



International Foundation  
for Integrated Care



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# Inter-Professional Team-Based Care: what does it take to develop competencies for integrated care?

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Canadian Home Care Association 2017 Home Care Summits

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@IFICinfo

# Why do we need interprofessionalism?

It's the same kind of problems for everyone— a lack of somebody picking the ball up and running with it for you... There's all sorts of things there, but how do you find out about them? I think there's a lot of assumptions that you know as much as they do about it and you don't. (Ken)

It seems like one person after another coming in to do different assessments on something else...It's not like one person comes in and assesses for everything, it was a never ending stream of people coming. (Carole)

What they put in the discharge letter, nothing was explained to me, what she should take at home and help we would have from social care. We brought her home and I was wondering how was I going to manage her? (Nilesh)

# Multi-disciplinary or Inter-professional?

- **Multi-disciplinary:** those from different specialisms working alongside one another
- **Multi-professional:** those from different professions working alongside one another
- **Inter-disciplinary:** those from different specialisms working with each another
- **Inter-professional:** those from different professionals working with each another
- **Trans-disciplinary:** specialists moving out of their discipline to form new roles and undertake alternative tasks



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What do we know about MDTs?

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# The year.....?

*“We have found that a multidisciplinary approach offers many advantages in diagnosis and treatment. A means must be found to assure that a patient receives comprehensive care, that is, care which satisfies a combination of physical, mental, and social needs. A catalyst is required to assure that all resources which may help a patient have been effectively mobilized. In our experience, designating a member of a multidisciplinary team as the coordinator met these requirements and overcame many of the potential obstacles patients faced in obtaining comprehensive care.”*

# Evidence for team (based) working

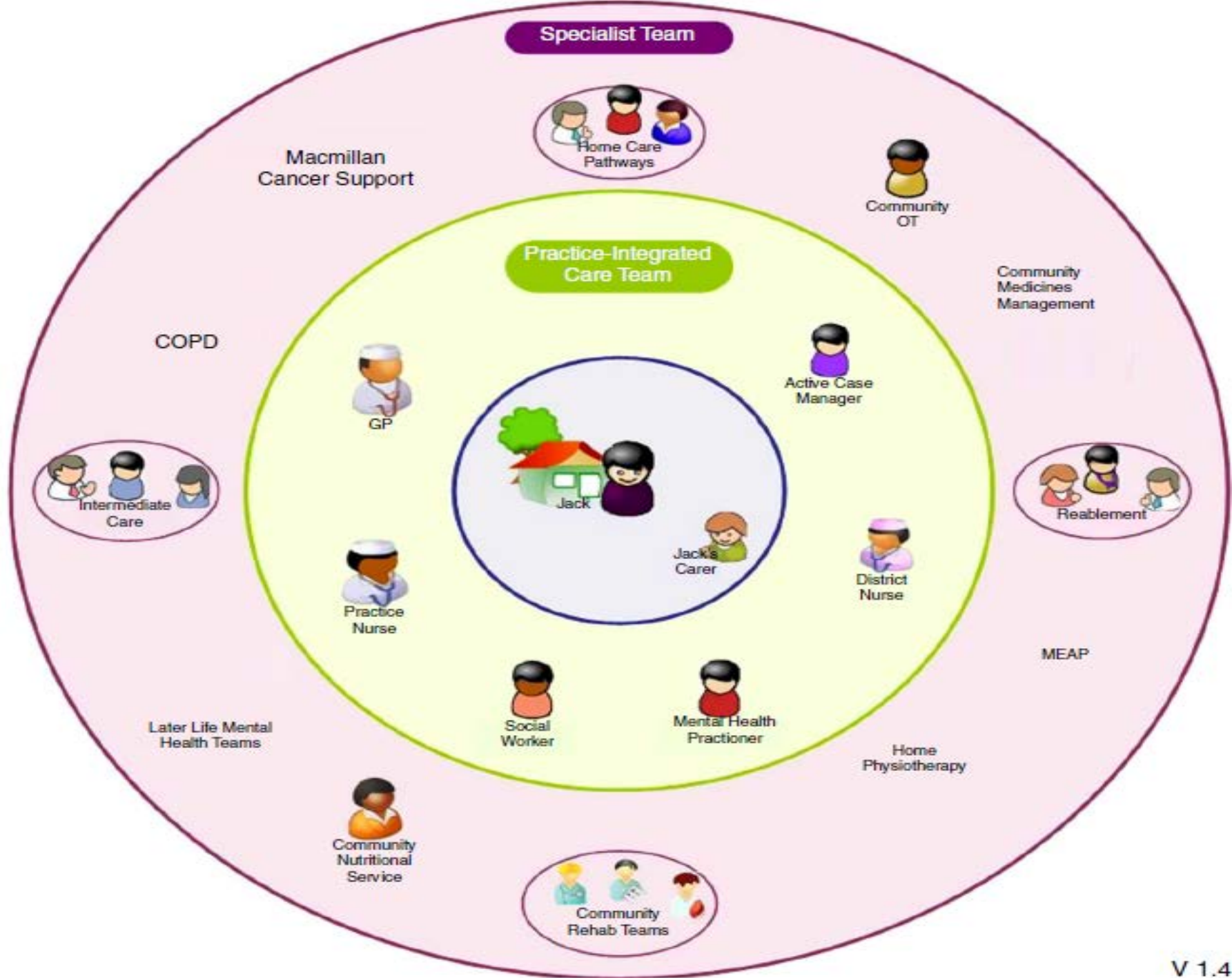
1. Reduced hospitalisation and costs
2. Reduced medical error
3. Increased effectiveness and innovation
4. Improved patient / service user satisfaction
5. Greater implementation of innovations
6. Lower patient mortality
7. Increased mental well-being of team members
8. Reduced turnover and sickness absence
9. More effective use of resources
10. Improved patient satisfaction

