HIP &E

"There's No Room for Silos." Interprofessional Education in Hospital to Home Integrated Care Programs

ORIGINAL RESEARCH

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ABSTRACT

Introduction: Interprofessional education (IPE) is critical for training health and social care providers and building workforce capacity for integrated care. This paper reports key informants' descriptions of IPE in training existing health care professionals to work in hospital to home integrated care programs in Ontario Canada.

Method: Utilizing a qualitative descriptive approach, 13 interviews were conducted with leaders of integrated care programs across the province. Data analysis employed a thematic analysis approach. Findings were interpreted through the lens of an interprofessional learning continuum model and competencies for integrated care.

Results: Formal and informal IPE within the integrated care programs can support competency development (e.g., role clarity, communication, and teamwork) for interprofessional practice within hospital to home integrated care programs. Key informants acknowledged the importance of cross sector IPE to understand patient care trajectories and provider roles more fully.

Discussion: The findings can inform future IPE programs and initiatives to enhance workforce capacity for integrated care.

IMPLICATIONS FOR EDUCATION AND PRACTICE

1. To prepare future health care providers (HCPs) to work in integrated care, it is important to include IPE and integrated care concepts/principles in formal academic training and offer student placements within established integrated care programs to facilitate learning and competencies early in their career.
2. There's no room for siloed approaches. IPE within and across health sectors can help health care providers understand the focus of the integrated care program (e.g., patient pathways, referrals) and the roles and responsibilities of various team members.
3. IPE in academic and practice settings should include content related to teamwork competencies, principles for collaborative practice, and foundations of integrated care.

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INTRODUCTION

Globally, population, health and economic trends are driving changes in the delivery of health care services. An aging population, including individuals living with more complex and comorbid health conditions, requires service and care by interprofessional health care teams. The availability of appropriate health human resources to provide the care required was at risk prior to the COVID-19 pandemic. Yet, the demand for competent, interprofessional collaborative teams to provide safe, quality health care has intensified throughout and post pandemic (Germaine et al., 2022). The World Health Organization's (2015) global strategy on people-centred and integrated health services calls for a paradigm shift in the way health services are delivered to meet the challenges faced by health systems worldwide. Hospital to home models of integrated care is one approach being implemented in Ontario, Canada.

Integrated care, as defined by the World Health Organization (WHO), is a multifarious concept due to the diverse perspectives of health care stakeholders. The integrated delivery of health services is a people-centred, upstream approach aimed to strengthen the quality of care received by individuals across the life span who have multidimensional needs thus depending on interdisciplinary coordinated care across various settings (WHO, 2016). Integrated care aims to resolve fragmentation in care provision leading to optimal care outcomes and experiences (Goodwin, 2016). Central to all models of integration is the notion of the patient/client's needs at the centre of their care with family, health and social care providers collaborating to provide comprehensive and holistic care. Integrated care teams aim to provide direct and accessible care to patients to facilitate their transition through health and social care systems.

New models of care require different models of learning, as there are limitations in current health care providers' abilities to support integrated health service delivery (Chehade et al., 2016). Education and workforce planning require knowledge and skills for team-based and person-centred models of care (Germaine et al., 2022). However, there are few examples of integrated care initiatives which invest in training the workforce to build competencies for integrated care (Stein, 2016).

The International Federation of Integrated Care (IFIC) and the WHO have identified additional competencies required by health and social care providers to specifically work in integrated care programs. Different competencies (e.g., knowledge, skills, and attitudes) are needed to manage health and care rather than disease and cure, and to work in teams across sectors (Stein, 2016). Health workforce competencies include knowledge-based acts that combine knowledge, skills and attitudes with existing resources to ensure safe quality outcomes for patients and populations (Stein, 2016). The Iceberg Model of competencies for integrated care describes both technical competencies such as skills and knowledge (e.g., health conditions) which are above the surface and directly influenced by education and training as well as behavioral competencies which are below the surface, such as attitudes individuals possess that may be indirectly influenced by education, training, and role models (Stein, 2016). The five integrated care competencies include: patient advocacy, effective communication, teamwork, people-centered care, and continuous learning (Langins and Borgermans, 2016). Behavioral and technical competencies when implemented with the aid of IPE can positively contribute to the process and delivery of integrated care. The five competencies for integrated care are similar to and expand on the six competency domains identified in the National Interprofessional Competency Framework 1) interprofessional communication 2) patient/client/family /community-centred care 3) role clarification 4) team functioning 5) collaborative leadership 6) interprofessional conflict resolution (Canadian Interprofessional Health Collaborative, 2010). Both sets of competencies are developed through interprofessional education.

