

Healthcare Workforce Readiness for Interprofessional Collaborative Practice

ASAHP Leadership Development Program Research Team

Elizabeth M. Adams, University of South Alabama

Anthony P. Breitbach, Saint Louis University

Lisa L. Dutton, St. Catherine University

Patricia Y. Talbert, Howard University

Andrew J. Butler, Georgia State University

MISSINGLOGIC, LLCSM

Tracy Christopherson & Michelle R. Troseth

Healthcare Workforce Readiness for IPCP

- ▶ This presentation is a project completed as part of the ASAHP Leadership Development Program
- ▶ **Purpose:**
 - ▶ Present a *unique approach* to addressing institutional/organizational challenges
 - ▶ Explore the *interdependent relationship* between *Interprofessional Education (IPE)* and *Interprofessional Collaborative Practice (IPCP)* through **Polarity Thinking™**
 - ▶ Create a *greater understanding* of this *polarity*
 - ▶ Recommend *action steps* for *moving IPE* and *IPCP forward*

Interprofessional Education (IPE)

Interprofessional education (IPE)

occurs when

students (learners) from *two* or *more professions*
learn

about, from, and *with* each other
to enable effective collaboration and improve health outcomes.

(WHO, 2010)

Interprofessional Collaborative Practice (IPCP)

Interprofessional Collaborative Practice (IPCP)

