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## IFMSA Policy Document Interprofessional Education and Collaborative Practice

**Proposed by Team of Officials**

**Presented to the IFMSA General Assembly March Meeting 2020, in Rwanda.**

### Policy Statement

#### Introduction:

In an era with immense globalisation, the health care system is facing many complex health challenges and a global shortage of health workforce. Interprofessional education (IPE), defined as the learning of two or more professions from each other to improve health outcomes, is increasingly recognised as a key strategy to address the global health workforce crisis/shortage and a necessary step to ensure a collaborative practice ready health workforce able to better address complex local health needs. IPE has also proven to play a crucial role in the improvement of patient care and safety, access to and coordination of health-services and health-outcomes in general.

#### IFMSA position:

The International Federation of Medical Students' Associations (IFMSA) believes in the importance of Interprofessional Education and Collaborative Practice (IPECP) as a key measure to improve patient safety and promote people centred care in universal health coverage, ultimately resulting in stronger health systems with improved health outcomes. We call on the need for context specific, integrated health and education policies that promote interprofessional education and collaborative practice in health professions curriculum and healthcare facilities respectively. We also reaffirm the importance and long-term impact of a strong, collaborative practice ready health workforce in improving health outcomes, strengthening health systems and achieving universal health coverage.

#### Call to Action:

IFMSA calls on **Governments** to:

- Develop concrete policies for interprofessional education and collaborative practice together with all relevant stakeholders with the aim of achieving context specific, integrated IPECP programs within the health system.
- Increase investment and mobilize technical and financial resources towards the development of IPECP programs.
- Integrate IPE across health professions education and promote the development of frameworks that guide health workforce competencies in collaborative practice in primary health care (PHC)
- Inclusion of IPE in the standards of quality medical education of accrediting and health regulation bodies.
- Lead curricula reform from the standard profession-based education to a longitudinal integrated health professions education that fosters principles of interprofessionalism and CP among students.
- Foster team-based healthcare systems by including IPECP in national strategies for GHW planning to holistically address populations and communities health needs and challenges.

IFMSA calls on **Medical Schools and Universities** to:



# IFMSA

International Federation of  
Medical Students' Associations

- Integrate IPECP in their education, research and services priorities as a measure to contribute to the social accountability mission of medical schools.
- Add population-oriented interprofessional collaboration competencies within their curricula to capacitate the future health workforce to better meet community needs and tackle health inequities.
- Implement competence-based teaching methods for IPECP like Interprofessional simulation-based learning or Interprofessional Training Wards (ITWs) to reduce errors in the communication between professions
- Ensure adequate allocation and institutional support to faculty development and organisation for implementation of IPE into undergraduate and postgraduate studies.
- Support feedback mechanisms and research for the continuous improvement of IPE practices in relation to student and patient outcomes.
- Promote interprofessional community-service learning as an effective model to train a collaborative-ready and socially accountable health workforce.

IFMSA calls on **Healthcare Students** to:

- Recognise the limitations of professional silos and the need for collaboration between different health disciplines to achieve optimal healthcare for patients.
- Advocate for IPE to be implemented in universities faculty through interactive methods that allow students to work in interprofessional teams on clinical cases and thematic projects.
- Create and participate in local or international platforms discussing IPE to learn and share insights on collaborative learning with other healthcare students and professionals.
- Recognize interprofessional collaboration as an essential tool for socially accountable education and health services that meet community health needs better.
- Promote and engage in interprofessional community-service learning initiatives as an effective socially accountable and population-oriented training model.