Interprofessional education (IPE) is a critical strategy to prepare the health care workforce for integrated service delivery models (Bookey-Bassett et al., 2022; Stein, 2016). IPE is defined by the Centre for Advancement of Interprofessional Education (CAIPE, 2016, p. 1) as "occasions when members or students of two or more professions learn with, from and about each other to improve collaboration and the quality of care and services." While pre-licensure IPE creates motivation and enhances skills, continuing post-licensure interprofessional development can immediately improve quality of care when it is employment-based between experienced HCPs (Barr, 2012; Institute of Medicine [IOM], 2015). Findings from reviews and evaluations demonstrate that post-licensure IPE goes beyond meeting immediate learner outcomes, such as improved knowledge or attitudes to creating practice change (Barr, 2012; Bookey-Bassett et al., 2022). However, minimum consideration has been given to how the current workforce is being trained to transform care across health sectors (Fraher et al., 2013; Stein et al., 2021). Further knowledge is necessary to understand how the key components of effective continuing IPE contribute to desired learner outcomes in the integrated care context (Rogers et al., 2018).

IPE is necessary for the development of collaborative practice ready HCPs who can provide comprehensive, holistic, person-centered care (Briggs et al., 2018; D'Amour & Oandasan, 2005; Khalili et.al., 2019). While most HCPs

have had some exposure to IPE as part of their formal academic education, there is much variation in how this knowledge is carried over to the practice setting. Further, how IPE specifically supports the ongoing development of the current workforce for integrated care remains unclear. A scoping review (Bookey-Bassett et al., 2022) explored the role of IPE in training practicing health care providers for integrated health care. Analysis of the 32 articles concluded that post-licensure IPE within plays a unique and important role in training health and social care providers to work in various models of integrated care but the degree to which this occurs in practice varies (Bookey-Bassett et al., 2022). Noted barriers to implementing continuing IPE in practice settings include lack of time and resources (Owen et al., 2014). As new hospital to home models of integrated care are implemented within various contexts, it is unclear whether IPE is incorporated as part of the health care system transformation to support the development of the current workforce for integrated care. Therefore, the purpose of this study was to report key informants' descriptions of the current state of IPE in training existing HCPs to work in hospital to home integrated care programs in Ontario, Canada. Here we describe the findings related to the following three research questions:

1. How do key informants describe their respective integrated care programs and the concept of integrated care?
2. How does IPE support implementation of integrated care?
3. What are the facilitators and barriers to implementing IPE in hospital to home integrated care programs?

METHODS

A qualitative descriptive approach was utilized with the aim of producing a summary of findings that are close to the information shared (Sandelowski, 2010). Ethics approval for this study was sought at the principal investigator's university. However, it was waived given individuals would provide information in their professional capacity regarding organizational policies, procedures, and practices versus personal information.

Key informants were identified through health care organization websites and research team networks across Ontario and recruited using a purposeful sampling approach. Our research assistant contacted senior leaders in potential sites by email to identify specific individuals involved in integrated care programs within their respective organizations. Eligibility criteria included individuals holding formal leader roles within integrated care programs in their organization. Key informants were recruited from varied health care settings in leadership positions across the province. Potential key informants were emailed an invitation letter to participate in a virtual interview (via Zoom) for the study. Additional informants were identified by key informants (snowball sampling). Participation was voluntary. Recorded verbal consent was obtained from all key informants prior to commencing the interviews. Interview questions were informed by an earlier scoping review (Bookey-Bassett et al., 2022) and can be seen in Table 1 Individual or dyad interviews were conducted by members of the research team using the Zoom platform; interviews were audio-recorded and transcribed. The Zoom-produced transcripts were cleaned and checked against the audio-recording by a trained research assistant.

Data analysis began with an inductive thematic analysis approach (Braun & Clarke, 2006). All members of the research team were engaged in the data analysis process for the purpose of promoting critical dialogue given the team's diverse positions and perspectives. Inductive analysis began with all team members independently reviewing four of the transcripts and then meeting to

INTERVIEW GUIDE	
1.	Tell us about the hospital-to-home integrated care program(s) you operate in your organization? *Prompts:* Is there a specific integrated care theory/model/framework used to guide the team's practice? What pillars/or values or concepts support or inform integrated care in your organization?
2.	What is your understanding of Interprofessional Education?
3.	What IPE training do current health professionals and care team staff receive to work in integrated care?
4.	How does IPE support implementation of integrated care? Perceived benefits to staff/patients? What training of healthcare professionals supported implementation of integrated care?
5.	What are the facilitators to implementing IPE in hospital to home integrated care programs?
6.	What are the barriers to implementing IPE in hospital to home integrated care programs? For example, how has COVID-19 impacted the delivery of integrated care and provision of IPE?
7.	Is there anything else you would like to share with us about the role of IPE in integrated care?

