ehpic™
It's about health.

Educating Health Professionals in Interprofessional Care:
Advancing the Future of Healthcare through Interprofessional Learning

UNIVERSITY OF TORONTO

UHN

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- Lindsay Herzog
- Darlene Hubley
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Faculty & Presenter Disclosure

Faculty: Victoria Boyd
Relationships with financial sponsors:

None

Faculty: Lindsay Herzog
Relationships with financial sponsors:

None

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Disclosure of Financial Support

Potential for conflict(s) of interest

- Nil

University of Toronto CPD Accreditation

Continuing Professional Development has awarded EHPIC (Educating Health Professionals in Interprofessional Care) 2025 with the following credits:

- College of Family Physicians of Canada Mainpro+® Certified Activity: 18.5
- Royal College Maintenance of Certification Section 1: 18.5 hours
- American Medical Association Category 1: 18.5 credits
- European Union for Medical Specialists UEMS-EACCME®: 18.5 credits
- Certificate of Completion in Continuing Professional Development: 18.5 hours

Our Lens

- Clinicians (audiology, cancer care, family medicine, rehab, orthopedics)
- Educators/Administrators (Hospitals & University)
- Researchers
- Parents/families
- Patients/citizens

Centre for Advancing Collaborative Healthcare & Education

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Program Information

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History of ehpic™ Recognizing Contributors

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What is ehpic™ ?

Educating Health Professionals In Interprofessional Care

This program aims to develop leaders in interprofessional education and practice who have the knowledge, skills and attitudes to facilitate learners and colleagues in the art and science of working collaboratively and partnering for care.

OBJECTIVES:

- Characterize the rationale for advancing interprofessional education (IPE) and collaborative practice (CP), including utilizing the Canadian Interprofessional Health Collaborative (CIHC) Competency Framework, for leaders across healthcare systems.

- Apply CIHC competencies to IPE/CP learning activities for students and/or clinicians.

- Develop strategies to enable increased faculty/clinical capacity and engagement in IPE/CP in academic and practice settings.

- Produce a specific organizational interprofessional project, initiative, or activity that can be implemented upon return to community.

Today's Agenda:

1. Welcome and Introductions
2. Background and Context of Collaborative Healthcare and Education

Break

3. CIHC COMPETENCY: Role Clarity and Negotiation

Lunch

4. CIHC COMPETENCY: Team Communication & Collaboration
   - Quality Improvement and Patient Safety

Break

5. CIHC COMPETENCY: Team Differences & Disagreements Processing
6. Initiative/Project Work Time
7. Reflection and Daily Evaluation

COURSE WEB PORTAL:

For program materials, please visit web portal:

https://events.myconferencesuite.com/EHPIC2025/page/CourseMaterials

Password is: Ehpic2025

INTRODUCTIONS:

GETTING TO KNOW EACH OTHER AT YOUR TABLE

Introduce yourself and your role to your group.

Discuss:

- Why are you passionate about this work?
- What is most important for you to advance in your context?

Co-Create Our Norms and Values:

Team norms are the traditions, behavioral standards and unwritten rules that govern how we function when we gather.

Discuss and write on your poster how your group would like to work together.

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Background & Context of Collaborative Healthcare & Education

HAVE YOU EVER HEARD SOMETHING LIKE THIS ?

> *I am stressed and I don't understand what to do… the social worker tells me to do one thing at home, the doctor something different and the pharmacist has another goal. We're a busy family… I don't have time and don't know how to do all these conflicting things. The only thing that matters is that my wife gets well.*

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What is Collaborative Healthcare ?

Occurs when **multiple health workers** from different professional backgrounds provide comprehensive health services by working with patients, their families, carers and communities to deliver the **highest quality of care across settings.**

World Health Organization

Framework for Action on Interprofessional Education & Collaborative Practice, WHO, 2010

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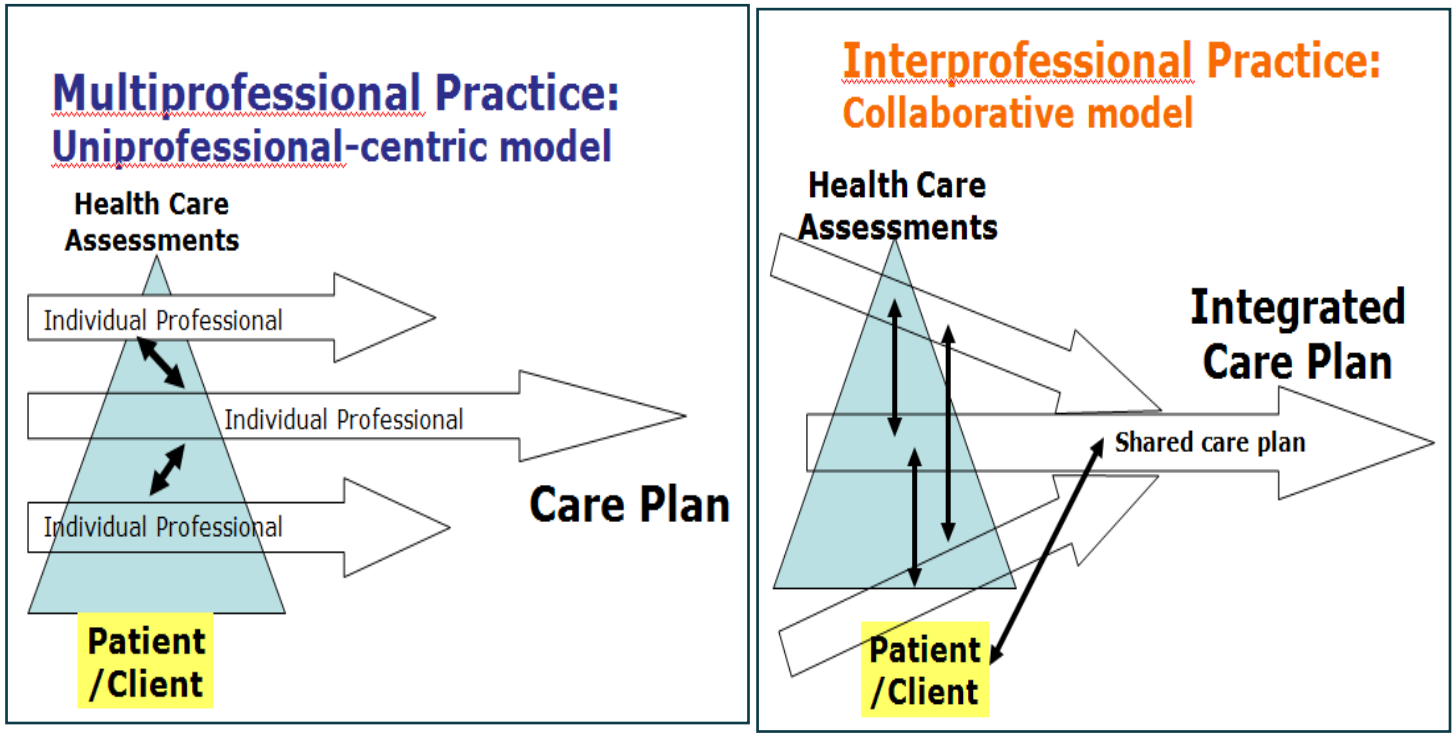
Collaborative Healthcare

- Clinical and non-clinical workers
- Regulated and non-regulated health care providers
- Cross-sectoral
- Spans across geographic boundaries

WHAT IS A TEAM ?