# Evidence for MDT working

**Cancer Care:** Studies which explored patient outcomes (29 in total) report positive impacts. These include increase rates of survival, improved patient satisfaction, and better diagnosis and/or treatment planning. (Prades et al 2013)

**Mental Health:** integrated team working is supported through better management, diversity of professions, social support and fewer job demands. Overall job satisfaction of team members is associated with the level of choice experienced by users and their satisfaction with these choices. (Huxley et al 2011)

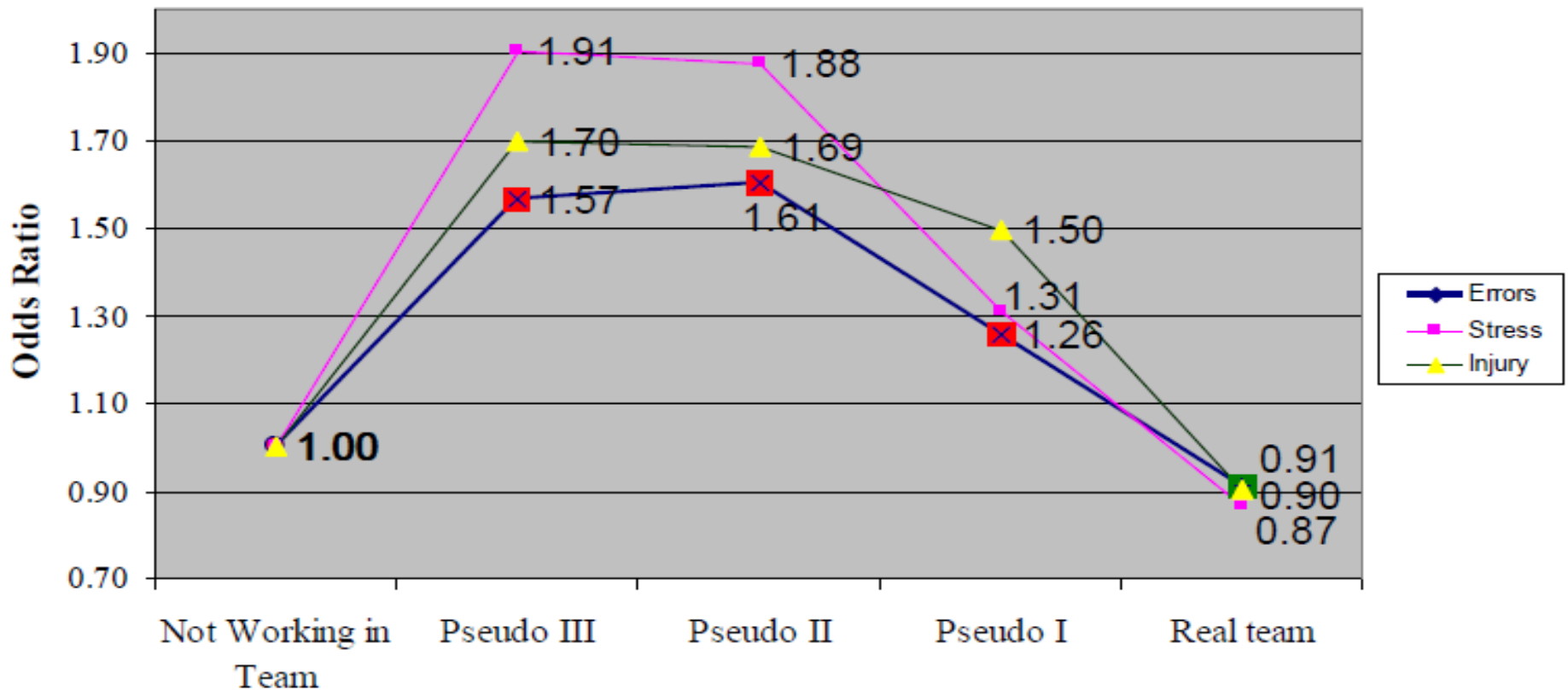
**Older People:** an integrated discharge team incorporating acute and community health staff, social workers, and the voluntary & community sector led to a reduction in length of stay of older people