Table 1 Interview Guide.

discuss initial impressions and key findings emerging from the data. These initial impressions were used to inform the development of a preliminary codebook, which was then used to guide the analysis of the remaining transcripts by the first three authors. Continued coding and identification of key themes were determined by SBB and SE, both experienced qualitative researchers. Team members (SBB, SE, AV) engaged with the data in meetings held over several weeks and all decisions were recorded to maintain a clear audit trail.

Deductive analysis also helped to organize the data using both theory and conceptual frameworks (Bingham, 2023). Specifically, codes and themes were created that aligned with key components of the interprofessional learning continuum model (Institute of Medicine [IOM], 2015) and specific competencies for integrated care as identified by Langins and Borgermans (2016). For example, the IOM (2015) model describes IPE as both formal and informal which occurs across a learning continuum beginning in formal academic programs and continuing into the practice setting in the form of continuing professional development (CPD) to support collaborative practice and team approaches to patient care. Both the IOM model and the integrated care competencies were also used to interpret the findings.

Strategies to increase the quality of our research included four domains of trustworthiness (Lincoln & Guba, 1985; Milne & Oberle, 2005): 1) authenticity techniques included ensuring accuracy of transcription and staying close to the participants words to reflect their perspectives; 2) transferability by offering a detailed description of the study methods and context: 3) credibility by involving a team of experienced researchers, with expertise in qualitative methods, IPE and integrated care who discussed the data using reflexive responses to emerging insights; and 4) criticality by documenting team decisions during the data analysis and coding processes.

RESULTS

KEY INFORMANTS

A total of 13 interviews with 15 key informants were conducted between November 2021 and June 2022. Eleven individual interviews and two dyad interviews were conducted. Key informants represented various disciplines including nursing (9), social work (2), business (3), physiotherapy (1), and held roles such as clinical manager, director of interprofessional practice, transitions care lead, and director of community partnerships and programs. The key informants represented 13 organizations, including 10 hospitals and three home care agencies in Ontario. The hospitals included both academic teaching and community hospitals. The organizations were located across various geographic areas of Ontario (i.e., urban and rural).

Key informants provided in-depth descriptions of their integrated care programs along with how IPE was integrated within the programs. Barriers and facilitators to implementing IPE in the hospital to home integrated care programs are also described. The findings are organized highlighting key themes addressing each of the research questions.

DESCRIPTIONS OF HOSPITAL TO HOME INTEGRATED CARE PROGRAMS

Key informants described the focus of their organization's integrated care (IC) programs in various ways. Data analysis revealed three key themes reflecting the various program descriptions: 1) serving specific patient populations using pathways and tailored approaches; 2) supporting a seamless transition of care across sectors; and 3) working as an interprofessional team. Key informants also identified the use of underlying theory or frameworks, formal and informal IPE within their IC programs.

Serving Specific Patient Populations Using Pathways and Tailored Approaches

Some key informants described their IC programs as those that focused on a particular patient population or group. Three specific patient populations were identified: patients with a specific disease or condition (e.g., cardiac disease, cancer, chronic obstructive pulmonary disease); older adults living with frailty; and patients with complex issues (e.g., patients undergoing total joint replacements such as hip or knee. While other IC programs were referred to as time-limited pathways as described by this key informant: *"Pathways are time limited…Typically there is an end date, and at times, there are patients that still require care, and then we have to transition them over to the home and community support services"* (Informant 4, hospital). In other programs, care pathways were described as "bundled care" funding models, which could be a hospital partnership with one specific home and community care provider, or a home care agency partnered with multiple hospitals driven by provincial bundled funding agreements. *"Our program is a 16-week bundle program. So, each client will get four months dedicated to them"* (Informant 8, home care).

Several IC programs specifically focused on older adults living with frailty with an emphasis on helping older adults transition from hospital back to living in their own homes. These programs were not disease specific but rather open to patients requiring multiple services in the home.

> *One is an 8-week stream for frail older adults who wish to age in place but, they have support at home, they have goals, etc., and then we provide as much upfront care and support we can, and then connect them with community services as needed etc… and the goal is independence.* (Informant 11, hospital)

Other programs were described as focusing on patients of various ages who had complex issues requiring ongoing follow-up and care in the home following hospital discharge yet were also usually time-bound (e.g., 16 weeks, 90 days). *"[We] No longer looked at individuals based on a disease type, we looked at individuals based on complexity"* (Informant 7, hospital*). "So those that were identified had the most complex care needs for up to 90 days"* (Informant 3, hospital). In addition, key informants spoke about their programs focusing on goals as identified by the individual, being person-centred, and focusing on "*enablement, seeing the person's potential not their deficits*" (Informant 7, hospital). They spoke about HCPs engaging with clients to determine what needs to happen in the home and who is the best provider to do that. "*We develop care plans based on the clients' actual needs versus a cookie-cutter approach*" (Informant 8, hospital). Key informants noted that the aim of these programs was to "*set the client and the team up for success"* (Informant 10, hospital). Patients received a written care plan about what to expect when they were discharged home such as what providers will be involved.

