Preamble

**Primary Care** includes comprehensive community based services which encompass promotion, prevention, care and treatment. Amongst others, this requires the development and strengthening of interprofessional collaboration, knowing different professionals and disciplines will be involved. Interprofessional collaboration does not emerge spontaneously. It requires appropriate conditions at a professional, an educational and policy level and in actual practice. This requires interprofessional education and training for professionals involved at all levels.

The aim of the European Forum for Primary Care Position Papers is to learn about the reasons for the variation in care and to identify possible solutions in order to improve primary care for the topics mentioned.

This position paper on Interprofessional Education (IPE) aims to support the improvement of integrated primary health care by primary health care professionals and to support better education for primary health care professionals. And how can IPE strengthen professional collaboration in the different countries in Europe?

I Outline and time frame

II Authors and contributors

III Disposition of EFPC Position Papers

IV Further description of the contents

I Outline and time frame

Time schedule and results

<table>
<thead>
<tr>
<th>Event</th>
<th>Details</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>First workshop</td>
<td>EFPC Conference Graz Austria - presentation of outlines for draft, engagement of interested participants</td>
<td>September 16&lt;sup&gt;th&lt;/sup&gt; 2011</td>
</tr>
<tr>
<td>Pre-draft version</td>
<td></td>
<td>March 2012</td>
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<tr>
<td>First draft</td>
<td></td>
<td>May 2012</td>
</tr>
<tr>
<td>Second workshop</td>
<td>Annual Wonca Conference Vienna Austria</td>
<td>July 4-7 2012</td>
</tr>
<tr>
<td>Third workshop</td>
<td>IV Biannual EFPC Conference Gothenburg Sweden</td>
<td>September 3&lt;sup&gt;rd&lt;/sup&gt;-4&lt;sup&gt;th&lt;/sup&gt; 2012</td>
</tr>
<tr>
<td>Fourth Workshop</td>
<td>3&lt;sup&gt;rd&lt;/sup&gt; European Conference EIPEN Ljubljana Slovenia</td>
<td>September 11-13&lt;sup&gt;th&lt;/sup&gt; 2013</td>
</tr>
<tr>
<td>Second Draft</td>
<td>Presentation at 35&lt;sup&gt;th&lt;/sup&gt; Alma Ata Declaration Conference on Primary Health Care, Kazakhstan</td>
<td>November 6-7&lt;sup&gt;th&lt;/sup&gt; 2013</td>
</tr>
<tr>
<td>Debating the paper</td>
<td>10&lt;sup&gt;th&lt;/sup&gt; Anniversary EFPC Conference Amsterdam, The Netherlands</td>
<td>August 31&lt;sup&gt;st&lt;/sup&gt; – 1&lt;sup&gt;st&lt;/sup&gt; September 2015</td>
</tr>
<tr>
<td>Final version to be approved by the EFPC Executive Committee</td>
<td>To be scheduled</td>
<td>December 2015</td>
</tr>
</tbody>
</table>

Loes van Amsterdam, PP IPE vs 29-11-2015
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III Disposition of EFPC Position Papers

Position Papers are one of the working tools of the European Forum for Primary Care. Therefore, we have followed the EFPC procedures surrounding the position papers. To support practitioners, researchers and policymakers in primary care, the position paper on Interprofessional Education (IPE) has the following content:

1. Clarifying concepts of IPE and formulating a clear problem from a primary care approach
2. Why IPE is a concern in/of primary care
3. Why IPE is (or should be) a concern at international European Union (EU) level
a. Problems and challenges in education on interprofessional and multidisciplinary teamwork
b. Organizational context of transformation of the education and training for multidisciplinary primary care
4. Experiences (both positive and negative), including country or system characteristics that influence these experiences
5. Lessons learned and the conditions (policies) that favor positive experiences to advance in terms of access, equity, efficiency, and quality
6. Recommendations of policy measures on national and European level
7. Identifying areas for further research
8. Addressing primary care from a comprehensive, multi-disciplinary, patient centred and community oriented approach

Abstract

Background: Interprofessional education is indispensable in primary care, as it enables professionals in health care and the social domain to collaborate in order to deliver integrated primary care. Healthcare and social support systems are population based and have become more complex. Professionals work more and more in client- or patient-centred teams. This requires interprofessional collaboration skills, which do not come naturally. Beside this, most professionals are educated in professional silo’s and often in systems that no longer match with daily practice in care.