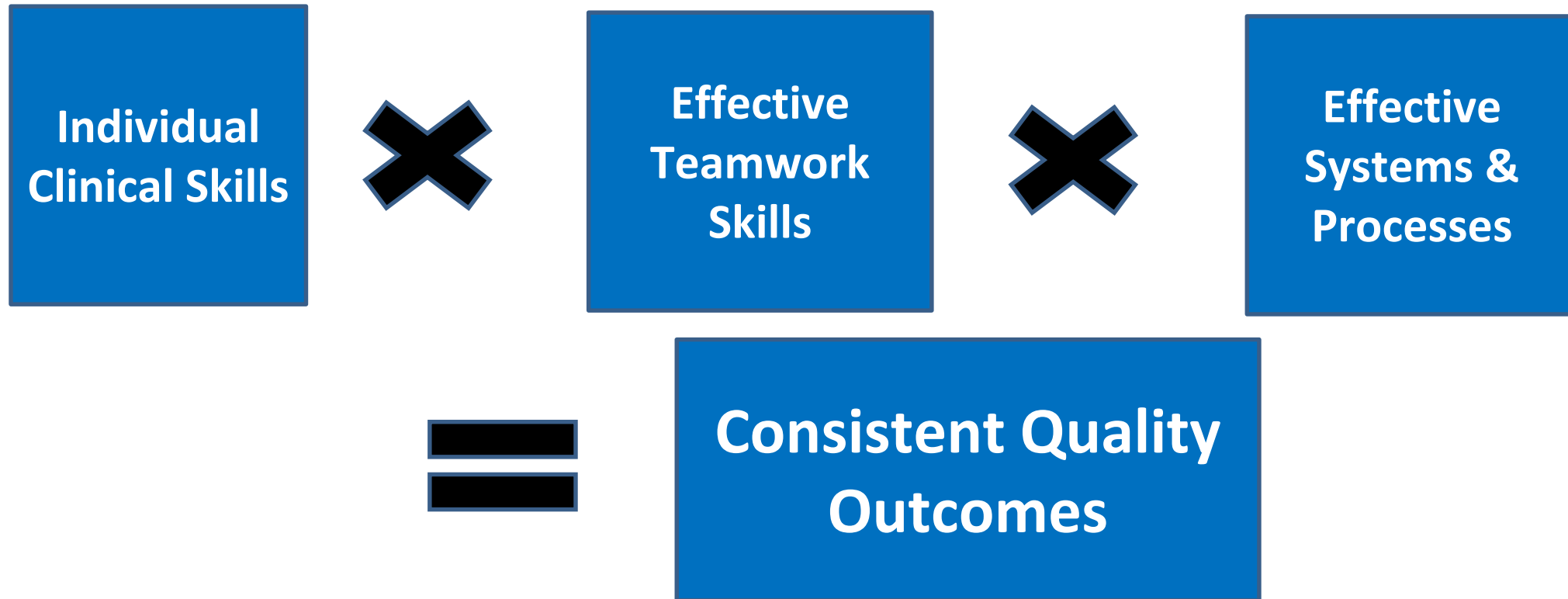
happens when

multiple health workers from different *professional backgrounds*
work together

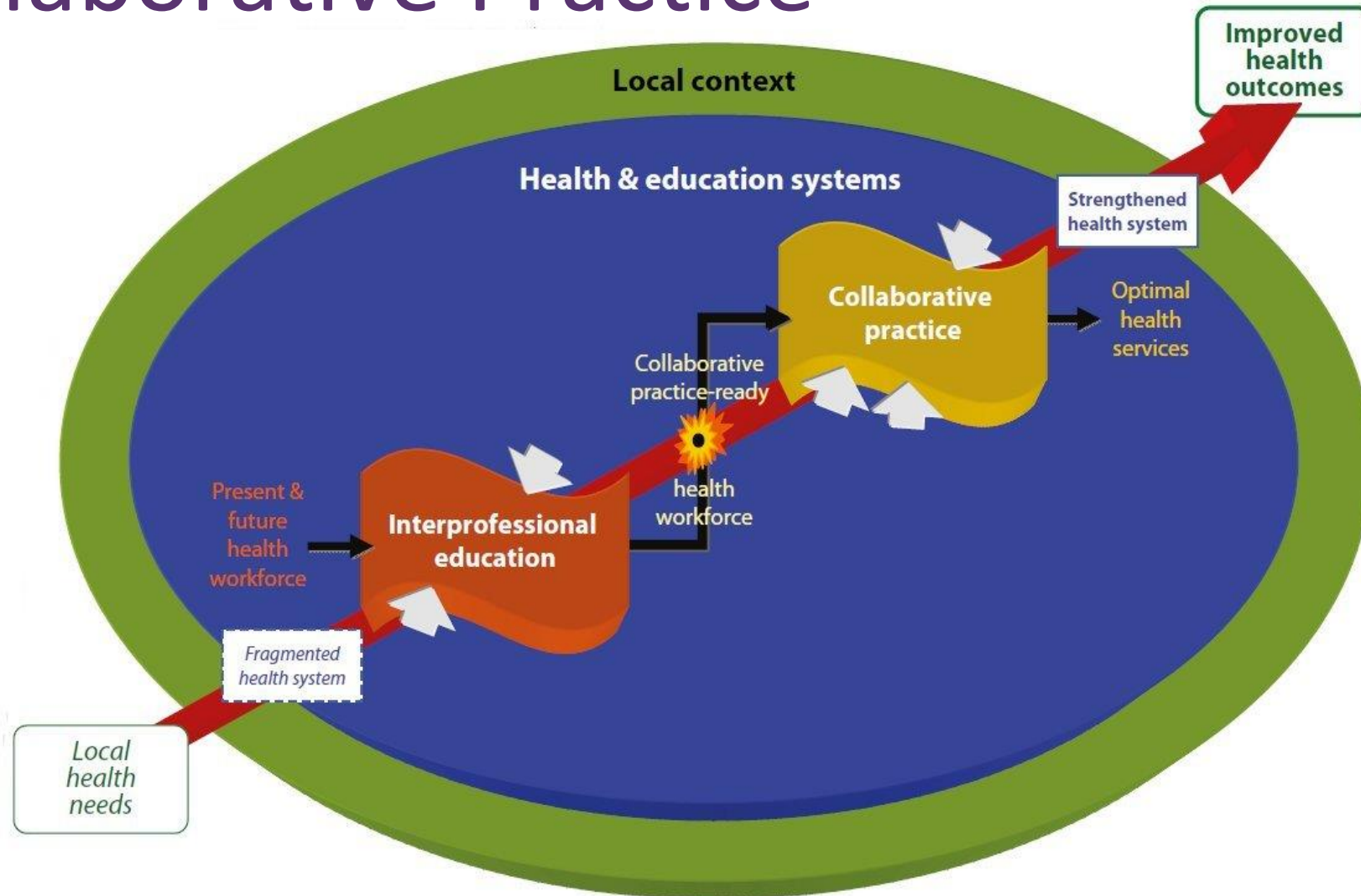
with patients, families, caregivers, & communities
to deliver the highest quality of care.

