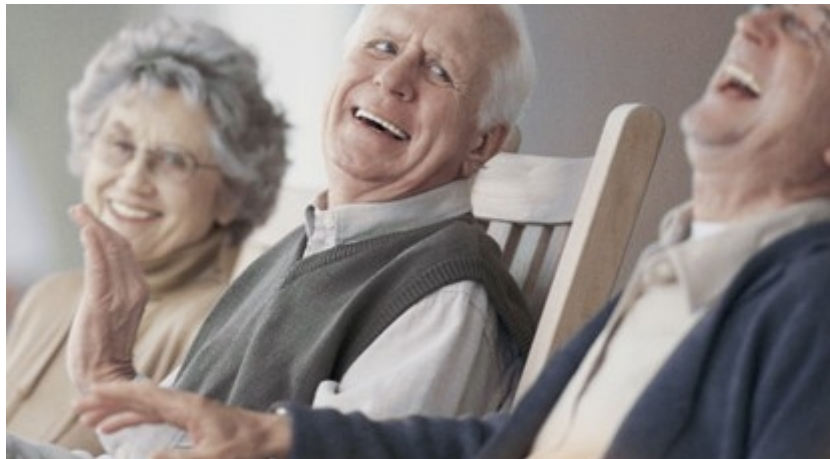


Council of Ontario Universities, Office of Health Sciences

HEALTH WORKFORCE EDUCATIONAL NEEDS FOR SENIORS CARE INTERPROFESSIONAL EDUCATION AND COLLABORATIVE PRACTICE

SYNTHESIS PAPER



Principle Investigators:

Marion C. E. Briggs, BScPT, MA, DMan
Assistant Professor, Clinical Sciences and
Director, Health Sciences and Interprofessional Education
Northern Ontario School of Medicine
Fellow, AMS Phoenix Project

Janet E. McElhaney, MD, FRCPC, FACP
Professor of Medicine, Northern Ontario School of Medicine
Senior Scientist, Advanced Medical Research Institute of Canada
Medical Lead for Seniors Care, Health Sciences North, Sudbury

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Notice

The views expressed are those of the authors and do not necessarily reflect those of COU or the Province

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Executive Summary

This needs assessment focuses on interprofessional education (IPE) and collaboration (IPC) related to seniors care. It is one of five needs assessments commissioned by the Council of Ontario Universities in November, 2013, with funding from the Government of Ontario, in order to help identify priority areas for implementing the educational recommendations in Dr. Sinha's *Living Longer, Living Well*. Interim results of the needs assessments also supported stakeholder discussions at the "Better Aging: Ontario Education Summit" held on Feb. 13, 2014.¹

This needs assessment identifies guidelines and priorities for implementing Recommendation 135 in Dr. Sinha's report:

135. The Ministry of Health and Long-Term Care and the Ministry of Community and Social Services should continue to support and promote interprofessional education and collaboration between physicians, nurses, and allied health and social care professionals focused around the care of older adults.

The assessment reviews the literature on interprofessional care and education with respect to seniors care in order to identify specific gaps or weaknesses with such models of care, and critical approaches for moving forward.

The **key identified gaps** in the literature included:

- lack of sensitivity to context in IPC/E literature as a result of a narrow scientific paradigm and related best practices approach
- lack of evaluation in terms of patient outcomes in IPC/E literature

Key potential priorities to guide future action include:

- Recognize education, research and practice as complex social and scientific processes that require a variety of qualitative and quantitative approaches to gathering evidence and a strong sensitivity to context.
- Develop, apply, and monitor evaluation and accountability metrics that reflect improvement trends in patient-oriented outcomes related to compression of morbidity, prevention of complications of care, and quality of life; develop and measure key indicators of progress in each of the dimensions.

¹ Dr. Sinha is the Provincial Expert Lead for the Ontario Seniors Strategy. Dr. Sinha identified enhanced education and training of health and social care professionals who work with older adults as a key enabler of a seniors-friendly Ontario.

- Integrated, person-centred care models to replace episodic care provided through differentiated care sectors.
 - Work with practice-education sites to develop longitudinal approaches to sector-integrated IP clinical placement opportunities that support learner contact with older adult patients over time and in multiple points in the health system, including home and community care, primary care, and acute care, e.g.
 - i. Placement in one community for an extended period (6-10 months) that includes longitudinal contact with specific older adults in multiple sectors.
 - ii. Within an integrated longitudinal placement, include multiple short-term program-based clinical experiences alongside a longitudinal approach to older adult care.
 - iii. Seek and integrate practice-based IPE into clinical environments that model and promote IPC as the standard of care.
- All graduates should be exposed to curriculum in both academic and practice-based settings that will prepare them to recognize the need for (minimum) and manage (ideal) interprofessional, integrated, person-centred care for older adults. This will require:
 - Development of IP curriculum based on the CIHC Interprofessional Competency Framework
 - Distinguishing between individual and collective IP competence and providing opportunities through structured practice-based learning for the skilled application of both
 - A comprehensive pedagogy of person-centred care for older adults that includes an emphasis on incorporating the impact of frailty on treatment choice and the impact of the context in which integrated care occurs in the context of patient/family identified goals of care
 - Emphasis on IPE in a practice-based setting, with particular emphasis on integrated, cross-sector services for older adults. Educational and practice-based settings will need to collaborate to articulate how cross-sector IPC can work and the pedagogical principles and strategies that will support student and practitioner learning
 - Classroom and academic curricula on the elements of a comprehensive geriatric assessment (CGA); students graduating from professional health education programs in medicine, nursing, physical therapy, occupational therapy, and physician assistant programs can articulate and apply the elements of a CGA; all other health and social care disciplines should be

- familiar with the elements of the CGA and be able to recognize when an older adult would benefit from a CGA
 - Content on how disease presentation varies in older compared to younger adults and identify the implications for assessment and treatment strategies generally, and relative to the focus of each discipline
 - Technologies to support longitudinal integrated care processes and pedagogy surrounding these technologies
- The ideals of social accountability should contribute to the design of education programs, including student admission criteria, and the design of person-centred health and social service accountability models:
 - Evaluation methods (such as developmental evaluation) that support critical practice development should be implemented with opportunities to share “approaches that work” among service providers, educators, researchers, older citizens and their support networks
 - Accountability metrics should report achievements and trends in patient-oriented outcomes
 - Key indicators that measure compression of morbidity, reduce complications of care, and enhance quality of life, should be developed, implemented and broadly reported
 - Policy orientations should shift from implementation of best practice to innovation of the relevant and effective practice in the local context
 - Policy should shift from compliance with standard practice toward measurement of outcomes
 - Evaluation strategies should include a concern with characterizing patient/family, service providers, and the health system (i.e., local context); a concern with understanding why, for whom and under what circumstances various interventions work and what outcomes were achieved.