When one person is not enough → increasing complexity

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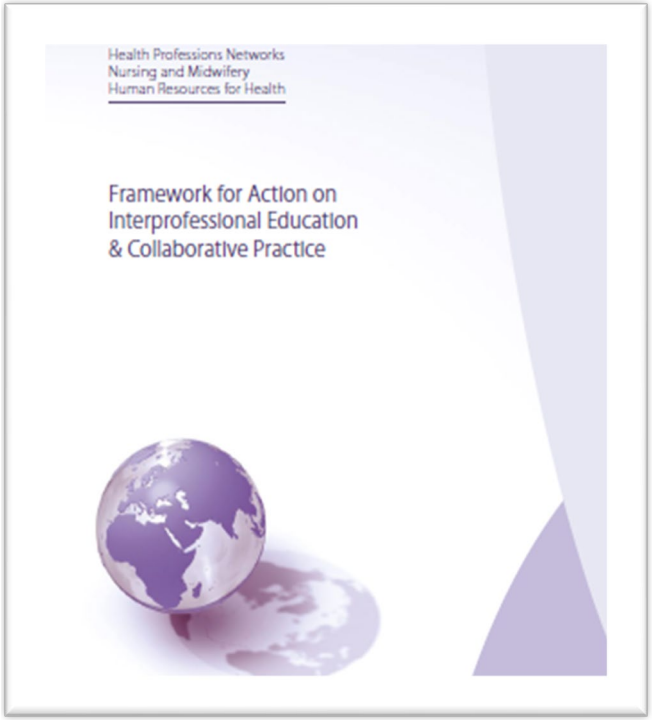
Interprofessional & Collaborative Practice:

IPC can decrease:

Client
- complications in care
- length of hospital stay

Hospital
- admissions
- clinical error rates
- mortality rates

Staff / Caregiver
- tension and conflict
- turnover



https://www.who.int/hrh/resources/framework_action/en/

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Access:

Shortage of

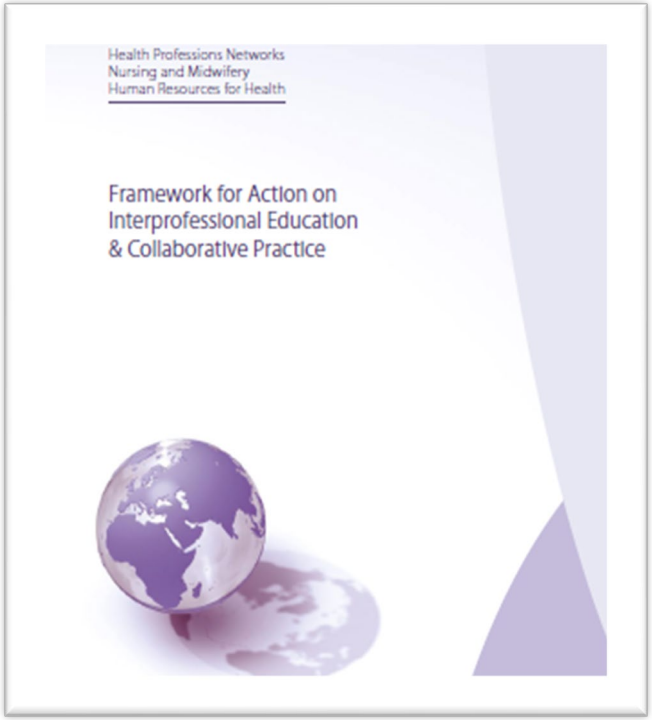
4.3 million health workers

world-wide

(WHO, 2010)

Estimated to be 10 million health workers by 2030 but not equitably across all countries

(Boniol, 2022)



Boniol M, Kunjumen T, Nair TS, et al. The global health workforce stock and distribution in 2020 and 2030: a threat to equity and 'universal' health coverage? BMJ Global Health 2022;7:e009316.

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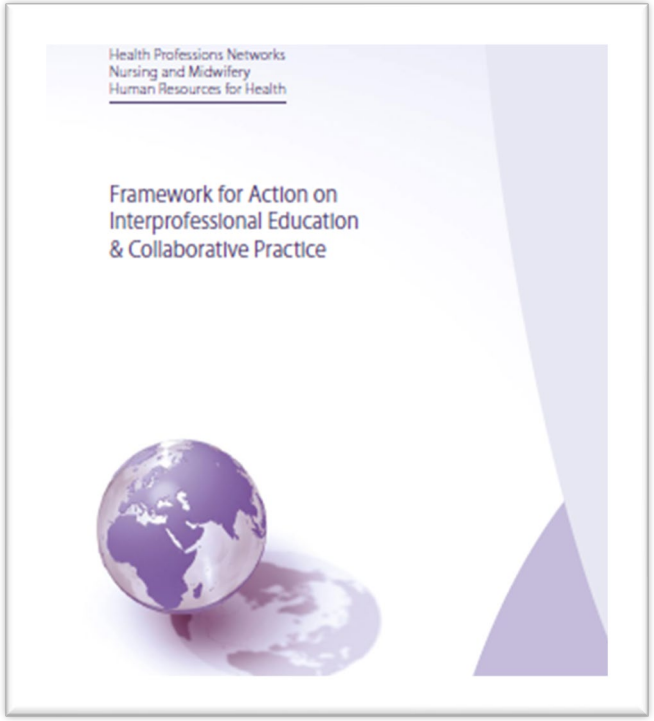
Interprofessional education occurs when two or more professions learn about, from and with each other to enable effective collaboration and improve health outcomes.

WORLD HEALTH ORGANIZATION, 2010



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IPE Student Outcomes from Literature Reviews

IPE enhances:

- Attitudes toward collaboration (Dyess et al., 2019)
- Collaborative behaviours (Spaulding et al., 2019)
- Interprofessional identity formation (Wood et al., 2022)
- Dialogue across perspectives, which shifts how professionals communicate (Boyd et al., 2022)
- Workplace-based interprofessional learning may improve morbidity and mortality outcomes (Webster et al., 2023)

IPE Value Proposition, CACHE, 2025

Accreditation Principles for IPE:

- Overarching direction for the development of accreditation standards that incorporate IPE.
- Provides links to resources that assist education programs to make curricular changes in support of the IPE standards.

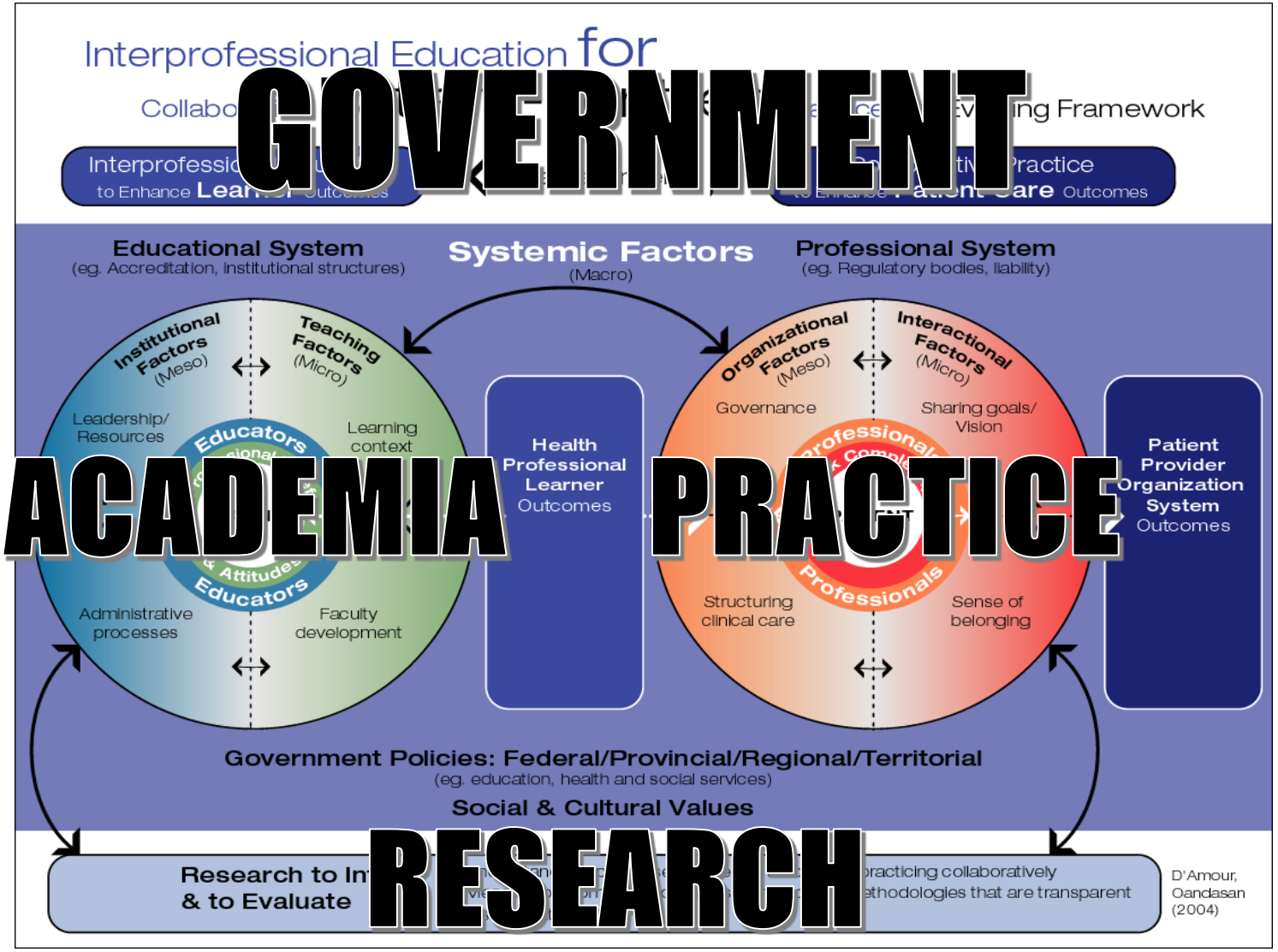
https://hpacprod.wpengine.com/wp-content/uploads/2019/02/HPACGuidance02-01-19.pdf