(WHO, 2010)

Factors Impacting Outcomes



Interprofessional Education and Collaborative Practice



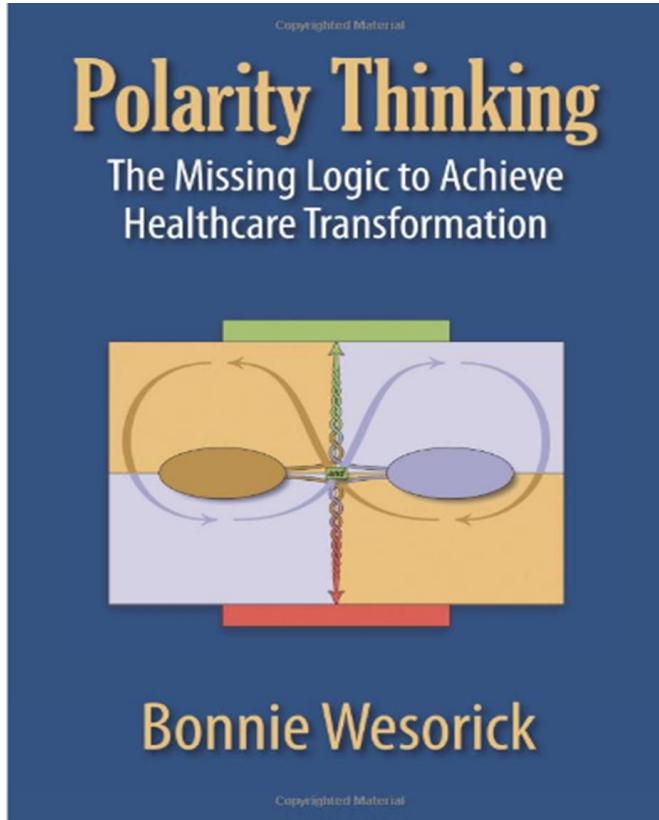
Quadruple AIM

- ▶ “Triple Aim”
 - ▶ developed as a *common goal*
 - ▶ to *improve* the *patient experience*, *improve population health outcomes*, and *reduce costs*

- ▶ “Quadruple Aim”
 - ▶ logical *evolution*
 - ▶ adds the goal of *improving* the *care experience* of *health care clinicians* and *staff*



Polarity Thinking



- ▶ **1975: Barry Johnson** developed the **Polarity Map[®]**
 - ▶ leverage the power inherent in interdependent pairs
 - ▶ identified key principles to describe *how polarity energy systems work*
- ▶ **1995: Bonnie Wesorick** introduced the **Polarity Map[®]** to an **international healthcare consortium** which led to
 - ▶ Publications relating to Polarity Thinking[™] in Healthcare
 - ▶ the Interprofessional Institute for Polarity Thinking[™] in Healthcare
- ▶ **2017: MissingLogic, LLCSM** established
 - ▶ Goal - *advance Polarity Thinking in Healthcare*

Polarity Thinking

The ***G A P*** between **IPE** and **IPCP** is *not* a *problem* to be *solved*.

Instead, it is a ***polarity*** that *requires management*.

- ▶ Polarities represent ***interdependent pairs*** of *values* or *perspectives*
 - ▶ **appear** to be competitive or oppositional
 - ▶ but **need each other** over time to achieve a greater purpose

Problem or Polarity?