Supporting a Seamless Transition of Care Across Sectors

While some programs were described as integrated care based on patient needs, others discussed the notion of their IC programs as focusing on a seamless transition or flow of care from the hospital to home. As stated by one informant, *"…between the acute care sector and the home care sector so that there is a seamless transition of clients' care from their acute care journey into home care (Informant* 9, home care). Another informant provided an example of how patients in their IC program are supported during care transitions. Patients are "*sent home with a care plan and a plan that tells them who's coming in and when…so the patient leaves feeling assured that they are actually going to see someone at home*" (Informant, 2, hospital). This was noted to be different from the usual care processes.

Some described their programs as partnerships between hospitals and multiple community agencies to support smooth care transitions across sectors. In some programs multiple agencies are required as different agencies contract different professional services. As described by one informant "*we only provide the OT services, it is another organization with behavioural therapists, and another one with the speech language*." (Informant 12, home care). However, other key informants' comments reflected the aim of seamless care being provided by one service provider. *"Clients receive care from one service provider organization, instead of the traditional home and community care where you have multiple companies coming in and different people*" (Informant 11, hospital).

In some of these new programs, home care organizations connected with their clients during the hospital stay: *"We are the service provider organization as well. So, we're playing two roles and when it's one agency, one organization there is such a seamless flow of everything, and it happens in minutes as opposed to days"* (Informant 9, home care). Others further described their programs as providing care as one team across health care sectors and having one electronic health record for patients. Having a place for one patient assessment, one patient record where all team members (from hospital and home care sectors) could share information and contribute to the patient/client care plan.

> *We do have one number to call, one team, and one electronic record. The homecare team is the holder of our electronic record, …and we share our information from our coordinators that input information into [the database] prior to our patients coming on board, and then our nurses and allied health care workers document in that system.* (Informant 4, hospital)

Working as an Interprofessional Team

Another way in which key informants described their IC programs was in how HCPs worked together as an interprofessional team. Key informants explained how the program involved multiple roles as well as how they worked collaboratively as a team within and across sectors. Informants identified key providers who were part of their IC teams, generally including nurses, physiotherapists, occupational therapists, personal support workers (PSWs), nurse practitioners and physicians. *"So, there are so many people involved in the care of these patients, and we really strive to make sure everybody's on the same page so we're all giving the patients the same information."* (Informant 1, hospital).

Importantly, other providers were also identified as key to the success of the IC programs. These included the surgeons' office staff, primary care providers, hospital team members, and a coordinating role, named differently by program (i.e., integrated care coordinators, navigators, and integrated care leaders). Several key informants described the importance of including surgeons' office secretaries in

the team as patients frequently contact surgeons' offices pre and post operatively for further information.

Navigators, IC coordinators and IC leaders were vital in operationalizing the integrated care programs. For example, navigators from inside the hospital will follow the patients as they transition home. IC coordinators were involved in coordinating patient visits, organizing PSW work schedules, and liaising with families. IC leaders were described as the main liaison for home care organizations "*The IC lead is the main lead for us as homecare organizations, where we get all the information delivered from the acute care side" (Informant 9, home care).* Integrated care leads were also referred to as "transitional planners," the main contact providing information and support to patients and families in the hospital (e.g., both preoperatively and postoperatively) as noted by this informant:

> *IC leads introduce the program to clients and get their consent if they are interested to be part of the program, and how their care is going to look like when they're part of the program, once they are discharged, and when they go home.* (Informant 9, home care)

Given the diverse team composition, key informants described how team members worked collaboratively within and across health sectors. For example, one participant from a hospital IC program *noted "we work very collaboratively. "It's part of our Ontario health care team and the region" (*Informant 3, hospital). Another participant from a home care organization described how their staff collaborate with the partner hospital:

> *So, we do have something called virtual rounds in place, bi-weekly our interprofessional team collaborates with IC leads, who are the clinical leads at [Name of Partner Hospital;] so they do case reviews they go over some complex cases to have like group discussion and learnings for others who may not have been part of those cases.* (Informant 9, home care)

As collaboration across sectors was historically not routine practice, key informants shared that developing purposeful relationships with providers beyond one's own organization is important but building relationships requires time and effort:

> *For me to be able to contact that PT, OT in the hospital takes effort, takes time and may or may not be successful, they may or may not be receptive. So, the connections with other teams and other care providers as soon as they're outside of the organization, it needs to be more purposeful to make those relationships.* (Informant 12, hospital)

Another informant noted that the program would not work without everyone working and learning together to problem-solve and provide patient care. As described "*One of the things that is super important for this program to work, and this model provides, is you can't be siloed. There's no room for silos, you just can't possibly do it.*" (Informant 11, home care).