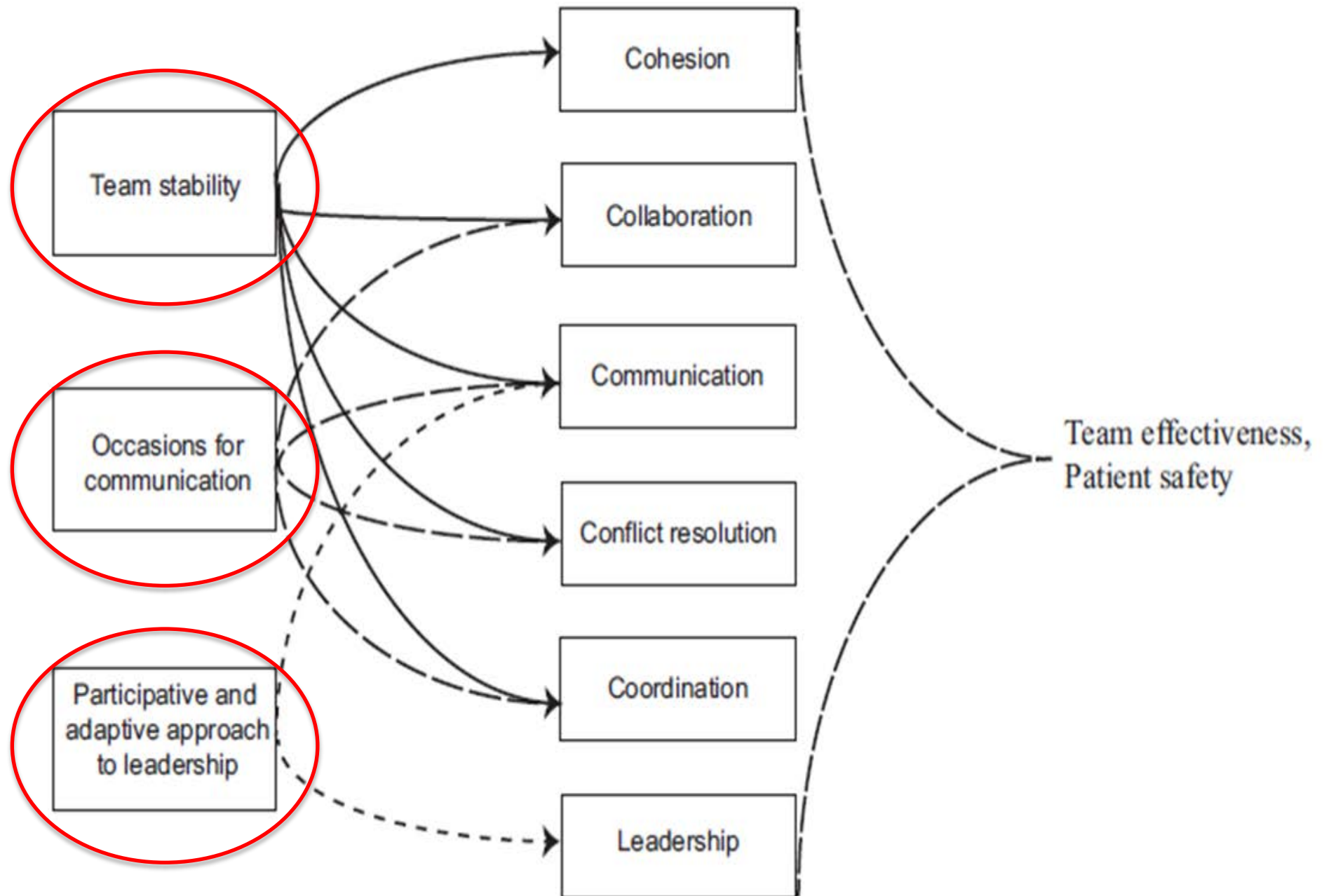
# Danger of Pseudo teams

**Working in Team and Errors, Stress and Injury**  
(170 acute trusts, 120,000 respondents)



Types of Team Working Patterns

[www.nhsstaffsurveys.com](http://www.nhsstaffsurveys.com)



## Inputs

Are the tasks to be undertaken by the team clear?

Does the team contain the right mix of knowledge and skills?

Is the organisation supportive of the team purpose?

## Processes

Does the team have achievable and agreed objectives?

