adults and their families across sectors, including a built-in evaluation component. The present Japanese and Australia/New Zealand models are possible templates for such an approach.</p>		

IPE THEMES/PRINCIPLES/FUTURE CONSIDERATIONS	Examples of Strategies & Policies	Interview Feedback
<p>13. This consortium, upon a successful evaluation, should explore an accountability framework through consistency and accreditation of these pre-licensure, post-secondary educational institution-based IPE programmes.</p> <p>14. Post-licensure IPE programmes are context-specific and should be made available to healthcare provider teams (including patients and their families) by the organizations in which the teams work, based on their agreed-upon needs. The education of collaborative teams should be customized and adaptable to each specific context.<sup>16</sup></p> <p>15. Innovative methods for post-licensure IPE need to be organized to address the time and physical constraints of attending continuing education and staff development sessions.<sup>17</sup></p>		

IPE THEMES/PRINCIPLES/FUTURE CONSIDERATIONS	Examples of Strategies & Policies	Interview Feedback
<p><b>Theme 3 – IPE Curriculum and Core Content</b></p> <p><b>Principles</b></p> <p>With the increasing complexity of our health and social systems, flexibility within the systems is critical to their future functioning. Accepting the inevitability of change as a constant mandates a need for flexibility. Focusing on capabilities of practitioners, as opposed to competencies, should be considered, because practitioner and team capabilities can change based on the needs of the older adult and family within a changing environment. Competencies are procedural skills that are far less flexible.<sup>25</sup></p> <p>IPE programmes should incorporate as a basic tenet a clear <b>Patient/Client-Focus to Practice</b>. In fact, patients/clients and family caregivers should be included in the development and delivery of programmes.<sup>16,34,37</sup></p> <p><b>Relational Capabilities</b> are essential for interprofessional collaborative practice. They focus greater attention on the often-referred to <i>softer skills</i> or qualities of compassion, empathy, respect, and trust in relationships with patients, families, and other teams.<sup>21,27,48-51</sup></p> <p>IPE programmes should encourage <b>Ethical Practice</b>, which encourages students/practitioners to understand their own value system and that of others, as well as the possible interactions between</p>	<p>In Denmark, the public demand for interprofessional collaboration has led to a ministerial order of integrating interprofessional elements in the curricula of various educational programmes. An interprofessional element has been integrated in the Danish Bachelor programmes in Education, Social Work, and Health. The University Colleges are in the process of implementing the new legislation. Although the IPE elements may vary across disciplines, different IPE programmes share the same basic goals, which are to become qualified to cooperate with persons from other professions and to take innovative approaches in interprofessional work.</p> <p>In addition to changes in curricula, projects to enhance IPE and IPC were introduced nationwide in Denmark. Interprofessional training units (ITU) were established across the country, the first of which was in Holstebro in 2004. The Holstebro ITU consisted of eight beds in an orthopedic ward with 30 beds. Students from nursing, occupational therapy, physiotherapy, and medicine were placed for two weeks of clinical training. It has been shown that placement at the ITU had a positive effect on students' attitudes and views of the other professions.<sup>53</sup></p> <p>In Sweden, educational institutes are required by law to include IPE elements in their curricula and training. In 1996, Linköping University was the first to implement an interprofessional training</p>	<p>“You know we need to be assessing students' interprofessional capabilities and those of our staff.....capabilities go a little beyond competence because they're about the application of those competencies – the ability to adapt them and react to different contextualls... So it's not that you take the list of competencies...capability is about adapting that into all sorts of different situations. But can you adapt your communication (as a competency) to working with older people, younger people, people with cognitive impairment, and people from a different culture, and those sorts of things.” (Participant 20)</p> <p>“I mean, I can point to some work that I know of focused on a programme called the Health Mentor Programme where – now this is at the student level – where students work with a “health mentor,” someone living with a chronic illness in the community. And this is...this is qualitative work that's been done at the University of Toronto and we're seeing that what these kind of longitudinal experiences, where interprofessional groups of students are actually embedded more in the community with a health mentor, they really open their eyes to what does safety mean in a community context. And, again, because the predominant lens is the hospital, I really truly believe that in terms of how we socialize most of our healthcare professionals, they really start to think about, ok, safety might look a little bit different in a home environment or in a community environment than it might in a hospital</p>

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<p>these, in order to enter into successful interprofessional collaboration that is patient/client-focused.<sup>17,19,25,42</sup></p> <p>It is felt that there should be <b>Sound Professional Practice (knowledge and skill)</b> within each discipline, delivered in conjunction with IPE knowledge and skill.<sup>17, 21,22</sup></p> <p>Literature suggests the content of interprofessional (IPE) should include:</p> <ul style="list-style-type: none"> <li>• relational capabilities</li> <li>• professional socialization<sup>16,17,23, 34,38</sup></li> <li>• collaborative knowledge and skill (respect and trust of others, understanding of roles and overlap, communication/negotiation skills)</li> <li>• conflict resolution skills<sup>42</sup></li> <li>• transformational leadership skills<sup>19, 21,42</sup></li> <li>• setting shared goals and shared decision-making strategies<sup>45,52</sup></li> <li>• inclusion of patient and family as key decision-makers in the planning of care</li> <li>• content related to the co-morbidities and complexities of older adults living independently in the community through case studies and small group learning, where groups consist of all healthcare providers, clients, and families that are involved in the team<sup>21</sup></li> <li>• Clinical placements are important to incorporate into practice settings and should correlate with classroom learning. More focus needs to be placed on real-life</li> </ul>	<p>ward (IPTW) at the department of orthopedics, to help undergraduate students become proficient in teamwork.<sup>54</sup> Students from medicine, nursing, physiotherapy, and occupational therapy perform the care, treatment, and rehabilitation of patients in the IPTW. Other IPTWs were established in Sweden based on this model. In Orebro, an IPTW was established in municipal care for older adults, including students from occupational therapy, nursing, and social work.<sup>55</sup> Reports on experiences with IPTW at the University of Linköping and other Swedish universities have been published.<sup>53,56,57</sup> Learning from the above-mentioned ITU model in Holestebro, Denmark<sup>53</sup> Karolinska Institutet in Sweden introduced ITUs at two geriatric wards.<sup>58</sup></p> <p>In Sweden and Denmark, patients/clients and family caregivers are included in IPE programmes, especially those focusing on home and community care.<sup>53,55</sup></p> <p>In Hokkaido Prefecture of Japan, in response to concerns about community health care, an IPE programme was introduced. The programme is meant to systemize several practical experience-training programmes and restructure them into one joint curriculum for community health care. The programme also provides students with an opportunity to interact with not only medical professionals, but also patients and their families and healthcare staff. Through IPE, students are expected to value community health care, deepen their understanding of the community, and develop a sense of mission and commitment</p>	<p>environment. So I think these kinds of experiences, the impact is it extends a student's or a practicing professional's worldview and it really helps them to understand, like, what is it really like for someone out there living with these chronic illnesses in their community. We don't get that kind of exposure. And I think those are perspectives that students and practicing clinicians can bring back to wherever they choose to work in the future". (Participant 16)</p> <p>"If one believes that, at the end of the day, this is all about relational-centred care, then you have to have ways to build those relationships. So, you know, it could be once a year that the whole team gets together and the focus of that time together is about setting common goals for the team or the organization. People have to see, I think, themselves in the work over time and finding those face-to-face moments, I do think, is really important. Our students at the pre-licensure level, we think of them as the most technological savvy cohort of people ever on this planet, right? And when...when they survey themselves, so they lead a survey about the IPE curriculum at U of T and they are very honest, they tell us what's working and what's not working, and they ask themselves questions about what are the most meaningful types of pedagogies and experiences. It's not the technology. We're busy developing more online stuff, they talk about the face-to-face small group with real patients/clients and practicing clinicians. So that, to me, gives some evidence for what people value even in a technological environment. Does it make a difference at the end of the day? I</p>