IFMSA calls on its **National Member Organisations (NMOs)** to:

- Advocate for IPE as a key to a collaborative-ready workforce, an important factor in achieving UHC through improved patient outcomes and safety.
- Participate in campaigns and raise awareness on the importance of interprofessional collaboration and its importance on health systems outcomes.
- Engage in and promote local, national and international activities tackling IPECP and interdisciplinary research opportunities for students.
- Identify stakeholders to work with in advocating for IPECP in health workforce development strategies and as an integral part of social accountability of medical schools.
- Join national interprofessional health students and professionals networks and coalitions to promote interdisciplinarity and the one health approach through collaborative projects

IFMSA calls on **Relevant Stakeholders (e.g.: WFME, AMEE, WMA etc.)** to:

- Develop resources that guide the design and implementation of IPE in curricula of health professions education by providing evidence-based information on its application and integration.
- Ensure the inclusion of IPECP in standards of accreditation of undergraduate medical education, postgraduate education and continuous professional development.
- Support health professions members or bodies in developing, implementing and evaluating IPE programs so students can be better prepared to meet communities' needs.
- Encourage the communities to be key change actors in large-scale medical and health systems.



## Position Paper

### Background information:

*"Interprofessional education occurs when students from two or more professions learn about, from and with each other to enable effective collaboration and improve health outcomes."* (World Health Organization, 2010). Consequently, Interprofessional collaboration refers to multiple health workers from different professional backgrounds working together to better serve their communities and to increase the quality in healthcare. These processes aim to create specific behaviours and competencies, which can further lead to better use of resources and medical & non-medical personnel, ultimately improving patient outcomes and safety. These attitudes include, among others, a sense of responsibility, assertiveness, transparency, mutual trust and respect (Bridges et al, 2011).

The 4 core competency domains of Interprofessional Collaborative Practice are represented by:

- Values & Ethics for Interprofessional Practice, revolving around patient-centred care and to equity and efficiency in healthcare delivery.
- Roles & Responsibilities. Understanding how an interprofessional team works and how it enables us to accurately lead a medical act in the patient's benefit.
- Interprofessional Communication, which teaches us how to find suitable languages with the help of general reading literacy and health literacy, context-applicable.
- Teams & Teamwork. Fair-play, good communication and collaboration through decision-making, problem-solving and outcome-based methods prioritize a patient-centered approach.

(Interprofessional Education Collaborative Expert Panel)

*"I will remember that I remain a member of society, with special obligations to all my fellow human beings"* (Hippocratic Oath). With this in mind, healthcare students and professionals should strive and concentrate their efforts on accomplishing the society's current needs.

### Discussion:

#### IPE in Accreditation & Quality Assurance

According to research, accreditation has been identified as one of the most significant challenges in the implementation of Interprofessional education (Sunguya et al., 2014). Despite the importance of IPE in developing a greater understanding of the role of the different health care professionals towards improvement of patient care (Birk, 2017), it is noticed that accreditation standards currently do not focus on the importance of its inclusion in curriculum, and in order for IPE to be supported, all accrediting bodies need to understand the issue and work together on tackling it and including it in their programs and to be identified within their standards (Smith et al, 2009). Some universities have already started including this topic in their curricula. However, many countries have not yet created a collective mandate for its inclusion in their courses, which results in the deficiency of regulations that ensure its inclusion and this will result in creating an untransformed community in which there are only a few health care professionals are ready for interprofessional collaborative practice (Zorek and Raehl, 2013).

Accreditation of IPE has also got its own benefits and one main benefit is that this accreditation will help responsible officials in colleges and schools in creating a standardized structure for curricula (Smith et al., 2009). It is recommended for accrediting bodies responsible for different professions to collaborate together to meet shared accreditation requirements in order to gain the privilege of faster adoption than leaving the process to each accreditation body alone. Unfortunately, developed countries are facing challenges in accrediting IPE according to several studies. For example, in the United States, according to the frequency of several accreditation documents, that clearly hold colleges and schools accountable to IPE, nursing and pharmacy graduates may be most prepared for interprofessional and collaborative practice (IPCP). However, no single best practice for the



incorporation of IPE-related language into the accreditation process emerged (Zorek and Raehl, 2013). Consequently, the related courses will face the obstacles of being dealt with less seriousness because of lack of standardization (Brett et al., 2013). Different medical schools have different approaches of teaching and efforts taken towards standardizing medical schools will provide an opportunity for accrediting Interprofessional education as a significant part of the courses.