Is the team encouraged to individually and collectively reflect and adapt their practice?

Is the leadership valuing of diversity and promoting a common vision?

## Outputs

Are there a common set of clinical and wellbeing outcomes?

Is the direct experience of service users and carers being gathered?

Are team members feeling motivated, engaged and supported?

“This “c factor” (the group’s collective intelligence) is not strongly correlated with the average or maximum individual intelligence of group members but is correlated with the average social sensitivity of group members, the equality in distribution of conversational turn-taking, and the proportion of females in the group.”

(Williams Woolley, Chabris, Pentland, et al. Science 2001)

# Leaders for quality cultures: Collective leadership

- An inspiring vision and compelling strategic narrative
- Clear priorities and objectives at every level from Board to front line
- Have supportive people in leadership and management roles
- Have high levels of staff engagement
- Learning and innovation is seen as everyone's responsibility
- Have high levels of **genuine team working** and co-operation across boundaries

# At the core: co-located, multi-disciplinary Integrated Care Teams



## Parallel Workflow Design



### ICT members:

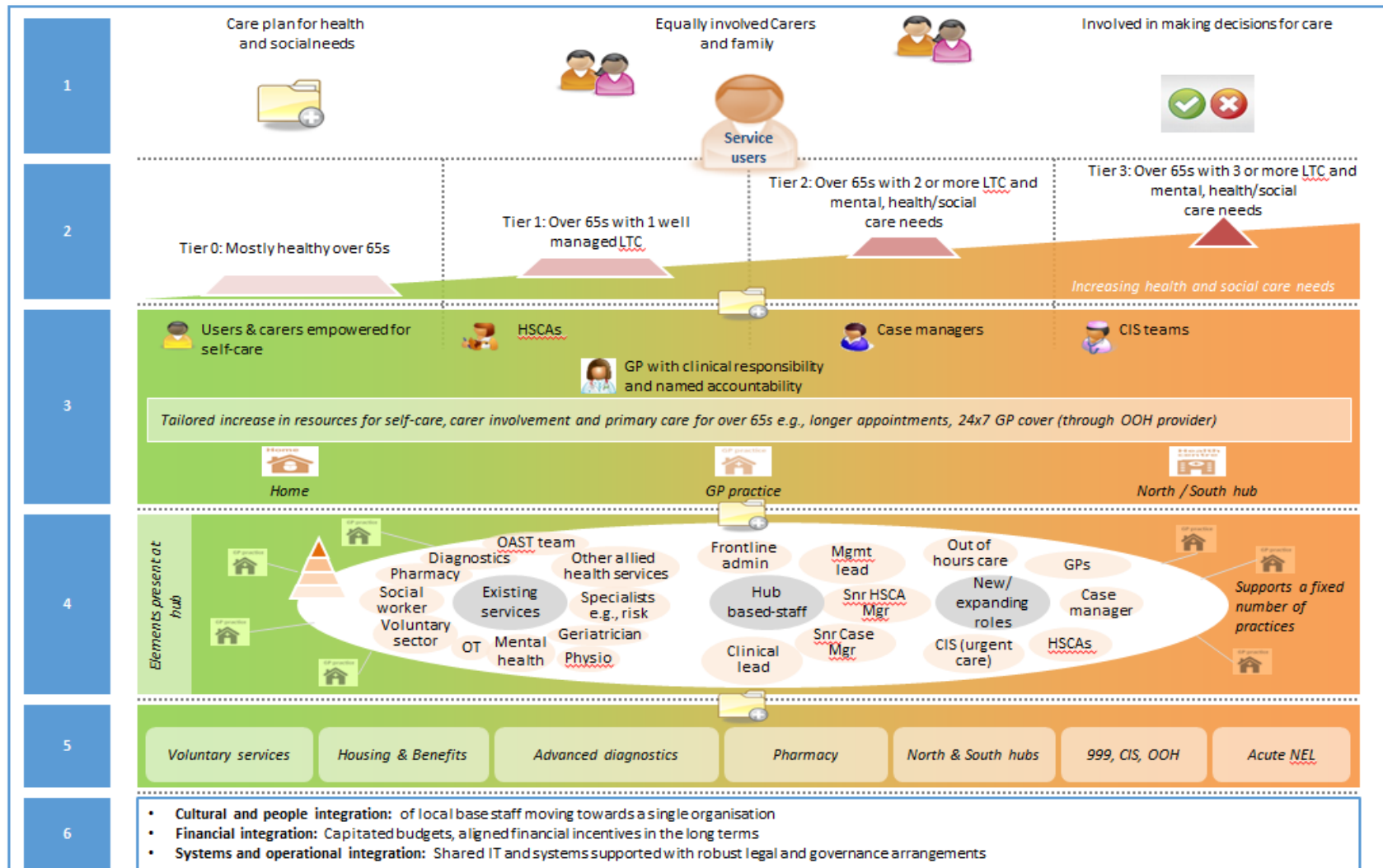
- Primary care provider
- RN case manager
- Certified medical assistant
- Case management support
- Coverage nurse practitioner/physician's assistant
- Dietician
- Behavioral health consultant
- Integrated pharmacist
- Integrated midwife
- Manager