IPE THEMES/PRINCIPLES/FUTURE CONSIDERATIONS	Examples of Strategies & Policies	Interview Feedback
<p>clinical experience</p> <ul style="list-style-type: none"> <li>• Clients and families should be consulted in curriculum development and content and included in the learning where possible in the post-licensure phase</li> </ul> <p><b>Future Considerations</b></p> <p>16. All students and IP team practitioners should be taught the importance of and how to engage in Reflective Practice<sup>16-19</sup></p> <p>17. Professional Organizations should be invited to engage in dialogue and planning for a standardized IPE curriculum<sup>20</sup></p>	<p>to community health care.<sup>59</sup></p> <p>In 2006, the Ontario government created the Interprofessional Care Steering Committee with the purpose of preparing a blueprint to guide government, educators, health caregivers, organizational leaders, regulators, and patients in how to make the adoption of IPC a reality. Four main pillars of the blueprint include 1) building a strong foundation upon which to implement and sustain IP activities; 2) sharing responsibilities for implementation of IP strategies among interested parties; 3) implementing system enablers for the IP to be taught, practised, and organized in a systematic way; and 4) leading sustainable change that recognizes the collaborative nature of IP care and embraces it in the health and education sectors in Ontario.<sup>60</sup></p>	<p>don't know. We don't have the evidence for that yet. But I do think there has to be some element of face-to-face, for sure, yeah. Yeah." (Participant 16)</p> <p>"So core competencies would include things like conflict resolution, being able to communicate, being able to listen, using client-centred services, coordinating care. What are... the seven principles of...Oh, you know what? One model that I can think about is Way and Jones, we did a lot of work". (Participant 17)</p> <p>"And I could actually argue that, because in the community and in primary care I've seen some beautiful examples like in Memory Clinics or in the Fall Clinic or the Heart Failure Clinic that I'm in now, there's beautiful interprofessional practice there, that people really understand how and why they need to collaborate. I don't see students graduating with that kind of integrated collaborative thinking and especially not in care for older adults.....they don't realize that if everybody just does what they are trained for, then you have massive gaps, especially with older people." (Participant 10)</p> <p>"I think part of it is that we have to...you know, it's hard to do IPC if groups aren't resourced to do IPC...So partly you've got to resource and make sure that those team members are supported to be a part of the team in order to actually have a team to do interprofessional collaborative practice together. I think once you actually have those teams, you create great learning environments where different professional learners can come</p>

IPE THEMES/PRINCIPLES/FUTURE CONSIDERATIONS	Examples of Strategies & Policies	Interview Feedback
		and learn together and be mentored.” (Participant 26)

IPE THEMES/PRINCIPLES/FUTURE CONSIDERATIONS	Examples of Strategies & Policies	Interview Feedback
<p><b>Theme 4 - Technological Innovation</b></p> <p><b>Principles</b></p> <p>Because the community is such a unique practice setting, where there is no one specific place where providers work as in the acute care sector, communication among providers, learners, the older adult, caregiver, and family can be problematic.</p> <p>Education and practice of providers in the field requires organizational and IT planning that centres around learner, practitioner, and patient-related processes to manage the older adult and family in home and community.<sup>21</sup></p> <p>There is a need for mobile technology and processes between agencies to enhance IP communication and documentation for seniors care in the home. This mobile technology and interagency processes should consider and accept the varying role-related responsibilities among caregivers.<sup>9</sup></p> <p><b>Future Considerations</b></p> <p>18. IPE programmes should consider the inclusion of learning related to technological innovations such as mobile technology, electronic documentation, and electronic communication systems for older clients and their families and caregivers in home and community.</p>		<p>“The Federation of Healthcare Professionals, and I was part of that, we just developed about a year and a half ago e-learning tools for healthcare professionals and it deals with frequently asked questions. There’s a website. And they created a milestone model where you could put in a scenario, a patient scenario, and it prompts you so that you can be aware of who the key players need to be or who the key healthcare professionals need to be, so that the client, if they move from the community to the hospital and back to the community, so it’s sort of a tool, a tool that you can use online to sort of learn in an interprofessional way, and it’s on the website, who the key players are and what information needs to be gathered, I guess, from...in terms of taking care of the client.” (Participant 17)</p>



IPE THEMES/PRINCIPLES/FUTURE CONSIDERATIONS	Examples of Strategies & Policies	Interview Feedback
<p>19. Because IPE involves many different providers in many different venues in the community, scheduling face-to-face class time for post-licensure programmes can be problematic. Alternative ways of learning through electronic classrooms, telemedicine, and videoconferencing should be explored.</p> <p>20. The use of simulation technology should also be explored to the full extent of its capabilities in teaching interprofessional collaboration and practice in the care of older adults and their families in the community.</p>		