GUIDING THEORY OR FRAMEWORKS FOR INTEGRATED CARE

Key informants were asked whether a specific integrated care theory/model/framework was used to guide their team's practice or inform the design of the program. Most informants did not identify any specific guiding theories or frameworks for integrated care but noted teamwork competencies that were relevant:

> *We didn't use any framework to tell you the truth, I know you want to make sure about role clarity and ethical decision-making and the healthy team functions kind of thing and we use bits and pieces from all of that. But it really was just a learning curve for myself ….before we just kind of figured out this is what we need to do.* (Informant 1, hospital)

Some informants indicated that the IC program aligned with the organization's mission and values for patient-centred care, value-based care, clinical efficiency, and a shared vision among leaders and staff. Others identified underlying key concepts/elements within existing integrated care frameworks such as the IFIC pillars e.g., person-centred, holistic approaches to care; working as a team and creating an environment to problem-solve together. As stated by one home care informant, "*Our objective is not just to finish the task, it's to do that full circle holistic lens of that patient…I might be here for a [wound care] dressing but what other needs does my client have?*" (Informant 4, hospital).

CURRENT IPE IN INTEGRATED CARE PROGRAMS

Key informants were asked about what forms of IPE training was provided to work in their IC programs. Informants described both formal and informal IPE strategies. Formal IPE included opportunities for planned learning activities involving two or more disciplines. The most common formal IPE occurred as part of staff orientation/onboarding to the IC program within the organization.

> *We do a lot of IPE here at [Organization]when we onboard new staff. Everybody that's getting hired into the hospital does it together at the same time, once a month… This is a great opportunity for them to meet each other, collaborate, and just learn the overall things that everybody has to know. It makes sense to put it together and teach everybody, the same time right.* (Informant 2, hospital)

A home care informant also noted the importance of IPE during orientation:

> *So, the training is part of the orientation it's embedded. We combine all the disciplines in the orientation for transitions, it's not the usual traditional LHIN [Local Health Integration Network (legacy home care structure)] training, where the nurses are in one group, the rehab go another day and so forth, all disciplines are combined in our onboarding."* (Informant 8, home care)

Formal IPE during staff orientation also included content and information about the hospital to home IC program such as the patient population and eligibility, care pathways, specific agencies involved and generally *"what the program was about and how referrals were going to work"* (Informant 2, hospital). Discussion about different team members' roles during orientation was viewed as important to understand how all team members would contribute to each patient's plan of care.

> *When this program was launched to talk to people about people's roles and what each person contributes from the identification of who would be appropriate for the program, to speaking with a client and family as appropriate, and to developing that initial plan of care.* (Informant 11, hospital)

Informants indicated IPE primarily occurred within the context of staff orientation at the organizational level (i.e., either in the hospital or the home care agency). Few programs engaged the interprofessional teams in cross-sector training: "*but if you were to ask me, did we bring the team members from across the sectors together for shared interprofessional learning- we actually didn't do that"* (Informant 3, hospital). However, as these IC programs are developing, some informants noted their programs were considering cross-sectoral education in the future: *"been looking at doing that, the next step is really looking at formal training curriculum around supporting home care and acute care coming together."* (Informant 10, hospital). In addition, several informants indicated the benefit IPE cross sector learning opportunities for both existing HCPs and students. "*I think that's a really, interesting opportunity, especially when they go out with other team members, and see how other team members work because they're not necessarily in the home together, sometimes they are, but more often they're not*" (Informant 11, home care).

Key informants also provided examples of informal IPE within the context of daily practice such as learning that occurred indirectly through team processes such as huddles, regular meetings, and interprofessional team rounds.

> *We build that into how we work and enable teams. So, within our own programs…teams do rounds. So as part of the rounds you're discussing, you're hearing, learning, and understanding because you have representation from a lot of different disciplines. We have, purposely structured quarterly in person events, by teams to have everyone from across the integrated care team come together, participate in specific education…* (Informant 4, hospital)

Other key informants referred to how "storytelling" was used within their team discussions to support learning with and from one another and share information regarding patient progress or challenges from different disciplinary perspectives.