### Some Outcomes:

36% decrease in ER visits between January 2000 and 2015

36% decrease in the rate of hospital admissions from 2000 to 2015

# My Care My Way: Model of Care





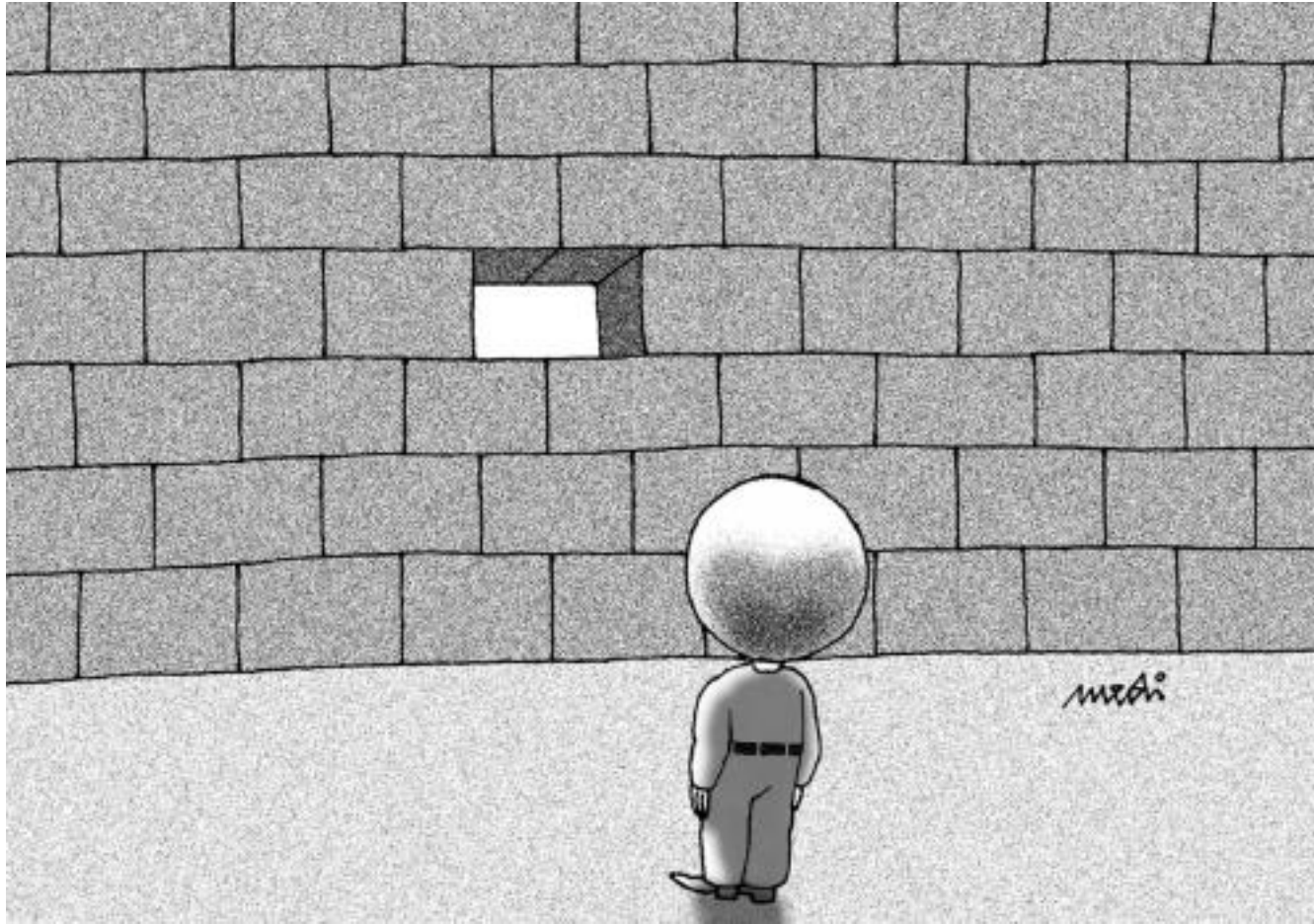
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How can we develop a nurturing  
environment for interprofessionalism  
and integrated care?

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# The common reality...



“The two words ‘information and ‘communication’ are often used interchangeably, but they signify quite different things. Information is giving out; communication is getting through.”