ACCREDITATION CANADA –
INTEGRATED CARE ACROSS TEAMS AND SECTORS

- Whereas traditional health care was designed to be disease-focused and centred on hospitals, with integrated care, we are forging partnerships throughout health and social services sectors to address all aspects of health and well-being, including the social determinants of health.

- We will also be working with system leaders around the world who are advancing integrated care, providing them with new evidence-based tools and resources that help them move forward along the integrated care journey.

https://accreditation.ca/news/whats-ahead-for-quality-in-2024/


Interprofessional Education for
Collabo
ing Framework
Interprofessio
to Enhance Lear
Practice
Outcomes
GOVERNMENT
Educational System
(eg. Accreditation, institutional structures)
Systemic Factors
(Macro)
Professional System
(eg. Regulatory bodies, liability)
Institutional Factors (Meso)
Teaching Factors (Micro)
Leadership/ Resources
Learning context
Educators
Administrative processes
Faculty development
ACADEMIA
Health Professional Learner Outcomes
Organizational Factors (Meso)
Interactional Factors (Micro)
Governance
Sharing goals/ Vision
Professionals
Structuring clinical care
Sense of belonging
PRACTICE
Patient Provider Organization System Outcomes
Government Policies: Federal/Provincial/Regional/Territorial
(eg. education, health and social services)
Social & Cultural Values
Research to In
& to Evaluate
practicing collaboratively
ethodologies that are transparent
RESEARCH
D'Amour, Oandasan (2004)

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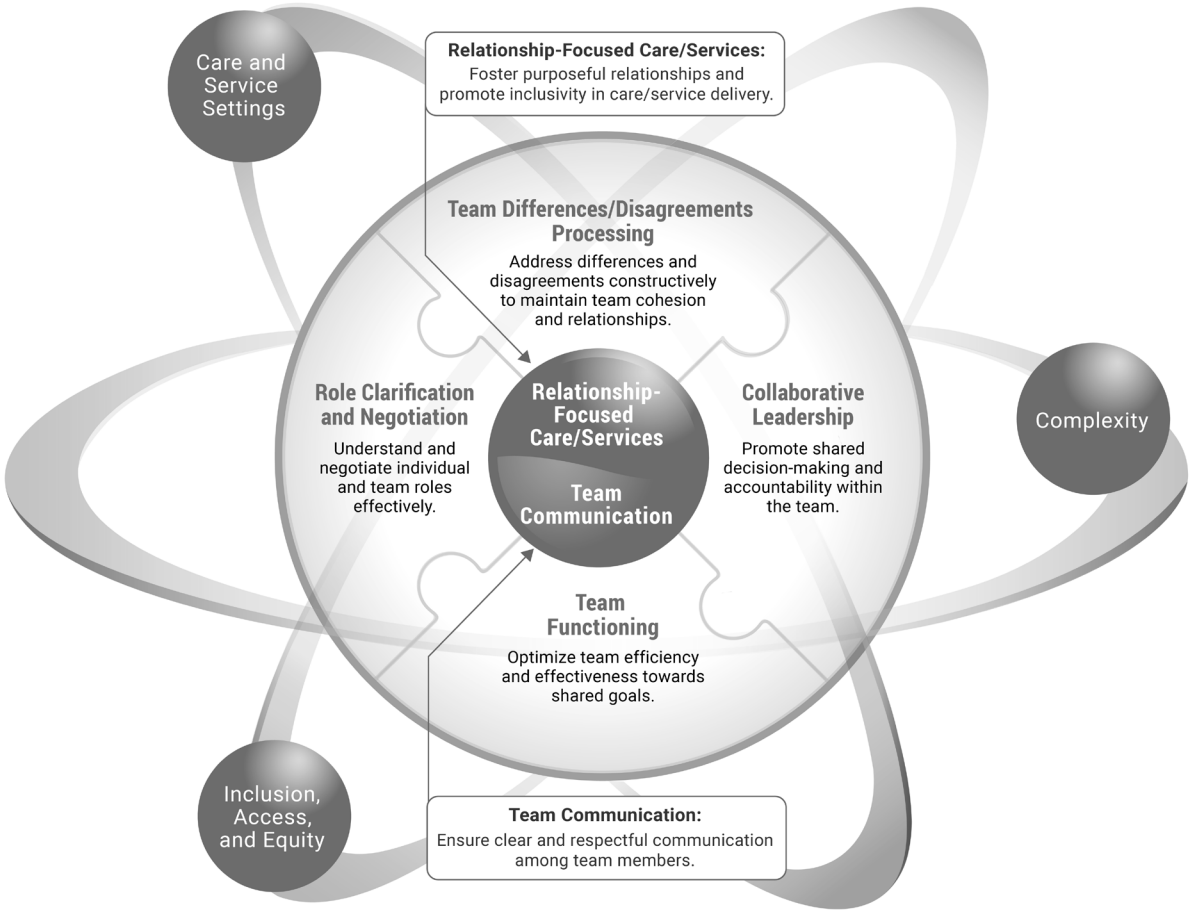
Practice and/or Education Example:
Lindsay Herzog

CIHC Competency Framework for Advancing Collaboration 2024



- **Role Clarification & Negotiation**
- **Team Communication**
- **Team Differences/ Disagreements Processing**
- **Team Functioning**
- **Collaborative Leadership**
- **Relationship-Focused Care/Services**

https://cihc-cpis.com

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IPEC CORE COMPETENCIES FOR INTERPROFESSIONAL COLLABORATIVE PRACTICE (2023)

FIGURE 7. IPEC CORE COMPETENCIES FOR INTERPROFESSIONAL COLLABORATIVE PRACTICE: VERSION 3 (2023)

- **Values and Ethics**

  Work with **team** members to maintain a climate of shared values, ethical conduct, and mutual respect.

- **Roles and Responsibilities**

  Use the knowledge of one's own role and **team** members' expertise to address individual and population **health outcomes**.

- **Communication**

  Communicate in a responsive, responsible, respectful, and compassionate manner with **team** members.

- **Teams and Teamwork**

  Apply values and principles of the science of teamwork to adapt one's own role in a variety of **team** settings.

https://www.ipecollaborative.org/2021-2023-core-competencies-revision

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CURTIN INTERPROFESSIONAL COMPETENCY FRAMEWORK

THE FRAMEWORK

The framework has three core elements:

- Client centred service
- Client safety and quality
- Collaborative practice

The core elements are underpinned by five collaborative practice capabilities represented in Figure 1.

These capabilities, which interact with each other to achieve the three core elements, consist of:

1. Communication
2. Team function
3. Role clarification
4. Conflict resolution
5. Reflection

The levels described equate approximately with the following:-

Figure 1.
Curtin Interprofessional Capability Framework (Brewer & Jones, 2010)

1	The novice student at the completion of the first year of an undergraduate degree.
2	The intermediate student at the end of the second or third year of an undergraduate degree or at the completion of the first year of a graduate entry masters degree.
3	The entry to practice level student at the end of the final year of an undergraduate or entry level masters degree.

https://farnsworth.curtin.edu.au/wp-content/uploads/sites/6/2017/11/interprofessional_A5_broch_1-29072015.pdf

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VIDEO SIMULATION

Team Huddle

Large Group Discussion:
What competencies do you see present in this video ?