## IPE & One Health

WHO defines one health as, "(...) an approach to designing and implementing programmes, policies, legislation and research in which multiple sectors communicate and work together to achieve better public health outcomes." One health is guided by the principles of human health intertwined with the animal kingdom and the environment. It is further strengthened in cases of diseases like salmonella, rabies and viral infections that arise from zoonotic sources. This approach brings together professionals' expertise who are active in different sectors, such as public, animal, plant or environmental health. This can result in an increased capacity to detect, respond to, and prevent outbreaks of zoonoses and food safety problems, gather epidemiological data and laboratory information across sectors and can tackle public health hazards that plague both humans and animals. With the worldwide rise of concern regarding the risk of infectious diseases and threats of potential endemics and pandemics, collaborative efforts between professions and disciplines working locally, nationally and globally provide adequate care to global health and security. Having an integrated curriculum in the context of one health will build good team work, communication with each professional knowing its role and responsibilities in the matter of provision of universal care in medicine (Courtenay et al., 2015) (Wilkes et al., 2019).

In the 1980s, Engel's biopsychosocial model represented a systematic approach that considered the patient a key element in the community and society. The concepts of patient-centered care and social determinants of health can be considered efforts to incorporate the biopsychosocial approach into the patient-health provider equation. Nowadays, this can be translated through the "One Health" framework on health challenges in this constantly changing global environment. In this matter, academic medical institutions have been asked to adopt One Health as a transdisciplinary program to research and education and related groups of students exist in several medical schools (Rabinowitz et al., 2017). Such programs have already been established in the USA, one at Texas A&M University and the other at the University of Washington. In the first case, students collaborate to collect data on major health issues in people, animals, and the environment and to offer valuable solutions for the community. What brings light to the future of One Health is that now Texas A&M medical students are able to choose this topic as one of their electives. At the same time, medical and public health students at the University of Washington work with the Center for One Health Research on different projects, involving both infections in humans and animals, antimicrobial resistance in various species, and the effect of natural gas extraction on their health (Lucey et al., 2017).

The Global Disease Detection program is another solid example of a one health and IPE approach, by offering a solution to the GHW crisis through joint attempts to respond to infectious diseases, develop laboratory systems, addressing the animal and human interface for zoonotic infections and conducting public health research (<https://www.cdc.gov/onehealth/>). A more concrete case is Rwanda, which faces several challenges, the one most relevant to our point of discussion being a very dense population (415/square mile), which leads to food insecurity and poor health. Improvement in communicable diseases and environmental stability represent core actions underwent by this central-Africa country, in collaboration with governmental agencies, specialties and community, aiming to achieve health for all. Rwanda has thus become a trailblazer in the East African Community in achieving One Health, emphasizing its importance in a health system development (Nyatanyi et al., 2017).

An Australian survey on the topic enhanced the idea of the One Health as a collaborative practice, but with well-defined roles. Thus, between GPs and veterinarians there is specific baseline knowledge on



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International Federation of  
Medical Students' Associations

different zoonoses with the need of understanding one's own professional limitations. In order to reach the full potential of One Health, we should see the 'big picture' of IPECP, taking into consideration the cultural diversity and aiming towards an outcome-based collaboration for our own well-being, our animals' and our environment's (Steele et al., 2019).

## **IPE & Universal Health Coverage**

A collaborative-ready health workforce is key to strengthening health systems and meeting populations' health needs. Current shortages in the global health workforce are an important barrier to health coverage worldwide (World Health Organization, 2019). Projections indicate a potential deficit of 18 million health care workers in the coming decades (Health Workforce and Services Draft Global Strategy on Human Resources for Health: Workforce 2030). This global workforce crisis calls for innovative solutions for needs-based global health workforce planning (Tomblin Murphy et al., 2019). Some current fragmented health systems struggle to meet the health needs of their populations, requiring system-transforming solutions to capacitate their workforce to deliver health care at their highest capacity. IPECP optimizes the strengths and skills of health workers and efficiency of the health care teams, hence they have been widely brought forward as a solution for a more efficient and adapted global health workforce. IPE leads to a collaborative-ready health workforce, which is a key element of more efficient and strengthened health care systems (World Health Organization, 2019) (Marie-Andrée Girard). Fragmented and siloed health services are insufficient to manage the increasingly complex health problems faced by populations (Nagelkerk et al., 2017). A closer collaboration between health care workers is required to address the health challenges faced by individuals, families and communities, especially through primary care, which is paramount to achieving universal health coverage (Lygidakis et al.) (*Strategy on Human Resources for Universal Access to Health and Universal Health Coverage*).