Aim: This position paper on IPE aims to support the improvement of integrated primary health care and to support better education for primary health care professionals. It also provides strategies and ideas that will help policy-makers implement the elements of interprofessional education to enable collaborative practice, in a way that will be most beneficial in their own domestic policy and jurisdiction in the different countries in Europe.

Methods: This Position Paper on IPE has been achieved through discussions and exchanges of views at four international conferences and workshops combined with desk research. A number of authors with different backgrounds and expertise were involved and a group of EFPC-members have contributed in different ways. This position paper aims to provide strategies and ideas that will help health care providers, educators and policy-makers implement the elements of interprofessional education to support collaborative practice.

Results: We have seen an increase of serious interest in IPE to enable interprofessional collaboration since we started working on this paper. Gradually there is more build-up of scientific evidence about the impact of IPE on the health benefits and health outcomes. Numerous key drivers of change have increased the interest in IPE in health and social care. The 1978 Declaration of Alma-Ata, proclaiming the importance of integrated primary care, laid a solid basis. Since then significant steps forward have been made. Especially authoritative and expert institutions have contributed internationally. The WHO study group on Interprofessional Education and Collaborative Practice Framework for action on interprofessional education and collaborative practice (Geneva, Switzerland, 2010) identifies the mechanisms that shape successful collaborative teamwork and outlines a series of action items that policy-makers can apply within their local health system. The Lancet Commission Report Health Professionals for the 21st Century (2010), emphasizes the importance of teamwork. The recent report of the Institute of Medicine of the National Academies Measuring the impact of Interprofessional Education and Collaborative Practice and Patient outcomes (Washington, USA, 2015) is a plea for alignment of education system and healthcare system. A conceptual framework for further research will be necessary to strengthen the evidence base for IPE.
Conclusions and discussion:

1. You cannot learn together if you don’t work together: experience is the best teacher for IPE
2. IPE should be introduced in the curriculum as early as possible: it is a vital part of professional expertise and is an addition to professional differentiation
3. A coordinated action plan that addresses multiple levels is mandatory to implement IPE.

Keywords: interprofessional education (IPE), multidisciplinary teams, interprofessional collaboration (IPC), teamwork, primary care, ........
IV Content

1. Introduction - Clarifying concepts of IPE and formulating a clear problem from a primary care approach

During conferences, meetings and discussions we have stated a strong need to formulate a clear vision on contemporary and future education of professionals. In our view it is important to facilitate interprofessional and multidisciplinary collaboration in primary health care through education and training of primary care professionals. However, we also perceive that professional education is fragmented, often outdated, or there is a mismatch of competences in regard to population and patient needs. We do not expect education to change by itself.

How can we clarify what we mean by Interprofessional Education (IPE)? Interprofessional education refers to occasions when practitioners (or students) from two or more professions in health and social care learn together during all or part of their undergraduate or postgraduate professional training or continuing professional development, with the object of cultivating collaborative practice for providing client- or patient-centred health care. Will this be sufficient to meet the needs in primary care?

There are two generally accepted definitions of IPE which have close similarities:

CAIPE (Centre For The Advancement Of Interprofessional Education, UK, 2002) definition of Interprofessional Education (IPE) is:

*Interprofessional education (IPE) occurs when two or more professions learn with, from and about each other to improve collaboration and the quality of care.*

The scope of IPE is (CAIPE 2002):

*IPE includes all such learning in academic and work based settings before and after qualification, adopting an inclusive view of “professional”.*

WHO (2010, p. 7) definition of Interprofessional Education (IPE) is:

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

2 IPE a concern for primary care

Today and in future, primary health care will mostly be provided by different professionals, often working together collaboratively or in teams to fulfil patients' health care needs. Therefore, IPE and associated concepts are a concern for EFPC. It will enable professionals to deliver better integrated care and offer the patient healthcare in a coordinated and ‘flowing process’.