THROUGHOUT YOUR EHPIC JOURNEY, YOU WILL EXPERIENCE:

- A weaving of competencies
- Emergent design
- Critical reflection and dialogue
- Simulation
- Assessment and Evaluation

BREAK

CIHC COMPETENCY:
ROLE CLARIFICATION & NEGOTIATION

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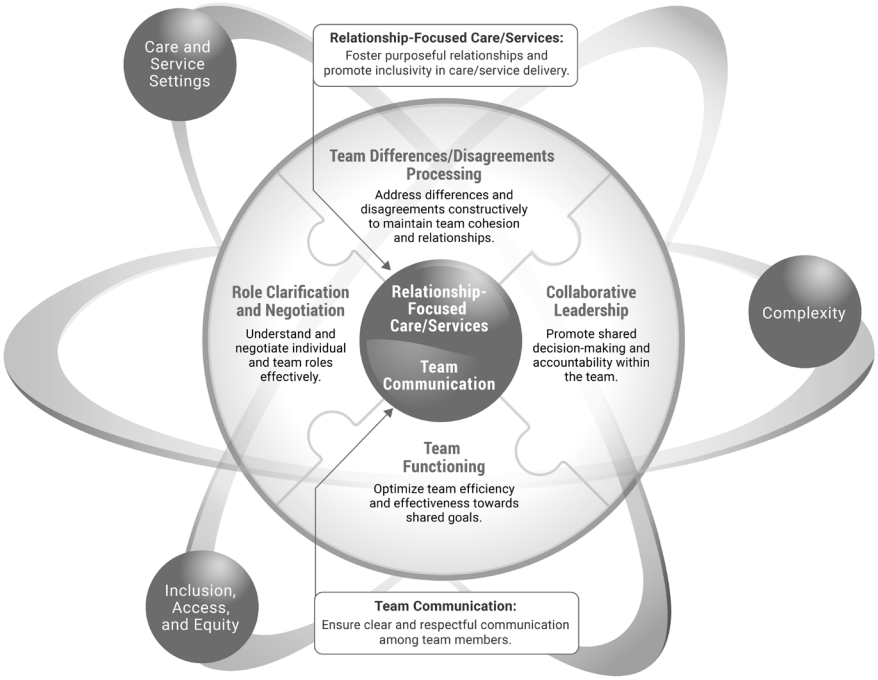
CIHC Competency Framework for Advancing Collaboration 2024



Role Clarification & Negotiation

All members of a team understand and negotiate their own role and the roles of all, and use their knowledge, skills, expertise, and values appropriately to establish and achieve collaborative relationship-focused care/services.

https://cihc-cpis.com

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Let's break down Role Clarification and Negotiation

Consider....

- Role Understanding
- Role Blurring
- Role Negotiation & Optimization

Role Understanding

Without knowledge of each others' roles and considering what others CAN DO, it is difficult for health care team members to develop respect, appreciation, and a willingness to work with one another.

ROLE UNDERSTANDING

Role clarity leads to better utilization of individual health care workers, improved communication, reduced error, and enhanced delivery of patient care.

Meuser, J., Bean, T., Goldman, J., Reeves, S. (2006). Family Health Teams: A New Canadian Interprofessional Initiative. Journal of Interprofessional Care, 20(4): 436-438.

“We may look in the same direction, even at the ‘same lines,’ and not see what our colleague sees.”

McKee, 2023

A SOCIOLOGICAL TAKE ON POWER

Rather than having power, or being at the top of the pyramid, or sharing power...

What if power operates on all of us, as a force, in all our relationships.

Here, power operates as a system. “Power relations.”

In these systems, we inhabit “subject positions.”

These “subject positions” dictate what we can say and not say, do and not do, how we see others, and how we are seen.

We are usually unaware of all of the above, unless we **critically reflect.** See the discourse, gain agency within the system. Maybe even change the discourse, and change the power relations.

Critical reflection adds a layer to reflection: questioning assumptions, challenging unhelpful power relations, toward social change.

Brookfield; Kemmis; Ng et al., 2015; 2017, 2019, 2020, etc.

Critical Reflection on our own ways of knowing

What assumptions am I making?

Where did I learn these values?

What values orient me?

How might someone whose role is different than mine look at this?

Why do I feel threatened when I am challenged on this issue?

"...quite literally, two opposing disciplinarians can look at the same thing and not see the same thing....."

PETRIE, H.G. (1976). DO YOU SEE WHAT I SEE? THE EPISTEMOLOGY OF INTERDISCIPLINARY INQUIRY? JOURNAL OF AESTHETIC EDUCATION, 10, 29-43.

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Interprofessional 'Quick Draw'

1. Choose a health profession at your table.

2. Draw this health professional in a creative way without using letters (you have 1 minute).

3. Guess the health professional – large group discussion.

Role Blurring and Overlap

- Professional turf wars emerge as conflicts between professionals with overlapping scopes of practices (Carpenter & Dickinson, 2008; Chung et al., 2012).
- In these turf wars, professionals consider interprofessional practice a threat to their own professional identity, and therefore resist collaboration (Wakefield et al., 2006).
- Lingard et al. (2002) noted uniprofessional training can result in the practitioner having narrow or distorted understandings of roles, skills and cultures of other professions

Uniprofessional Role Socialization

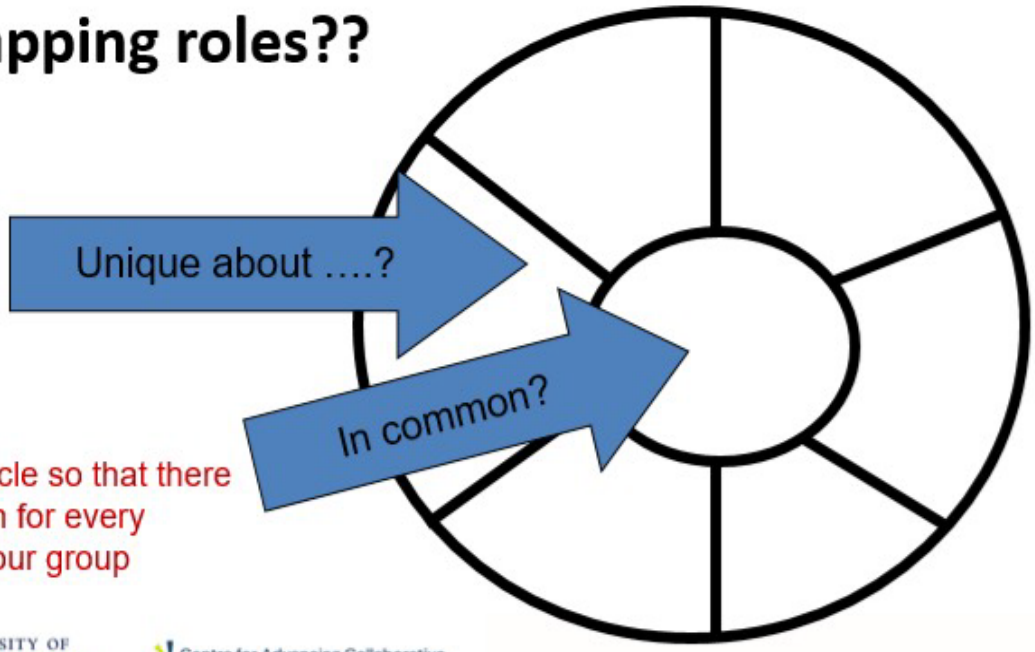
- Profession-specific socialization is rooted in the concept of professionalism where each health care professional is positioned in competition with others to improve their profession's social status (Cameron, 2011; Hind et al., 2003).
- Each health care profession creates their own silos with common experiences, norms, language and culture (Hall, 2005).
- In this individualist discourse, learners are socialized in isolation from those in other related professions to ensure the development of an in-group silo'd uniprofessional identity (Khalili et al., 2013).