Sydney J Harris



# Workforce changes requiring new competencies for integrated care

- Nurse-led care / Nurse as main care provider
- Multidisciplinary protocols / pathways
- Multidisciplinary staff
- Nurse involvement
- Pharmacist involvement
- Team meetings
- Case manager/Care coordinator
- Provider training
- New position
- Task re-distribution
- Shared medical appointments

Busetto et al. Project INTEGRATE: Workforce Changes in Integrated Care Interventions. Presentation at the ICIC15, Edinburgh 2015



# What are competencies?

“K(nowledge) S(kills) A(ttitudes) are the abilities and characteristics that enable a job holder to accomplish the activities described in a task statement that describes what the job holder does.”

(Quinones, Ehrenstein 1997)

- Knowledge – what I know
- Skills – what I can do and how
- Attitudes – why I do it

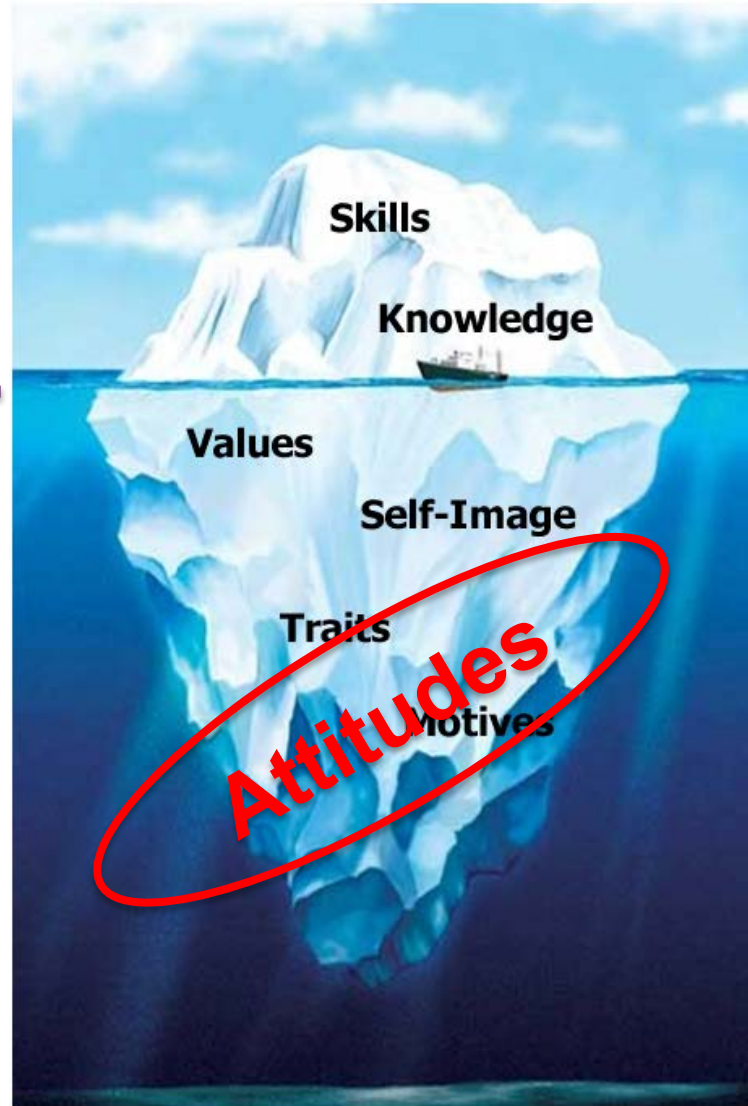


Competencies

# The Iceberg Model of Competencies

Technical  
competencies

Behavioural  
competencies



Can be influenced  
directly through  
education and training



What we know and  
can do

What we perceive and  
what motivates us



May be influenced  
indirectly through  
education and training  
and role models

# 5 competency clusters for integrated care

Competency Cluster	Definition
PATIENT ADVOCACY	<b>Ability to promote patients' entitlement</b> to ensure the best quality of care and <b>empowering patients</b> to become active participants of their health
EFFECTIVE COMMUNICATION	<b>Ability to quickly establish rapport</b> with patients and their family members in an empathetic and sensitive manner incorporating the patients' perceived and declared culture
TEAM WORK	<b>Ability to function effectively as a member of an inter-professional team</b> that includes providers, patients and family members in a way that reflects an understanding of team dynamics and group/team processes in building productive working relationships and is <b>focused on health outcomes</b> .
PEOPLE-CENTRED CARE	<b>Ability to create conditions for providing coordinated/integrated services</b> centred on the patients and their families' needs, values and preferences <b>along a continuum of care and over the life-course</b> .
CONTINUOUS LEARNING	<b>Ability to demonstrate reflective practice</b> , based on the best available evidence and to <b>assess and continually improve the services</b> delivered as an individual provider and as a member of an interprofessional team.