EFPC is not the first platform that sees this as a serious concern. In the recent past others have expressed interest in this topic. We name the following.


The Lancet Report ‘Health Professionals for a New Century: Transforming Education to Strengthen Health Systems in an Interdependent World’ - Education for Health Professionals for the 21st century, stood up for Transformative learning (December 2010), as to educate professionals in teams and as change agents.

In the Netherlands the Raad voor Volksgezondheid en Sport (RVZ, Dutch advisory board for the ministry of health)) published a report on new professions in Care and Cure sector (April 2011). It sees a solution in new and renewed educational programs and regards their advice as a ‘wake up call’. In a follow up, the Dutch minister of Health installed an advisory committee for innovation of healthcare professions and education (2012). At present this committee has developed a new vision, with 2030 as perspective, on healthcare and welfare, the professions and the education which will be needed, which enfolds both IPC and IPE.

And yet, at the same time we see some persistent problems that hold back strong development or changes. For one, universities, colleges, vocational and specialty training institutions find it very hard to agree on multidisciplinary and especially interprofessional educational programs. This seems to be due to the way the educational system is constructed and the cultural differences between the professions, each focusing on their own domain in so called silos.

3. IPE a concern at international European Union (EU) level

Problems and challenges in education for interprofessional collaboration and multidisciplinary teamwork in primary care

Future primary health care will mostly be provided by different professionals to fulfil patients’ health care needs and deliver community oriented and integrated services. This Position Paper (PP) will support practitioners, educators and policymakers in primary care. The earlier mentioned World Health Organization (WHO), European IPE Network (EIPEN) and The Lancet Global Independent Commission also stress the importance of IPE. Therefore, Interprofessional Education (IPE) is a concern not only for the EFPC but for stakeholders on a European Union level as well.

The 1978 the Alma Ata declaration the definition of primary care (PC) already focused on Health promotion and prevention, intersectoral collaborative approach, and population based health and social care.

Since then progress has been made to develop this vision. At the same time, we must conclude that interprofessional education is still not mainstream and needs to be helped forward on a European policy level. It remains important to exchange experiences and ideas about the education of new healthcare professionals and the continuing professional development of those already in the workforce. It is helpful to communicate within a network, not only on a national, but on a European or even global scale.

It seems unavoidable to educate and train (new) professionals to enable them to work in a team, to review them on interprofessional and multidisciplinary collaboration, and to transform them into change agents. How can we find ways to attain this? This reformation of the educational system seems to ask for a multi-national approach. In the European context the EFPC will have the opportunity to reflect on the subject, to gather
good examples, practice based evidence (good practice), national and international literature, and to identify supportive and detracting indicators. It can be helpful to clarify the scope and to develop a shared understanding of the subject.

As described in the EFPC Position Paper ‘Impact on continuity on quality of care within Primary Care’ (2013): It is necessary to face the challenges of society with problems of chronic conditions, increasing globalisation, issues of access to health care and of continuous quality improvement.

Or as said at the conference in Graz (2011) in a firm conclusion of participants of the workshop: ‘We have the responsibility to make the need of educational changes and experiences in regard to this more visible’.

Organizational context and transformation of the education and training for interprofessional and multidisciplinary primary care

Questions we can ask ourselves: What is the evidence that IPE leads to better processes, outcomes or experience of care? What further types of studies are required? Does IPE have to be obligatory, for institutions, teachers, students alike? Which areas or types of learning are most appropriate for IPE? How can institutions or workplaces be encouraged to incorporate this issue in their educational programs? What is the optimal timing of IPE in the curriculum? We also put into discussion: Do we want a broadly educated healthcare professional? Or do we need specialist healthcare professionals with discretionary power? To obtain some answers we have collected and identified a number of good practices but also barriers for IPE.