Uniprofessional to Interprofessional Role Identity

- Interprofessional group identity was proposed in place of uniprofessional identity and to form a new in-group in learner identity.
- Pettigrew (1998) describes this as the merging of in- and out-groups in the formation of a new unified professional group.
- Khalili (2013) suggests three stages to accomplish this through a collaborative climate of respect and trust: 1) breaking down barriers, 2) role learning and 3) interprofessional identity development.

Activity: The Wheel

What is unique about your role? Where is the common ground? How do we negotiate our overlapping roles??



Divide the circle so that there is one section for every member of your group

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Centre for Advancing Collaborative Healthcare & Education (CACHE)

Role Negotiation:

Which health care professionals are designated to do this in the workplace context? (Who **is** doing it?)

Who has legislated scope? (Who **could** do it?)

Who is competent now (or could be) to provide to clients/patients/families ? (Who **can** do it?)

ROLE NEGOTIATION AND OPTIMIZATION:
WHO IS DOING IT? WHO COULD DO IT? WHO CAN DO IT?

Tasks	Medical Office Assistant (MOA)	Notes
Greeting and Way Finding	Best Suited	
Check In Patients	Best Suited	
Pre-Visit Vitals	Best Suited	
Rooming	Best Suited	
Administer Medications	Not In Scope	
Administer Vaccines	Not In Scope	
Wound/Foot Care	Not In Scope	
Triage Presenting Concerns	In Scope	
Perform Diagnostic Assessment	Not In Scope	
Send/Track/Complete Referrals	Best Suited	
Health System Navigation	Best Suited	
Justce System Navigation	Not In Scope	
Healthy Lifestyle Councelling	Not In Scope	
Answering Phone Calls	Best Suited	
Booking Appointments	Best Suited	
Triaging Waitlist	In Scope	[Name] handles this
Initiating Intakes from Waitlist	Best Suited	
Mental Health Assessment	Not In Scope	
Mental Health Therapy	Not In Scope	
Crisis Support	In Scope	MHC or Peer Support
Provide Basic Needs Support	In Scope	
Housing Support	Not In Scope	[Name] handles this

Practice/Education Example:
Darlene Hubley

Case:

Weaving the CIHC Competencies Together

The *ehpic IPE Case* is an IPE activity that can optimize opportunities for interprofessional learning and weave each of the competency domains together. The person in the case study is Dora Chung, a 56 year old woman who is living with Type 2 Diabetes and with knee pain.

This six-part client case study could be integrated into curriculum and simulations.

Case Example:

Activity 1: The Professions and Weaving in Role Clarification and Negotiation

- Articulate the profession/discipline you are representing. Discuss with the rest of your small group and list the health disciplines represented in your group:
- Start to create a collective scenario that brings together multiple health care professionals interacting with Dora. Now identify one critical piece of information that *each* profession must exchange, discuss and negotiate with one other health care professional on the team to ensure quality patient care is provided.

Small Group Activity:

How are **you** applying the Role Clarification and Negotiation competency in your work?

Role Clarity and Negotiation

Key Summary and Takeaways

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Understanding and Optimizing Role Clarification. . .

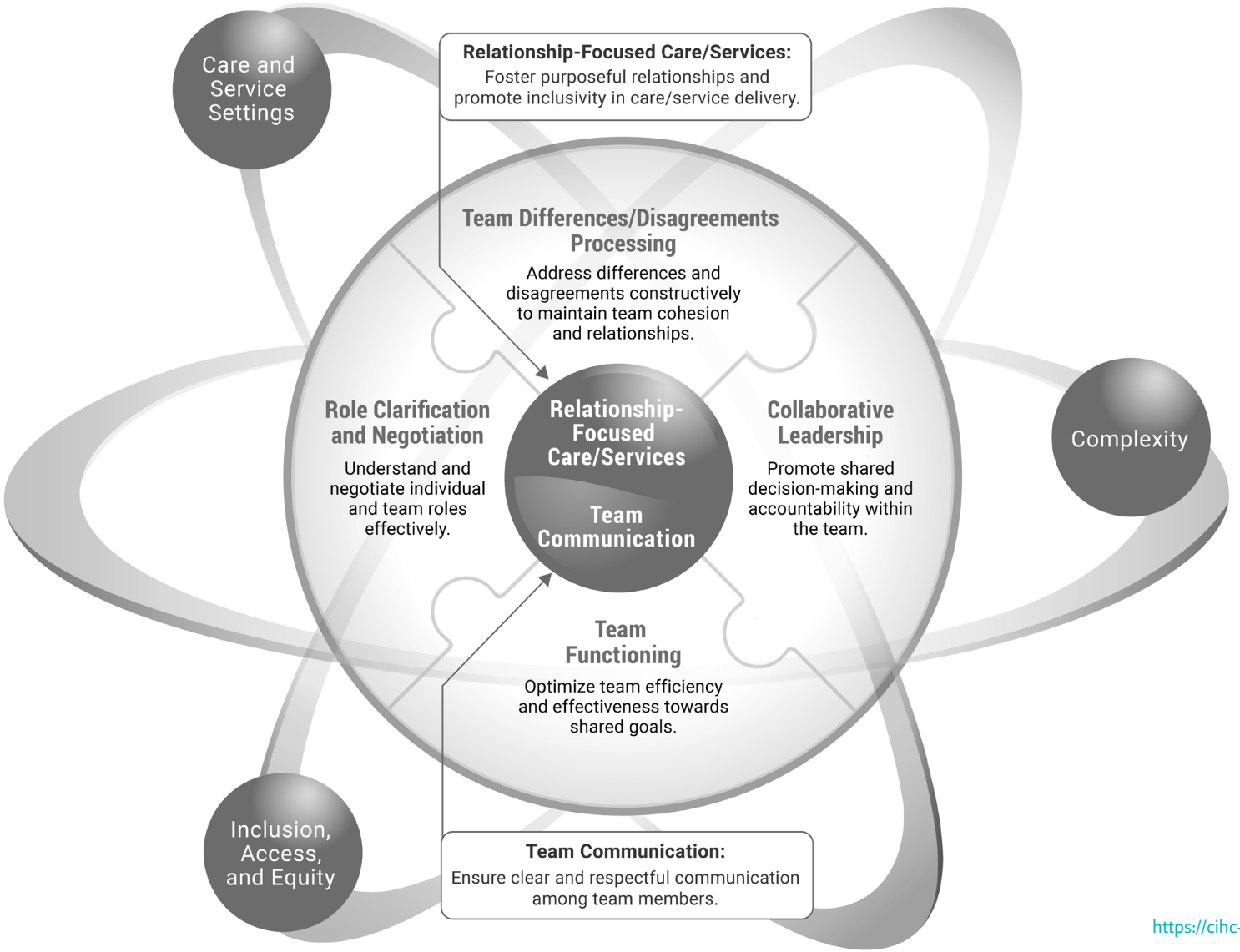
Health care professionals need to:

- ✓ take the time to clarify roles and responsibilities
- ✓ openly express their ideas and feelings
- ✓ this builds respect and value for different roles and their capabilities
- ✓ promotes sharing of knowledge to enhance joint decision making

LUNCH

CIHC COMPETENCY:
TEAM COMMUNICATION

CIHC Competency Framework for Advancing Collaboration 2024



https://cihc-cpis.com

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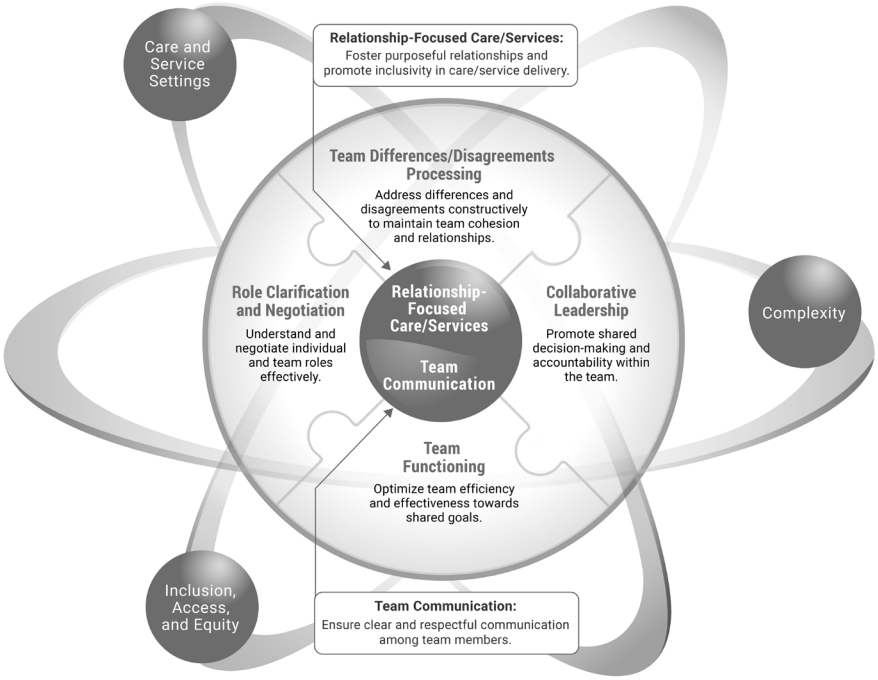
CIHC Competency Framework for Advancing Collaboration 2024