Background

The 2012 report by Dr. Samir Sinha, *Living Longer, Living Well*¹, identifies the importance of adequately trained and supported care professionals as a key enabler for a seniors-friendly Ontario. In November, 2013, the Ministry of Health and Long-Term Care (MoHLTC) provided the Council of Ontario Universities (COU) with funds to commission five needs assessments in order to help identify priority areas for moving forward with implementation of Dr. Sinha's educational recommendations. This needs assessment documents a synthesis of the work undertaken and identifies priorities for moving forward in response to interprofessional education (IPE)/ collaboration (IPC) opportunities in the care of older adults. The project was to document:

- Innovative and best practices in Canada and internationally in collaborative care models for older adults that integrate student or provider learning
- Potential gaps in such models of care in Ontario
- Opportunities for further development of collaborative care models; and
- Possibilities for integrating student and practitioner learning into these models

Approach/Method

We proposed and undertook a meta-narrative approach to the knowledge synthesis phase of the needs assessment. Meta-narrative method is a six phase approach to synthesizing literature and experience, and developing priorities for moving forward. The phases include planning, search, mapping, appraisal, synthesis and identifying priorities. In the planning phase, we gathered an interprofessional team together who brought diverse expertise and experience, and shared an abiding interest in improving the health of people as they age. Our project principle investigators were Dr. Janet McElhaney, a world-renowned translational science researcher and geriatrician, and Dr. Marion Briggs, a physiotherapist by background with expertise in approaches to health care education and practice informed by complex perspectives. Dr. Elizabeth Boryki has had experience as a geriatric clinical nurse specialist and was our needs assessment method consultant. Her expertise in health informatics was invaluable in developing an approach to data collection, management and interpretation. Ms. Jami van Haaften and Ms. Irma Sauvola hold Masters in Library Science and contributed to the literature search method and to organizing the search spreadsheets as well as the synthesis strategies. Library technicians at HSN Sudbury also provided important assistance with this work. Our Assistant, Ms. Barbara Rickaby, participated in finding, tracking, and summarizing the extensive literature and contributed to identifying the themes and their

implications. Ms. Debbie Szymanski, an advanced practice nurse at HSN Sudbury, facilitated the team process and contributed to our thinking throughout.

Meta-narrative is an emergent approach that includes a systematic inquiry of white and grey literature, books and textbooks guided by the searcher's experience, current understanding, and the new insights that emerge throughout the process. Our initial search was guided by broad search terms that related IPE and IPC to education or services for older adults. We realized through the process that much of the literature provided inadequate descriptions of the disciplines involved in the interprofessional team or the processes that they used that made them a team (something different that a collection of individuals who happen to work together with a specific program or patient population) and that even when it did, there was often no, or a very limited, attempt to link an identified team-based practice approach to patient outcomes. We thus determined to limit the ongoing review to literature in which team-based practices were described at least nominally and where there was some effort to relate these practices to patient-related outcomes.

The meta-narrative approach does not necessarily stop when the question is considered to have been "answered". Meta-narrative analysis can be an ongoing phenomenon where the analysis pauses at points (such as writing this report) to synthesize the emerging understanding and then continues as knowledge is modified through further review of existing and new literature, and through the experience gained by the application of its synthesis in practice. While meta-narrative does not exclude quantitative studies, the focus is on qualitative and mixed method studies as these data are likely to provide more nuanced details that are helpful to developing policy priorities grounded in the ongoing experience and development of 'practice-based-evidence-based practice'. That is, this method acknowledges theory and practice as two aspects of the same phenomenon and thus embraces the paradoxical association of practice and theory, privileging neither.

The Aging, Community and Health Research Unit at McMaster University developed a scan that looked at IPC/E in the home and community care context for older adult care, funded by the Ministry of Health and Long-Term Care to complement this needs assessment. The McMaster group made significant and welcome contributions to IPE and IPC which can be found in their report *Interprofessional Education and Interprofessional Collaboration in Home and Community Care of Older Adults and their Families*. Our own group focused on IPE/IPC in the acute care, geriatric rehabilitation and long term care domains. The distinctions between these sectors are quite artificial from a patient-centred perspective, which at all times was a centering principle for our work. It is far too common for interprofessional education and collaborative practice to

become ends in themselves. The patient gets lost as practitioners consider strategies to understand roles and scopes of practice, develop team processes and dynamics, and become good at conflict resolution. Thus, we have not attempted to present data from different sectors independently.

Summary of Results/Findings

Three key considerations were operationalized in the literature review and synthesis process. Early in the search process we recognized that much of the literature – both gray and white – that referenced IPE or IPC, defined the terms but did not describe the interprofessional strategies in sufficient detail to generate an understanding of who was involved or what the processes were that made a collection of individuals in practice or learning, a “team”. Moreover, many articles about IPE or IPC in the context of senior’s care made no attempt to correlate a particular kind of team-based practice to change in patient outcomes. While we appreciate the challenge of research that could demonstrate this link, its absence was nevertheless notable. Publications that did not identify the education/care team or link interventions to patient-focused outcomes were excluded. Finally, some of the literature did not make explicit whether or how interprofessional education or treatment interventions and/or the measurement of outcomes were person-centred. Our own bias is that person-centred education and care is almost universally mandated (notwithstanding a highly variable and inconsistent application) because it is intuitively better and potentially more cost-effective. Publications that had neither person-centred care nor outcomes as an easily identifiable feature were not included in the final synthesis unless there was another compelling reason to include them.