Educational concepts can offer solutions across borders, such as the CanMeds* model, developed in Canada and applied in a number of countries. Or we can look at the Expanded Chronic Care Model (WHO) and see what this can offer us on the matter of reshaping education and training.

Figure 1: CanMeds model

4. Experiences and developments, including country or system characteristics that influence these experiences

Loes van Amsterdam, PP IPE vs 29-11-2015
This chapter includes some clear practical examples and provides a summary of these examples and provides further information about studies on IPE.

At the EFPC conferences in Pisa (2010) the first ideas about interprofessional education were put into discussion. At the following EFPC conferences in Graz (2011) and Gothenburg (2012) further discussion followed and experiences were exchanged. At the Wonca conference (Vienna 2012) and the EIPEN conference (Ljubljana-Slovenia 2013) workshops were held in which further input was given and experiences and recommendations were given. A number of very appropriate examples were brought in. The following drivers, inhibitors and realisations were given.

A. drivers for IPE

Kazachstan: to be able the work together, it is important to become ‘friends’ first. This is not done through education, but by socializing, such as inviting one another for a meal or a drink.

Switzerland: there has to be a need for cooperation: in the past years there were too many patients and not enough doctors. This fact became the incentive for collaborative teams.

Italy: GP’s and nurses working in teams for people with chronic diseases and are successful. Though as soon as the financing stopped, the teams stopped.

B. inhibitors

The Netherlands: breaking down hierarchical barriers and to learn to speak each other’s professional language, are essential to be able to value one another in teamwork and fulfil different team roles. Healthcare is organized in different levels, visualized in the form of a pyramid.

Albania: collaboration: interference or cooperation? Relations between GP’s and mental healthcare providers asked efforts to establish relationships and ensure continuity of treatment; they were sometimes perceived as interference rather than an invitation for cooperation. <1. See References>

Hungary: a practice nurse, with 15 years’ experience in primary care is still considered illegal by the authorities.

C. realisations.

The Netherlands: we see an increase of interest in IPE, which is shown through examples of collaboration between midwifery and obstetrics, in local social and health care teams, or in constructions where students run specific units, e.g. a recovery hotel.

Sweden: a widely supported broadening in medical training of general practitioners (GP’s) and other disciplines. Also a method with two weeks working on patients’ cases in a multidisciplinary setting.

UK: medical and nursing students have a year completely generic tuition (UK).
The following studies give a cross section of illustrations of research and literature on IPE

- **Timing of the IPE in the curriculum**

An Australian cross-sectional survey used the Readiness for Interprofessional Learning Scale (RIPL) to evaluate the attitudes of undergraduate students toward interprofessional learning. A total of 741 students in medicine, nursing, midwifery, nursing-emergency health, physiotherapy and nutrition-dietetics were questioned. Students with prior experience of IPL had significantly stronger attitudes toward participation in IPL compared with those without, for each of the attitude domains of the RIPLS (Teamwork and Collaboration, Professional Identity, Roles and Responsibilities). Data suggest that shared learning may be an important precursor in the development of interprofessional collaboration skills for students. Authors conclude that IPL should be introduced in the undergraduate curriculum as early as possible.

<All references to be placed at the end of this paper>

- **IPE and social accountability**

Ghent university (Belgium) introduced a community-oriented primary care exercise for third-year medical and master of social work and social welfare studies students. During one week, small groups of students visit patients and their caregivers in underserved neighbourhoods. With the monitoring of local general practitioners and social workers, these experiences are combined with public health data to develop a community diagnosis. The aim is for the students to develop a greater understanding of the situation of individual patients in the community, to appreciate the roles of patients’ different caregivers and to learn to combine data from different sources in a joint learning experience with students from different disciplines. Besides learning how to look at health care from a community perspective, students appreciate the opportunity to get to know students from other disciplines and learn to understand the complementary roles of different health care disciplines. This prepares students for effective interprofessional collaboration in practice.