Problem to Solve

- ▶ Not ongoing, end point exists
- ▶ Solution: present *independent* alternatives
- ▶ Stands alone
- ▶ *No need* to include alternatives for the solution to work

Polarity to Manage

- ▶ Ongoing, no end point
- ▶ Manage together with *interdependent* alternatives
- ▶ Cannot stand alone
- ▶ *Alternatives* need each other to *optimize* the situation over time

How All Polarities Work

Polarities are an *energy system*:

- We often *experience* the energy as “*negative*” *tension*
- It can actually be *negative* and/or *positive*, depending on *how* we *understand* and *approach* it

The energy in polarities:

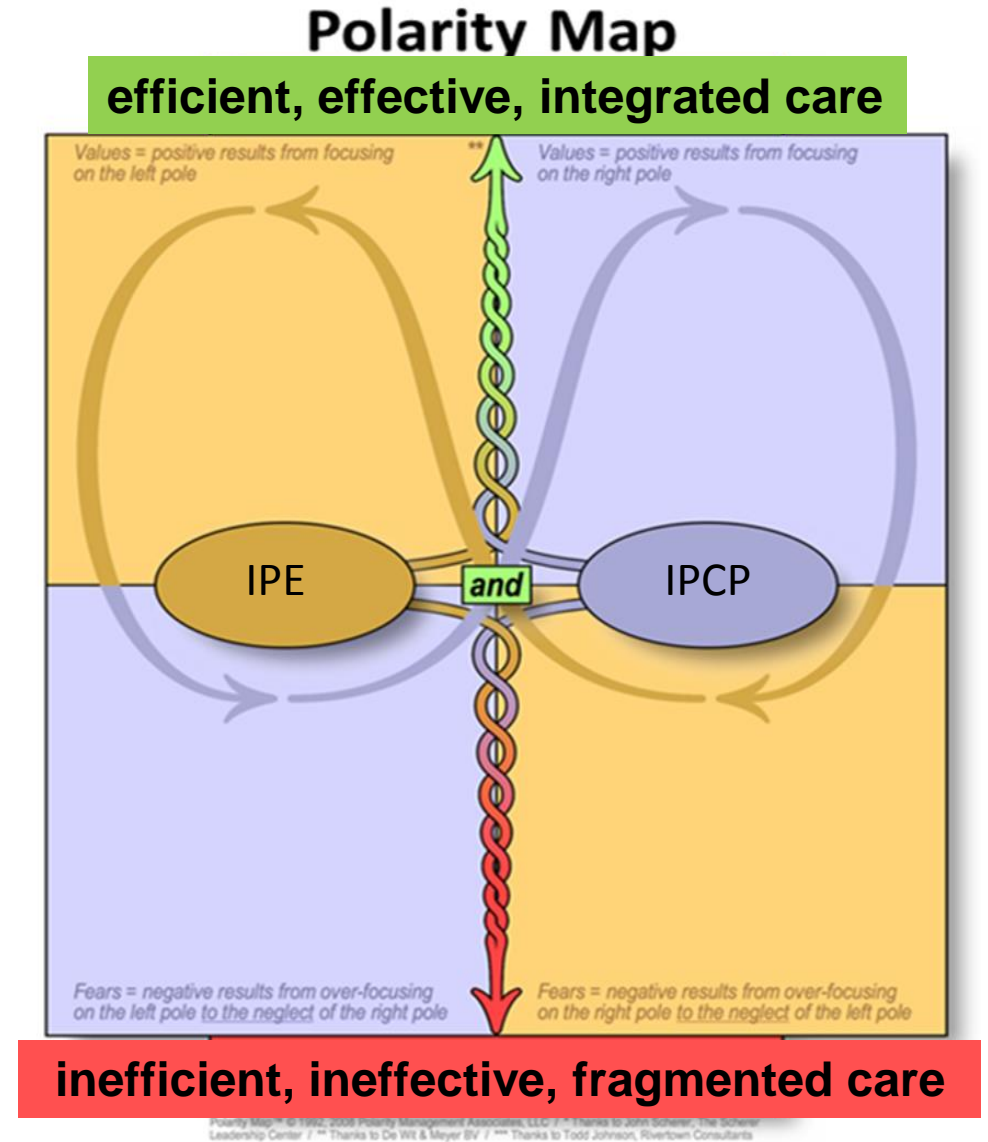
- has a **predictable flow**
- **oscillates** around **both poles** in the shape of an *infinity loop*
- Is *unavoidable, unsolvable, indestructible, unstoppable*, and *leverage-able*