IPE THEMES/PRINCIPLES/FUTURE CONSIDERATIONS	Examples of Strategies & Policies	Interview Feedback
<p><b>Theme 5 - Faculty Resources and Engagement</b></p> <p><b>Principles</b></p> <p>Literature suggests faculty teaching in the IPE programmes must have:</p> <ul style="list-style-type: none"> <li>• leadership support and a strong commitment to IPE/IPC.<sup>16,23</sup></li> <li>• a positive attitude for teamwork with other health and social professionals.<sup>22</sup></li> <li>• appropriate preparation in teaching content within the IP programme<sup>17</sup>, which is not necessarily core content within their own professional programme.</li> <li>• workloads in their core professional programmes should reflect their involvement in the IPE programme.<sup>17</sup></li> </ul> <p>IPE should be valued by universities and legislated by governments.</p> <p><b>Future Considerations</b></p> <ol style="list-style-type: none"> <li>21. Faculty teaching in IPE programmes should be champions of IPE and IPC.<sup>17</sup></li> <li>22. Assess faculty's willingness and strength of conviction in the benefits of IPE and the development and utility of IP collaboration, especially in the care of older adults and their families in home and community.<sup>21</sup></li> </ol>		<p>"You should note that down, because not all faculty here believe in the concept of IPE. It's often regarded as the soft and fluffy, touchy feely, be nice to one another and respectful. And they don't understand that one of the ultimate goals of IPE is patient safety." (Participant 11)</p> <p>"Well, funding, faculty involvement, teachers, and flexibility in healthcare delivery models (<i>are important for sustainability</i>)." (Participant 11)</p> <p>"You know, to support good interprofessional models of practice, I think one needs to actually have strong leadership that recognizes the value of that. And you have to have a team commitment." (Participant 26)</p>

IPE THEMES/PRINCIPLES/FUTURE CONSIDERATIONS	Examples of Strategies & Policies	Interview Feedback
<p>23. IPE educational opportunities, in particular coaching and mentoring skills, should be made available for faculty members showing interest and commitment to teaching in IPE programmes.<sup>22</sup></p> <p>24. Faculty who are recruited to teach in IP programmes from their core programmes should be given protected time to teach IPE and this should be considered as part of their teaching load.<sup>17</sup></p>		

IPE THEMES/PRINCIPLES/FUTURE CONSIDERATIONS	Examples of Strategies & Policies	Interview Feedback
<p><b>Theme 6 – Research and Program Evaluation</b></p> <p><b>Principles</b></p> <p>Because of the variability across IPE programmes, they are difficult to evaluate. Aspects such as where they are being delivered, for how long, who the learners are, what the programme content is, and what the learning activities are contribute to the variability.<sup>16,17,21,24,26,27,61</sup></p> <p>More effort is required, particularly in pre-licensure, university-based programmes, to standardize core programmes and more clearly define the core content, thereby allowing for the development of programme standards and ease of programme evaluation.<sup>22,23</sup></p> <p>Specific desired outcomes of IPE must be defined with input from older adults and their families.</p> <p><b>Future Consideration</b></p> <p>25. More research is required in development, delivery, and evaluation of IPE effectiveness in producing care providers capable of interprofessional collaboration at the point of care.<sup>16,23,24-27</sup></p>		

IPE THEMES/PRINCIPLES/FUTURE CONSIDERATIONS	Examples of Strategies & Policies	Interview Feedback
<p><b>Summary of Facilitation and Sustainability of IPE</b></p> <p>In order for IPE to be most effective and sustainable, it requires:</p> <ul style="list-style-type: none"> <li>• Strong patient and family focus</li> <li>• Strong government and organizational support with the primary focus more that of patient well-being, with cost-effectiveness, although important, being a secondary concern</li> <li>• Organizational support translated into policy</li> <li>• Investment in human resources and capital</li> <li>• Interministerial and interorganizational cooperation and planning</li> <li>• Institutional and government support (including financial, physical and human resources)</li> <li>• Individual practitioners with values, attitudes, and commitment to the care of older adults and their families, willing to work together in teams across the care continuum in a seamless fashion</li> <li>• Consistent core curricula, facilitating more effective programme evaluation</li> <li>• Committed, competent faculty</li> <li>• Relevant learning experiences, with an emphasis on clinical placements within well-functioning IPC teams who can act as role models for learners and provide real life experiences</li> <li>• Non-threatening learning environments</li> <li>• Role understanding and mutual respect for competency/capability</li> </ul>	<p>The IPE models presented from Japan, Denmark, and Sweden indicate that government and institutional support and collaboration of efforts are crucial for the development and sustainability of IPE programmes.</p> <p>Government/Organizational support plays an important role in IPE. For instance, in England, the government first focused on continuing professional development in its workforce strategy for health and social care.<sup>62</sup> The government then shifted its emphasis abruptly to pre-licensure IPE with the turn of the millennium.<sup>63</sup> The shift in the governmental preferences led to a shift of funding towards pre-licensure IPE, hence, more focus on IPE in universities and colleges.</p>	<p>“But, our challenge is, it’s easy to get all the healthcare professionals to the table for the training except the physicians.” (Participant 19)</p> <p>“Public engagement...for the sustainability and also flexibility in the community setting, you need actually to prime and prompt and engage the public or the client or, you know, people to ask for it... you know the bottom-up, top-down approach, you need to have the bottom-up. You need the clients, the community asking for it. You need tell them so they can see it, recognize it, and actually attach a value to it, what we also mentioned to you they don’t see because they have no way of knowing that it’s happening”. (Participant 19)</p>

IPE THEMES/PRINCIPLES/FUTURE CONSIDERATIONS	Examples of Strategies & Policies	Interview Feedback
<ul style="list-style-type: none"> <li>• Trust</li> <li>• Good leadership and communication skills</li> <li>• Reflective and ethical practitioners with a genuine interest in and commitment to the care of older adults</li> <li>• For pre-licensure IPE programmes, an accountability structure and quality standards may play an important role</li> <li>• Post-licensure education that is context-specific and ongoing, with content defined by individual teams engaged in IP. This is particularly important in the care of older adults with complex comorbidities living in the home and community.</li> <li>• Consideration of consortium models of interested post-secondary educational institutions, as implemented in Japan and other countries.</li> </ul>		