- **Preparation for collaborative behaviour and collaboration skills**

The McMaster University (Canada) introduced a gross anatomy dissection course for students from the medicine, midwifery, nursing, physician’s assistant, physiotherapy, and occupational therapy program. The 10 weeks’ program consisted of an anatomy and scope-of-practice presentation, a small-group case-based session, and a dissection during a weekly three-hour course. Quantitative data revealed significant improvements in positive professional identity, competency and autonomy, role clarity and attitudes toward other health professions. Qualitative analysis of intraprofessional focus group interviews revealed meaningful improvements in a number of areas including learning anatomy, role clarity, and attitudes towards other health professions. The longer duration of the course resulted in a growing trust in each other and the ability to work as a team.
Interprofessional learning during practice (workplace learning-WPL) occurs spontaneously when healthcare professionals from different disciplines are working together. In Flanders (Belgium), general practitioners collaborate with specialised nurses from palliative home care teams. General practitioners stated to learn during this collaboration. The specialised palliative care nurses received a train the trainer program to become a facilitator of physicians’ workplace learning. Evaluation shows that it is feasible to train nurses for this task and as such to enhance interprofessional workplace learning.


Practice-based interprofessional education

The Common Learning Programme in the North East (UK) offered practice-based interprofessional education to pre-qualification students in health and social care. A mixture of students (social work, physiotherapy, nursing, SALT, medicine, radiography and occupational therapy) on practice placements worked together on specific cases in order to model real interprofessional teams. The programme consisted of seminar sessions, discussions, design of a work plan implementation of the work plan and reflection afterwards with the whole group. Some items having to do with professional roles and team working were planned for discussion. Other items rose spontaneously depending on the context (setting) of the practice placement and on the mixture of students in the group.


Changing student attitudes toward interprofessional learning and collaboration

The Widener University (Pennsylvania, USA) offered a short, six-hour interprofessional educational intervention to undergraduate students from clinical psychology, physical therapy and social work. Four sessions (introduction on interprofessional collaboration, introduction of a clinical case, group discussion as a mock interprofessional team) were held under faculty supervision. Attitudes toward learning from and collaborating with other disciplines were measured using the Interdisciplinary Education Preparation Scale, the Readiness for Interprofessional Learning Scale (RIPL) and the Attitudes Toward Healthcare Teams Scales. All increases in the post-scores showed statistical significance. This study indicates that even a short educational intervention can lead to changes in attitudes toward learning and collaboration.
Interprofessional learning and quality improvement of patient care

The Leicester model of IPE focuses on enhancing the quality of patient care by bringing together a student team and the patient’s current professional team. Both teams work and learn alongside one another using experiential learning, enquiry through case analysis and application of evidence to practice and reflection. Both teams gain new knowledge, problem solving skills and insights into team working.


Student involvement in the design and implementation of IPE

Student leadership facilitates the implementation of IPE by motivating their peers to join. Longstanding implementation is equally enhanced by student involvement.


Recommendations from graduates

The delivery of IPE should continuously be evaluated. One way of doing this is asking feedback from students. This study in Australia used focus groups to explore the view of recent graduates from different disciplines, being in practice for two years. Participants described their experiences, i.e. silos and social interactions, the dissonance between the stated faculty values and the educational practice and how they missed opportunities for IPE during clinical placements. Finally graduates made several recommendations to improve IPE at university, a major recommendation being the integration of IPE in other courses and not offering it as a stand-alone course.


Social accountability of IPE

A study in South Africa explores the impact of an IPE program on preparing graduates to practice in rural and underserved areas. The focus was on participants’ interest in IPC and Practice and on their intentions for or against future practice in rural or underserved areas. Both aims were considered to be reached though suggestions for improvement during clinical placements and supervision were mentioned.


