

May 10<sup>th</sup>, 2007

Dear Stakeholder,

On behalf of the Steering Committee, we wish to express our appreciation for your attendance and participation at the stakeholder consultation on March 19<sup>th</sup>, 2007 at the MaRS Collaborative Auditorium in Toronto.

We greatly appreciate your perspectives on the proposed concepts and themes for interprofessional care and your opinions on the activities and initiatives that will have the greatest impact in facilitating and implementing interprofessional care in Ontario.

We have attached an analysis report on the stakeholder consultation. In general, there was a high level of support for the direction that we are taking with respect to the proposed activities for the implementation of interprofessional care.

Again, we thank you for taking the time from your busy schedules to participate on March 19<sup>th</sup>.

Your input was invaluable and we are now engaged in the development of the Blueprint. We will let you know when the Blueprint is posted on the website. In the meantime, if you have any questions, please do not hesitate to contact one of us ([tclosson@sympatico.ca](mailto:tclosson@sympatico.ca); [Ivy.Oandasan@uhn.on.ca](mailto:Ivy.Oandasan@uhn.on.ca)) or Carmela Bosco, Project Lead ([bosco@look.ca](mailto:bosco@look.ca)).

Sincerely,



---

Tom Closson  
Co-Chair



---

Ivy Oandasan  
Co-Chair



**Analysis  
of  
IPC Stakeholder Consultation  
held at  
MaRS Collaborative Auditorium  
Toronto, Ontario  
March 19<sup>th</sup>, 2007**

## TABLE OF CONTENTS

<b>Summary</b> .....	Page 3
<b>Findings</b> .....	Page 5
▪ Areas of support.....	Page 5
▪ Issues raised.....	Page 6
▪ Requiring clarification.....	Page 7
▪ Other comments.....	Page 8
▪ Identified activities that will leverage IPC.....	Page 10
<b>Stakeholder Consultation Process</b> .....	Page 11
<b>Appendix A: Feedback Form Statistics</b> .....	Page 12
▪ 'Lighthouse' activities.....	Page 13
<b>Appendix B: Statistical Analysis of Feedback Forms</b> .....	Page 14
<b>Appendix C: Pulling it Together for Patient-Centred Care</b> .....	Page 15

## Summary

The Interprofessional Care Project stakeholder consultation was held on March 19<sup>th</sup>, 2007 in Toronto at the MaRS Collaborative Auditorium. Health care and education stakeholders were asked to provide their perspectives on the proposed themes and concepts for interprofessional care (IPC), as well as their opinions on activities that would have the greatest impact in the facilitation and implementation of interprofessional care in Ontario.

Approximately 157 health and education stakeholders attended the consultation. Of the 157 stakeholders in attendance, 129 participated in the discussion tables. Of the 129 participants, 106 completed feedback forms at a response rate of 82%. Stakeholders also identified forty-two 'lighthouse' projects<sup>1</sup>.

### Key comments by stakeholders during discussion groups:

- There is general support for IPC (95%), however, there needs to be a flexible and adaptable infrastructure in place to support IPC at the grassroots level.
- The level of support is dependent on stakeholders' knowledge of and experience with IPC.
- IPC should be seen as an enabler in support of sustainability and efficiency of health care resources.
- There is a need to focus on the current environment and how the cultural change of IPC will impact on the current practice by health care professions and educators.
- There is no uniformity in the understanding of certain IPC themes and terms, such as shared responsibility and the reasons for IPC, therefore further clarification of the IPC concept and context is required.

### Key activities identified and ranked as having the greatest impact on the implementation of IPC in each of our four themes:

- Building the foundation:
  - ♦ Develop entry level curricula
  - ♦ Define core IPC competencies
  - ♦ Develop partners-in-care<sup>2</sup> engagement strategy
  - ♦ Build consensus on mandatory liability protection and insurance
  - ♦ Provide evidence on IPC outcomes and benefits
- Sharing responsibility:
  - ♦ Learn the lessons from demonstrated projects
  - ♦ Design and implement an evaluation framework
  - ♦ Develop a multi-level accountability framework that outlines roles and responsibilities
  - ♦ Introduce performance monitoring and public reporting

---

<sup>1</sup> Highlight projects where leadership in interprofessional care and education has been demonstrated and consider ways to assist them in providing and disseminating their best practices as evidence of positive outcomes.