Interprofessional health care teams are better prepared to maximize their skills and manage cases conjointly, therefore providing better health-services to the patient and improving the outcomes of the health system (World Health Organization, 2019). IPE has been widely accepted as a way of achieving the Triple Aim for health systems: improving the patient experience of care, improving the health of populations and reducing per capita costs of health care ("Barr, H. (2015) Interprofessional Education-The Genesis of Global Movement - CAIPE") (*Core Competencies for Interprofessional Collaborative Practice: 2016 Update*). Evidence suggests that implementing IPE presents various health benefits both in acute and primary care, including, but not limited to, better access to health care, improved patient safety, discharge expedition, a reduction in medical errors, and increased patient satisfaction (World Health Organization, 2019) (CAIPE) (Vuurberg et al., 2019). These improved health outcomes can positively contribute to addressing some of the most pressing global health challenges such as maternal and child's health, HIV and AIDS, malaria, health in humanitarian crisis, non-communicable diseases and mental health (World Health Organization, 2019). To add more, it was reported that IPECP approach led to improvements in patients' healthcare, regarding HgbA1C, cholesterol and blood pressure (Committee on Measuring the Impact of Interprofessional Education on Collaborative Practice and Patient Outcomes et al., 2015). Chronic patients suffering from morbid psychological affliction also benefited from this collaboration (Phillips et al., 2016).

Each region presenting its own health challenges and needs, policy makers and governments must adopt a population or needs-based approach when developing IPECP strategies. Contextualization is a crucial step in developing interprofessional collaboration policies and regulations that are tailored to local health needs. Including IPECP in legislation is a way of championing for further collaboration among health care workers. Increased collaboration leads to optimal health outcomes, therefore representing a key building block for improved health systems and a key component in global health workforce planning strategies (World Health Organization, 2019) (Tomblin Murphy et al., 2019) (Marie-Andrée Girard).

## **IPE & Social Accountability**



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International Federation of  
Medical Students' Associations

Integrating IPECP as a strategy to meet populations' health needs better is in line with the social accountability of medical schools. There is an undeniable link between a collaborative-ready health workforce and the improved health outcomes for patients. Based on this evidence, medical school should consider including IPECP in their education, research and service activities (Boelen et al, 1995). A team approach is required to address the multifaceted health problems of individuals and persistent health disparities within populations, especially when providing care to vulnerable populations facing health inequities (Eggenberger et al., 2019) (Greer et al., 2018). The case for interdisciplinary health teams therefore also rests on addressing social and health issues. In Brazil, *Family Health Teams*, made up of one doctor, two nurses and community workers, were created to follow families and deliver primary care (World Health Organization, 2019). The abundance of social and health problems in Brazil led to the implementation of various interprofessional education programs with the goal to adapt health services to the local reality and health necessities ("Barr, H. (2015) Interprofessional Education-The Genesis of Global Movement - CAIPE")

*The Interprofessional Education Collaborative provides Core competencies for Interprofessional Collaborative Practice* to be integrated in health professions education. These competencies and their sub-competencies are community and population oriented and promote health equity through patient and family centered interprofessional health care services. They include using one's own knowledge when engaging in interprofessional teams who complement their expertise in developing strategies to address the health care needs of patients. Interprofessional practice enables health workers to benefit from the skills and abilities of complementary health care professions to optimize health care and meet population health needs (*Core Competencies for Interprofessional Collaborative Practice: 2016 Update*). Interprofessional teams offer a more holistic response to patients health needs, a greater continuity of care and improved health outcomes ("Barr, H. (2015) Interprofessional Education-The Genesis of Global Movement - CAIPE") (World Health Organization, 2019). Collaborative practice is crucial to better adapted and socially accountable health services and calls for IPE competencies to be integrated in health curricula.