> *Having the speech paths [pathologists] meet the OTs [occupational therapists], the physios [physiotherapists] - that has enriched the conversations because we always make time for ethical scenarios and clinical sharing, content sharing. Has anybody got a case they'd like to talk about and get their input, and it has been amazing to just kind of shuffle the mix.* (Informant 12, hospital)

IPE Supporting Competencies for Integrated Care

Informants identified specific competencies (knowledge, skills, and attitudes) that were considered valuable to work within their integrated care programs. For example, informants emphasized role clarity as a competency. The need for HCPs to understand both hospital and home care roles was noted to be important for successful integrated care. IPE afforded an opportunity to define roles and develop the team member's skills:

> *One of our pathways, we brought in our ostomy nurse from the hospital because this was going to be a new need and requirement ongoing, and so we had a planning meeting, we had homecare nurses our integrated care coordinator, nurses, the ostomy*

> *nurse, the wound care specialist and leaders that were developing all working together. So that we had an understanding of what's your role? What do you see your role out in the community? And how is that different, the same, so that we're not overlapping?* (Informant 4, hospital)

Another informant noted the need for ongoing knowledge "*…there is a lot of growth that needs to happen, a lot of learning, a lot of facilitated conversations because we don't really understand what each other can do and bring to the table.*" (Informant 12, hospital). In addition to being clear of everyone's role, having "the basics" of what an OT or a RN does, key informants noted the importance of teamwork competencies. For example, knowing how to work with others, being able to develop trusting relationships with team members. One informant described the need for more team training. "*The team would benefit from some professional facilitation and learning how to work together as a team*" (Informant 12, hospital). Skills such as team communication for the purposes of shared goal setting and developing a shared client service plan were recognized as being important for integrated care. Communication between hospital and home teams was seen as important to "*make sure we're all on the same page*" (Informant 2, hospital) and so that "*patients aren't having to repeat themselves*" (Informant 10, hospital).

Specific attitudes were viewed as important for working in the IC programs. These included having a positive attitude towards ongoing learning "*it's really important for continuing education and continuous learning, lifelong learning, because there's always new stuff to learn out there.*" (Informant 1, hospital). Others noted the need for health care professionals to be "*adaptable, things may change, quick learners and people who could be leaders*" (Informant 9, home care). Another important attitude identified was the belief in wholistic or person-centred approaches to care. "*A more comprehensive view into the patient; identifying what other pieces are required for holistic care.*" (Informant 10, hospital).

FACILITATORS TO IMPLEMENTING IPE IN ONTARIO HOSPITAL TO HOME INTEGRATED CARE PROGRAMS

Key informants referred to three key facilitators to implementing IPE in their IC programs: 1) using multiple diverse and teaching learning strategies; 2) having protected education time; and 3) integrating IPE as an expectation of employment.

Informants described multiple, diverse teaching learning strategies used in implementing IPE as part of staff training in the IC programs. Bringing the interprofessional hospital and home care staff teams together was noted to create a better understanding of the program. Key informants shared examples of cross-sector training which included team meetings, rounds, and opportunities for staff to spend time learning from each other.

> *[It]is an overview of our program and kind of the model that we use and it's with the joint teams, so they would have a chance to meet kind of the acute care team, as well as, the home care team coming in and it will be a little bit about you know what is the homecare experience like, but then also from an acute care you know the pathways that we create so the standards of care.* (Informant 10, hospital)

Sharing program information and patient care trajectories among the hospital and home care staff through booklets and pamphlets was mentioned. The notion of enabling two-way flowing of information sessions or learning opportunities was important. One-on-one education was also used on some occasions.

Designating specific protected time for staff education was identified as necessary for the IC program success. Example quotes reflecting this facilitator are noted here "*… we have that little bit of time once a week, we do daily huddles but at least once a week, we have a really robust educational in-service time that's protected*" (Informant 1, hospital).

Several key informants described embedding IPE and training within the processes of onboarding and orientation of new staff. It was described as an expectation, part of the employment contract, for staff to be able to learn with and from other disciplines what the IC program and model of care is about.

> *This is part of our contract, this is how the program works, this is how the model of care works. When we start missing those links that's when we start to fall apart and then not everybody has that full wholesome understanding and the philosophy doesn't continue on.* (Informant 4, hospital)

BARRIERS TO IMPLEMENTING IPE IN ONTARIO HOSPITAL TO HOME IC PROGRAMS

Key informants referred to three specific barriers to implementing IPE in their IC programs: the COVID-19 pandemic, staffing issues and having a lack of time for education. The COVID-19 pandemic's public health policies and need for distancing limited the opportunities for in-person learning or meetings. Like other health care settings, meetings moved to online platforms of which "*making a connection virtually with people…that's the*

biggest barrier, right now because of COVID-19" (Informant 2, hospital). Staffing issues, such as having available staff, were also identified as a barrier to implementing IPE in the IC programs. The lack of health human resources was noted.

> *Human resources, we don't have enough of any of them…We don't have a lot of any allied health so PT, OT and social work, dietitians, it's a very small group so getting those people involved to free up time to be able to do the education would definitely be a barrier.* (Informant 2, hospital)

Having a lack of time for planned education was also noted as a barrier.

