Interprofessional Education and Care For Seniors
An Environmental Scan
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Executive Summary

This environmental scan explored the academic and grey literature to identify current knowledge of and best practices related to the training or implementation of interprofessional teams, including personal support workers (PSWs) as members of teams, to improve community-based seniors care.

The majority of relevant literature appears to come from program evaluations of the implementation of community interprofessional teams, as opposed to the training of health professionals. Ontario specific studies were found. Research showed that interprofessional teams resulted in significant improvement in care for seniors at home, including shorter referral times when necessary and easier access to services that allowed seniors to remain at home. There was little in the literature with respect to interprofessional teams and unregulated health professions, including PSWs. One Ontario paper states that PSWs play an integral role in the lives of seniors requiring home care and that they should be included in the interprofessional collaborative work.

With respect to interprofessional education, it is recommended that some common practice terms be developed for seniors living at home in Ontario. It has been reported that there is a lack of cohesion among health professionals who work with seniors in the community. These professionals do not have a common vocabulary and sometimes have different work methods, which impedes their ability to communicate and function like a team. Additionally, the curriculum for delivering effective seniors care should foster joint decision making, team work and shared responsibilities.

Conestoga College, Mohawk College and Lakehead University participated in brief telephone/email interviews to determine current state and best practices at these schools. Interprofessional education is only beginning to be incorporated into the curriculum. Mohawk College is currently revising their programs to include simulated exposure to care of seniors in home care, and will be including interprofessional education as part of this exposure.
Introduction

Over the past decade there has been a significant movement towards interprofessional collaboration and education within healthcare. Interprofessional collaboration and education (IPC/IPE) has become a key factor in initiatives designed to increase the effectiveness of health services currently offered to the public (D’Amour, Ferrada-Videla, San Martin Rodriguez, & Beaulieu, 2005). The Interprofessional Care: Blueprint for Action states that interprofessional practice is an essential characteristic of our healthcare delivery system, and that preparation for practice must be formally incorporated into the academic and continuing education of health professionals (Health Force Ontario, 2007). Simply putting people together to work does not necessarily create effective teamwork (Ryan, McCann, & McKenna, 2009).

Recent studies, both qualitative and quantitative, as well as systematic reviews have shown IPE interventions are 1) well received, 2) linked to positive learner reactions and changes in perceptions and attitudes, and 3) related to improvements in knowledge and skill development for better collaborative practice (Canadian Interprofessional Health Collaborative, 2009a; Hammick, Freeth, Koppel, Reeves, & Barr, 2007). While there is less available evidence in relation to direct benefit to patients, there are studies that show improvements in healthcare processes, patient satisfaction and clinical outcomes (Reeves, Perrier, Goldman, Freeth, & Zwarenstein, 2013). IPE has been delivered in a variety of settings, with various modalities of teaching, and various durations of learning from one hour sessions to full courses. The consensus is that one size does not fit all.

While IPE/IPC is taught and practiced across a range of settings and professions, the research shows that historically, the main professions involved have been medicine and nursing (CIHC, 2009). The objective of this paper is to understand the available evidence that can guide IPE approaches to improving care for seniors living in their homes, including the role of community and personal support workers (PSWs). It is important to identify current gaps in knowledge, as well as the learning needs of key professionals, to ensure solutions will be appropriately prioritized, targeted and structured.

For healthcare professionals working with older adults, a strong competence in geriatrics is a common requirement because the clinical presentations and health needs of frail seniors are unique and often co-occur in complex ways. These complex health problems create interdependencies among health care providers and therefore require a comprehensive, interprofessional approach to care. IPC, as outlined in Interprofessional Care: Blueprint for Action (Health Force Ontario, 2007) is mandatory when providing care to frail seniors (D’Amour et al., 2005; Mion, Odegard, Resnick, & Segal-Galan, 2006; Ryan et al., 2009).

This environmental scan will explore the academic and grey literature to identify current knowledge of and best practices related to the training or implementation of interprofessional teams to improve community-based seniors care.
Methods
This environmental scan was conducted using two primary methods: A literature search and telephone interviews with some of Ontario’s leaders in interprofessional education for at-home healthcare.

The literature search was conducted with the assistance of a librarian from the Northern Ontario School of Medicine. Databases searched included PubMed, CINAHL, Cochrane Library, Scholars Portal, and ProQuest. Our goal was to identify publications on interprofessional collaboration or teamwork intersected with at-home healthcare and/or care for seniors.