<sup>2</sup> As health care delivery is not only provided by regulated and unregulated health professions, the partners-in-care strategy acknowledges the need to partner with family, friends and volunteers within the community who are also significant caregivers within a patient's healthcare team.

- Implementing systemic enablers:
  - ◆ Application of the electronic health record
  - ◆ Sustainable funding
  - ◆ Legislative review to identify IPC opportunities
  - ◆ Implementation of standards that embrace IPC
- Leading sustainable cultural change:
  - ◆ Provide support to IPC champions in promoting and advocating IPC
  - ◆ Implement a public engagement or awareness campaign
  - ◆ Implement coaching teams and mentorship programs
  - ◆ Incorporate IPC in continuing education programs
  - ◆ Reward positive outcomes arising from IPC implementation

### **Key Recommendations:**

Stakeholders expressed a high level of support for interprofessional care and recommendations for its implementation:

- Create infrastructure for the implementation of IPC to begin gradually at the grassroots level, beginning with the regulated professions.
- Focus on obtaining grassroots level support for IPC before the adoption or implementation of an accountability framework.
- Utilize key enablers such as appropriate funding, support for champions and electronic health records for successful implementation.
- Build IPC from existing programs and ensure that efforts are not duplicated.
- Monitor IPC achievements based on evidence, evaluation and the benefits for the health care and education systems, but especially on patient care delivery.
- Communicate the benefits of IPC within the health care and education systems clearly and concisely.
- Ensure continuous stakeholder engagement throughout the IPC process with respect to development and implementation.

## Findings

### Discussion Session Groups

It appears there is a significant level of support for IPC by all stakeholders based on the responses from the feedback forms. The discussions that took place among the session tables provided further insight into stakeholders' views of the proposed IPC themes and concepts, the understanding of IPC and the best approach to the implementation of IPC.

Key issues discussed at the session tables based on four categories include:

#### 1. Areas of support

##### *IPC Infrastructure:*

- Emphasis on the need for funding, resources and the structures that must be put into place to support IPC at the grassroots level in order to achieve successful implementation.
- Support for infrastructure as long as it does not create a bureaucracy.
- Leadership is key for IPC to work, thus the need for champions but champions based on teams and not individuals.
- More information is needed on how to initiate and maintain IPC in the practice setting.
- While 81% *agree to strongly agree* that the LHINs have a role in IPC implementation, caution was expressed with regard to ensuring an infrastructure can be put into place in an area that currently does not exist within LHINs (i.e. education and training).

##### *Concept and Context:*

- IPC should be positioned as:
  - ♦ Improving patient care,
  - ♦ Improving providers' work lives,
  - ♦ Increasing productivity in serving patients, and
  - ♦ Providing linkages and partners among other members of the health care team
- The four "Es" of IPC concentrate on efficiency, evidence-based, education and expense/expenditure-reduction.

##### *IPC Implementation:*

- Implementation should be approached in a staged and gradual manner starting at the grassroots level and with regulated professions. Efforts should be focused on current champions having demonstrated how IPC can easily be adopted. Devising a layered approach towards implementation will achieve effective buy-in from the users and providers of the health care and education systems. Within each layer/stage, there is a need to articulate what IPC would look like.
- There is support for an accountability framework but it may be too early for implementation.
- IPC implementation should "keep it simple". The proposed approach appears top-down rather than bottom-up. A bottom-up approach may receive wider acceptance for implementation. IPC needs to evolve over time at the grassroots level. As such, the approach should start at the bottom.
- Implementation should gradually start with regulated professions and within the hospital/primary care settings – given these sectors have more experience in IPC.

- Utilizing existing IPC champions will be more effective in settings such as community health centres.