> *So how do you find the time, how do you get the teams together, is it that you'll do a short in service with nurses because they're available this time and then another short in service with the allied health team because they're available at a different time.* (Informant 1, hospital)

DISCUSSION

In this study, key informants described various hospital to home integrated care programs and the use of IPE in preparing existing HCPs to work in the program. The structure and focus of these programs were quite diverse. The hospital to home integrated care programs were described in terms of three broad themes: 1) serving specific patient populations (e.g., patients with a specific disease, the frail elderly, individuals with complex issues) using pathways and tailored approaches; 2) supporting a seamless transition of care across sectors; and 3) working as an interprofessional team. These program descriptions are consistent with the literature in that integrated care takes many forms (Goodwin, 2016; Sullivan-Taylor et al. 2022). Further, the programs described align with key principles and components of integrated care such as clearly defined patient populations, optimizing patient flows and transition, and enabling people-centered care teams (IFIC, 2020; Sullivan-Taylor et al., 2022).

The extent of IPE implementation within the IC programs in this study varied. Key informants described examples of both formal and informal IPE within the IC programs. IPE content during orientation focused on patient care trajectories, professional roles, and responsibilities, with less emphasis on how to work as a team. Yet some informant responses acknowledged the importance of role clarity, communication, and teamwork. Examples of informal IPE were noted as those that occurred through existing work practices such as interprofessional rounds, program orientation, and new bundles of care. These findings confirm the importance of interprofessional learning for HCPs along a continuum that is context specific as continuing professional development (CPD) (Institute of Medicine, 2015). Content for continuing IPE as CPD regarding roles, communication and teamwork supports workforce competence for integrated care (Langins & Borgermans, 2016; Stein, 2016).

Most informants did not describe specific theories or frameworks underpinning the integrated care programs. However, some informants referred to key concepts of integrated care such as teamwork, communication, and holistic care. Several evidence-based models and frameworks are available to guide the successful implementation of integrated care. For example, Canada has recently developed a national standard, the Integrated People-Centred Care in Canada, to guide health care organizations through their integration journey (Health Standards Organization, 2021). However, the degree to which these have been embedded in hospital to home IC programs could be further explored in future work. Given informants were not familiar with specific theories or frameworks for integrated care suggests this is a knowledge gap which could be addressed through including such content in formal IPE in academic programs and as continuing IPE, post-licensure, within integrated care teams.

The limited discussion of how formal IPE theories and integrated care frameworks and strategies were embedded in the IC programs is also consistent with findings in the interprofessional literature. The lack of theory within IPE curricula or programs has been acknowledged and critiqued in the literature; yet theories, frameworks and models are recommended to enhance the overall focus and relevance of education to practice (Lackie et al. 2020). IPE and other training of current health care professionals can serve as a foundation to learn with, from and about each other to work in integrated care (Bookey-Bassett, et al., 2022; Chehade et al., 2016; Fraher & Brandt, 2019; Lette et al., 2019)

IPE is well-recognized as an important strategy to develop competencies for collaborative practice and working in teams (Khalili et al., 2019). Communication and collaboration within the context of an interprofessional team (CIHC, 2010) are also required competencies for integrated care (Langins & Borgermans, 2016; Stein, 2016). In this study, informants' descriptions of IPE suggested some "conceptual blurring" or a lack of clarity regarding the concepts of IPE, interprofessional collaboration and integrated care. These findings suggest the importance

of having clear terminology related to interprofessional practice (Khalili et al., 2021; Reeves et al., 2018).

Informants offered examples of how IPE has supported the implementation of their IC programs. These included informing staff how the programs would operate (e.g., patient population and referrals) and how each team member would contribute. Through IPE, key competencies and knowledge for IC care were revealed. For example, team communication for shared goal setting, and having a positive attitude towards holistic person-centred care, and continuous lifelong learning were noted by informants as beneficial when implementing the IC program. These findings reflect the IC competences identified by (Langins & Borgermans, 2016).

The findings indicate that working as a team across hospital and home care sectors is novel and can benefit from formal and informal IPE. Yet, the notion that a few programs have implemented cross-sectoral IPE for hospital and home care staff is an important finding. As described, there was a sense of value in having cross-sector training to enable staff to understand the patient care trajectories and provider roles more fully. The need for learning across systems and pathways is recognized by the WHO's global strategy on integrated care (2015) as critical to workforce development yet there is a lack of literature describing to what degree this occurs (Germaine et al., 2022). Ongoing IPE for HCPs in practice is recommended to maintain continued competence and bolster staff's ability to manage new patient populations or program implementations (Institute of Medicine, 2015).

Facilitators to implement IPE in the IC programs reflect those identified in the research literature. For example, the key facilitators in this study included: using multiple, diverse teaching learning strategies; having protected education time; and integrating IPE as part of new staff orientation. Using multiple teaching learning strategies is consistent with both IPE and adult learning theories and CPD for HCPs (CAIPE, 2016; Knowles, 1984). Protected education time has been identified as a critical success factor in many studies to enable role understanding, engagement of learners, development of relationships and trust among team members (Khalili et al., 2022; Orchard et al., 2017). Integrating IPE within the staff orientation program is important for health care providers to get to know their roles and those of their hospital to home team members.