A search strategy was devised using three categories: 1) Interprofessional, 2) Seniors, and 3) Care at Home. The Interprofessional category was defined using the strategy used in the BEME Systematic Review on Interprofessional Education by Hammick et al. (2007). The seniors category was defined by geriatric*, elder*, “old age”, “Senior adult”, “Senior citizen”, gerontolog*, aged, “seniors” and “older adults. And lastly, the Care at home category was defined by homecare or “home care”, “at home”, residence, house, “living in the community”, “community care”, dwelling, “in the home”, “in their home”.

In addition to the above search strategy, the following MEDLINE subject headings were used: interprofessional relations, Interdisciplinary communication, Education, Professional, Allied Health occupations, Patient care team, Home care services, Home health aides, Home nursing, Health Services for the aged, Aged (69-79), Aged 80+, Geriatrics, Professional Competence, Education, Interdisciplinary. Additional searching was done using Google and Google Scholar to search for grey literature, and any reports of interprofessional homecare models in use in Ontario.

This scan does not claim to be a systemic review of the topic, but rather presents a sampling of current trends in interprofessional education and care related to seniors aging at home and the home care health setting.

We identified a number of provincial leaders with respect to the implementation of interprofessional education and seniors’ or at-home care. Leaders were identified via the literature search, through personal contacts of the research team, and among applicants for SIM-one’s recent Simulation Resources for Personal Support Worker (PSW) Training funding program. One member of the research team contacted each leader by telephone and/or email for a semi-structured interview to learn about their activities and advice.

Current State Assessment
Conestoga and Mohawk Colleges were contacted regarding IPE activities in their programs that train health professionals to take care of seniors at home. Loyalist College had been contacted regarding specific simulation activities for a different environmental scan (MacDonald, Galbraith, Smith & Willett, 2013); however, they did provide some IPE information that has been included below.
Conestoga College indicated that since their College has a strong interprofessional mandate, and since collaboration is already in place, it has been relatively straightforward to build IPE into care for seniors. Additionally, part of the College’s strategic mandate is to deliver resident focused care tailored services. Once a year there is an interprofessional week in healthcare settings including acted scenarios. One example has been an infection control scenario with nursing, PSWs, occupational and physical therapy assistant (OTA/PTA) and paramedic participants.

Nursing (both Bachelor of Science Nursing and Practical Nursing), PSW, paramedic, and OTA/PTA students IPE when they are learning about caring for seniors at home. Students follow other professions, as well as dieticians and housekeeping, to learn about what they do, as well as participate in interprofessional case scenarios. Educators review the scenarios with other professions to ensure accuracy of roles, behaviours and situations. Conestoga is in partnership with the Schlegel Villages (long term care homes and retirement living centres), where the leadership also places a strong emphasis on interprofessional care. Students doing placements in the Villages are able to learn directly in this environment about the role of the professional within the interprofessional team. Mohawk College indicated that they are not ready for IPE for seniors care at home in their simulation labs at the current time. PSW and nursing students currently get exposure to home care and interprofessional situations through clinical placements, and PSWs get three weeks of community consolidated experience, but it is not all at the interprofessional level. They are currently revising their health professions programs to include simulated exposure to care of seniors at home, and will be including IPE as part of their exposure. Changes will take place as part of the academic program plan with in the next two years.

Educators at Loyalist College said that they are adding at home IPE simulation to their PSW curriculum. At the current time, they participate in a pre-determined IPE scenario in a long-term care home setting. Practical nursing and PSW students are doing routine assessments – but then discover the patients vital sign have changed, and a dressing needs changing. In the scenario, students must work together and adapt to changing priorities. Normally the nursing student takes over, but now the PSW is included. Afterwards they sit down together for de-briefing. Additionally, PSW and nursing trainers are paired for a two-day session, where the first day is the gentle persuasive approach and the second day - IPE.

Colleges also have Program Advisory Committees, that have community partners across sectors and professions, which help direct the curriculum. They provide input on what they doing in practice, and also give advice on what qualities they are looking for in new graduates.