IPE through community-service learning has been adopted and supported by universities as an approach to increase social accountability (Greer et al., 2018) (Holmqvist et al.) (Dugani et al., 2011). Longitudinal service-learning programs are a proposed approach in reforming medical education to better address social determinants of health. Florida International University Herbert College of Medicine provides a required longitudinal interprofessional program through which student teams are assigned to a household in an underserved community. Outcomes of the program include an increase in usage of preventive health services and delivery of free health and social services. Over six years, student teams also identified 1,403 remediable social determinants of health on which they took action through interprofessional advocacy efforts (Greer et al., 2018). Student-run clinics are another approach to addressing health inequities and have been running in the United States since the 1960s and in Canada since the 1990s. Disparities in health care access and health challenges have made delivering health services to underserved populations the core mandate of Canadian student-run clinics. An interprofessional or team-based approach is a core value of these student-run clinics and is emphasized in the various stages of training. Interprofessional learning enables students to benefit from other team members skills and knowledge (Holmqvist et al.). Interaction between students, principles of adult learning and learning methods linked to real world practice have been shown to increase effectiveness of interprofessional education (World Health Organization, 2019). Student-run clinics integrate all these components, equipping students with the competencies to readily work in collaborative practice teams.

## IPE in the Curriculum

Since the 1960s, the occurrence of IPE initiatives has become more prevalent in many countries. This increase is driven by concerns about the quality assurance of healthcare, the extent of avoidable deaths, and the ability of healthcare workers to meet the diverse needs of the aging population. With



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International Federation of  
Medical Students' Associations

the establishment of interprofessional conferences, journals, and networks, pioneers of IPE are able to provide support to less-experienced educators around the world. In the United States, the Interprofessional Education Collaborative recognized the correlation between collaboration skills amongst clinicians and improved quality, accessibility, and safety of patient-centered care. Similarly, interdisciplinary teamwork has been determined by the Institute of Medicine as a core learning area for healthcare students. However, despite the increasing interest in interprofessional implementation in the curriculum, the progress of establishing IPE is uneven across institutions globally. An IPE review conducted by the Council of Europe found that IPE was implemented in only a few European countries. In fact, a survey by Lee, Celletti, Makino et al. in collaboration with WHO in 2012 regarding the attitudes of medical school deans towards IPE in Malaysia, The Philippines, South Korea, and Japan received only thirty-five responses out of 146 schools with the results indicating that there was only one IPE program in each of Malaysia and the Philippines and four in Japan. Similarly, the implementation of IPE between professions and between universities are also uneven. In Japan, while half of their medical schools reported implementation of IPE, the development of collaborative competencies is emphasized only for dietician and pharmacy courses but not for physiotherapy, occupational therapy and social work courses. Difficulties of IPE implementation often stem from logistical barriers of aligning rigid curricula that is further exacerbated by the lack of financial and administrative support.

The Council of Europe suggests promoting IPE through information distribution at seminars, expertise consultation in planning and implementing IPE programs, and systematic evaluation. As curriculum design transition from “trial and error” and broad heading curricular inputs to competency-based outcomes, it is crucial to determine learning outcomes for IPE. Importantly, interactive small group learning serve as the foundation of IPE and cannot be simply replaced with common interdisciplinary learning in large classes. Referencing six medical schools in the United States, curriculum developers can develop a common model for team training before specifying the curriculum with an academic focus, clinical focus, community focus or a balance to cater towards local context. According to CAIPE, IPE implementation in university-based pre-qualifying courses are best planned collaboratively between faculties while engaging various community layers such as professional associations, employing agencies, student bodies, patients, and carers to take into consideration the needs and interests of these stakeholders as well as to maximize on support and existing resources. To address the problematic logistical arrangements that may arise with IPE, universities can consider allocating time for an annual week-long activity where students from different programs come together to engage in interprofessional learning along with continuous IPE supplementation throughout the rest of the year. One best-practice format that is currently implemented in many countries are Interprofessional Training Wards (ITW), which enhance the student learning outcomes and patient satisfaction rates (Oosterom et al., 2019). Importantly, effective IPE relies on curriculum that connects educational activities with learning outcomes and assessments enhanced by implementation of adult learning such as problem-based learning, adoption of learning arrangements that reflect real world practices, and encouragement of peer interactions.