*Cultural change:*

- Cultural shift is key to implementing IPC, beginning at the educational level (pre-licensure and licensure). As education is an essential part of IPC, there needs to be a stronger partnership between government, health care management and educational institutions (build concept of team delivery into the beginning of training)
- Incentives are needed in order to affect change.
- Stakeholder engagement must be conducted early on as it will take time to influence change within current practices.

## 2. Issues raised

*Building the Foundation:*

- Evaluation is a necessity but must be based on what IPC achieves and not IPC itself.
- Identify specific population groups that would benefit the most from IPC.
- The need for evidence on IPC/IPE (interprofessional education) curricula development.
- Efforts focused on funding towards projects and not towards the system or patient care.
- Although there was 92% support for the “partners-in-care strategy”, further clarity is needed as to what we mean by “partners-in-care” and who should be involved.

*Sharing the Responsibility:*

- Though participants strongly supported the concept that IPC implementation is a shared responsibility, it was unclear as to what is meant by “sharing responsibility.”  
Questions raised included:
  - ♦ What would encompass “sharing responsibility “?”
  - ♦ Who is accountable?
  - ♦ What does sharing liability mean?
  - ♦ What are the expectations?
  - ♦ How does “sharing responsibility” impact on funding?
  - ♦ How could “sharing responsibility” be applied to current environments? For example, shared responsibility does not replace individual responsibility.
- As there is a strong belief in shared responsibility and/or accountability, there is a view that the government should assume sole responsibility for funding the implementation of IPC and that stakeholders can participate through contributions ‘in-kind’.
- Implementing shared responsibility will be a challenge unless the Blueprint can clearly articulate that it is embedded into the system.
- Exercise caution in implementing IPC in collective/service agreements as current agreements act as “barriers” to facilitating IPC.
- There is support for an essential accountability framework, however it was clear that implementation of an accountability framework at the onset may not be appropriate as you need to get the “buy-in” first.
- Although there is support for more demonstration projects, 27% disagree and feel that it is time for action.

### *Implementing Systemic Enablers:*

- Concern that IPC will create more bureaucracy and the potential for duplication of services.
- The role of LHINs is important to consider for IPC implementation, however, its current structure does not include education and training.
- The need for incentives to make change as well as establish benchmarks.
- Funding needs to be allocated equally among providers and educators who will practice and teach IPC.
- Funding for incentives and introducing adequate compensation models for providers is important in order to get “buy-in” for practitioners to practice IPC. Financial incentives should support the team and not the individual.

### *Leading to Sustainable Cultural Change:*

- A cultural shift is necessary before you can impose shared responsibility and accountability.
- Training alone will not achieve IPC success.
- Strategic direction from the Ontario government on cultural change is important.
- Change must occur in both curriculum and practice environments for IPC to succeed.
- Systematic change requires funding that includes equitable compensation for all providers practicing IPC.
- Recognize and address the current practice environments among professions and the potential resistance to change by acknowledging the:
  - ♦ Presence of hierarchy
  - ♦ Fear of cultural change
  - ♦ Fear that an IPC regulatory framework may adversely impact current responsibilities

## **3. Requiring clarification**

### *Definition of IPC:*

- Caution was expressed about defining IPC too broadly as the focus should be centred on patient needs. Issues raised:
  - ♦ Who should be involved - regulated and unregulated; and community as well as “providers”?
  - ♦ What is IPC – a process to do what?
  - ♦ What is the end result?
- The need for clarification on the difference between team-based care (the preference) and IPC (where the focus is how we do things rather than what we deliver).
- The role of leadership should be incorporated into the definition.

### *Purpose of IPC:*

- Clarify the advantages of IPC (i.e. reduction of resources, quality vs. quantity)
- What are we trying to implement and resolve?
- Is IPC a philosophy to patient care delivery? Philosophy vs. proscription on how to do it? – Is it a value-based cultured philosophy?
- What does IPC look like? Especially among different settings.
- Outline the context guiding IPC implementation that should be directly linked to government strategies and how they achieve the desired outcomes.