Introduction to High Level Themes

The Table below summarizes the high level themes, provides synthesis statements supporting the themes, and articulates the policy priorities that arise from the synthesis statements. We start by a challenge to the traditional application of “best practice” as

Researchers, practitioners and policy makers face a choice between two competing kinds of practice knowledge ...

✎ Evidence-based Practice:

- Based upon technical know how and skills; drive to standardization
- Equated with a ‘search for certainty’ and accountability
- Policy tells people what to do and how to do it

✎ Critical Practice:

- Concerned with **critical exploration and development** to promote innovative forms of practice and education that work locally
- Makes creative use of uncertainty and considers context as vital
- Policy tells people what outcomes are needed and what improvements in outcomes are expected (**why**, not what or how)

Stepney, P., Rostila, I., (2011). Towards an integrated model of practice evaluation balancing accountability, critical knowledge and developmental perspectives. *Health Sociology Review* 20(2). 133-146.

policy that compels practitioners to directly translate something developed through broad synthesis in the local conditions in which they learn or practice (Stepney, 2011; see insert). The theoretical framework for this challenge is complexity theory which is also the theoretical underpinning for developmental evaluation – a strategy we recommend and articulate in some detail, for supporting critical practice

and the emergence of context-relevant, integrated, interprofessional approaches to how health and social care systems can develop to support healthy aging. When referring to integration or integrated services, we mean seamless, patient-centred transitions between service types (e.g. ICU and medicine) or service sectors (e.g. acute care, outpatient and primary care, long term care ...). We argue that complexity theory is better able than linear approaches to explore and explain the social nature of health professional education and healthcare practices, and both support and compel a deep exploration of the lived experience of collaboration between patients, students, and practitioners in health and social care in their local context (Briggs, 2012). Through this deep exploration, contextually relevant education and care processes can be developed and continuously improved. Complexity theory emphasizes the importance of context while also supporting the integration of more linear approaches to education and practice strategy (such as randomized controlled trials). Complexity theory also supports an evaluation and accountability strategy where metrics emphasize achievements in patient-oriented outcomes such as compressing morbidity, reducing the complications related to care, and enhancing quality of life, rather than holding people to account to a particular way in which those outcomes must be achieved. This is a radical departure from how “best practices” are often considered in government and/or health and social service policy domains, but one we see as critical to the evolution of relevant practices.

Complexity perspectives also support integrated longitudinal interprofessional education and care models, which is the second high-level theme. It is important to clarify that integrated care does not require integrated organizations (Goodwin, et al, 2014). Organizational restructuring may still not achieve integrated patient care and is generally associated with major costs and upheaval that, at least in the short run, can reduce focus on person-centred principles. Just as there is no single best interprofessional practice that meets needs in every context, there is also no single organizational model or approach that best supports patient care (ibid). It has been demonstrated that integration of health and social care processes is critical to improved services and outcomes for older adults. We argue that longitudinal integration of interprofessional practice-based learning is equally important. Practice-based education for many allied health professionals is organized by body system (e.g. musculoskeletal, neurology, cardio-respiratory, mental health) and placements are typically 4 to 8 weeks duration. Geriatric objectives are often achieved in one patient experience at a time and full placements on a geriatric service or team are generally not required and do not often happen. Nursing programs often place students in long term care for their first placements where they may be assigned personal care duties that they may not perform once they are licensed professionals. While long term care provides excellent learning opportunities, these initial experiences put some students off caring for older adults as they enter practice. The need to find ways to demonstrate the exciting challenge of working with older adults is widely recognized (often termed “making seniors – or seniors care – sexy”) and we argue that longitudinal practice-based placements (with or without virtual or technology-mediated components) may offer one route that has not yet been explored in health disciplines outside medicine.

The third high level theme relates to specific content that we understood from our synthesis discussions are essential for health and social practitioners to master to support the evolution of outstanding care for older adults. There is wide consensus that improving students and practitioners ability to provide effective interprofessional collaborative care for older citizens is important and that longitudinal practice-based education in interprofessional practice is a critical component. In addition, specific competencies in the approach to and care of older adults should be included in the curriculum of health care professionals, such as the unique presentation of illness in older adults, comprehensive geriatric assessment, including the assessment and impact of frailty on treatment choice. While further evidence is needed to determine the pedagogical approaches that would be best suited to establishing this curriculum, a curricular thread approach, rather than a single course, should be considered. This means that, for example, the unique presentation of disease and specific geriatric

assessment strategies would be part of a general course about orthopedics or neurology, rather than a stand-alone course.

**J.W. McConnell Family
Social Innovation Generation (SiG)
Key Lessons**

<http://www.mcconnellfoundation.ca/en/programs/social-innovation-generation>

- ✎ 'Scaling' innovations is not about growing programs or organizations, but about increasing their impact in ways that are appropriate to different contexts.
- ✎ Even successful projects can rarely be 'duplicated'; what is required is a deep knowledge of what works - and why - so that the essence can be preserved while allowing for flexibility and adaptation to different circumstances.
- ✎ The notion of 'best practices' or templates for success stifles innovation. 'Next practice' better describes an approach based on continuous observation and adaptation.
- ✎ Conventional evaluation methods, which test outcomes against set objectives, can stifle innovation, which requires risk, experimentation, freedom to fail and the chance to learn from failure and the unexpected.
- ✎ The Foundation participated in the creation of Developmental Evaluation: balancing creative and critical thinking in guiding and assessing innovation.
- ✎ While the term 'social innovation' has spread quickly, along with notions of complex adaptive systems and related concepts, it is not clear that its use is leading to or associated with transformational change.
- ✎ The Foundation has learned that collaboration across sectors requires concerted effort to overcome differing organizational norms and values. It requires a commitment to social learning that includes the ability to adapt one's own viewpoints and practices.