How to prepare staff for the implementation of IPE
Faculties (i.e. schools) of medicine along with their sister health discipline faculties can be important organisational vehicles to promote, cultivate, and direct IPE. The authors present information they gathered in 2007 about five Canadian IPE programs to identify key factors facilitating transformational change within institutional settings toward successful IPE, including (1) how successful programs start, (2) the ways successful programs influence academia to bias toward change, and (3) the ways academia supports and perpetuates the success of programs. Initially, they examine evidence regarding key factors that facilitate IPE implementation, which include (1) common vision, values, and goal sharing, (2) opportunities for collaborative work in practice and learning, (3) professional development of faculty members, (4) individuals who are champions of IPE in practice and in organizational leadership, and (5) attention to sustainability. Subsequently, they review literature-based insights regarding barriers and challenges in IPE that must be addressed for success, including barriers and challenges (1) between professional practices, (2) between academia and the professions, and (3) between individuals and faculty members; they also discuss the social context of the participants and institutions. The authors conclude by recommending what is needed for institutions to entrench IPE into core education at three levels: micro (what individuals in the faculty can do); meso (what a faculty can promote); and macro (how academic institutions can exert its influence in the health education and practice system).


A more recent article on this subject presents the following. With the growth of IPE and interprofessional practice in health professional schools, faculty members are being asked to take on new roles in leading or delivering an IP curriculum. Faculty members mainly feel ill-prepared to face the challenges of this curricular innovation. The University of Missouri – Columbia and University of Washington, partnered with six additional academic health centres (2012–2013) to pilot a faculty development course to prepare faculty leaders for IPE. A variety of techniques, were used as: including didactic teaching, small group exercises, immersion participation in IPE, local implementation of new IPE projects, and peer learning. The program positioned each site to successfully introduce an interprofessional innovation. The participating faculty confirmed the value of the program and suggested that more widespread similar efforts were worthwhile. Key elements to make this faculty development successful were: peer learning arising from a faculty development community, adaptation of curricula to fit local context, experiential learning, ongoing coaching/mentoring, especially as it related to actual participation in IPE activities.


- IPE being part of universities’ culture enhances longevity of implementation

Institutions are increasingly considering interprofessional education (IPE) as a means to improve healthcare and reduce medical errors in the United States. Effective implementation of IPE within health professions education requires a strategic institutional approach to ensure longevity and sustainability. In 2007, the Medical University of South Carolina (MUSC) established Creating Collaborative Care (C), an IPE initiative that takes a multifaceted approach to weaving interprofessional collaborative experiences throughout MUSC's culture to prepare students to participate in interprofessional, collaborative health care and research settings. In this article, the
authors describe C’s guiding conceptual foundation and student learning goals. They present its implementation framework to illustrate how C is embedded within the institutional culture. It is housed in the provost’s office, and an overarching implementation committee functions as a central coordinating group. Faculty members develop and implement C activities across professions by contributing to four collaborating domains-curricular, extracurricular, faculty development, and healthcare simulation-each of which captures an IPE component. The authors provide examples of IPE activities developed by each domain to illustrate the breadth of IPE at MUSC. The authors believe that MUSC’s efforts, including the conceptual foundation and implementation framework, can be generalized to other institutions intent on developing IPE within their organizational cultures.


• **Learning from others: comparison of three universities**

The past decade witnessed momentum toward redesigning the U.S. healthcare system with the intent to improve quality of care. To achieve and sustain this change, health professions education must likewise reform to prepare future practitioners to optimize their ability to participate in the new paradigm of health care delivery. Recognizing that IPE is gaining momentum as a crucial aspect of health care professions training, this article provides an introduction to IPE programs from three different academic health centres, which were developed and implemented to train healthcare practitioners who provide patient-centred, collaborative care. The three participating programs are briefly described, as well as the processes and some lessons learned that were critical in the process of adopting IPE programs in their respective institutions. Critical aspects of each program are described to allow comparison of the critical building blocks for developing an IPE program. Among those building blocks, the authors present information on the planning processes of the different institutions, the competencies that each program aims to instil in the graduates, the snapshot of the three curricular models, and the assessment strategies used by each institution. The authors conclude by providing details that may provide insight for academic institutions considering implementation of IPE programs.