*Use of appropriate language to clarify what we mean:*

- How is 'Partners-in-care' different from "patient-centred care"? It was suggested to use "Partners in Health."
- Define 'lighthouse' activity projects.
- Clarify the themes and concepts in particular "shared responsibility".
- Use of the term accreditation may be confusing. Do we mean including IPC within existing accreditation or a separate accreditation process.
- Clearer understanding about the Regulated Health Professions Act (RHPA) and understanding the role of "delegation", "authorizing" or "controlled acts" within the IPC context. It was suggested that further research is required to know when it is best to delegate, and how to delegate within an IPC environment.

#### **4. Other comments**

*IPC modeling and approach:*

- Offer flexible IPC model.
- It is too early to tie IPC to funding.
- Electronic health record is very important for IPC.
- Build from existing programs and strategic directions. For example, the inclusion of leadership competencies in achieving outcomes and accountability based on current models such as community health centres.
- Toolkits are not the answer; you need to create supportive environments.
- The need for collaboration and integration between practice centres and educational institutions, as this is not the case within the current LHINs infrastructure.
- The focus of IPC appears more hospital based with less of an impact in the community setting.

*Consistent level of engagement in order to get "buy-in":*

- Provide financial and education incentives especially at the practice level.
- Frontline engagement is needed in decision-making and planning of IPC.
- Focus on new professions and students– it will not be as practical for those who have been in practice for a long time.
- Buy-in needs to come at the grassroots level, especially regarding new practitioners. This would also include the family, and individual patients, as they are involved in continuum of care.

*Effective communication:*

- Have patients be the 'storyteller' – the patient becomes the most common source of information in a community based system.
- Articulate the benefits of IPC to the various stakeholders.
- Use common language.
- Focus on engaging the public rather than public awareness.
- Develop a strategy on dissemination and knowledge transfer from 'lighthouse' activities, as there is no central vehicle to access information on successful IPC models.
- Government must convey stronger and more consistent messaging to direct providers towards IPC.
- Increase communication between health care and education sectors, particularly at the practice level, to improve awareness/knowledge of existing best practices.

## Identified activities that have the greatest leverage for advancing IPC

Participants were asked to identify three key activities that would have the greatest leverage for advancing IPC within the identified themes discussed. The top four key activities were then identified and ranked within each theme as follows:

### 1. Building the Foundation

- 1<sup>st</sup> 1.2 Develop entry-level curricula for entry health care workers including clinical experience
- 2<sup>nd</sup> 1.1 Define and agree on core IPC competencies
- 3<sup>rd</sup> 1.6 Develop a 'partners-in-care' engagement strategy – inclusive of all partners including volunteers & families

#### Tied for 4<sup>th</sup>

- 1.3 Build consensus and implement adequate mandatory liability protection and insurance
- 1.4 Provide (& evaluate) the evidence on the outcomes/benefits of IPC

### 2. Sharing the Responsibility

- 1<sup>st</sup> 2.5 Demonstrate and share/disseminate IPC results through
  - Funding targeted demonstration projects / Centres of Excellence / 'Lighthouse' projects
  - Implementing a provincial/mechanism that facilitates knowledge transfer, dialogue and identification of best practice information – build from current practices
- 2<sup>nd</sup> 2.3 Design and implement an IPC Blueprint evaluation framework

#### Tied for 3<sup>rd</sup>

- 2.1 Develop multi-level accountability agreement framework that outlines the roles and responsibilities of various stakeholders and government in IPC implementation
- 2.4 Introduce IPC performance monitoring & public reporting

### 3. Implementing Systemic Enablers

- 1<sup>st</sup> 3.5 Implement the electronic health record to facilitate effectively and timely IPC communication and collaboration across the continuum of care/include legislation
- 2<sup>nd</sup> 3.6 Provide sustainable funding and resources to enable IPC including:
  - Providing incentives for implementation
  - Provide adequate compensation models for all professions to practice IPC
  - More funding for team care and training
  - Successful demonstration projects need sustainable funding to transfer the knowledge at the practice level.
- 3<sup>rd</sup> 3.2 Complete a focused legislative review with the aim of prioritizing and targeting specific IPC opportunities for systemic change – including RHPA, Profession Specific, Associated and General legislation – regulation framework
- 4<sup>th</sup> 3.1 Seek out accrediting bodies for the purpose of implementing standards that embrace IPC – organization, education, practice site, practitioners, and practitioner accrediting organizations.