**Interprofessional Education: Background**

In this scan, we have used the often cited definition of IPE: Interprofessional Education occurs when two or more professions learn with, from and about each other to improve collaboration and the quality of care (Centre for the Advancement of Interprofessional Education, 2002).
In 2010, the Canadian Interprofessional Health Collaborative (CIHC) (2010a) developed A National Interprofessional Competency Framework that 1) outlines ideal characteristics necessary for collaborative practice and 2) provides an approach to interprofessional education and collaborative practice. Within this integrative approach, six competency domains have been identified which build upon and “highlight the knowledge, skills, attitudes and values that shape the judgments essential for interprofessional collaborative practice.” The domains include 1) Interprofessional communication, 2) Patient/client/family/community-centered care, 3) Role clarification, 4) Team functioning, 5) Collaborative leadership, and 6) Interprofessional conflict resolution. Within each domain, specific descriptors and indicators reflect the level of experience and context of the learners and practitioners. The competency framework can readily be integrated into various learning and practice contexts. The CIHC (2010b) states that “A collaborative practitioner recognizes the knowledge, skills, attitudes, and values that come together to influence judgments that are all part of the complex interactions involved in collaborative practice.”

Similarly, the World Health Organization (WHO) (2010) outlines interprofessional learning domains and teamwork including leadership, roles and responsibilities, communication, learning and critical reflection, relationship with and recognizing the need of the patient, and ethical practice.

A stakeholder study on the areas of needs for seniors living in the community was conducted in the UK (Shield, Enderby, & Nancarrow, 2006). This study revealed that seniors desire to have interprofessional practitioners who have a broad spectrum of knowledge and skills in both health and social needs. They felt that an interprofessional generalist practitioner would have excellent communication and counseling skills such as tact and empathy, an understanding of seniors needs, have the ability to coordinate services and provide advocacy as well as the ability to suggest practical solutions. They also would have good management skills and knowledge of all the other practitioners’ roles, resources and systems. Additionally, an interprofessional practitioner would have knowledge of common ailments and first aid and medications.

Below, in each section we present each interprofessional competency, and, where applicable, apply each competency to IPE for at-home and community-based care for seniors. For some competencies there is limited information for senior’s care and general information has been presented. Overall, this may provide guidance about the goals and outcomes of IPE courses and events.

**Interprofessional Communication**

The literature on high performing interprofessional teams across the continuum of care shows that there is a strong need for effective and clear communication (Brock & Doucette, 2004; Legault et al., 2012; Pugh et al., 1999; Zillich, McDonough, Carter, & Doucette, 2004). CIHC (2010) states that learners and practitioners from differing professions need to “communicate with each other in a collaborative, responsive and responsible manner” (p.16). Communication needs to be authentic, transparent, consistent, and incorporate full disclosure. Types of respectful communication required
in an interprofessional environment include attentive listening and other non-verbal modes, as well as verbal methods of consulting, discussing, debating and negotiating. Legault et al. (2012) note that while varied schedules, frequent community visits and part time status can impede communication, methods of communication such as care conferences still offer opportunity for dialogue and problem solving together. Technology was also seen as a communication tool for discussion both in and out of client health records.

Sheehan, Robertson and Ormond (2007) discovered that teams that are more interprofessional in nature use collaborative language that is inclusive, such as making use of the word ‘we’ when discussing their work. Teams that communicate frequently and employ shared terminology and linguistic practices are more interprofessional in nature. Role modelling of inclusive language and raising awareness of language may be important for influencing effective and collaborative attitudes and behaviours in interprofessional education.

In addition to interprofessional communication among health service providers, it is imperative that the health care team recognizes the client as an active participant in care. The 2011/2012 Community Care Access Centre Quality Report (2012) provides feedback from patient surveys indicating a need for care providers to improve how they communicate with clients. As a result of this feedback, several CCACs have implemented a new approach to patient-centered communication which encourages dialogue focused on patient and family needs.

An IPE pilot project conducted by Dacey, Murphy, Castro Anderson, and McCloskey (2010) found positive results in some of the competencies for IPC. The education was on patient centred senior care. They found that the educational pursuit increased communication and developed respect among the various professions. Participants felt an increase in their confidence level in functioning well as a professional on an interprofessional team. They also developed increased respect for other professions, and a more positive attitude toward older adults. Dacey et al. (2010) contend that IPE with students at various levels of education can enhance interprofessional care. They agreed with many others that scheduling can be an issue; however, they found that the use of several information technology platforms and reflective journals supported the learning foundation. Small groups of learners that met weekly were of benefit.