## INTERPROFESSIONAL COLLABORATION

IPC THEMES/PRINCIPLES/FUTURE CONSIDERATIONS	Examples of Strategies & Policies	Interview Feedback
<p><b>Theme 1 – Common Operational Definitions of IPC</b></p> <p><b>Principles</b></p> <p>With the complexity of providing IP collaborative care in home and community, it is essential that older adults, as participants in these IPC models, understand what interprofessional collaboration means, who the members of the team are, what their role is on the team, and what the roles of the different team players are. In an environmental scan conducted in the Ottawa region in 2008 by Casimiro et al.<sup>29</sup> it became clear that clients and families are not always well-informed on these issues. For these models to be successful in the clinical realm, a common operational definition, understandable by all participants, is fundamental.</p> <p>The most commonly used definition of interprofessional collaboration was proposed by the Canadian Interprofessional Health Collaborative (CIHC) in June 2007. It aligns with the definitions proposed in a number of other important studies in the area, albeit with some expansion of ideas.<sup>30,34,64</sup></p> <p><b>“Interprofessional collaboration is a partnership between a team of health care providers in a participatory, collaborative and coordinated approach to shared decision making around health and social issues”.</b></p>	<p>The CIHC’s definition of IPC is the definition used in governmental and organizational documents in Canada and all over the world.<sup>36, 60, 65</sup></p> <p>The Journal of Interprofessional Care and two biennial international conferences in interprofessional collaboration are examples of platforms for dialogues and discussions involving definitions, concepts, and models of IPC.</p>	<p>“We intentionally, much to some people’s chagrin, dropped interprofessional (<i>from our definition of IPC</i>) because we wanted to make sure that there was more of a sense of inclusivity, not just regulated professions, not even just including non-regulated health providers, but also individuals, families, and caregivers. So really collaborative practice assumes all the players ...assumes all the players who are involved in some sort of a health encounter.” (Participant 6)</p> <p>“What I usually see in teams is they...they will either cooperate well or they coordinate well. They just don’t partner well. And so that’s where the partnership piece and the inclusion of the patient and caregiver is usually where they...the weaknesses are and that’s really the crux of collaborative practice.” (Participant 01)</p> <p>“The health care system in Canada is wonderful. However, they can’t do everything. They are so specialized, that no one person is going to see your loved one the same way that you do. I discovered the only person who has the whole picture is the caregiver.” (Caregiver quote – Study 1)</p> <p>“Yeah. And so maybe that’s involving people from social services. So if I think about the community, it’s sometimes hard to differentiate when you’re thinking about the social determinants of health. Is this a healthcare person involved with this</p>

IPC THEMES/PRINCIPLES/FUTURE CONSIDERATIONS	Examples of Strategies & Policies	Interview Feedback
<p>There are varied definitions used in the field; however, they are expanded versions of the CIHC’s definition.</p> <p><b>Future Considerations</b></p> <ol style="list-style-type: none"> <li>4. Based on input from our interviews with experts and review of the literature, it became apparent that the terms <i>interprofessional education</i> and <i>interprofessional collaboration</i> may be misnomers. Because present definitions do not include the client and family as key members of the process, nor do they take into consideration social care providers and unregulated providers, we suggest that a more appropriate terms for the process is <i>collaborative practice (CP)</i> in lieu of IPC.</li> <li>5. A common operational definition of IPC requires more dialogue and agreement around the expansion of currently acceptable definitions.</li> <li>6. Clients, families and caregivers should be included as active members of these discussions, as well as key members of the geriatric IPC team and this should be implicit in the definition.</li> <li>7. Social care and community service providers, as well as unregulated caregivers, should be included in the definition of IPC in any integrated, community-based, older adult/family collaborative care model.</li> </ol>		<p>client, patient, elder? Or is it a social service person? We artificially divide those from a governmental perspective. But yeah, I think it needs to be much more inclusive, for sure, yeah.” (Participant 16)</p> <p>“I mean, I have PSWs I work with, they have a PSW certificate, but their experience and knowledge is amazing. And then you have physicians that have just graduated from med school, their knowledge might be amazing in a certain area but they have zero expertise. And so having the two put together that’s where the learning is going to happen and that’s where they’re going to understand each other’s role in trying to address the person’s needs in the community. To have the time to do that and to build those strong teams, that’s not happening either.” (Participant 11)</p> <p>“If all those sectors, <i>acute, primary care, and community</i> are better integrated, you’re going to get better care. And I think that collaborative practice, or IPP, offers an opportunity to de-fragment, better integrate, increase outcomes, reduce risks.” (Participant 06)</p>



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<p><b>Theme 2 – Client and Family-centred Focus and Understanding of Who Constitutes the Team</b></p> <p><b>Principles</b>            Given the nature of home and community IP collaborative practice, where the delivery of care often occurs within the confines of the client’s home and where multiple care providers are dispersed in a large geographical space within the community, the nature of the provision of home and community care for older adults and their families differs considerably from acute care delivery.</p> <p>The concept of being a contributing member of an IPC team, where the older adult and family set the goals for care in collaboration with the team, may be foreign to many older clients and to some care providers. Many older adults have been conditioned to believe that the care providers are in the driver’s seat when it comes to deciding the best approaches in care. Indeed, some care providers may also believe this to be true. Putting the clients at the centre of care and seeking their input in decision-making is a shift in thinking for both clients and care providers.<sup>21,29,30</sup></p> <p>There is a need for inclusion and integration of health, social, and community services across all sectors to adequately address comprehensive, yet targeted, care of older adults living in the community.<sup>21,29,30</sup></p> <p><b>Future Considerations</b></p> <ol style="list-style-type: none"> <li>8. Patient-centeredness must be strongly encouraged in collaborative practice models and integrated IPC teams should strive to include patients and their families as key</li> </ol>		<p>“Basically, it doesn’t matter where you go but there’s still this perception that the patients or the clients we deal with are empty vessels and we have to help them to get all the knowledge into their heads. In other words, we situate ourselves in this power relationship with them that just ignores that these people are real people and they have, especially those with chronic diseases they’ve been living with them for a long time, they have so much they can teach us and it’s us giving up this attitude that, you know, you be quiet, we’ll tell you what to do. And to me that’s absolutely critical. And I think there’s a whole lot of perception that as people get older, you know, they get more infirm and incapable of doing this and my experience is that’s not the case. But we don’t give them an opportunity; so, therefore, why should they participate with us?” (Participant 01)</p> <p>“I’m not a part of any decision-making really, the doctor tells me what’s wrong and what I need to do.” (Client Quote-Study 1)</p> <p>“It’s frustrating because I have separate people who deal with my problems separately...but, we’re all...everything’s interconnected, everything is me.” (Client Quote-Study 1)</p> <p>“It’s exhausting but it needs to be done so what I’m learning is, I need to get extra help in addition to my family so the...working with the CCAC has.....learning how to work with professionals has been very useful in reducing my stress level and knowing how to properly manage him.” (Caregiver)</p>