### 4. Leading a Sustainable Cultural Change

- 1<sup>st</sup> 4.2 Identify, prepare, advertise, reward & support IPC champions – organization, education, others
- 2<sup>nd</sup> 4.1 Implement a public awareness campaign / provincial communication strategy
- 3<sup>rd</sup> 4.3 Institute coaching teams / mentorship program

#### Tied for 4<sup>th</sup>

- 4.4 Incorporate IPC in continuing education programs/activities
- 4.6 Reward positive outcomes arising from IPC implementation

## Stakeholder Consultation Process

### Objectives

Directed by the Steering Committee of the Interprofessional Care Project, the objectives of the stakeholder consultation were to:

- Seek perceptions about the collective impact of the proposed activities on the stakeholders
- Solicit comments and ideas about specific activities or concepts that were not addressed during the 2006 June Summit (shared responsibility activities, partners-in-care strategy, IPC champions)
- Capture ideas that will help to make the action plan more concrete
- Identify 'Lighthouse' projects or activities

### Overview

Approximately 210 health and education sector stakeholders were invited to participate at a one-day stakeholder consultation on March 19<sup>th</sup>, 2007 at the MaRS Discovery District in Toronto. Stakeholders had the option to participate in the morning or afternoon session. Participants were assigned one of 9 tables that included a facilitator and recorder. The facilitator was a member of one of the three working groups reporting to the IPC Steering Committee. There was a mix of representation at each table from hospital, community, acute, academia, professional associations, consumer, regulated, and government at the provincial level. Each table had approximately 7 to 9 participants.

Following the context setting presentations by Co-Chairs, Tom Closson and Ivy Oandasan; Joshua Tepper; and from the Ministry of Training, Colleges and Universities [Frances Lamb (am) and Monique Wernham (pm)], participants were asked to consider a one-page summary, "Pulling it Together." (See appendix C). The summary was prepared by the Steering Committee to highlight the integrated priorities and action plans developed by the working groups. Participants were to consider this summary and the following questions posed during their discussion groups:

- On specific issues: What do the following mean to you? How can each one be effectively implemented? Who needs to be involved? What is an appropriate timeframe?
  - ♦ Theme 2: Shared Responsibility and Corresponding Activities
  - ♦ Partner-in-Care Engagement Strategy
  - ♦ IPC Champions
- General discussion within the remaining themes (Foundation, Systemic Enablers and Cultural Change):
  - ♦ Which activities would you identify as having the greatest leverage/impact?
  - ♦ What steps would you take to effectively implement the activities that you have identified as having the greatest leverage/impact?

At the end of each session, each participant was asked to complete a feedback form (see appendix A)

# APPENDIX A

## Feedback from Participants Interprofessional Care (IPC) Project – Stakeholder Consultation March 19, 2007

Your feedback is greatly appreciated

Participant Feedback Totals

For each item, please check one:

	Strongly Disagree	Disagree	Agree	Strongly Agree	N/A
1. I believe that IPC implementation is a shared responsibility across stakeholder groups	1	3	25	77	
2. Local Health Integration Networks have a significant role in IPC implementation	1	9	48	43	5
3. An IPC accountability framework is an essential mechanism for IPC implementation	3	12	44	40	7
4. I believe the collective activities as presented today will advance IPC in Ontario	1	4	67	24	10
5. It will be important to evaluate & publicly report on IPC implementation activities	2	2	44	52	6
6. A 'partners-in-care' engagement strategy is a critical element in an IPC Blueprint	2	6	44	45	9
7. It is possible to build support for IPC in collective agreements	4	12	54	19	17
8. We don't need more demonstration projects; it is time for action.	5	26	32	34	9
9. A provincial IPC coordinating, integrating structure / mechanism is very important	3	10	46	41	6
10. We need to evaluate & share the results of existing IPC activities	1	1	36	67	1
11. I believe my organization would be willing to be a leader in IPC implementation	1	4	44	49	8
12. If invited, I would participate in a future consultation session.	2	2	36	63	3
13. Did you attend the Summit last June or read the proceedings report? If yes - the type of work presented today reflect the spirit and direction I believe was initiated at the Summit and/or report.	4	3	25	20	54

In my opinion, the activities that have the greatest leverage for advancing IPC (from the list presented today) are as follows:

1.	
2.	
3.	