Patient/client/family/community-centred care

The CIHC (2010b) competency in this domain states that learners and practitioners should seek the input of the patient/client, family, and community, and that it be valued and integrated into the plan of care. The patient/client is viewed as an expert in their situation and they have the right to maintain control of the care to be provided. In 2009, 89% of Canadian seniors had at least one chronic condition. Twenty five percent of Canadian seniors aged 65 to 79 and 37% of those 80 years and older reported having four or more of a wide-ranging list of chronic conditions (Public Health Agency of Canada, 2010). The use of an interprofessional approach around the delivery of chronic disease prevention and management to at-risk populations in primary care settings yields
positive outcomes for patients, providers, and health systems, and significant improvements in quality of care (Barrett, Curran, Glynn, & Godwin, 2007; Hogg et al., 2009). As a key component of interprofessional practice, recognizing and involving the client as an active participant in care is imperative. Responding to the chronic disease epidemic, the advance of self-management models and programs across Canada have begun to introduce self-management support as a means to educate healthcare professionals on how to best support their clients to become active self-managers. The literature further supports this shared decision making in interprofessional care (IP-SDM) as it is seen as cost-effective while enhancing quality care in the community, especially for seniors who have and will continue to be the highest users of home care services. Shared decision making between health professions and clients/families will develop more acceptable sustainable care goals (Légaré et al., 2013).

Barnes, Carpenter, and Dickinson (2006) convey the need for the users’ voices to be heard and their views and perspectives be valued and to have influence. They impart that users have a stake in partnership. Professionals require the skills, attitudes and values in order to work with the users as partners in an interprofessional team. They articulate that there is an important role for service users in the provision of interprofessional education. Abley, Bond and Robinson (2011) contend that the voice of seniors is critical, as they found that the viewpoints of seniors in relation to their own vulnerability differed greatly from professional viewpoints. These authors assert that asking seniors if and when they feel vulnerable and setting interprofessional goals to address these areas would guide the team to work on alleviating and resolving problems. This would also assist with re-aligning the goals of professionals with the needs and perspectives of their clients in order to promote patient-centred collaborative care.

**Role clarification**

The CIHC (2010b) competency for role clarification states that learners and practitioners should “understand their own role and the roles of those in other professions, and use this knowledge appropriately to establish and achieve patient/client/family and community goals.” Each team member must be able to listen and identify where shared knowledge exists, and to articulate individual skills and knowledge held in their own scope of practice. They need to recognize when their skills and knowledge should and can be utilized. Appropriate use of practitioner knowledge and skills are required to address patient/client care.

Team functioning increases when role clarity is delineated, and when positive self-attitudes and attitudes towards the other professions on the team is held by individuals on the team (Sheehan et al., 2007). One of the significant features of a collaborative interprofessional team is the ability to openly and freely state opinions as well as feeling valued by others (Sheehan et al., 2007). Kelley and Aston (2011) found that a better understanding of the roles of team members by students contributed to more effective patient care. Xyrichis and Lowton (2008) found that when there is a lack of understanding of roles, tasks and clear goals conflict can arise.
Professional scope of practice and ongoing accountability to competency training is generally legislated by provincial governments and monitored by professional colleges. Ensuring that interprofessional teams have the ability to share and learn from each scope of practice in a proactive manner, will reduce turfism, while promoting role clarity, mutual respect and support for continuing professional development in a shared model of care.

The health literature around interprofessional collaboration and health service provider teams confirms that clear definition of roles is imperative for a high-performing team (Humbert et al., 2007; Legault et al., 2012; San Martín-Rodríguez, Beaulieu, D’Amour, & Ferrada-Videla, 2005). Stephenson and Richardson (2008) profess that interprofessional curricula needs to develop an understanding of the various ways differing professions formulate health care problems and how each individual profession and practitioner might utilize similar or different evidence bases in addressing client concerns. This would allow for a shift in dialogue to professional paradigms and collaborative formulation and problem solving as opposed to just learning about one another. They also assert that a common methodology of assessment that acknowledges client functioning as an open system that is contextual is required. Patient centred care also requires reflection and reflexivity of all collaborative partners.

Research on interprofessional collaboration by Mueller, Klingler, Paterson, and Chapman (2008) demonstrates that despite growing interest around IPE, the IPE needs of occupational therapists and physiotherapists have been lacking within the research. In looking further at the needs of an IPE education program, common needs were identified, such as knowing each other’s roles, responsibilities, scope of practice and skill sets. Instruments to further this IPE objective included case studies, team meetings, collaborative techniques, and shadowing other professions.

Belanger and Rodriguez (2008) contend that team functioning requires trust and ongoing education to support success. Mayer and Davis (1999) profess that unless there is a perceived risk, trust is not always necessary for collaboration, however as primary care moves towards a collaborative approach to care, it is essential that an environment of trust exists within the care team. Trust can be achieved with attention to 3 factors: competence, receptivity, and shared values and principles (Mayer, Davis, & Schoorman, 1995; Mayer & Davis, 1999).