5. **Lessons learned and the conditions (policies) that favour positive experiences to advance IPC in terms of access, equity, efficiency, and quality of primary care**

The challenges to be faced, in terms of urgency and future demands, are to offer high quality affordable healthcare, for an ageing population with an ageing workforce, while shifting from problem oriented to goal oriented primary care with an increasing influence of patients.

**Evidence (IPEC 2012, Thistlethwaite 2012):** <the following can perhaps best be put in a scheme/matrix>

- Learning together enhances future working together
- IPE fosters positive interaction among different professions
- IPE improves attitudes towards other professionals
- IPE activities are diverse
• Good evaluation methodology and data are progressing, but still limited regarding Primary Care.

Problems, barriers, solutions:

• Cultural differences between the professions, each focusing on their own domain (silo)
• Focus more on communication and collaboration between professionals
• Make better use of existing integrated settings for IPE (act as change agents)
• Bridge the gap of cultural barriers between populations and countries
• Legal and financial barriers have to be taken in each country, be creative in finding solutions
• Professional accreditation organizations mandate only for their own professions
• Make multi-disciplinary accreditation for joint efforts possible
• Construction of the educational system
• Hard to come to agreements on interprofessional and multidisciplinary educational program
• Start experimenting on a small scale, within your own reach.

6. Recommending policy measures on national and European level

Bridging rationalities is a necessity to bridge gaps between professionals.

Socialization through education, experience and raising is seen as a serious problem, that obstructs interprofessional education and collaboration.

How to influence change on the different levels?

Different levels were identified at which influences for change is expected to be effective: functional, cultural/personal, educational, clinical, legal and financial, system level.

To name some examples at each level: <the following can be presented in a scheme/matrix>

1. Functional level:

• Communication about IPE
• (Develop) a shared understanding
• (Gather) good examples, practice based evidence
• Literature reviews (national/international)
• To further identify supportive and detracting indicators
• Develop mutual power of change.

2. Cultural / personal level:

• To answer the need of the patients/population is under all circumstances our starting point!
• Different cultural background professional-patients; professional has to adapt (Sweden)
• Professionals are ' imprinted' for hospital care (Italy)
• Students come with stereotyping ideas: new roles for different type of practitioners (UK)
• Uncover differences
• Discuss: who and what is the person, the function, hierarchy level
• Values – personal and professional – need to be open, explicit
• Shift from profession-centric (and defensive attitude) to patient-service centered practice
3. **Educational level:**

- Paradigm shift in professional education at all levels
- Introduction of ‘transformative learning’ (scientists/professionals act as ‘change agents’; The Lancet Commission 2010)
- Use of theatre, playing each other’s professional role, videotaping and discussing (Italy)
- Training of pre-graduate students in communication with non-medicals (Switzerland)
- Training to learn the same (medical) narrative (Switzerland)
- The use of multidisciplinary case studies (Switzerland)
- Team oriented training, enhance teambuilding, highly accredited for gp's and nurses alike (Slovenia)
- Teach the teachers: start early, including nursery teachers, kindergarten, schools.

4. **Clinical level:**

- Require senior managers to collaborate
- Facilitate communication between professionals, e.g. data communication
- Develop education specific for primary care professionals.

5. **Legal and financial level:**

- Illegal to employ practice nurse as it is not accepted by the authorities (Hungary)
- Multidisciplinary teamwork (gp’s-nurses) not continued after stopped financing (Italy)
- Distinguish clearly between the (legal) authority of different professionals (Slovenia)
- Evidence is needed that IPE/Integrated care increases value and improves care
- Change regulations so that they are in tune with education/practice/funding
- Insurance system changes are needed.