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<p>decision makers on the team.</p> <p>9. Older adults and their families should be seen as key decision makers and equal members of the team.<sup>21, 28-30</sup></p> <p>10. Older adults should have clear understanding of who is on the team and the roles of each team member and what services they can provide vis-à-vis the specific role of the older adult client and family.</p> <p>11. With the complexity of the community care system and the difficulty older adults experience with the navigation through this system, it is essential that they learn their role in identifying their priorities, their needs and how, with the help of the IPC team, they can get their needs met. More work is required to achieve this important goal.</p> <p>12. The role of a “system navigator” should be re-examined for possible inclusion in any integrated care model from acute and community sectors as a bridge to helping the client and family manoeuvre through the transition from hospital to home/community and through the complex community system networks.</p>		<p>Quote-Study 1)</p> <p>“At the palliative stage, the teams are beautiful, the assessments...the...the care coordinators are thorough, the communication is very clear to the other healthcare providers that come in. Up until then, it’s very disjointed so I...and people just do piecemeal approach and not a holistic approach. I...I really, strongly feel that if we could do that...that kind of integrated, interprofessional communication and collaborative care earlier, people would be much healthier for a longer term and we would put the resources where we could have that optimal health in aging earlier and we wouldn’t be at that palliative stage so soon.” (Caregiver Quote-Study 1)</p> <p>“If there’s anything that caregivers need it would be much more psychological support and counselling. As a caregiver, there are multilevel roles you are playing, so you really do need counselling support to help you advocate.” (Caregiver quote – Study 1)</p>

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<p><b>Theme 3 - Interprofessional Collaboration Models in the Care of Older Adults and their Families</b></p> <p><b>Principles</b></p> <p>"Collaboration among individual professionals is a first step in developing collaborative relationships among community constituents, agencies and professional groups (p.298)." <sup>67</sup></p> <p>There is no one IPC model to fit every population of patients. The models vary significantly in focus and implementation among context-specific patient groups. <sup>21,28,30</sup></p> <p>IP work varies with context, intensity of need, workforce availability, and pragmatism <sup>68,69</sup> but there must be better understanding of how differences in context, systems, mix of professionals, agencies, roles, and services influence IP work and patient outcomes for community-dwelling older adults. <sup>21,28-30,70</sup></p> <p>Best practices vary across programmes and few, if any, are universal, making evaluation difficult. Best practices must be modified to individual programmes and client characteristics.</p> <p>There are a number of models in practice, including some good ones that, although not yet evaluated, do hold some promise.</p> <p>Team effectiveness and patient outcomes are context</p>	<p><b>Virtual Wards (An IPC model providing transitional care):</b> Virtual wards (VWs) foster collaboration, care integration, and effective transition. The aim was to reduce hospital readmissions by providing short-term transitional care to high-risk and complex patients in the community recently discharged from hospital. <sup>71,72</sup> Patients were provided home-based care by an IP team. In Canada, VWs were piloted in Toronto and Manitoba. <sup>72</sup> Teams varied in the different projects; however, they usually included a physician, a nurse, and a care coordinator. Evaluation of programmes showed significant reduction of readmissions rates and VWs were well perceived by patients and providers. <sup>73</sup></p> <p><b>Patient First model from Australia:</b> This model successfully linked hospitals and community-based healthcare services for the elderly. All stakeholders including clients were involved in the planning, implementation, and evaluation of the stages of the project. The overall results indicated patients who participated displayed a reduced demand for acute hospital services and hospital readmission. <sup>74</sup></p> <p><b>IPC rehabilitation model from New Zealand:</b> The Enhanced Intermediate Care Assessment and Treatment Team (EICATT) programme began in 2012. The programme is helping older people return home earlier, after serious falls or injuries. The EICATT programme is designed for older people who are transferred from hospitals to a rehabilitation village before returning home. The team includes geriatricians, specialist nurses, physiotherapists, occupational therapists, and social workers who meet</p>	<p>"I really think that, for seniors especially, a healthcare team would be...and, you know, if you could put them sort of all in one place and I wouldn't have to drive to twelve different offices...I know that's not feasibly possible, but...there...you know, for seniors especially, they need the familiarity and that place to go to." (Caregiver Quote-Study 1)</p> <p>"I think probably the more major stumbling blocks are just the disconnection of home care, home and community care service providers from the rest of the system. So you think about... a client's journey from a hospital, for instance, so an elderly client is in a hospital, they have a suite of service providers that are caring for them in acute care. They are being planned for discharge. They get hooked up with the CCAC case manager, that case manager then connects them in some way to service providers in the home and community care sector once they get discharged from the hospital. So we, as home care providers, we never get to talk to the nurses that cared for that client in the hospital. We don't get to have a case conference with the physician, the primary physician, to understand their plan of care. It's all in writing and it's all referral based and it's all filtered through the CCAC case manager.....So we then take on the home care components of that directed by the CCAC case manager, and I just think we're</p>

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<p>specific and there is no <i>strong</i> evidence that good team functioning improves patient outcomes.<sup>30</sup></p> <p><b>Future Considerations:</b></p> <p>13. Partners involved in planning and implementation of IPC care models in the home and community care of older adults and their families should plan for built-in programme evaluation, with a specific focus on team effectiveness and improved patient outcomes for the older adult population in the community. Committed partners in the model of care, including the clients, need to see the benefits of the programme.</p> <p>14. There is a need for more randomized controlled trials (RCTs) to study the effectiveness of IPC models that focus on the care of older adults and their families, with particular emphasis on direct and indirect patient outcomes. Although research to date has provided some evidence for system and organizational outcomes, such as reduced hospital stays and nursing home use, better team functioning, improved community care, and increased patient and care provider satisfaction, more research is required to demonstrate team effectiveness and its relation to improved patient outcomes.<sup>21,29,30</sup></p> <p>15. Descriptive observational and other qualitative studies are required to understand the experiences of older adults and their families with these particular</p>	<p>weekly. To date, the programme is well received by clients and providers.<sup>75</sup></p> <p><b>Northumberland PATH model:</b> Started in 2012, funded by the Change Foundation, the project involves a large group, including primary care providers, a technology partner, experts in geriatric care, and influential citizens. Patients and caregivers collaborate with providers across the community/system to co-design changes to improve healthcare transitions and experiences. The Foundation plans to present all that it learns from the Northumberland PATH, related research, and public engagement into a capstone Summit in 2015 that will result in key recommendations for change.<sup>76,77</sup></p> <p><b>IMPACT model:</b> Project IMPACT (Interprofessional Model of Practice for Aging and Complex Treatments), initiated in 2008 at Sunnybrook Health Sciences Centre in Toronto, is a model of IP primary care for elderly patients with complex health care needs. The comprehensive team comprised family physicians, a community nurse, a pharmacist, a physiotherapist, an occupational therapist, a dietician, a community social worker, and trainees from each discipline. The main objective of IMPACT is to design and evaluate a new interprofessional team-based model of care for community-dwelling seniors with complex healthcare needs. Evaluation of the model so far has shown a better outcome for patients and positive feedback from patients, clinicians, and trainees.<sup>78</sup></p> <p><b>PACE model:</b> The Program of All-inclusive Care for the Elderly (PACE) is an American long-term care delivery and financing innovation aimed at preventing</p>	<p>talking about interprofessional collaboration – from that perspective we’re really missing a lot.... We don’t get to talk to the physiotherapist that was doing rehab or with that client or other professionals in hospital. So there’s a lot of missed opportunity from a professional, interprofessional collaboration perspective.” (Participant 18)</p> <p>“That’s why we’re blessed in this community because we’re a tiny health team and we only have a catchment area of twenty-four thousand patients. We have twenty-eight doctors and we have then our family health team of dieticians, visiting nurses, geriatric specialists, diabetes specialists, congestive heart failure specialists...so we’ve got the whole gamut and our people can make house calls which is important for older adults.” (Healthcare Provider Quote-Study 1)</p> <p>“We have a terrible system filled with silos. Everybody keeps trying. The very best that I have seen so far is the Family Health Teams because we really collaborate. It is still a huge challenge working with outside agencies.” (Healthcare Provider Quote-Study1)</p> <p>“Swedish study, called Too Complex and Too Time-Consuming to Fit In (Geary and Shumacher, 2012). It’s a study of why primary care providers’ views of integrating</p>