The level of physician involvement in interprofessional practice can be as varied as the practice setting. Literature posits that physicians have been acculturated to believe that they are ultimately responsible for patient care and thus respond with the need to practice autonomously. However, according to the CanMEDS Physician Competency Framework, a key role for the physician is that of collaborator, in which one works in partnership with others in the multi-professional environment to achieve patient-centred care (Frank, 2005). Elements of this role include, but are not limited to shared decision making, respect for the healthcare team, understanding roles and responsibilities, and learning together. This framework encourages physicians to work with others to assess, plan, provide, and integrate care for patients while participating effectively in
interprofessional team meetings and reflecting on overall interprofessional team function (Frank, 2005).

**Team functioning**

CIHC (2010b) highlights that in team functioning “learners/practitioners understand the principles of teamwork dynamics and group/team processes to enable effective interprofessional collaboration”. Team functioning requires collaboration in a safe inclusive environment, which requires open communication and attentive listening, trust, and mutual respect. An awareness of the impacts of micro and macro systems on care and a commitment to problem solving and shared decision-making and ethical standards are required. Team members need to have an awareness and understanding of team developmental dynamics.

Collaborative working and effective communication impact student learning and personal practice (Kelley & Aston, 2011). On interprofessional teams decisions affecting patient outcomes are made amongst the team and individual contributions are acknowledged (Sheehan, et al., 2007). Further, team members understand the roles and contributions of others on the team and value one another. Health professionals must be mindful of the fact that they have a dual membership that includes membership on the interprofessional team along with membership to their professional bodies.

Xyrichis and Lowton (2008) conducted a comprehensive literature search and thematic analysis of interprofessional teamwork in community care. There were two main interprofessional teamwork themes that emerged and six categories. The two themes were team structure and team processes; within these were the categories of team premises, team size and composition, organizational support, team meetings, clear goals and objectives, and audit. A common site enhances team information transactions and communication processes, and also increases personal familiarity. Regular team meetings that foster enhanced communication and conflict resolution can occur more often in a common site. Smaller teams appear to function better and have greater participation than larger teams. Teams with greater diversity of occupations appear to have greater overall effectiveness and innovation that seem to promote patient care and trust. The status of a team member can have an impact on the effectiveness of the overall team functioning and decision-making. A shared delineation process for a leader can promote effective team functioning. The longer teams work together the better they can function, and organizational support for teamwork and encouragement of innovation is crucial. Audit can facilitate teamwork as it acknowledges individual contributions and value, as well as self-respect. Problem identification, resolution, and solution development along with providing support and praise can occur through a regular appraisal process. Regular audits could promote stronger relationships with the patient/client/family and promote more effective care.

It has also been reported that there is a lack of cohesion among health professionals who work with seniors in the community. These professionals do not have a common vocabulary and sometimes have different work methods, which impedes their ability to communicate and function like a team. Using models such as Interprofessional-Shared
Decision-Making (IP-SDM) might improve team communication and function as well as facilitate client-centered, sustainable health care goals. Lack of time, high staff turnover, and a perceived need to add SDM to their role-related tasks were reported as primary barriers for health professionals to implement SDM in home care with seniors. These factors can negatively impact team cohesion and interprofessional communication, reducing quality of care for seniors. Home support workers perceive that they have a high level of control for using IP-SDM in the home care context, along with occupational therapists and physicians. This confidence to adopt IP-SDM is important because this group is the largest unregulated group working with elderly in the home, so there is potential to make changes if this group is taught how to use this framework to improve team function and overall patient engagement with shared decision-making (Legare et al., 2013).

**Collaborative leadership**

According to CIHC (2010b), learners/practitioners engaged in interprofessional practice need to understand and apply leadership principles that are supportive of a collaborative practice model. Leadership skills are particularly significant for team leaders and faculty who manage or facilitate interdisciplinary group work because of the challenges of interdisciplinary teams, such as sharing professional roles and expertise, planning and decision making, while delivering quality patient care within complex contexts (Nancarrow et al., 2013).

The leader must be aware of the different roles, behaviours and values of different health care workers. Hall and Weaver (2001) say that a leader must be able to identify the stage of development of the team and apply appropriate approaches. They go on to say early stages require directive approaches, with more emphasis on tasks and less emphasis on relationship behaviours. As the interprofessional team matures the leader needs to further encourage the teams sense of ownership and responsibility. Then, the leader must delegate more and provide less socio-emotional support. When the group is mature they will be autonomous and the group itself will have full responsibility for the required tasks and group dynamics/relationships.