6. **System level:**

- A multi-national approach
- Put lessons into practice
- Political choices and accountability (local, regional, national)
- Do we have to follow societal development?
- Patient safety is increased by teamwork, but patients can be left out, because healthcare professionals focus on their own responsibilities:
  - Pressure from outside or/and patient organizations.

7. **(Identifying) areas for further research.**

There seems to be no shared view on what can best be addressed during each phase of education or work place learning. The CIHC report *A National Interprofessional Competency Framework* (2010) and the Expert Panel report *Core Competencies for Interprofessional Collaborative Practice* (2011) are both authoritative reports about IPE and IPC. Questions which arise and remain mainly unanswered in these reports, articles and exchanged experiences are what elements can best be learned at what time during education and practice? For instance, can competencies regarding attitude best be addressed during undergraduate education, whereas team-decision making can be best learned when working with real patients and teams?

More in general, it would be very helpful to development a framework for further research, which can gradually be filled with results and discussions derived from academic, educational and practice research.
8. Addressing primary care from a comprehensive, multi-disciplinary, patient centred and community oriented approach

From thinking to doing?

In a practice or educational setting you can start at a small level as follows:

- What belongs to your own discipline? What to the other discipline(s)?
- What do we have in common?
- What does the patient/person need?
- Start small and aim for (quick) results: pick low hanging fruit.
- Continue from there on: take cuttings for new plants.

Strategy for action (CAIPE, 2013):

1. Make your own case for IPE: strategic, organizational or practice level for the introduction of IPE to support collaborative practice
2. Develop your own toolkit which will guide and help to present a strong argument to key people in your own country of the need for the introduction of IPE to underpin collaborative practice
3. Find a peg to hang your arguments on for a business case
4. The business case contains:
   - Context (your own): identify relevant policies on education, health and social care, government agenda’s on a national, regional or local level
   - Benefits/Value added: highlight the benefits of IPE for collaborative practice
   - Who should be involved/persuaded: look for support among key people or organisations, target the right individuals and identify the benefits for them of their organisation
   - Resources/Evidence needed to support your case: evidence of effective IPE, evaluations and published examples of the impact on patient care, national and international reports that can support your case, design a pilot study in one area, use a realistic phased plan in your business case.

9. Conclusions

Although there is no all-embracing report on IPE, enough (practice derived) evidence shows that Interprofessional Education leads to professionals in both health and social care, who are well equipped for contemporary and future primary care service delivery. In an increasing complex setting of needs, it leads also to an increase of patient safety, patient’s and professionals’ satisfaction at the same time. This Position Paper hopes to inspire and support professionals, students, policymakers, managers and governments at all levels, and with the European diversity. It provides practical and theoretical information for all those concerned to strengthen primary health care, through the support and implementation of IPE. This paper aims to offer support for IPC and IPE within everyone’s own context.

References:

<List of references to be added, based on references mentioned in the above proposed article.>

1. Interprofessional education in post-graduate training, an Albanian experience, E. Shkurti, August 2012

Further information:
European Forum for Primary Care
The basic aim of the Forum is to improve the European population's health by promoting strong Primary Care. This is done by monitoring the state of Primary Care in the European countries, by collecting information on conditions that matter for strong Primary Care, and by exchanging experiences. The Forum supports PHC services at local or regional level, influences (health) policies at national and international level (EU, WHO) and supports research. The Forum connects three groups of interested parties: the health care field, health policy makers, and the producers and evaluators of health care information. These interested parties work at three levels: the local or district level, the national level, and the supra-national level. By linking policy practice and research the Forum intends to stimulate policy making based on vision and evidence as much as it intends to support PC practice oriented towards quality and equity.

European Forum for Primary Care (EFPC): www.euprimarycare.org
Jan van Es Institute (Jvei): www.jvei.nl
European Interprofessional Practice & Education Network (EIPEN): www.eipen.eu
Centre for the Advancement of Interprofessional Education (CAIPE): www.caipe.org.uk
World Health Organization (WHO): www.who.int

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