Analysis and Thematic Synthesis

The following pages outline four high level themes that emerged from our needs assessment team synthesis discussions. Below each, are several synthesis statements, which in summary format, outline the major points from our discussion of the findings from both grey and white literature, books, and websites, integrated with the considerable wisdom and experience of our team. From these themes and statements, priorities for moving forward emerged that impact educational policy. There is some overlap between what emerged in our discussion and the focus of other COU needs assessment teams – notably, the team reviewing the competencies required for health and social care program graduates. This provides an interesting opportunity for triangulation of needs assessment results from teams whose work processes did not overlap beyond the Better Aging: Ontario Education Summit held in Toronto on Feb. 13, 2014.

High Level Theme 1	
Complexity perspectives are needed to guide the design, execution and evaluation of interprofessional education and collaborative practices in the care of older adults	
Synthesis Statements	Implications for Pre/Post Licensure Education, Research, and Practice Policy Development
<p>Health services and practice education in any context, but especially in the context of health services that support the health of older adults, are extremely complex. Just as complex, are the biopsychosocial factors that influence the cognitive (competence), physical (confidence), and social (connection) health of older adults.</p> <p>Competence, confidence and connection are the cornerstones for healthy aging and are most influenced by the personal values and circumstance of the older adult and the local context in which s/he lives and interacts with the health and social care systems.</p> <p>Health services and practice education are social processes informed by</p>	<p>To support the care of older adults through appropriate and effective IPE and IPC that take complexity perspectives into account, education, research and practice policies and curricula in pre and post-licensure contexts must:</p> <ol style="list-style-type: none"> 1. Articulate the nature of education, research and practice as complex social and scientific processes requiring a unique and integrated approach to innovation and change. 2. Define integrated research and evaluation strategies, and improvement processes appropriate to support social innovations in IPE and IPC practices. 3. Compare and contrast these strategies and processes with traditional scientific methods and processes and demonstrate how these health and social science strategies can be effectively integrated. 4. Promote an inclusive, integrated approach to what constitutes legitimate evidence. This means: <ol style="list-style-type: none"> a) embracing qualitative and quantitative evidence generated through a wide variety of methods and methodologies; b) legitimizing and explaining evidence-informed practice as practice-based evidence and evidence-based practice; c) understanding social processes of change;

High Level Theme 1	
Complexity perspectives are needed to guide the design, execution and evaluation of interprofessional education and collaborative practices in the care of older adults	
Synthesis Statements	Implications for Pre/Post Licensure Education, Research, and Practice Policy Development
<p>evidence; translation metaphors to explain the relationship between evidence and practice are misleading.</p> <p>Individual patients and their families and health services providers interact in multiple local contexts. The contingent relationships within them have unique characteristics at any point in time and continue to evolve in unique ways.</p> <p>“Best” (in terms of education and practice) is therefore, also a fundamentally heterogeneous concept.</p>	<p>d) differentiating deductive/inductive, essentialist/constructionist understanding of epistemology and valuing both.</p> <ol style="list-style-type: none"> 5. Demonstrate competence in practice-based developmental evaluation strategies (see Section that immediately follows this table for an explanatory description of Developmental Evaluation). 6. Differentiate “best practice” as applied in both a-contextual and contextual perspectives and articulate the value of “best principles”. 7. Develop, apply, and monitor evaluation and accountability metrics that reflect improvement trends in patient-oriented outcomes related to compression of morbidity, prevention of complications of care, and quality of life; develop and measure key indicators of progress in each of the dimensions.
<p>Representative supporting literature: Asplund, et al, 2000; Counsell et al, 2000; Hickman, et al, 2007; Landefeld, 1995; Landefeld, 1998; McConnell Family Foundation Social Innovation Generation (SiG) http://www.mcconnellfoundation.ca/en/programs/social-innovation-generation; Stacey, 2005, 2012; Dornan, 2010; Eva, 2010; Menin, 2010; Regher, 2010; Price, 2005; Cooper, et al, 2004; Davis and Sumera, 2006; Tsoukas, 2005; Fenwick et al. 2011; Patton, 2011; Fagen, 2011; Gamble, 2008</p>	

High Level Theme 2	
Integrated, person-centred care models are needed to replace episodic care provided through differentiated care sectors.	
Synthesis Statements	Implications for Pre/Post Licensure Education, Research, and Practice Policy Development
<p>Long term outcomes cannot be convincingly linked to single or even multiple prior interventions because of ongoing complex interacting factors related to the patient, his/her environment and the health and social care system.</p> <p>Understanding these multiple interacting factors, how they impact an older persons health, whether (and if so how) they can be modified to improve patient-oriented health outcomes is supported by service integration.</p> <p>A person-centred approach that includes longitudinal contact through service integration and longitudinal practice-based education strategies is required. When longitudinal contact should begin for learners and for older</p>	<p>To support the evolution of service models that are oriented to integrated, person-centred care using interprofessional collaboration in the care of older adults, health professional education programs must:</p> <ol style="list-style-type: none"> 1. Work with practice-education sites to develop longitudinal approaches to sector-integrated IP clinical placement opportunities that support learner contact with older adult patients over time and in multiple points in the health system, including home and community care, primary care, and acute care. Home in this context is defined as the patient's principle residence no matter where that is. Specifically, retirement homes, assisted living, long term care, and hospice or palliative care are included in the definition of "home". How longitudinal exposure develops could take multiple forms and needs to be defined. Examples might include: <ol style="list-style-type: none"> a) Placement in one community for an extended period (6-10 months) that includes longitudinal contact with specific older adults in multiple sectors; b) Within an integrated longitudinal placement, include multiple short-term program-based clinical experiences alongside a longitudinal approach to older adult care; c) Alternative preceptor models (such as multiple discipline-specific and interprofessional preceptors);