In a recent review article on principles of good interdisciplinary teams, Nancarrow et al. (2013) identified Leadership and Management as the top theme for high functioning teams. Specific characteristics included having a clear leader and clear direction, democratic, shared power, support/supervision, personal development aligned with management and a leader who acts and listens.

Leadership is required from all members and the role of leader may be shared or may change depending on the area of expertise required within the context of care. Teams that work collaboratively and share common understandings and common goals are more interprofessional in nature (Sheehan et al., 2007). Working interprofessionally “requires greater sensitivity to social issues within the team and willingness to share roles to develop collaborative ways of working” (Sheehan et al., 2007). Leaders must foster collaborative language, a sense of belonging and mutual sharing among team members.
Ultimately, a team leader needs to adapt their leadership style to the level of maturity of the team (Hall & Weaver, 2001).

**Interprofessional conflict resolution**

According to CIHC (2010b), conflict resolution on interprofessional teams needs to be done respectfully, constructively, and collaboratively. Conflicts can arise among team members or patients/clients. The scope of this section is on conflict between team members.

Potential and common areas where conflict arises are typically in relation to differing roles and values, power differentials, accountability, scope of practice and goals. CIHC, brown Xyrichis and Lowton (2008) state that interpersonal or interprofessional conflict can create barriers to teamwork by lowering team effectiveness and destroying interpersonal team relationships. Individual providers need to be aware of effective and constructive strategies to address inevitable disagreements.

There was no available literature on conflict resolution specific to community care for seniors. General findings are presented, and can be applied to interprofessionals working in community settings.

Barr (2005) discusses realistic conflict theory that states that groups with different objectives will have discriminatory inter-group relations whereas groups with common objectives will have conciliatory behavior. Similarly, Petrie et al (1976) presents ‘Idea dominance’ which means that a clear and recognizable idea must ‘serve as a focus for teamwork, rather than the traditional focus of each profession’ (Hall & Weaver, 2001). However, as Xyricis and Lowton (2008) state, ‘in depth exploration of what team goals should be and in what way and by whom these should be developed is lacking.’

Health professionals learn their roles, responsibilities and values from profession specific education systems, which leads to preconceived notions of their role on the health care team. Without IPE, Hall and Weaver (2001) state that different professions can then have a poor understanding of other professions roles and responsibilities, which can lead to conflict. The authors go on to suggest that areas of overlapping competencies and shared responsibilities can lead to better teamwork and less conflict. However, when one profession does not recognize another profession’s potential this can lead to underutilization of expertise and subsequent resentment.

A study of conflict on interprofessional primary health teams, through semi structured interviews of physicians, nurses, receptionists, pharmacists and social workers, revealed barriers and strategies to conflict resolution (Brown et al., 2011). Major barriers were lack of time and workload, people in less powerful positions, lack of recognition or motivation to address conflict and avoiding confrontation for fear of causing emotional discomfort. With respect to community care, individuals (such as personal support workers) in less powerful positions is a probable barrier to resolution – and these professions with traditionally less status must have their concerns and views recognized and valued.
Strategies for resolution were broken down into individual strategies and team strategies. Individual strategies included open and direct communication, a willingness to find solutions, showing respect and dignity, and humility. Team strategies included intervention by team leaders and the development of clear conflict management protocols. In this study team leaders were office managers, family physicians or executive directors. One nurse participant stated that having a manager with training mediation to be helpful, and this helped her be able to facilitate the disagreement and find solutions. Key attributes of leaders designated in conflict resolution were people who were accessible, approachable, non-judgmental, good listeners, and the ability to keep a respectful distance from the conflict. It was also acknowledged that it was helpful to have a manager or director in charge of conflict resolution because this person had the time to resolve issues and develop protocols, whereas individuals with more clinical responsibilities were more pressed for time, and/or had the responsibility as an additional add-on (Brown et al., 2011).

An Ontario guide by Edgelow et al. (2009) on teaching interprofessional competencies in pre-registration settings found that dealing with interprofessional conflict had limited published IPE curricula, and makes suggestions for developing this area so conflict resolution is thoroughly incorporated into Ontario health professions educational training from the beginning of training. The suggested curricula items include theories of conflict, source of conflict, role of conflict, conflict style, conflict management and conflict resolution. It is acknowledged in this report that it focused on the 23 regulated health professions in Ontario, as well as social workers given their extensive involvement in the healthcare settings. It is thought that similarly, these topics should be extended to personal support workers as this group is involved in community and long term care settings.