Key Points about the IPE/IPCP Polarity

1. IPE and IPCP represent an ***ongoing*** and ***persistent*** challenge
2. Neither can ***stand alone*** → IPE & IPCP need each other
3. ***Often addressed*** at from ***one point*** of ***view*** (education or practice)
4. The ***greater purpose*** will not be ***sustained*** without ***attention*** to ***both***

▶ Creating the Polarity Map®:

- ▶ Makes the **polarities** *visible* and *actionable*
- ▶ Identify 2 **values** or **perspectives** as **neutral**
- ▶ **Positive & negative outcomes** of each are described *in 4 quadrants*
- ▶ Outcomes developed through broad **engagement** of **stakeholders**
- ▶ Poles are bound together by energy, represented as the **infinity loop**
- ▶ **Over focus on 1 pole leads to neglect of the other**
 - ▶ Leads to loss of positive of outcomes of the neglected pole



Polarity Map

Action Steps

How will we gain or maintain the positive results from focusing on this left pole?
What? Who? By When? Measures?

Action Steps

How will we gain or maintain the positive results from focusing on this right pole?
What? Who? By When? Measures?

Action Steps:
Strengthen each pole

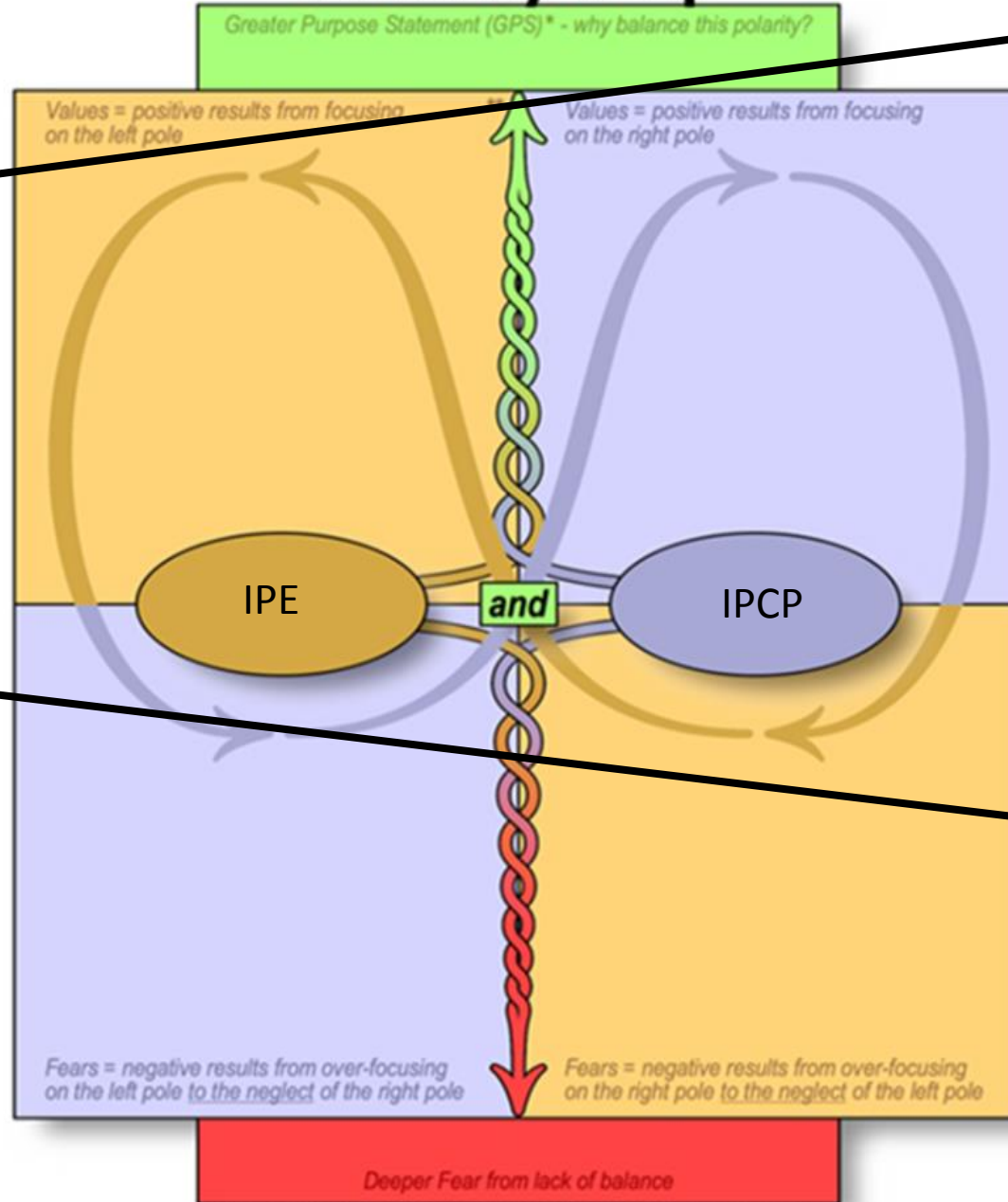
Early Warnings***

Measurable indicators (things you can count) that will let you know that you are getting into the downside of this left pole.

Early Warnings

Measurable indicators (things you can count) that will let you know that you are getting into the downside of this right pole.

Early Warnings:
Signs that 1 pole is over emphasized



2018 ASAHP Summit


Healthcare Workforce Readiness for Interprofessional Collaborative Practice