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Synthesis Statements	Implications for Pre/Post Licensure Education, Research, and Practice Policy Development
<p>adults accessing multiple services needs to be identified, and may be related to a particular frailty score.</p> <p>A common service integration strategy is the use of case managers to guide and coordinate complex care needs. These initiatives could be improved by ensuring they are patient, not sector focussed. In particular, it is important that case managers continue to be involved in care planning and management during hospital admissions.</p> <p>The definition of “home” should include retirement homes, assisted living and long term care settings. Curative, restorative, maintenance and palliative care can and should happen at home, no matter where home is.</p> <p>Integration of health and social care</p>	<p>d) “Virtual” interprofessional student placements that specifically incorporate longitudinal contact with a defined cohort of older adults and alternative supervision and evaluation models (e.g. further develop and specifically target programs like UBC’s Health Mentors Program or Queen’s First Patient program to serve this unique purpose);</p> <p>e) Consider technology-mediated opportunities for interprofessional learners to follow the health journey of designated older adults over time.</p> <p>2. Emphasize practice-based interprofessional education that incorporates progression from exposure through immersion and mastery of IP competencies across a defined longitudinal IPE curriculum.</p> <p>3. Seek and integrate practice-based IPE into clinical environments that model and promote IPC as the standard of care. Too often, students report they do not find collaborative practice environments in which they can practice and continue to develop their IPC skills.</p>

High Level Theme 2	
Integrated, person-centred care models are needed to replace episodic care provided through differentiated care sectors.	
Synthesis Statements	Implications for Pre/Post Licensure Education, Research, and Practice Policy Development
policies and practices in both service and learning is critical to the development of a skilled workforce and elder friendly communities – development of elder friendly hospitals is one step, but in itself insufficient.	
Sample supporting literature: Barnes et al, 2012; Cohen et al, 2002; Cole et al, 1994; Counsell et al, 2000; Gill et al, 2002; Hughes, et al, 2000; Gill et al, 2002; Hebert, et al, 2003; Hughes, et al, 2000; Johri et al, 2003; Leung, et al 2004; Preen et al, 2005; Roberts, et al, 2007; van Crean, et al, 2010;	

High Level Theme 3	
There are specific competencies that all health and social practitioners need to be exposed to and many they need to master to support the evolution of outstanding person-centred care for older adults no matter where in the health and social sector services are accessed and provided.	
Synthesis Statements	Implications for Pre/Post Licensure Education, Research, and Practice Policy Development
Population demographics make it clear that all health and social care providers will need at least basic competence in	Health and social care education programs must take the emerging populations demographics very seriously and ensure that all graduates are exposed to curriculum in both academic and practice-based settings that

High Level Theme 3	
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Synthesis Statements	Implications for Pre/Post Licensure Education, Research, and Practice Policy Development
<p>key issues foundational to providing person-centred approaches to the health issues of older adults. Many will need more than basic competency.</p> <p>Progression of IPE curriculum through exposure, immersion and mastery levels with an emphasis on the complex issues of older adult health is necessary and will provide a solid foundation for collaborative practice in any domain of practice.</p> <p>There are clinically important distinctions between individual and collective competence.</p> <p>The ideals of person-centred care are widely accepted as laudable. The focus on IPE and IPC is intended to support person-centred care but an unintended consequence of focusing on team</p>	<p>will prepare them to recognize the need for (minimum) and manage (ideal) interprofessional, integrated, person-centred care for older adults. This will require:</p> <ol style="list-style-type: none"> 1. That all health education programs develop IP curriculum based on the CIHC Interprofessional Competency Framework; at minimum, all graduates are able to consistently apply all competencies at the immersion level. 2. Health education programs (and graduates) distinguish between individual and collective IP competence and provide opportunities through structured practice-based learning for the skilled application of both. 3. Health education programs develop a comprehensive and central pedagogy of person-centred care for older adults that includes an emphasis on incorporating the impact of frailty on treatment choice and the impact of the context in which integrated care occurs in the context of patient/family identified goals of care. 4. Emphasis is placed on IPE in a practice-based setting, with particular emphasis on integrated, cross-sector services for older adults; this means that educational and practice-based settings will need to collaborate to articulate how cross-sector IPC can work and the

High Level Theme 3	
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Synthesis Statements	Implications for Pre/Post Licensure Education, Research, and Practice Policy Development
<p>dynamics and personal/interpersonal competencies is that they can become ends in themselves.</p> <p>Person-centred decisions about care are impacted by many factors including the values, beliefs and goals of care that older adults and their families hold, the degree of frailty of the older adult, and factors related to the context in which care is being provided. All of these must be taken into account.</p> <p>Disease presentation in older adults is often atypical. If this is unknown or missed by health and social care practitioners, misdiagnosis and inappropriate care may result and have significant impact on current and future health and well-being.</p>	<p>pedagogical principles and strategies that will support student and practitioner learning.</p> <ol style="list-style-type: none"> Professional health education programs include classroom and academic curricula on the elements of a comprehensive geriatric assessment (CGA); students graduating from professional health education programs in medicine, nursing, physical therapy, occupational therapy, and physician assistant programs can articulate and apply the elements of a CGA; all other health and social care disciplines should be familiar with the elements of the CGA and be able to recognize when an older adult would benefit from a CGA. Graduates of professional health education programs are able to articulate how disease presentation varies in older compared to younger adults and identify the implications for assessment and treatment strategies generally, and relative to the focus of each discipline. Graduates of health programs need to be competent in the use of technologies to support longitudinal integrated care processes.

