IPC Competencies in the North American Health Care Sector

Advancing Theory and Evaluation Approaches

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Simon Kitto, PhD
Director of Research, CPD, University of Ottawa
Associate Professor, Department of Innovation in Medical Education

Objectives of presentation

1. Provide overview of IPC competency frameworks
   - Physician-specific
   - Interprofessional
   - Evaluation tools
2. Discuss the limitations of existing frameworks & evaluation tools
3. Use a competency framework to evaluate interprofessional competencies and/or collaboration

Definitions

- **Interprofessional Collaboration**: "Interprofessional work that involves different health and social care professions who regularly come together to solve problems or provide services." (Reeves et al., 2008)
- **IP Competencies in health care**- Integration of knowledge, attitudes, behaviors, values and/or skills that enable effective inter-professional work (IPEC, 2011)

The North American Context

How IP competencies have been conceptualized in Canada & the United States

Physician – Specific Framework: CanMEDS (2015)

ROYAL COLLEGE OF PHYSICIANS AND SURGEONS OF CANADA / COLLÈGE ROYAL DES MÉDECINS ET CHIRURGIENS DU CANADA | CanMEDS

Collaborator Role

- Participate effectively and appropriately in an IP team
- Effectively work with other providers to prevent, negotiate and resolve IP conflict

National Interprofessional Competency Framework (2010)

cihcpis
Canadian Interprofessional Health Collaborative
Consortium pancanadien pour l'interprofessionnalisme en santé

- Interprofessional communication
- Patient/client/family centered care
- Role clarification
- Team functioning
- Collaborative leadership
- IP conflict resolution

Core Competencies in Collaborative Practice (2011)

IPEC Interprofessional Education Collaborative

Values and ethics

Roles & responsibilities

Interprofessional communication

Teamwork & team-based care

Limitations of existing frameworks & evaluation tools

Limitations of competency frameworks

- Focuses on individual level competencies
- No theory to explain how individual competencies will translate into effective IP collaboration in complex systems
- No attention to social factors that shape possibilities for IP:
  - Socialization and training
  - Medical dominance
  - Institutional & professional culture(s)

How are IP competencies evaluated?

- Dominant approach to measure competency through surveys using quantitative tools
- Most commonly used tools measure practitioners'
  1. **Attitude**: towards other disciplines and teamwork
  2. **Behavio**r: application of IP learnings to practice
  3. **Knowledge/skills:** about IP and collaboration

(Oandasan & Reeves, 2005; CIHC, 2009; CIHC, 2012)

Limitations of existing evaluation approaches

- Reduces complex social phenomenon to variables
- Assumption that individual IP competence = collective competence
- Behaviors, attitudes and values situated within local contexts that survey tools alone cannot capture
- Not enough to measure outcomes-we need to know the context and mechanisms behind what we observe

Need for realist approach and mixed methods

Need for a **realist approach** to evaluating IP collaboration that:

- Is theory-driven
- Unpacks Contexts, Mechanisms & Outcomes
- Asks "What works for whom, in what respects, and how? "
- Uses mixed methods

Theory of Collective Competence

Towards IP frameworks and evaluation informed by collective competence

Collective Competence

- Theory of collective competence emerges from **social learning theory**: learning is cognitive process that takes place within a social context
- **Collective competence** refers to the cultural processes of:
  1. Making collective sense of events in the workplace
  2. Developing and using a collective knowledge base
  3. Developing a sense of interdependency (Boreham, 2004)

Making collective sense of events in the workplace

- Interprofessional health care teams often faced with complex and ambiguous challenges
- It is often difficult for groups to ascertain the object of activity
- In order to effectively collaborate around an issue, groups must develop a collective sense of the event and resolve contradictions
- But, in order to make collective sense of events, you need a shared knowledge base.

(Boreham, 2004)

Developing and using a shared knowledge base

- The ability of organizations to make collective sense of events depends on capacity to develop and maintain a collective knowledge base that is more enduring than individual knowledge
- Organizations possess collective knowledge above and beyond individual knowledge
- With an enduring collective knowledge base, the knowledge of a group does not disappear when an individual leaves or retires

(Lyles and Schwenck, 1992; Von Krogh et al., 1996)

Developing a sense of interdependency

- Health care organizations are composed of sub-systems and cultures
- What is rational to one sub-system may not align with group goals
- A sense of interdependency is required to overcome fragmenting tendencies of sub-systems
- Interdependency not static, contingent on circumstances and context (ex. crisis)

(Schien, 1992; Boreham, 2004)

What happens when you don't have collective competence?

The example of rapid response systems

Kitto, S, Marshall, S, McMillan, S, Grant, R, Shearer, B, Finnigan, M, Hoggins, T & Buist, M (2014), Activation issues in the rapid response system: An analysis of professional and interprofessional socio-cultural factors, *Journal of Interprofessional Care.*

The Rapid Response System Physiological Criteria / Triggers

Airway	• Respiratory distress • Threatened airway
Breathing	• Respiratory rate >30 breaths per minute • Respiratory rate <6 breaths per minute • Oxygen saturation <90% on oxygen • Difficulty speaking
Circulation	• BP <90mm Hg despite treatment • Pulse rate >130 beats per minute
Neurology	• Decreased LOC • Fitting
Other	• Concerned • Need for treatment and prompt help

(Shearer, Marshall, Buist, et al., 2012)

Lack of collective understanding of RRS events

Professions had different knowledge bases around criteria

- Staff unable to articulate exact criteria
- Unit-specific informal criteria and protocols
- MD has authority to change criteria

Two separate knowledge systems and decision pathways

Profession	Pathway Type	Junior Staff	Senior Staff
Nursing	Hierarchical	Rarely activated the RRS without nursing consensus	Comfortable activating the RRS as a patient management tool
Medicine	Autonomous	Underuse the RRS out of concern for being perceived as competent	Felt calling a RRS took away training opportunities for junior medical staff and students.

The Effect: "Workarounds"

"If [the patient] meets the criteria and or you're not happy with the medical decision that's being made, and you'd like, in effect a second opinion … we'll call a call just to get some quick decisions made by ICU"

(Senior Nurse)

The outcome: Collective Incompetence

- Refers to the cultural processes where:
  1. There are multiple profession-based understandings of events in the workplace that drive clinical behaviour(s)
  2. There are multiple profession-based development and use of knowledge bases
  3. There is a sense of profession based intradependency

Conclusion

3 Things to consider

1. Existing competency frameworks limited by:

- Individualist approach
- Lack of theoretical framework to capture complexity of IPC

2. Need for evaluation approaches supported by

- Theory
- Explore context-outcomes-mechanisms
- Asks: What works for whom, in what respects, and how?

3. Collective competence:

- Collective competence is one promising theoretical foundation for IPC frameworks and evaluation

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Thank you!
Any questions?

Dr. Simon Kitto
skitto@uottawa.ca