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<p>models. These types of studies could further inform the findings of experimental studies.</p>	<p>unnecessary use of hospital and nursing home care and keeping seniors in their home and community longer. It has been implemented widely in cities and states across the USA, serving enrollees in day centres and clinics, their homes, hospitals, and communities. Enrolees must be 55 years of age or older, live in the geographic catchment area, and be referred by the state as eligible for the programme. Outcomes of the programme have been positive including good consumer satisfaction, reductions in institutional care, and controlled utilization of medical services, but start-up of the programme requires substantial time and capital.</p> <p><b>All-inclusive Care of the Elderly (ACE) Unit model:</b> Mt. Sinai Hospital in Toronto, Canada has implemented an ACE Unit for geriatric patients that is modelled partially on PACE but within the funding confines of the Canadian healthcare system. It is an integrated care model that uses multidisciplinary teams in the care of older adults and their families in a seamless system across the acute and community sectors. It is a relatively new programme but is already showing promising results (conversation with Dr. Samir Sinha).</p> <p><b>TAPESTRY project (EMS and community care):</b> TAPESTRY (Teams Advancing Patient Experience: Strengthening Quality) is a programme offered by the Department of Family Medicine in collaboration with the McMaster Family Health Team and other sites across Canada (<a href="http://www.HealthTapestry.ca">www.HealthTapestry.ca</a>). Community volunteers make home visits to older patients to help them meet self-identified goals to stay healthier longer. Volunteers work in collaboration with the Family Health Team to help patients navigate the</p>	<p>older adults into treatment decision-making – it’s too complex, too time-consuming to fit in. So...so patients can advocate for time and I think, really, across the board if we’re going to call people complex it means there’s no shortcut solution. It means there’s no magic wand waving that’s going to solve the problems. If we really want to own these problems, take them seriously and call it good quality of care, then we have to find the time.” (Participant 12)</p>

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	<p>healthcare system. Patients can use their Personal Health Record to interact with and inform other members of their circle of care, such as community care nursing and family caregivers. The programme is in the early stages of evaluation. Drs. Jenny Ploeg and Ruta Valaitis from the ACHRU and McMaster School of Nursing are co-investigators.</p> <p><b>Toronto Central EMS project:</b> Ontario is investing 6 million dollars in the expansion of community paramedicine programmes to improve access to home care and community support services for seniors and other patients with chronic conditions. This will allow paramedics to apply their training and skills beyond the role of emergency response and can include home visits to seniors who frequently call EMS, educating seniors in their homes about chronic disease management, and helping refer patients to their local CCAC. Community paramedicine programmes will work with teams of health professionals, to co-ordinate care for individual patients with complex chronic conditions. These programmes will help seniors live independently, while helping reduce unnecessary emergency room visits and hospital admissions. A six-month study of this programme found that, when paramedics responding to emergency calls referred patients to community services, there was a 50% decrease in the number of repeated 911 calls and a 65% decrease in the number of emergency department transports. (from MOHLTC website)</p>	

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<p><b>Theme 4 - Care Provider, Organizational, and Government Support</b></p> <p><b>Principles</b></p> <p>There is government commitment across the globe to closer working between professionals to improve health but this is poorly understood by users/clients/patients.<sup>29,30</sup></p> <p>Care provider and organizational, as well as government, support is required to sustain successful collaborative practice.</p> <p>The concept of interprofessional collaboration in the seamless care of older adults and their families should be embedded in organizational culture and values and should, in turn, be strongly supported and valued by care providers either in or affiliated with that organization.<sup>80</sup></p> <p>Our review suggested that the organizational and government support for IPC is often driven by health economics, patient safety, and quality healthcare outcomes, in that order. Although health economics is an essential driver, patient safety and healthcare outcomes should be the priority and would be more likely to engage clients, families, and healthcare providers.<sup>30</sup></p> <p><b>Future Considerations</b></p> <p>16. Interprofessional collaboration should be</p>	<p>Countries around the globe have realized that health requires a community focus, an “all-policies” focus, a focus on prevention and wellness, and an IP focus facilitated through teamwork in learning and practice. Despite strong organizational and government support, policies have not been fully issued to implement IPC in most health systems.</p> <p>Health Canada’s initiative of Interprofessional Education For Collaborative Patient-Centred Practice (ECPCP) in its “Pan-Canadian Health Human Resource Strategy”<sup>81</sup> promoted collaborative practice amongst disciplines and optimized clinical decision-making by including patients and their families. However, many years after this initiative was introduced, it is still not translated into policy or legislation.</p> <p>Some Scandinavian countries, such as Sweden, implemented laws requiring IPC in health care, especially for the elderly, in healthcare organizations and in community and home settings.<sup>82</sup></p> <p>In England, a policy called Transforming Community Services was launched in 2008 to shift more health care from hospitals to settings closer to people’s homes, but it was mostly concerned with structural changes rather than with how services could be changed.<sup>83</sup> The King’s Fund convened a working group of community providers to explore the steps that are required to</p>	