Team Communication

All communicate with each other in a collaborative, responsive and respectful manner while paying attention to content and relational elements of communication.

https://cihc-cpis.com

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Communication Think-Pair-Share

From your work, think of an example when communication went well or not well.

What influences from the team enabled or derailed the communication?

Due to the **fluidity** of membership of teams AND because of the lack of **co-location** of health professionals in many settings…

defining the **"Team"**
and determining **Who** to engage
in **Teamwork** can be challenging

Quality and Collaboration

Crossing the Quality Chasm envisions:

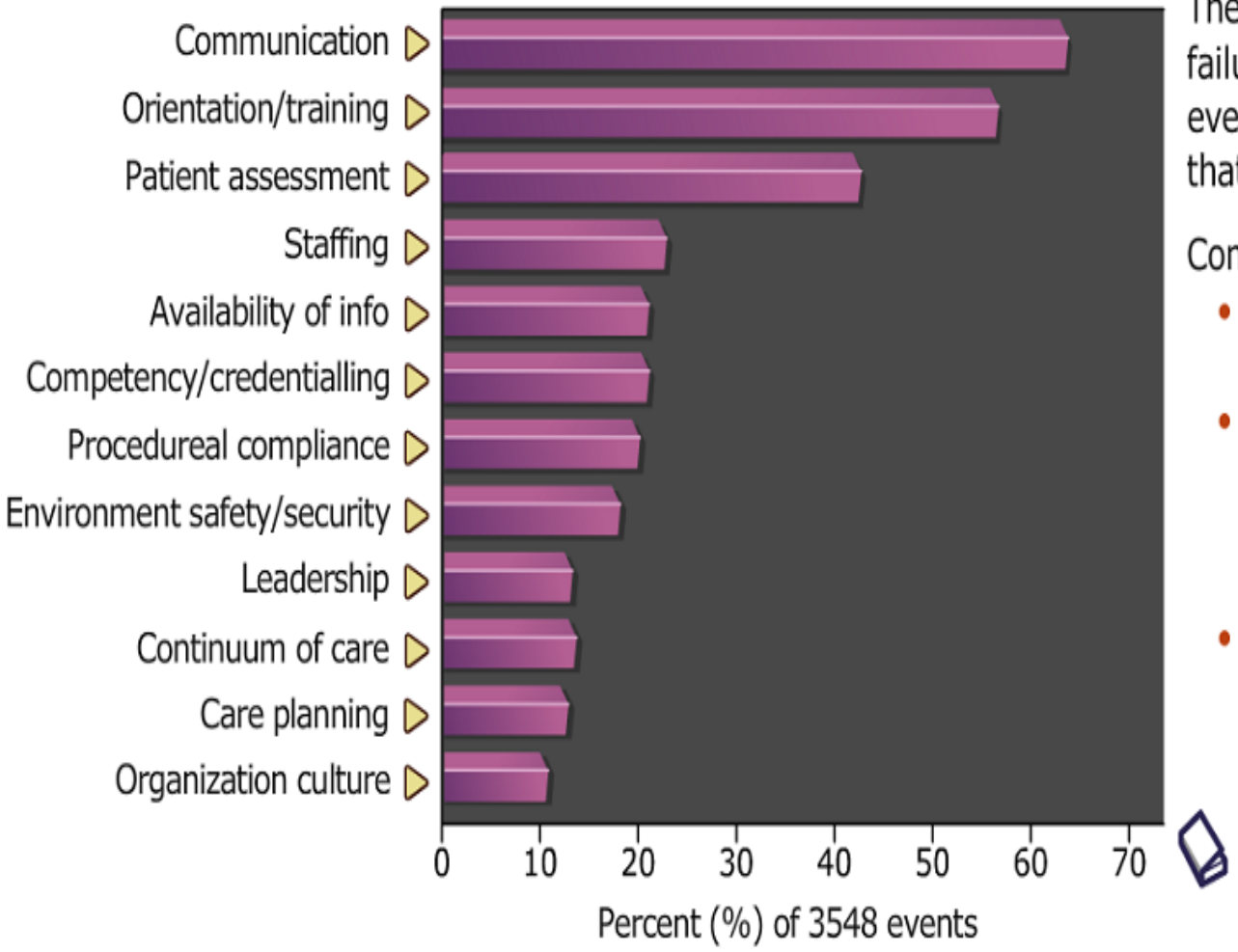
- A future where clinicians "understand the advantage of high levels of cooperation, coordination and standardization to guarantee excellence, continuity, and reliability.
- **Cooperation** in patient care is more important than professional prerogatives and roles.
- A focus on **good communication** among members of a team, using all the expertise and knowledge of team members."

Institute of Medicine, 2001

How is this possible?

2.3 Is Communication Important in Healthcare?

Root causes of sentinal events (all categories; 1995-2005)



The evidence is clear that communication failures lead to adverse events. Sentinel events are preventable adverse events that result in serious injury or death.

Communication failures were:

- The largest contributor to wrong site surgery and delays in treatment
- The second-most-common cause for medication errors, patient falls, and adverse events during and after an operation
- The third-largest contributor to restraint deaths and adverse events involving ventilated patients

What percentage of issues between professionals are due to the lack of inter-personal communication skills and not the competencies of the parties?

> “... Health care practitioners who are confident in their ability to raise crucial concerns observe better patient outcomes, work harder, are more satisfied, and are more committed to staying.”

MAXFIELD, GRENNY, MCMILLAN, PATTERSON & SWITZLER, 2005

VIDEO SIMULATION

One Less Thing

Debrief

Would you describe this as collaborative practice – why or why not?

What is the impact of this interaction on patient care?

What could have been done differently?

Communication Tools

SBAR Communication Tool

S **Situation**
Briefly describe the situation.
Give a succinct overview.

B **Background**
Briefly state pertinent history.
What got us to this point?

A **Assessment**
Summarize the facts.
What do you think is going on?

R **Recommendation**
What are you asking for?
What needs to happen next?

https://www.ihi.org/resources/tools/sbar-tool-situation-background-assessment-recommendation#downloads

Surgical Patient Safety Checklist

Table 1. Elements of the Surgical Safety Checklist.*

Sign in
Before induction of anesthesia, members of the team (at least the nurse and an anesthesia professional) orally confirm that:
The patient has verified his or her identity, the surgical site and procedure, and consent
The surgical site is marked or site marking is not applicable
The pulse oximeter is on the patient and functioning
All members of the team are aware of whether the patient has a known allergy
The patient's airway and risk of aspiration have been evaluated and appropriate equipment and assistance are available
If there is a risk of blood loss of at least 500 ml (or 7 ml/kg of body weight, in children), appropriate access and fluids are available
Time out
Before skin incision, the entire team (nurses, surgeons, anesthesia professionals, and any others participating in the care of the patient) orally:
Confirms that all team members have been introduced by name and role
Confirms the patient's identity, surgical site, and procedure
Reviews the anticipated critical events
Surgeon reviews critical and unexpected steps, operative duration, and anticipated blood loss
Anesthesia staff review concerns specific to the patient
Nursing staff review confirmation of sterility, equipment availability, and other concerns
Confirms that prophylactic antibiotics have been administered ≤60 min before incision is made or that antibiotics are not indicated
Confirms that all essential imaging results for the correct patient are displayed in the operating room
Sign out
Before the patient leaves the operating room:
Nurse reviews items aloud with the team
Name of the procedure as recorded
That the needle, sponge, and instrument counts are complete (or not applicable)
That the specimen (if any) is correctly labeled, including with the patient's name
Whether there are any issues with equipment to be addressed
The surgeon, nurse, and anesthesia professional review aloud the key concerns for the recovery and care of the patient

* The checklist is based on the first edition of the WHO Guidelines for Safe Surgery.[15] For the complete checklist, see the Supplementary Appendix.