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Synthesis Statements	Implications for Pre/Post Licensure Education, Research, and Practice Policy Development
Sample supporting literature: Caplan et al, 2004; Asplun et al, 2000; Ellis, et al, 2011; Hickman, et al, 2007; Hughes, et al, 2000; Inouye, 2000; Inouye, Bogardus et al, 2000; Deschot et al, 2012; Gill et al, 2002; Hickman et al, 2007; Leung, et al, 2004; Lingard (in Hodges and Lingard, 2012); Mion et al, 2003; Mudge, et al 2012; Nagly et al, 2002; Saltvedt, et al, 2002;	

High Level Theme 4	
The ideals of social accountability contribute to the design of education programs, including student admission criteria, and the design of person-centred health and social service accountability models	
Synthesis Statements	Implications for Pre/Post Licensure Education, Research, and Practice Policy Development
Social accountability (SA) models of health professional education programs are increasingly common and mandated for Faculties of Medicine. This commitment requires programs to direct research, education and service activities to meet the health issues of the communities served by their graduates (WHO,	<ol style="list-style-type: none"> 1. The implications and impact of SA mandates on student selection, curriculum design, and practice-education should be carefully considered by health and social care programs. 2. Evaluation methods (such as developmental evaluation) that support critical practice development should be implemented with opportunities to share “approaches that work” among service providers, educators, researchers, older citizens and their support networks. See the next section for a description of development evaluation. 3. Accountability metrics should report achievements and trends in

High Level Theme 4	
The ideals of social accountability contribute to the design of education programs, including student admission criteria, and the design of person-centred health and social service accountability models	
Synthesis Statements	Implications for Pre/Post Licensure Education, Research, and Practice Policy Development
<p>2010). Anticipated changes in population demographics support greater attention being given to the care of older adults in health and social care educational programs.</p> <p>SA mandates may support policies that screen students for health and social care programs with personal characteristics that make them more likely to select for practice with older adults.</p> <p>We have challenged “best practice” as a policy imperative. No single best practice in education or practice emerged in our needs assessment that could be definitively applied in all circumstances and we have presented evidence grounded in complexity theory that local context is a vital consideration. This does not mean that</p>	<p>patient-oriented outcomes.</p> <ol style="list-style-type: none"> 4. Key indicators that measure compression of morbidity, reduce complications of care, and enhance quality of life, should be developed, implemented and broadly reported. 5. Policy orientations should shift from implementation of best practice to innovation of the relevant and effective practice in the local context. 6. Policy should shift from compliance with standard practice toward measurement of outcomes. 7. Evaluation strategies should include a concern with characterizing patient/family, service providers, and the health system (ie local context); a concern with understanding why, for whom and under what circumstances various interventions work (mechanism) and with the outcomes achieved. This approach is possible in developmental evaluation and is the foundation of Realist Evaluation.

High Level Theme 4	
The ideals of social accountability contribute to the design of education programs, including student admission criteria, and the design of person-centred health and social service accountability models	
Synthesis Statements	Implications for Pre/Post Licensure Education, Research, and Practice Policy Development
<p>good ideas and 'practices that work' should be disregarded. Practices that work in one context may well have important application in another similar context, and should be given serious consideration. However, from policy perspective, we argue that it is not best practice that should be mandated, but progressive improvement in patient-oriented outcomes.</p> <p>Virtual and in-person networks to explore "practices that work" should be structured and supported with equal voice given to educators, researchers, clinicians, students, older adults and their families/informal support givers.</p>	
Wong, 2012; Pawson, 2004; WHO, 2010; THENet Evaluation Framework, 2011; Boelen et al, 2012; Patton, 2011; Gamble, 2008;	

Developmental Evaluation

The evaluation of complex interventions in health care requires a shift from the gold standard of randomized clinical trial to developmental methodology that can establish “best practice” in the real world of patient care. This is particularly true in the care of seniors where health and social care systems must be integrated to optimize health outcomes and quality of life. In our day to day practice, person-centred care is informed by “best practice” but must be contextualized to the local context and improvised according the patient needs and what the caregivers can provide as in **Figure 1** (Briggs, 2012).

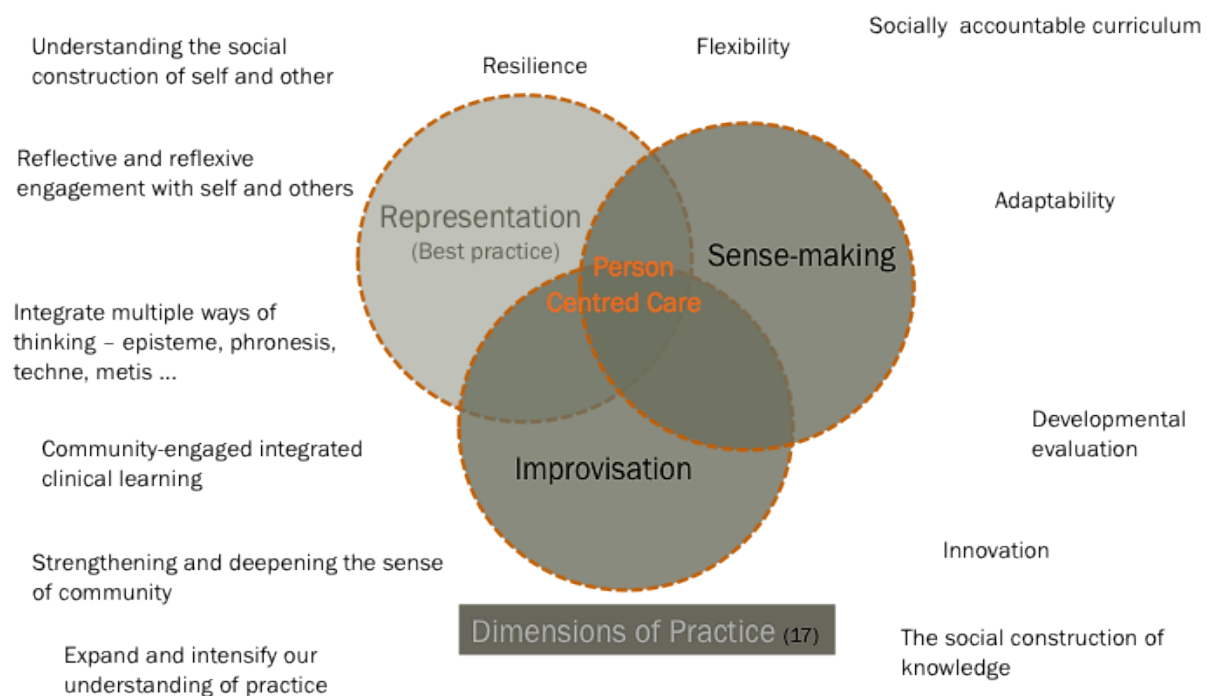


Figure 1: Dimensions of Practice and Sample Topics that need New Emphasis in Health Professional Education