*Langins/Borgermans. Competent health workforce for the provision of coordinated/integrated health services. Working Document. WHO Regional Office for Europe 2015*

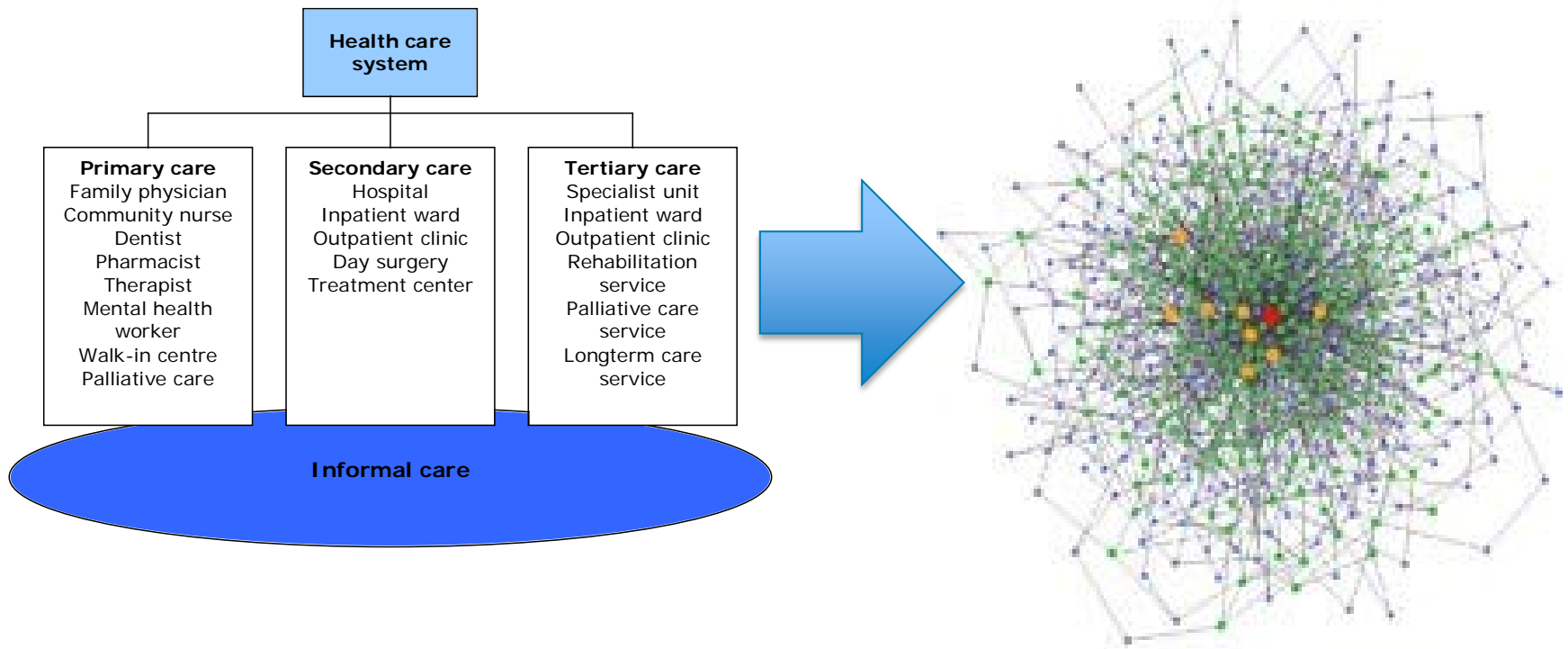
# Transforming educational models

“...all health professionals in all countries to be educated to mobilize knowledge and to engage in critical reasoning and ethical conduct so they are competent to participate in patient and population-centred health systems as members of locally responsive and globally connected teams.”

*Frenk et al. 2010. Health professionals for a new century: transforming education to strengthen health systems in an interdependent world. The Lancet. Vol. 376: 1923-1958.*



# If care is moving from silos to networks...



...education and training must move along!



# The principles of good education

“If planning is done by individuals rather than by groups, by departments rather than by faculty interested in and working on of mutual interest, then an autocratic, discipline- oriented, fragmented curriculum is inevitable. The potentates will be department chairmen defending the boundaries of their discipline and vying for their share of recognition ... to prevent the development of this situation, ... **planning must be undertaken by groups**, not by individuals, and **by mixes of faculty members** who are approaching similar problems from various angles with a variety of methods, techniques and background experiences. ... Qualities of **imagination, flexibility, adaptability and leadership** ...become of paramount importance.”

Spaulding, Canad. Med. Ass. J. April 12. 1969, vol. 100:661-2.