## 'Lighthouse' Activities:

It will be important to shine a 'light' on and share the 'light' from IPC activities that are currently being funded or underway across Ontario so that others can benefit from the experiences. If you are aware of any 'lighthouse' activities, please identify them for the Project Team:

1. Centennial College: Interprofessional Disaster/Emergency Action Studies (IDEAs) Project
2. Ontario Pharmacists Association/Canada Health Infoway (CHI)/Group Health Centre – Sault Ste. Marie EMRxtra Project
3. Stroke Team; Geriatric Team; Skin and Wound Care
4. Group Health Centre and Victoria Order of Nurses – nurse practitioner led family health team in Sudbury
5. Communities of practice program in Northern Ontario
6. Health Innovation Expo
7. Community Health Centres
8. Advance Home Care Team – Launched Middlesex Community Care Access Centre
9. Cancer Care Ontario – Palliative Care Integration Program
10. George Brown Dental Hygiene Program Links with Long Term Care in Toronto
11. Winchester Interprofessional Project
12. Michener Institute – IPC curriculum for allied health programs
13. Canadian Patient Safety Institute - Safer Health Care Now
14. CCHSA accreditation standards
15. Assertive Community Treatment teams in psychiatry
16. RGP teams
17. Geriatric psychiatry community teams
19. Toronto CCAC and family physicians – Palliative Care CSS agencies supporting seniors post discharge
20. Expansion of Shared care model in mental health
21. Fanshawe College and University of Western Ontario Palliative Care Project
22. CAMH – electronic IDE care plan – key pillar in forwarding IPC
23. Grand River – Pharmacists as part of CME team at Grand River hospital
24. Ottawa Hospital – organizational implementation of IPC
25. Ontario College of Family Physicians Collaborative Care Network (i.e. Hawkesbury, Huntsville, Peterborough and North Bay)
26. George Brown: Centre for Health Sciences IPE Education –IPC clinical placements for students and curriculum mapping and IPC credit system that they are developing
27. Autism Ontario and Sick Kids Hospital
28. PIECES training –understanding dementia in LTC homes
29. Southlake Regional Health Centre Arthritis Program
30. Ontario Hospital Association – series of project outcomes
31. Ontario Primary Health Care Transition Fund projects
32. MORE OB program – obstetrics patient safety program
33. Toronto Rehabilitation – integrated education placement program in rehabilitation
34. Michener institute – introduction of the IPC Curriculum for all allied health programs
35. SCO Health Service in Ottawa
36. University Health Network Act
37. Ontario Chiropractic Association – St. Michael's Hospital chiropractic integration project - chiropractor and collaboration
38. Ottawa Hospital
39. Anesthesia Care Team Project
40. Sick Kids Child Development Strategy – Advancing IPC practice strategy through families
41. IMPACT McMaster University – pharmacists in family health teams
42. Health Care teams – MOHLTC (i.e. operating room, emergency, and critical care)

Name & Contact Information (if desired) \_\_\_\_\_

## APPENDIX B

### Statistical Highlights from Feedback Forms (Appendix A)

- 96% agree to strongly agree that the IPC implementation is a shared responsibility.
- 81% agree to strongly agree that the LHINs have a role in IPC implementation.
- 85% agree to strongly agree that an accountability framework is an essential mechanism for IPC implementation.
- 95% agree that activities presented at the stakeholder consultation will advance IPC in Ontario.
- 96% indicated that it will be important to evaluate and publicly report on IPC implementation activities.
- 92% support that the 'partner-in-care' engagement strategy is a critical element in the Blueprint.
- 82% agree that it is possible to build support for IPC collective agreements; however 13% disagreed.
- On the need for more demonstration projects:
  - ♦ 27% disagree
  - ♦ 32% agree
  - ♦ 35% strongly agree
- 87% agree about the importance of a provincial coordinating and integrating structure for IPC.
- 98% agree the need to evaluate and share the results of existing IPC results.
- 94% agree to strongly agree that organizations would be willing to lead in the IPC implementation.
- 96% expressed interest in participating in a future consultation session.
- Of those who responded, 86 % felt that the work presented at the stakeholder consultation reflected the direction that was initiated at the 2006 June Summit and/or proceedings report.