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<p>based on the need for improved patient outcomes and safety with cost effectiveness being a secondary driver.<sup>31</sup></p> <p>17. Organizational culture should support and value interprofessional collaboration in the seamless, intersectoral care of older adults and their families, if they are to implement it in a successful manner.</p> <p>18. Organizations that implement IPC programmes to provide this kind of care should employ care providers with like values.</p>	<p>change community services in ways that will help create the transformation promised in that policy. A key step is to build multidisciplinary teams for people with complex needs, including social care, mental health, and other services.<sup>14</sup></p> <p>In late 2007, immediately after the release of Interprofessional Care: A Blueprint for Action in Ontario<sup>60</sup> the Ontario Ministry of Health and Long-Term Care (MOHLTC) convened a multidisciplinary, cross-sectoral, Interprofessional Care Strategic Implementation Committee, with individuals from academic institutions and professional associations, as well as caregivers and regulators. The goal of the committee was to work with the health and education sectors to implement the IPE/IPC recommendations of the blueprint at the system, organizational, education, practice, and policy levels. The final report of this committee was tabled in May 2010 (Implementing Professional Care in Ontario, May 2010).<sup>84</sup> Over the next four years, IPE programmes were initiated in academic institutions and IPC collaborative practice teams were implemented in many areas of the healthcare system. Partners responsible for excellence in care for all Ontario have demonstrated a strong commitment to IPE and IPC as a platform for providing that care including, academic educators, healthcare organizations, regulators, individual healthcare providers, patients, and government. Much work has been done to date but more remains to be done.</p>	



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<p><b>Theme 5 - Technological Innovations</b></p> <p>Because of the complexity of providing interprofessional care for older adults and their families in home and community as outlined throughout this report, appropriate and thorough communication among care providers, caregivers, and clients, as well as across sectors, is essential in the coordination of this care. The majority of academic papers and grey literature address the need for technological innovations for collaborative practice in the community. It has been lauded as one of the key elements in supporting the success of integrated models of care for older adults and families across the system and specifically in home and community. 3,21,29,30</p> <p>Common assessment and care planning instruments and integrated data systems are commonly listed infrastructure supports for integrated care<sup>3</sup>, both across the system and, more importantly, in the community sector where services are widely spread out and team communication is more difficult because of time and geographical challenges.</p> <p>Although there is presently much work occurring with better communication systems among care providers and clients in the community, such as electronic documentation that can be shared across the system, many issues remain to be addressed to render the system workable. Emailing, teleconferencing, and video-conferencing are applications that are now readily available for virtual team meetings across sites that have the potential to improve time management and negate the geographical issues. Handheld devices</p>	<p>The designing and building of a mobile health (mHealth) solution to support community health providers in providing evidence-informed care to older adults with multiple chronic conditions who have experienced a stroke. <b>Markle-Reid..., Ploeg, J., Gafni, A., Valaitis, R.</b><sup>85</sup>: The MOHLTC has funded a qualitative descriptive study where end users will be engaged in the design of the mHealth application. This app will be web-based with a mobile phone platform. The app will include the following functions: a communication tool for all care providers in the circle of care; the Stroke Management Protocol embedded within a safety framework; a safety checklist based on best practices with alerts to relevant professionals, including primary care practitioners; and trending of client status/progress over time. This information will be accessible by health team members and will provide key metrics, statistics, and summary information in the form of standardized reports to the interprofessional team as needed. This innovative technology has great potential to improve evidence-informed care for older adults with multiple chronic conditions and their caregivers. It is presently under development.</p>	<p>“The EMR, it’s a fantastic tool for collaboration and efficiency.” (Care provider-Study 1)</p>

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<p>and PDAs serve a functional purpose in keeping participants connected across sites and applications (apps) to improve client care are continually being developed and tested. More work is required in these areas.</p> <p><b>Future Considerations</b></p> <p>19. Technological innovation can go a long way in facilitating IPC and IPE in the care of older adults and families, as well as facilitating interprofessional communication across sectors and the community. Partners should encourage innovation in this area and provide the up-front funding for the innovative technologies that promise long-term efficiency and effectiveness in care delivery.</p> <p>20. IPC teams across the sectors and particularly in the community should have a strong information technology (IT) network with common medical records and charting systems to prevent duplication of efforts and facilitate interdisciplinary communication.</p>		

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<p><b>Theme 6 - Process, Structure, and Outcome</b>  <b>Evaluation of Collaborative Models in the Care of Older Adults and their Families</b></p> <p>There is a general consensus across the academic and grey literature that many general and context-specific IPC programmes in the care of older adults and their families in home and community have been implemented with varying outcomes. Some partial programme evaluation has been conducted but, although there is anecdotal evidence of their effectiveness in improving patient outcomes, little if any strong evidence of improvement in patient outcomes exists (Casimiro et al., 2011; Trivedi et al., 2013).</p> <p>There has been some evidence in individual studies of positive organizational and system outcomes, such as improved team functioning, better client and caregiver satisfaction, reduced hospital and long-term care admissions, and better cost efficiency, to name a few, but more rigorous research is required to demonstrate strong evidence for IP team effectiveness and improved patient outcomes.</p> <p><b>Future Considerations</b></p> <p>21. While integrated care models theoretically may improve care in the community and reduce hospital stay and nursing home use, more rigorous studies and observational research are required to fully understand the effectiveness of IPC on targeted populations</p>	<p><b>Trivedi et al.</b><sup>30</sup> point out, in a systematic review of 41 RCTs conducted worldwide and reporting user outcomes for IP care of community-dwelling older adults, that there is lack of evidence linking IP work to explicit outcomes for these clients. Further, it is not clear how different systems, contexts, professionals, agencies, roles, and services influence the effectiveness of IP work and collaboration. Based on this review, it is clear that the process of IPC is poorly documented and there is lack of evidence on the cost effectiveness of IPC. However, integrated models of care have the potential to improve the processes of care and reduce hospital or long-term care use. Further, the role of case/care management as an interprofessional related intervention needs further research.</p> <p><b>Markle-Reid, Browne and Gafni</b><sup>86</sup> reported the results of 3 community-based RCTs in Southern Ontario, noting that nurse-led health promotion disease prevention (HPDP) strategies had statistically significant improvement in care for seniors in the home. They recommended multiple home visits, multidimensional assessments, IPC, and co-ordination of care by case managers with expertise in geriatrics. Further, they reported that interventions that engaged clients, family, and other healthcare providers were effective in improving the clients' overall quality of life scores (HRQOL), with no additional healthcare delivery costs, compared with the control group with usual home care</p>	<p>"I think we have under-explored the horizons that are represented by IPE and IP collaboration. So my recommendation is do more and evaluate what works. And in this field do it quickly . It truly needs to be supported, nurtured and championed. We just need to bite the bullet and fund a bunch of interprofessional centres for aging. Integrate social and medical care, throw away the disease model, you know. Buy into Mary Tinetti's <i>End of Disease Era</i>. Set up interprofessional assessment. Deal with patient's function and symptoms. You know, forget about their risk reduction if they're over 80 for their Lipitor." (Participant 12)</p> <p>"I think one of the facilitators that we don't often talk about but is really part of the whole business model, that's a very influential factor, is that there is evidence that using collaborative team-based approaches can actually reduce the bottom line in the system. And I think because so many policy makers and so many health delivery decision-makers are so conscious of money and the unsustainability of the system, I think that's a real leverage point." (Participant 06)</p> <p>"So we have...we run a model, SMILE ...so you're going to have to think about interprofessional collaboration in a different way because this is very much on the CSS side of things, so there's really very little professional designation in this model. But it is...it is very interprofessionally collaborative but with different people. The way</p>