Findings

(After checklist introduced):

The **rate of death** reduced from **1.5%** to **0.8%** (P=0.003).

Inpatient **complications** reduced from **11.0% to 7.0%** of patients (P<0.001).

Haynes, Weiser et al. NEJM (2009): 360;5: 490-499

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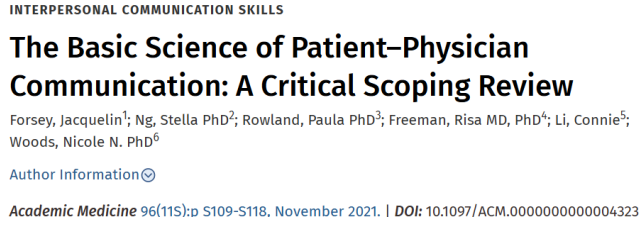
SURPASSING THE LIMITS OF TOOLS:

From “solutionism” and tools to continuous, reflective practices and adaptive expertise



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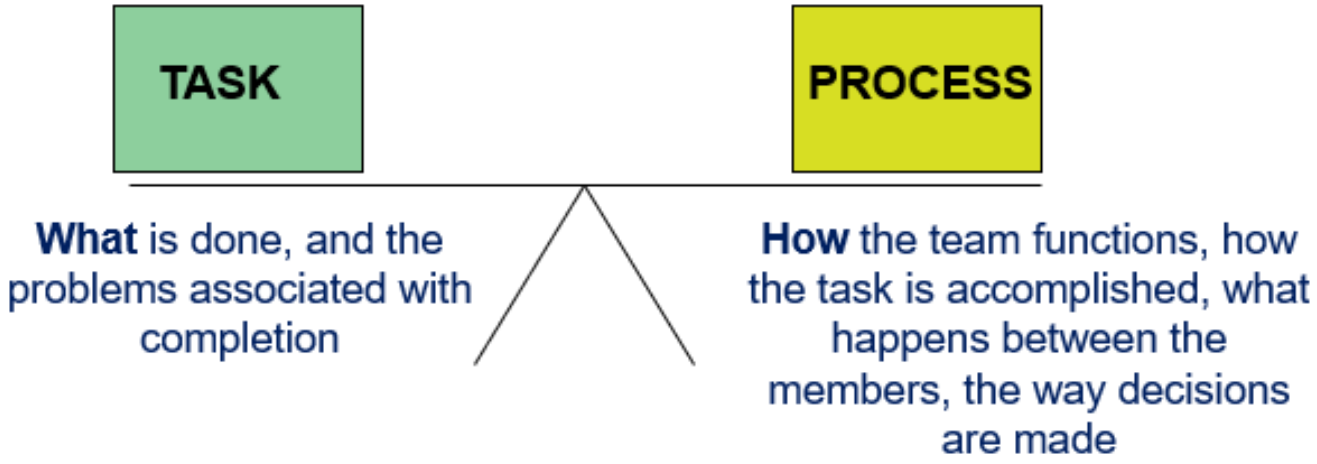
PROCESS AFFECTS OUTCOME

High performance teams require BALANCE of:



https://www.ihi.org/resources/tools/sbar-tool-situation-background-assessment-recommendation#downloads

How can you improve ?

3.4 Safety Briefings or Safety Huddle

Safety Briefings are a quick and simple method for team members to identify potential and real patient safety issues for prevention purposes.

Safety briefings are:

1. Non-punitive
2. Less than 5 minutes
3. Easy to use
4. Applicable to all patient safety issues

Similar to 'bullet rounds', safety briefings are generally organized in an intraprofessional venue. Where members of the team openly discuss safety issues they are aware of for their patients and collectively problem solve the issues and options to prevent them.

Sample Safety Briefing- comments about safety issues:

"The floor has been polished and I'm worried my patients may slip"

"There is a new resident on the floor"

"Several nurses have called in sick today"

What kind of problems are these?

Inexperience or lack of familiarity

Potential solutions?

- Orientation tour from all health disciplines
- Provide extra support to residents
- Confirm significant orders if changes are planned, with senior resident/staff

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Characteristics of Effective Teams

- Effective communication
- Use of reflection and feedback for continual improvement and growth-time set aside for this activity
- Effective work processes

Schmidt et al, 2006

Practice Example: Interprofessional Bullet Rounds

Goal: To provide accurate, concise and transparent info in a timely and consistent fashion

What was established:

- Daily at 9 AM with every member of IP team
- Max of 20 mins & only 30 seconds on each patient (longer conversations can be taken off-line)
- All staff educated on what info should be provided: look for barriers to discharge, state length of stay, summary of patient plans of care, speak to unique situations
- All info/decisions are updated on white board by noon

Practice/Education Example:
Victoria Boyd

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Case:

Activity 2: Building Team Communication and Learning into the Case

- What is Dora's main healthcare issue(s) identified by the team?
- For each of the health professionals involved in the case, articulate what their priority goal for Dora's health care would be using her/his health professional lens.
- Now using team communication with Dora and her caregiver, create a shared team goal:

How are **you** applying Team Communication competency in your work?

Team Communication

Key Summary and Takeaways

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BREAK

CIHC COMPETENCY:
TEAM DIFFERENCES/DISAGREEMENTS PROCESSING

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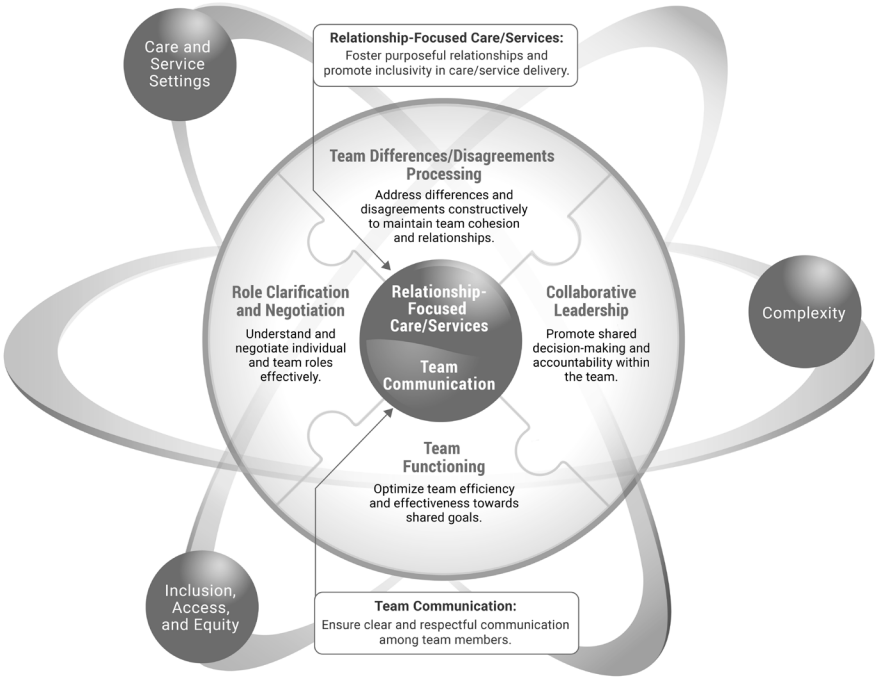
CIHC Competency Framework for Advancing Collaboration 2024



Team Differences/

Disagreements Processing

All members of a team actively engage constructively in addressing disagreements.

https://cihc-cpis.com

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Addressing Conflict... Comfort with Differing Opinions

WORKING TOGETHER

Your group is in the process of generating an activity outline adapting a uniprofessional falls prevention in-service for an interprofessional education learner group.