Barriers to implementing IPE in the integrated care programs also are consistent with those identified in other settings (Khaliili et al., 2022; Owen et al., 2014). For example, barriers identified in this study included the COVID-19 pandemic, staffing issues and having a lack of time for planned education. Overcoming these barriers requires organizational and leadership support (Owen et al., 2014). Overall, our findings from this study align with previous studies indicate that IPE does indeed have an important role to play in developing competencies to work collaboratively in hospital to home integrated care programs. (Bookey-Bassett et al., 2022; Stein 2016).

IMPLICATIONS FOR WORKPLACE LEARNING AND CPD TO SUPPORT IPE FOR INTEGRATED CARE

There are several implications to consider in preparing the current and future health care professionals to work in hospital to home integrated care programs. Integrated care programs require health professionals and other staff to work and learn together as interprofessional teams exemplifying our theme of *"no room for siloed approaches"*.

Study findings can inform both content and methods of IPE in integrated care programs. Using IPE approaches within and across sectors can help HCPs understand the focus of the program (e.g., patient pathways, referrals) and the roles and responsibilities of various team members. This is important to ensure all team members are on the same page and have a shared vision of the program. A balance of formal and informal IPE along with multiple teaching learning strategies provided by educators with specialized facilitation skills is recommended. Content should include topics related to competencies and principles for collaborative practice and integrated care. When clarifying individual provider roles within the team, the focus should go beyond the general role of a nurse or a social worker to emphasize the unique aspects of the respective role within the specific practice context. Further, roles such as navigators, IC coordinators and IC leads as members of the interprofessional team should be clearly identified. Additional staff such as those in surgeon's offices should be considered as part of the larger team and included in IPE team training so that they understand the overall care trajectories of patients and the roles of the care team members. Content on how to function as a team and evaluate team performance are also important for ensuring ongoing program success.

Protected time for continuing professional development (CPD), related to team development, in the workplace is critical (Orchard et al., 2017). Given that many current HCPs have not had formal IPE training specific to working in hospital to home integrated care, adequate time for team development should be embedded in practice (Bajnok et al., 2012; Reeves et al., 2006). Enabling an adaptive learning environment for knowledge sharing and learning activities is a key component of integrated care (Sullivan-Taylor et al., 2022). Integrated care continues to evolve as evident during the COVID-19 pandemic and

it is crucial that IPE is adapted to meet the changing demands of patient populations (Bookey-Bassett et al., 2022). To prepare future HCPs to work in integrated care programs, it is important to include IPE and integrated care concepts/principles in formal academic training and offer student placements within established IC programs to facilitate learning and competencies early in their career. Both the IPE and integrated care literature acknowledge the importance of patients and family as members of interprofessional, integrated care teams. Involving patients and families in educating current and future professionals provides opportunities to give clients a voice and contributes to the learning culture (Sullivan-Taylor et al., 2022).

This study has some limitations in that the findings are only representative of 13 hospital to home integrated care programs in Ontario, with potential selection bias, and thus may impact the transferability of results. Further we did not explore IPE within the context of integrated primary health care teams. However, the insights gained from the diversity of key informants from various regions of the province provide a glimpse of how IPE is currently being implemented in hospital to home programs and where gaps can be addressed. Future research can explore the use of IPE within a wider range of integrated care programs and include evaluation of the effectiveness of IPE on health professional and patient outcomes.

CONCLUSION

This study highlights key informants' descriptions about the current state of IPE in training HCPs to work in hospital to home integrated care programs in Ontario, Canada. The findings provide examples of the need for both formal and informal IPE in these IC programs. Gaps in understanding of terms such as IPE, IPC and integrated care were evident and indicate a need for conceptual clarity. Facilitators and barriers to implementing IPE in the programs were identified and recommendations to address these were proposed. Interprofessional teamwork, learning together, and having no room for silos reinforced the importance of continuing interprofessional learning for existing HCPs in the context of hospital to home integrated care programs. The findings can inform future IPE programs and initiatives to support workforce capacity for integrated care. Finally, our findings align with a previous scoping review in that IPE has a role to play in developing competencies to work in integrated care programs. IPE should be incorporated and adapted to meet the changing needs of patient populations, shifting roles of health care providers, and evolving health care systems.

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COMPETING INTERESTS

The authors have no competing interests to declare.

AUTHOR CONTRIBUTIONS

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SE: Conceptualization, Internal Grant Funding, Research Ethics Waiver Approval, Investigation, Methodology, Writing Original Draft, Writing- Review & Editing

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