**Interprofessional Education: Methods**

There continue to be discussions and various perspectives on when and how IPE should be introduced to students in their academic training (Gilbert, 2010). However, many institutions have approached IPE from their own contextual perspectives. Investment from administration and faculty is necessary for the success of implementing IPE in institutions (Graybeal, Long, Scalise-Smith, & Zeibig, 2010). There have been various systematic reviews on the effects of IPE (Canadian Interprofessional Health Collaborative, 2009; Hammick et al., 2007; Scott Reeves, Perrier, Goldman, Freeth, & Zwarenstein, 2013). These illustrate that IPE ranges quite broadly in relation to the duration, the learning activities, and the participating professions participating (Reeves, Goldman, Burton, & Sawatzky-Girling, 2010).

Barr (2005) states that IPE should begin early in the training period and extend throughout a person’s professional career. Health Force Ontario through the Interprofessional Care Strategic Implementation Committee has written a guide to developing core curriculum for educators in pre-registration learning settings. This guide presents an Ontario Pre-Registration Interprofessional Education Model and Framework that integrates interprofessional competencies into the curriculum (Health Force Ontario,
Within the framework there are a range of teaching activities that take the students from exposure to the competencies to immersion to mastery. At the exposure level there is didactic teaching discussion, journal club, seminars, shadowing to case studies, enquiry based learned, small group work to online forums to standardized patients, role play, simulation, small group work to eventual mastery with clinical placements, contact with patients/clients, and team scenarios. Within each activity level there are specific assessment exercises that evaluate a student’s mastery (Health Force Ontario, 2009). It is thought that this guide is applicable to all health care workers in the community, and not only the regulated health care professions.

The CIHC (2009) report on synthesizing the evidence to foster evidence based decision making found that literature mostly reflected programs to post licensure learners; however, IPE is increasingly found as a classroom or practice-based activity in pre-licensure learners. They also found that most IPE lasted from one to five days, although the range was from one-two hours to established programs. Most common methods were seminar based discussion, group problem solving and role play.

A review of IPE studies between 2005-2010 conducted by Abu-Rish and colleagues (2012) determined that the most common IPE strategies utilized were small group discussion, followed by case and problem based learning, large group lectures, reflective exercises, clinical teaching and direct interaction with patients, and community based projects. The learning occurred most frequently between two or three professional students, though occasionally more. Small group discussion allows for more interaction and team building than a didactic approach of learning. Simulation based learning is being adapted more often and is likely to become more integral to IPE. Further research demonstrates that learners find value in IPE and they develop and acquire collaborative knowledge and skills (Reeves et al., 2010). Within the literature there is some valuable information that correlates with the six competency domains outlined by CIHC (2010b).

**Program evaluations**

Community and primary care include prevention and health promotion, early identification, treatment and maintenance. The social determinants of health offer a social structure for holistic care. A study conducted by Goodman et al. (2011) in England demonstrated that the definitions of interprofessional working (IPW) or collaboration differed among various professionals working with seniors living in the community. An online survey of 91 managers at a variety of health and social care organizations was conducted along with a review of 50 IPW documents related to seniors living at home. Language was context dependent and differed across organizational levels and may be linked to definitions used by funding sources. A variety of communication methods were used such as core electronic records and shared assessments. A similar Canadian based study was not found in this environmental scan. Therefore, it is recommended that some common terms be developed for IPE for seniors living at home in Ontario. However, there needs to be recognition that there may be differences in terms utilized within the practice realm.
Lam, Plein, Hudgins and Stratton (2013) contend that successful geriatric IPE programs can be established and conducted in various practice settings. They stated that sustainable IPE programs require commitment and participation by organizations and site preceptors, faculty and students from various professions. While delivering seniors patient centred care the curriculum should foster joint decision-making, teamwork and shared responsibilities.

A pilot study of an interprofessional collaborative care model at Stonechurch Family Health Centre in Southern Ontario employed an interprofessional shared care model for seniors living in the community (Moore et al., 2012). The evaluation determined that this program allowed for shorter referral times, easier access to services, and could allow seniors to remain at home.

An integrated care program in southeastern Ontario known as Seniors Managing Independent Living Easily (SMILE) empowers seniors who live at home to get access to individualized home support services based upon their needs. However, there appears to be a long wait time for services (MacLeod, 2012). The Interprofessional Model of Practice for Aging and Complex Treatment based was piloted at Sunnybrook hospital in Toronto. MacLeod (2012) believes that this model could provide an example of interprofessional integrated care where seniors could access a team of professionals at once. Professional collaboration and communication could be fostered along with those in roles of unregulated care positions including personal support workers. Prevention and early intervention programs along with access to services for complex needs is required for seniors who live at home and wish to continue doing so.