Developmental evaluation provides the opportunity for early phase piloting and development, more multidimensional rather than linear evaluation processes, integration of process and outcome evaluation, and recognition that complex interventions need to be tailored to the local context rather than standardized in their implementation, supports not only implementation but sustainability of changes in practice. The theory of complex adaptive systems is highly relevant to insights as to how change occurs in large health care systems especially where integration with the social care system is needed.

Complex interventions in the delivery of health care are generally described as those containing several interacting components that range from those within the experimental and control groups, the behavioral changes needed from those delivering or receiving the care, the number of groups or organization levels being targeted in the intervention, the variability of outcomes measured, and the flexibility in tailoring the intervention to the local context. For instance, change at the front lines of clinical care has been shown to not only be dependent on the individual's own ability to enact change but also the level of support they perceive from the managers and executives within the organization (IP Compass).

The rationale for interprofessional collaboration and education in the care of seniors is often cited as its ability to support person-centred care. But IPE/IPC and person-centred care is challenged by standard approaches to implementing "best practice" through randomized trials of interventions in the care of seniors, particularly those demonstrating improved functional outcomes. One of the most well-known examples of this in geriatric medicine is the development of Acute Care for Elders (ACE) Units in hospitals across the US and Canada. ACE Units have been designed to prevent the loss of independent physical function often experienced by seniors during the course of an acute illness requiring hospitalization. This functional decline is associated with serious sequelae including an increase in disability from which many never recover, high rates of hospital re-admission, nursing home placement, and mortality (40% will die within 12 months of hospitalization). The routine processes of acute care may contribute to the progression or persistence of functional decline, even when the acute illness is "successfully treated". The Acute Care of the Elderly (ACE) Unit was initially developed at the University Hospitals of Cleveland as an acute care general medical service designed to promote the independent functioning of patients during their hospitalization. The integration of geriatric assessment into optimal medical and nursing care of patients in an interdisciplinary environment has several key elements tailored to each individual patient's needs: a prepared environment, patient-centered care, multidimensional assessment and nonpharmacologic prescriptions, medical care review, and home planning. "Standards of care" served to reduce the risk of iatrogenic illness resulting from polypharmacy, use of physical restraints, and diagnostic procedures. "Nurse-initiated guidelines" to prevent functional decline and restore independent patient functioning were developed. These standards and guidelines formed the elements of care to be implemented in a randomized trial in the US to demonstrate the effectiveness of ACE Unit. This trial showed marginal cost:benefit related to a mean reduction in length of stay but did not demonstrate the improved functional outcomes achieved in the original ACE Unit. Despite this outcome of the randomized trial, ACE Units have been developed in many hospitals across Canada without any further

randomized studies. In addition geriatric consultation on specific units, comprehensive discharge planning, and nutritional support, also appear to have beneficial effects on clinical outcomes of hospitalization. These studies highlight the need for implementation of ACE principles for all vulnerable seniors who are at risk of functional decline in hospital even though standardized implementation failed to achieve the potential outcome. Persistent use of RCT's as the "evidence base" for this care model is akin to the hammer and nail analogy (**Figure 2**). This example highlights the need for approaches to implementation that include interprofessional collaboration and education and "best principles" in identifying "critical practice" for truly person-centred care.



Figure 2

To address the limitations of randomized trials, which necessarily identify best practices and implement standardized care processes, we propose an alternative approach: Developmental Evaluation was developed to determine the capacity of social innovation to address intractable social problems in Canada. This type of evaluation supports the process of innovation where the destination and path forward are not clearly defined (the essence of a complex intervention where there is a high degree of connectivity and interdependence) and where ongoing interactions create emergent result that are both

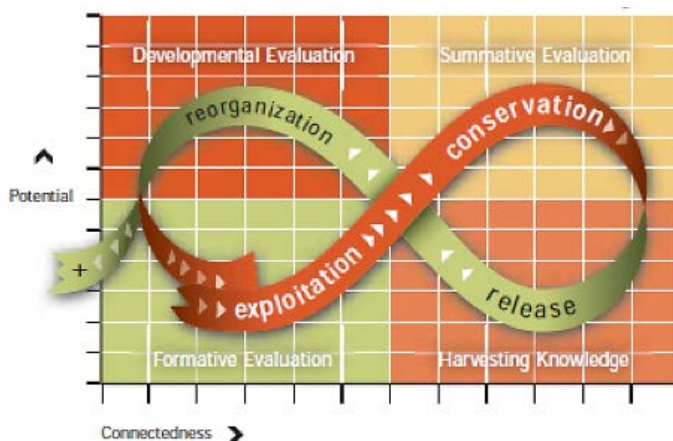


Figure 3

and to prepare for formative evaluations (develop an effective and dependable model) and summative evaluations (judgment of merit) as illustrated in **Figure 3** (Gamble. 2008, p17). Developmental evaluation helps collaborators to recognize and work through differences in perception

that may fragment the work or present barriers to ongoing development. Surveys, interviews, observations and other tools from complexity science are used to inform the developmental evaluation process.