IPC THEMES/PRINCIPLES/FUTURE CONSIDERATIONS	Examples of Strategies & Policies	Interview Feedback
<p>(Trivedi et al., 2013; Markle-Reid et al., 2013).</p>	<p>service. There were insufficient data to generalize results beyond Southern Ontario but they do suggest the need for further research to determine which interventions were most successful, why they were successful, and how they should be incorporated into home care services given that HPDP strategies were incorporated with no extra cost to the system.</p> <p><b>A pilot study of an IPC model at Stonechurch Family Health Centre</b> in Southern Ontario used an IP shared-care model for seniors living in the community.<sup>21,87</sup> It was determined that this programme reduced referral times for seniors, provided easier access to services, and successfully allowed seniors to stay at home.</p> <p><b>Victorian Order of Nurses SMART In-Home Programme</b> provides one-on-one volunteer-facilitated exercise visits to help shift the balance away from potential frailty, empowering seniors to maintain their own wellness. This involves volunteer-facilitated functional fitness classes (1 hour/per week) brought to community-dwelling seniors who may otherwise not be able to participate or gain the benefits of appropriate physical activity. Twenty VON sites across Canada currently offer VON SMART programmes, with a long-term goal of having the programme in place in all sites. There is anecdotal evidence of excellent results and plans are underway for a full scale programme evaluation.</p>	<p>that the programme runs is that elderly clients have a particular allocation of funds. We...we have a case manager, usually a professional so a social worker or a nurse, that works with the client to understand what their particular needs are from an IADL and ADL perspective, and we...we help the client. We match the client with those services..... it's things like, you know, driveway shovelling or wood cutting or taking an elderly person out to go grocery shopping, those kinds of things, to appointments and that kind of stuff. So it's not the medical model at all and when we think about interprofessional collaboration we think about that model....It is working very well!" (Participant 18)</p>

IPC THEMES/PRINCIPLES/FUTURE CONSIDERATIONS	Examples of Strategies & Policies	Interview Feedback
	<p><b>Seniors Managing Independent Living Easily (SMILE) Programme</b> empowers seniors to live at home through access to individualized home support based upon their needs. This is an integrated programme in south-eastern Ontario that has a long wait list for services.<sup>88</sup> Through interaction with users of the model, it is apparent that access to community services for seniors partners well with prevention and early intervention programmes to support seniors who wish to continue living at home. Programme evaluation has not yet been conducted but anecdotal evidence suggests that is well received in the south-east Local Health Integration Network (LHIN) with other LHINs showing interest in implementing the programme.</p> <p>A pilot study of a 6-month <b>interprofessional community-based intervention for older adults with diabetes and multiple chronic conditions</b> is being carried out in Guelph, Ontario (Markle-Reid et al, in progress). The intervention includes a series of home visits by a nurse and dietician from Diabetes Care Guelph (DCG) and a monthly group education programme offered by the Guelph Wellington Seniors Association (GWSA) in partnership with DCG. Interprofessional collaboration between interventionists from DCG and the GWSA is supported by monthly face-to-face case conferences. Preliminary feedback from the interventionists indicates that the case conferences have helped them function as a team, prepare for upcoming group sessions, and identify relevant community programmes and services to discuss with participants for health</p>	

IPC THEMES/PRINCIPLES/FUTURE CONSIDERATIONS	Examples of Strategies & Policies	Interview Feedback
	promotion and chronic disease management. Effects of the intervention on diabetes self-management will be evaluated. <sup>89</sup>	

IPC THEMES/PRINCIPLES/FUTURE CONSIDERATIONS	Examples of Strategies & Policies	Interview Feedback
<p><b>Summary of Facilitators/Sustainability of IPC in Home and Community Carefor Older Adults and their Families</b></p> <p><b>Key Considerations for Successful Collaborative Practice</b></p> <p>Teams should have common goals and values, willingness to persevere with the programme, and mutual reliance and respect.</p> <p>Teams should have a defined geographical area and a common home base to facilitate communication.</p> <p>Teams should have a strong IT network with common medical records and charting systems to prevent duplication of efforts and facilitate interdisciplinary communication.</p> <p>Teams should develop an adaptable practice that allows for flexibility and facilitation of outreach activities.</p> <p>Relationship building is essential and will allow for capacity building initiatives, encourage support of people outside the team, and enhance a mutual respect for the importance of time.</p> <p>There is a need for transformational leadership within interprofessional teams.<sup>30, 80</sup></p> <p>Government and organizational support, adequate funding, and common influences and values of</p>	<p>In countries where IPC is endorsed, resources (i.e., financial, human, or technical) played a central role in the development or regression of collaborative practice. For example, in England, pressure on healthcare resources has led to a reduction of technical and financial resources directed toward training and education.<sup>91</sup></p> <p>Scarcity of human resources can also be an obstacle to IPC. For instance, in Japan, more care workers are needed every year but they are difficult to recruit and retain because of the lower pay, more difficult working conditions, and lower chances of promotion compared with other specialties.<sup>92</sup></p> <p>In some Scandinavian countries, such as Sweden and Denmark, where financial and technical resources are available, IPC is incorporated in healthcare systems and legislated.<sup>82,93</sup></p> <p>In Sweden, older people’s needs are often assessed in the context of care planning upon discharge from hospital, where professionals collaborate in teams planning the care, together with the older person. These professionals are assigned to carry out tasks where their specific expertise is needed. They enjoy various degrees of autonomy or discretionary power in judging the needs and rights of the clients.<sup>82,94</sup></p> <p>Transformational leadership within IP teams is incorporated in Sweden health teams, such as home planning teams (HPT) or discharge planning</p>	

<b>IPC THEMES/PRINCIPLES/FUTURE CONSIDERATIONS</b>	<b>Examples of Strategies &amp; Policies</b>	<b>Interview Feedback</b>
stakeholders can also facilitate team collaboration. <sup>90</sup>	teams (DPT) for elderly patients. A registered nurse as case manager is the leader of the HPT, while a social worker is the leader of the DPT. <sup>82</sup>	



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