(“Barr, H. (2015) Interprofessional Education-The Genesis of Global Movement - CAIPE”) (CAIPE) (World Health Organization, 2019)

## **IPE & Research in Medical Education**

IPE has been documented and has been gaining attention globally since decades (“Barr, H. (2015) Interprofessional Education-The Genesis of Global Movement - CAIPE”) (Newton et al., 2015). The growing interprofessional movement fueled the need for reviews and researches to build frameworks, strategies and guides for IPE. Initial developments in this area emerged from local initiatives, generating uneven and culture-specific advancements in its progress and implementation (“Barr, H. (2015) Interprofessional Education-The Genesis of Global Movement - CAIPE”) (World Health Organization, 2019) (CAIPE). Research evidence and examples of existing projects in IPE worldwide enabled the creation of the *WHO Framework for Action on Interprofessional Education and*



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*Collaborative* in 2010. This framework lays a foundation for IPE implementation by providing strategies and sharing best practices, but highlights the need for further research evidence in some regions (World Health Organization, 2019). Developments in this field led the way for the emergence of journals on the topic, such as the *German International Journal of Health Professions* ("Barr, H. (2015) *Interprofessional Education-The Genesis of Global Movement - CAIPE*") and the *Journal of Interprofessional Care*, active since 2014 and 1992 respectively, which contribute to fostering worldwide advances through research dissemination.

National and international reviews done within universities to assess IPE demonstrated the necessity of frameworks for coherent progress in the area. Such reviews were conducted in Australia, Brazil, the United States and Europe amongst others and led to the creation of national strategies, networks and frameworks on IPE. The Council of Europe four-stage strategy highlights the importance of systematic evaluation of IPE models and practices ("Barr, H. (2015) *Interprofessional Education-The Genesis of Global Movement - CAIPE*"). Evaluation of such courses in medical schools and universities through rigorous research design and data interpretation supports sustainability of the programs (CAIPE). It has also been acknowledged that expertise and knowledge in IPE is strengthened by research and evaluation (*Core Competencies for Interprofessional Collaborative Practice: 2016 Update*). Research shows that there is a current lack of objective measures and control groups in IPE studies (Remington et al, 2006). There is a need for evidence-based recommendations on education models and best practices to guide a methodological implementation of IPE (Newton et al, 2015) (Remington et al, 2006) (Reeves et al, 2013). Numerous studies have been conducted at individual medical schools and universities to describe education models and activities, including qualitative and researches investigating students' perception ("Barr, H. (2015) *Interprofessional Education-The Genesis of Global Movement - CAIPE*") (West et al., 2016) (Curran et al, 2010). However, comparative evaluations of different practices allowing researchers to recognize successful programs elements are still scarce (Remington et al, 2006) (West et al, 2016). The development of effective, sustainable and outcome-based programs calls for a methodological and disciplined approach to IPE design and evaluation processes (Zhang et al, 2011). Such an approach includes defining learning outcomes that evidence the added value of interprofessional learning (Thistlethwaite, 2012) and providing clearer reporting requirements for evaluation (Abu-Rish et al, 2012).

Future medical education research in the field should focus on assessing the effectiveness of interprofessional teaching models through objective measurements of student behaviors outcomes, short-term and long term, and patient outcomes following a well-defined framework for evaluation (Remington et al, 2006) (Thistlethwaite, 2012) (Abu-Rish et al, 2012).



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