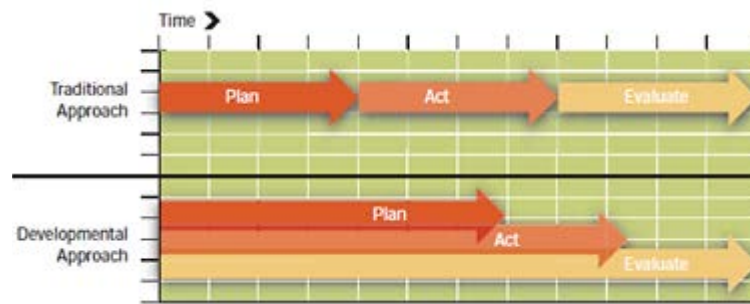
Developmental evaluation supports innovation through the conceptualization and articulation of the problem, by helping to frame the issue and its dynamics. Relevant data and observations are systematically subjected to interpretation and judgment, and supports accountability while allowing a high degree of flexibility. Accountability frameworks should identify the critical outcomes to be achieved by the intervention to help drive the process. Adaptation of models and addressing unique challenges at a particular site demand a high degree of flexibility and creativity within the groups' practices help to mature the process trialing and re-trialing the intervention. **Textbox 1** (Adapted from Patton, 2011, p23-26) provides a comparison of traditional evaluation methods with those of a developmental evaluation process.

Evaluation Component	Traditional Evaluation	Developmental Evaluation
Purpose	Validate a model or hypothesis; accountability	Development, adaptation
Situation	Stable, goal oriented, predictable	Complex, dynamic, changing
Mind-set	Effectiveness, impact, compliance	Innovation, learning
Measurement	Based on predetermined indicators	Based on emergent indicators
Unexpected consequences	Paid token attention	Paid serious attention
Evaluation design	By evaluator	Collaborative with program staff
Evaluation methods	Emphasis on RCT's	Emphasis on how outcomes change
Evaluation results (ideal)	Best practices	Best principles
Evaluator qualities	Strong methodological skills, credibility with external authorities and funders	Strong methodological skills, credibility with organizational and program staff

Textbox 1: A Comparison of Traditional and Developmental Evaluation Approaches

The “researcher” is embedded in the process with key decision makers using evaluative feedback to inform future actions. This approaches contrasts with that of a randomized trial where the researcher is an external observer of the effect of a preset implementation of best practices and guidelines and related indicators that does not engage the local care team in the local context to address the local challenges to implementation. Developmental evaluation does not prescribe a particular set of methods and although the components have similarities to commonly used PDSA (Plan Do Study Act) cycles, the steps are overlapping as shown in **Figure 4** (Gamble, 2008, p.31). There is no recipe or template of standardized questions but rather a process of reflexive inquiry into the data to guide and develop how the emerging program unfolds. This is dependent on the local context and the people involved, and doing what makes sense in the local situation. Contextual relevance is preferred over methodological rigor.

For example, a process of formative then summative evaluation was used in the development of the initial ACE Unit, with a committed group of geriatricians, an



enthusiastic interdisciplinary team, and organizational support including the environmental modifications needed to support this care model. Harvesting the knowledge from the experience of building that initial unit, was used to standardize the

Figure 4

implementation of ACE Units in a randomized clinical trial. This prescription dismisses the local context of the patients and providers in the process of implementation and thus the improvement in functional outcomes that was gained through the approach to developing of the initial ACE unit could not be replicated in the randomized trial. Inherent in a person-centred approach is the essential value of understanding the needs of the specific patient population in the context of the local health care system, and the critical interprofessional collaborations and related educational processes needed to make the ACE Unit program a success. **Textbox 2** outlines 10 key points needed for Developmental Evaluation. Adapted from Patton, 2011, p.75)

1. Reflecting on what is useful and sensible for evaluation is the foundation of developmental evaluation.
2. Internal and external approaches can be used in developmental evaluation but needs to include providers at the front lines of care to understand the local context.
3. Identifying mechanisms that facilitate progress can be used to materials for program development (e.g., interprofessional development processes, interprofessional curriculum guides, interprofessional practice statements templates for staff/student meetings and retreats)
4. Watching for and being open to what emerges is central to developmental evaluation.
5. Timely engagement and rapid feedback is required for developmental evaluation (e.g., similar to a PDSA cycle but using development rather than improvement strategies)
6. Evaluation becomes the engine for program development rather than the endpoint of program implementation as in a randomized clinical trial.
7. Ongoing program development and evaluation becomes mutually reinforcing to ensure sustainability.
8. Project leadership and support is critical for developmental evaluation.
9. Competent evaluators immersed in care processes of the organization are essential for successful developmental evaluation.
10. Development evaluation produces more than improvements; it supports innovation in program development.

Textbox 2: Ten Key Points on Developmental Evaluation Approaches

Developmental evaluation is thus a viable alternative to the identification and implementation of best practices, and randomized clinical trials of standardized implementation of those practices and related guidelines. Especially in the integration of health and social care systems to improve health and functional outcomes in older people, the “best practice” is the one that takes into account the complexity of person-centred care, considers the available resources and specific supports and constraints of the local context, and is modified by the people involved in providing and receiving care.

Appendix A: The Needs Assessment Team

Principle Investigators:

Marion C. E. Briggs, BScPT, MA, DMan

Assistant Professor, Clinical Sciences and Director, Health Sciences and Interprofessional Education

Northern Ontario School of Medicine

Fellow, AMS Phoenix Project

Janet E. McElhaney, MD, FRCPC, FACP

Professor of Medicine, Northern Ontario School of Medicine

Senior Scientist, Advanced Medical Research Institute of Canada

Medical Lead for Seniors Care, Health Sciences North, Sudbury

Methodology Consultant:

Elizabeth Borycki, RN, PhD, University of Victoria

Needs Assessment Assistant:

Barbara Rickaby, BSc

Needs Assessment Librarians:

Jami van Haaften, MLS, AHIP, HSN Sudbury; Irma Sauvola, BSc, MLIS, DPA, HSN Sudbury

Project Facilitator:

Ms. Deb Szymanski, RN, HSN Sudbury

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