## **APPENDIX C            ‘Pulling It Together for Patient-Centred Care’**

(March 9th, 2007)

### **1.            Building the Foundation**

*Critical to the success of IPC implementation are key foundational activities upon which other activities can be built. Support is required for health care providers and patients, who form the building blocks of an IPC environment.*

- 1.1 Define and agree on core IPC competencies
- 1.2 Develop entry-level curricula for entry health care workers including clinical experience
- 1.3 Build consensus on and implement adequate mandatory liability protection and insurance
- 1.4 Provide the evidence on the outcomes/benefits of IPC
- 1.5 Optimize roles and responsibilities through an appropriate delegation model
- 1.6 Develop a ‘partners in care’ engagement strategy – inclusive of all partners including volunteers & families

### **2.            Sharing the Responsibility**

*All health care providers, decision-makers, policy-makers and government and patients have a shared, collective role in the implementation of IPC. For this reason, sharing the responsibility has been identified as a key principle for IPC implementation.*

- 2.1 Develop multi-level accountability agreement framework that outlines the roles and responsibilities of various stakeholders and government in IPC implementation
- 2.1 Implement multi-stakeholder ongoing provincial structure /forum for ongoing IPC coordination, integration, dialogue & decision-making.
- 2.2 Design and implement an IPC Blueprint evaluation framework
- 2.3 Introduce IPC performance monitoring & public reporting
- 2.4 Demonstrate and share/disseminate IPC results through
  - o Funding targeted demonstration projects / Centres of Excellence / ‘Lighthouse’ projects
  - o Implementing a provincial/mechanism that facilitates knowledge transfer, dialogue and identification of best practice information

### **3.            Implementing Systemic Enablers**

*The extent of transformation required for IPC implementation requires capitalizing on specific ‘levers’ that will enable systemic change:*

- 3.1 Seek out accrediting bodies for the purpose of implementing standards that embrace IPC – organization, education, practice site, practitioners, and practitioner accrediting organizations.
- 3.2 Complete a focused legislative review with the aim of prioritizing and targeting specific IPC opportunities for systemic change – including RHPA, Profession Specific, Associated and General legislation
- 3.3 Build IPC into MOHLTC/LHIN service agreements, funding models and Memorandum of Understandings (MOUs)
- 3.4 Build support for IPC implementation within collective agreements
- 3.5 Implement the electronic health record to facilitate effectively and timely IPC communication and collaboration across the continuum of care.
- 3.6 Provide sustainable funding and resources to enable IPC. This includes:
  - o Providing incentives for implementation
  - o Provide adequate compensation models for all professions to practice IPC
  - o More funding for team care and training
  - o Successful demonstration projects need sustainable funding to transfer the knowledge at the practice

### **4.            Leading a Sustainable Cultural Change**

*IPC is a significant cultural change process. A change in healthcare service delivery as far-reaching as IPC demands an approach that recognizes its magnitude and importance and seeks to implement supports that will initiate and sustain the cultural shift over time:*

- 4.1 Implement a public awareness campaign / provincial communication strategy
- 4.2 Identify, prepare, advertise, reward & support IPC champions – organization, education, others
- 4.3 Institute coaching teams / mentorship program
- 4.4 Incorporate IPC in continuing education programs/activities
- 4.5 Provide support for the entry to practice learner to embrace IPC early (includes admission criteria)
- 4.6 Reward positive outcomes arising from IPC implementation
- 4.7 Develop tool kits (organization implementation, faculty/preceptors, leader/champions, practitioners, family, etc)
- 4.8 Introduce new IPC processes for regulated health professions – shared competencies, collaborative quality assurance