1. Decide who is on this committee (patients, students, faculty, clinicians, admin., funders, etc.) and decide which role each of you will play. Choose a role (perspective) that you currently don't hold.
2. ***Your Task: Create 2-3 interprofessional learning objectives***
3. One thing.... **S**

Another way to think about Conflict: Multiple Stories

In any conflict scenario there are always multiple stories at play

- "I am not being respected"
- "He/she is not willing to…"
- Our profession never gets due attention

The Ladder of Inference

I won't share information with her!

She thinks I'm incompetent

She's bored & doesn't value what I'm saying

She wants me to hurry up

Colleague Yawns

Argyris & Schon 1974,1996; Senge 1990

Conflict Modes

Source: Thomas-Kilmann Instrument

Thomas & Kilman,1974

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Conflict Mode Think/Pair

- Think about a time you had a disagreement and considering your own conflict mode/style, what would be the best approach to address the issue

Conflict mode/styles:

- Forcing/Competing
- Avoiding
- Accommodating
- Compromising
- Collaborating

Dispute Resolution

OBEFA

- **O**pen Statement – “I have a problem…”
- **B**ehaviour – When you do X …”
- **E**ffect – “ The consequences are Y…”
- **F**eelings – “This makes me feel Z…”
- **A**ction – “I would like us to resolve this problem together…”

Decision-Making Study

Classic study (Boulding, 1964):

- Groups of managers formed to solve a complex problem
- Judged in terms of quality and quantity of solutions generated
- Groups identical in size and composition
- Half included a disrupter that played the role of critic

Boulding, E. (1964). Further reflections on conflict management. In R.L. Kahn & E. Boulding (Eds.), *Power and conflict in organizations.* New York, USA: Basic Books

- Groups reassembled
- However, they were given permission to eliminate one member

Who was asked to leave the group?

Synergies of Interprofessional Education & Simulation

With slides from
Ryan Brydges PhD

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What is Simulation ?

- Simulation is the imitation or representation of one act or system by another.
- Simulation education is a bridge between classroom learning and real-life clinical experience
- Healthcare simulations can be said to have four main purposes – education, assessment, research, and health system integration in facilitating patient safety.

Society for Simulation in Healthcare

INTERPROFESSIONAL SIMULATION

Interprofessional simulation (IPS) is defined as a simulation experience where different professions collaborate using a representation of a patient care situation to achieve shared learning (Failla & Macauley, 2014).

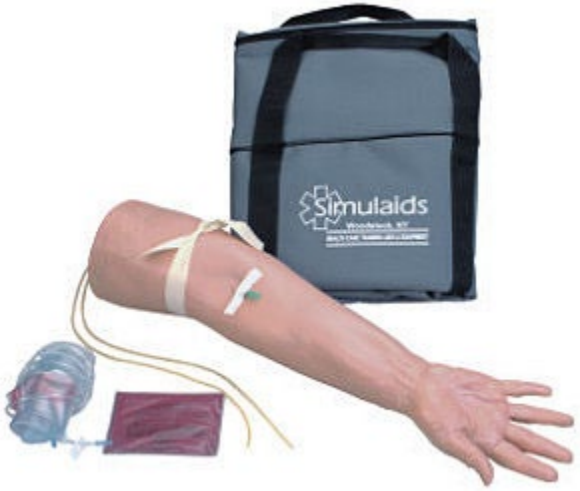
Palaganas et al., 2014

(Proposed) Sim-IPE Benefits

- Ability to practice in a safe(r) environment
- Mimics a real-life environment so HCP's might act and perform as they normally would
- Increases the opportunities to practice in a team-based environment
- Learner and faculty engagement
- Opportunity to explore team-based issues,
- e.g., historical issues of power and diversity in healthcare

Palaganas et al., 2014

Spectrum of Simulation
(slides with permission from Jennifer Macauley)



Conflict / Disagreement

- Can be beneficial
- Your decision to address
- Work with others to find common ground
- Dealing with conflict is essential to healthy relationships and better client care

Working With Multiple Stories, Positions and Interests

Principles:

- People need to be heard
- People have noble intentions somewhere within their position / interest
- There is always common ground – we just need to locate it
- It takes curiosity…asking questions

Practice/Education Example:
Dean Lising

Conflict in Interprofessional Life

Learning Objectives:

1. **Define** conflict and relevance to interprofessional teams
2. **Assess** and **reflect** on conflict styles and responses to interprofessional conflict
3. **Consider** sources and factors of interprofessional conflict that create a climate for collaboration
4. **Understand** importance of engaging and reframing conflict towards interprofessional collaborative care

PRACTICE/EDUCATION EXAMPLE: TEAM CONFLICT TOOLS

- Ask for clarification (non-judgmental)
  - Help me understand…
  - Tell me more…
  - Can you explain that a bit more?
  - What else are you thinking?
- Make an impact statement (how you are affected)
  - What I'm thinking…
  - I'm concerned that…
  - I've been considering…
- Generate solutions (win/win)
  - Would you be open to…
  - Could we consider…
  - What can we do about this?
  - What about…
  - I wonder if there is a way…

Adapted from Greene & Ablon, 2006 & Hospital for Sick Children, Cultural Competence Workshop, 2013

Case:

- **Activity 3: Processing Team Differences/Disagreements**

- Collaborative healthcare is strongly needed when the patient's care is complex. Examine your case and see if you have built in some complexity into the patient's care. (For example – the patient is unable to pay for her medications or the patient's husband is ill and she is suffering caregiver distress – or you find out the patient does not speak the language.)

- This "IP catalyst" provides the critical lever that must be addressed by the team if best care is to be provided. It ensures that the team can process any team differences/disagreements. Identify at least one critical IP catalyst for this case:

Small Group:
How are **you** applying
Team Disagreements
Processing competency
in your work?

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Team Differences/Disagreements Processing

Key Summary and Takeaways

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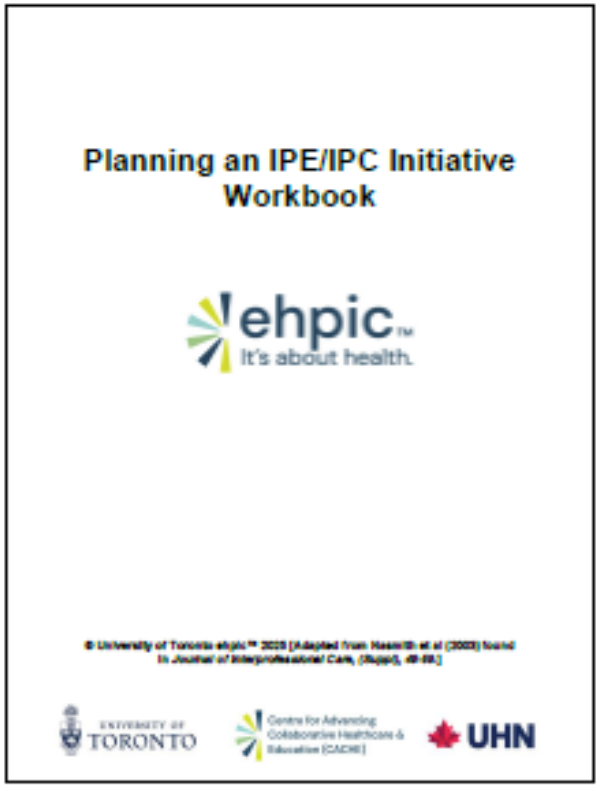
INITIATIVE/PROJECT WORK TIME



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Today's Agenda:

1. Welcome and Introductions
2. Background and Context of Collaborative Healthcare and Education

Break

3. CIHC COMPETENCY: Role Clarity and Negotiation

Lunch

4. CIHC COMPETENCY: Team Communication & Collaboration
   - Quality Improvement and Patient Safety

Break

5. CIHC COMPETENCY: Team Differences & Disagreements Processing
6. Initiative/Project Work Time
7. Reflection and Daily Evaluation

TOOLS & RESOURCES

- IPE/ICP Competency Framework
- Interprofessional Icebreakers
- Video Clips
  - Team Huddle
  - One Less Thing
- Interprofessional “Quick Draw’
- Wheel of Role Clarification & Negotiation Activity
- Communication Tools
- Ladder of Inference
- Conflict Modes
- Project/Initiative Workbook