## BUILDING TEAM WORK COMPETENCIES

## TRANSFORMING WAYS OF KNOWING

**ACT**  
as team member

**PRACTICE**  
as team member

**THINK**  
as team member

**PREPARE**  
self as team member

**CREATING  
COLLABORATIVE  
CARE**

acquisition

application

demonstration

**CONTEXTUAL**  
knowing



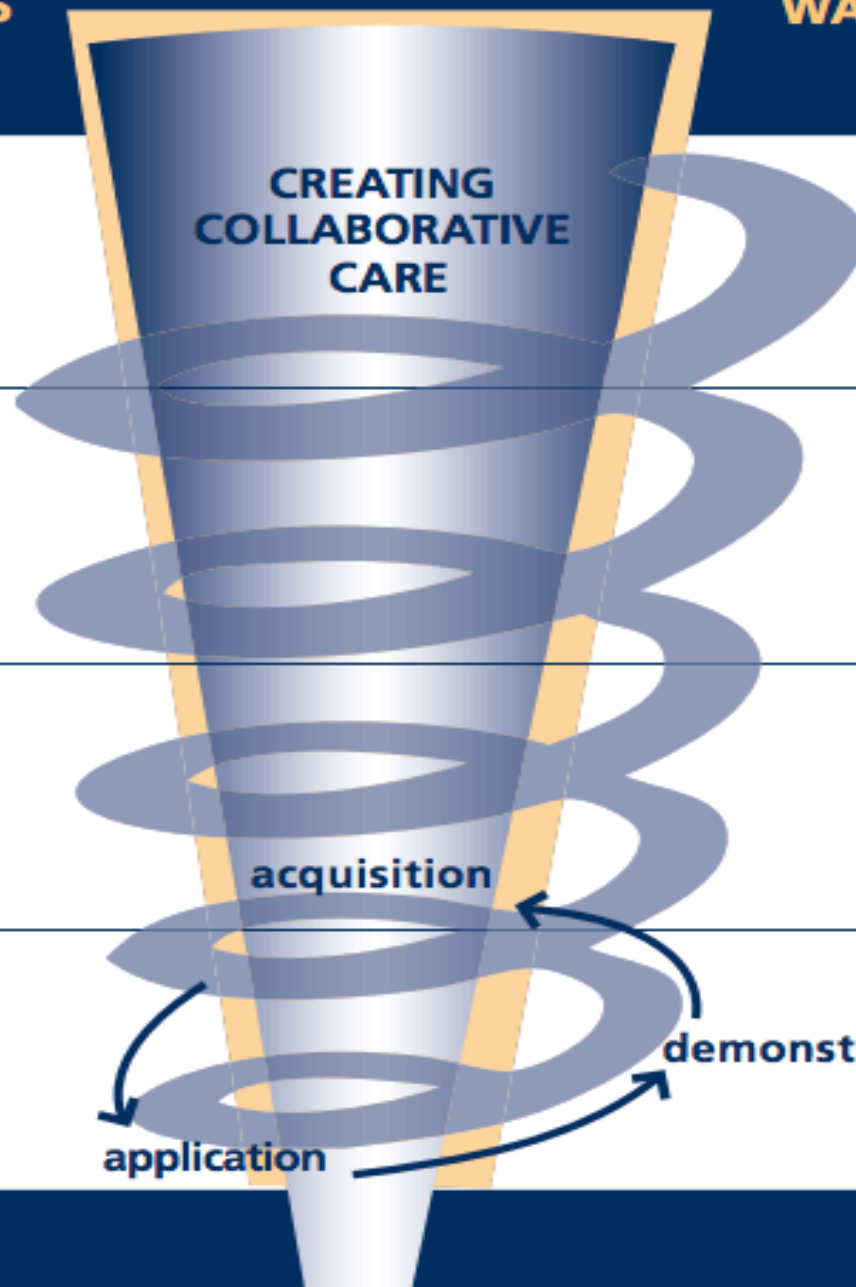
**INDEPENDENT**  
knowing



**TRANSITIONAL**  
knowing



**ABSOLUTE**  
knowing



# Competencies for integrated care: levels and roles

## System

To adapt professional education and training systems; to understand integrated care needs; to create enabling framework and allow for flexible and creative environment.

## Organisation

To lead and manage integrated care across sectors and professions; to manage change processes; to understand integrated care needs and create continuous learning environment.

## Professionals

To work in inter-disciplinary teams across settings; to actively engage patients, families and communities; to understand integrated care needs and participate in continuous education programmes.

## People

To actively participate in own care management; to engage in building healthy communities; to understand integrated care needs and practice life-long learning.



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To conclude.....

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„An integrated and multidisciplinary approach is necessary to achieve a health care supply chain connecting with the needs and demands of the patient. [...] In the future, primary care and care at home will be the standard and multidisciplinary cooperation will be the key to a more patient oriented approach.“

*Van Oosterbos, IJIC (2) 2006*

# What do we want?