MacLeod (2012) asserts that personal support workers play an integral role in the lives of seniors requiring home care and that they should be included in interprofessional collaborative work. She mentions a pilot project that occurred at Baycrest Hospital in Toronto where PSW’s participated on interprofessional teams caring for seniors which had positive outcomes that should be replicated in the community. She vies for the development for more integrated care programs for home and community care.

Markle-Reid, Browne and Gafni (2013) reported the results of three community-based randomized control trials in Southern Ontario, noting that nurse-led health promotion disease prevention (HPDP) strategies had some statistically significant improvement in care for seniors in the home. They recommended multiple home visits, multidimensional assessments, interprofessional collaboration and coordination of services by case managers with expertise in geriatric training. Interventions that engaged clients, family and other health professionals, were effective in improving client’s overall quality of life scores (HRQOL), with no additional health care delivery costs when compared with “usual or control group” home care service. Although there was insufficient data or study power to generalize results beyond Southern Ontario, the results suggest more research is required to capture what interventions were most successful, why they were successful and how to incorporate into home care services given that HPDP strategies were incorporated with no additional societal cost for home care services.
Issues for seniors
Seniors often present with needs in various domains that create complexity for care. Within the literature there is a lot of information related to safety in mobility and fall prevention as important for seniors. Many seniors require support in personal self care, daily living activities and with consistent medication regimes. Personal hygiene, vision care, dental care, hearing needs, and daily meals food and nutrition are common areas of need and support for seniors living in their homes. Seniors may require support accessing day programs, in home care services (e.g. OT, PT, etc.) and referrals. Seniors who wish to remain in their homes as they age often can’t manage all of the tasks of caring for a home such as home maintenance and home modifications, maintenance, domestic activities and cleaning. Financial concerns such as paying bills, dealing with pensions, disability funds, subsidies, managing accounts and navigating Service Canada, understanding documents and legal information can be confusing and daunting tasks that require support. Seniors with mobility challenges require supports around access, transportation and completing errands. Vehicle maintenance and alternate modes of transportation need to be addressed. For some seniors, living alone can create isolation and loneliness, and many have decreased social and leisure activities and interactions. Memory and mental acuity appear to decrease as many seniors age. Individuals with dementia or Alzheimer’s may report fewer needs compared with the reports of their caregivers and professionals. This creates difficulties with assessment and care. Spirituality and religious needs for seniors also need to be assessed and attended to. Spiritual struggles need to be identified and spiritual strengths need to be supported, facilitated and nurtured.

Community Care Access Centres across Ontario are the single point access to connect people to the most appropriate quality in-home and community services to meet their needs. In an effort to further meet client need, the system navigator role was introduced in some areas to help people safely stay in their homes and communities by connecting them with a range of services, including, but not limited to: homemaking, meal programs, transportation, day programs and recreational services.

Literature Gaps
The is a lack of evidence reported in the United Kingdom to link interprofessional care (IPC) outcomes to seniors in the community (Trivedi et al.,2013). While integrated care and shared delivery models do theoretically improve care in the community, reduce hospital stay and nursing home use, more rigorous studies and observational research are required to fully understand the effectiveness or IPC on targeted populations (Trivedi et al., 2013).

There is a lack of theoretical and conceptual frameworks within IPE programs described in the literature. Abu-Rish et al. (2012) advise that more detailed conceptual frameworks in IPE will enable better assessment of research objectives, teaching methods and the outcomes achieved.

Key Recommendations
Resources needed for IPE and Home Care

Collaboration between health care professions and various home care agencies require organizational and IT planning that centers around patient-related processes to manage client care in the community. There is a need for mobile technology and processes between agencies to enhance interprofessional communication and documentation for seniors care in the home. Emphasis on mobile technology and inter-agency processes should consider and accept the varying role-related responsibilities among caregivers (Winge, Johansson, Nystrom, Lindh-Waterworth & Wangler, 2010).

Enhanced Communication and Shared Pathways

Shared care planning that incorporates joint decision-making among the IP team is recommended, using common or shared documents and processes and face to face meetings to ensure effective communication about patient care plans (Trivedi et al., 2013).
References


Trivedi, D., Goodman, C., Gage, H., Baron, N., Scheibl, F., Iliffe, S., … Drennan, V. (2013). The effectiveness of inter-professional working for older people living in the