- ▶ **Focus:** Sustainable collaborative health care through education-practice partnerships
- ▶ Open to **leaders** from **academia** and **practice**
- ▶ **Goal:** mutually explore the current realities of both environments and the interdependent relationship between them
- ▶ **Proposed outcomes:** *actions steps and identification of outlets for dissemination*
- ▶ Participants invited to complete an IPE/IPCP **polarity assessment survey** before the summit workshop
- ▶ Facilitated by Tracy Christopherson and Michelle Troseth from MissingLogic, LLCSM

Pre-Summit Survey

- ▶ The pre-summit survey had 2 parts:
 1. **Demographic** questions
 - Role, profession, work setting, years of healthcare service, and highest level of education
 1. **Sixteen questions** relating to the *frequency* with which the respondent *experienced* or *observed* specific **behaviors**
 - The Likert-type scale



almost never = 0 points
seldom = 25 points
sometimes = 50 points
often = 75 points
almost always = 100 points

Pre-Summit Survey

- ▶ Survey questions addressed 4 areas:
 - ▶ ***Positive outcomes*** associated with a **focus** on
 - (1) interprofessional education and
 - (2) collaborative practice

 - ▶ ***Negative outcomes*** associated with **over-focusing** on either
 - (3) interprofessional education or
 - (4) collaborative practice

Survey Data - Demographics

- 15 survey respondents

PROFESSION	
Athletic Trainer	2
Care Manager	1
Nurse	1
Physical Therapist	3
Physician	1
Speech-Language Pathologist	3
Other	4

HIGHEST LEVEL OF EDUCATION	
MS	4
PhD	9
MD	1
Doctorate of Practice	1

ROLE	
Dean	1
Director	1
Executive	2
Faculty	6
Professor	2
Other	3

SETTING	
Academic	9
Practice	0
Academic and Practice	6

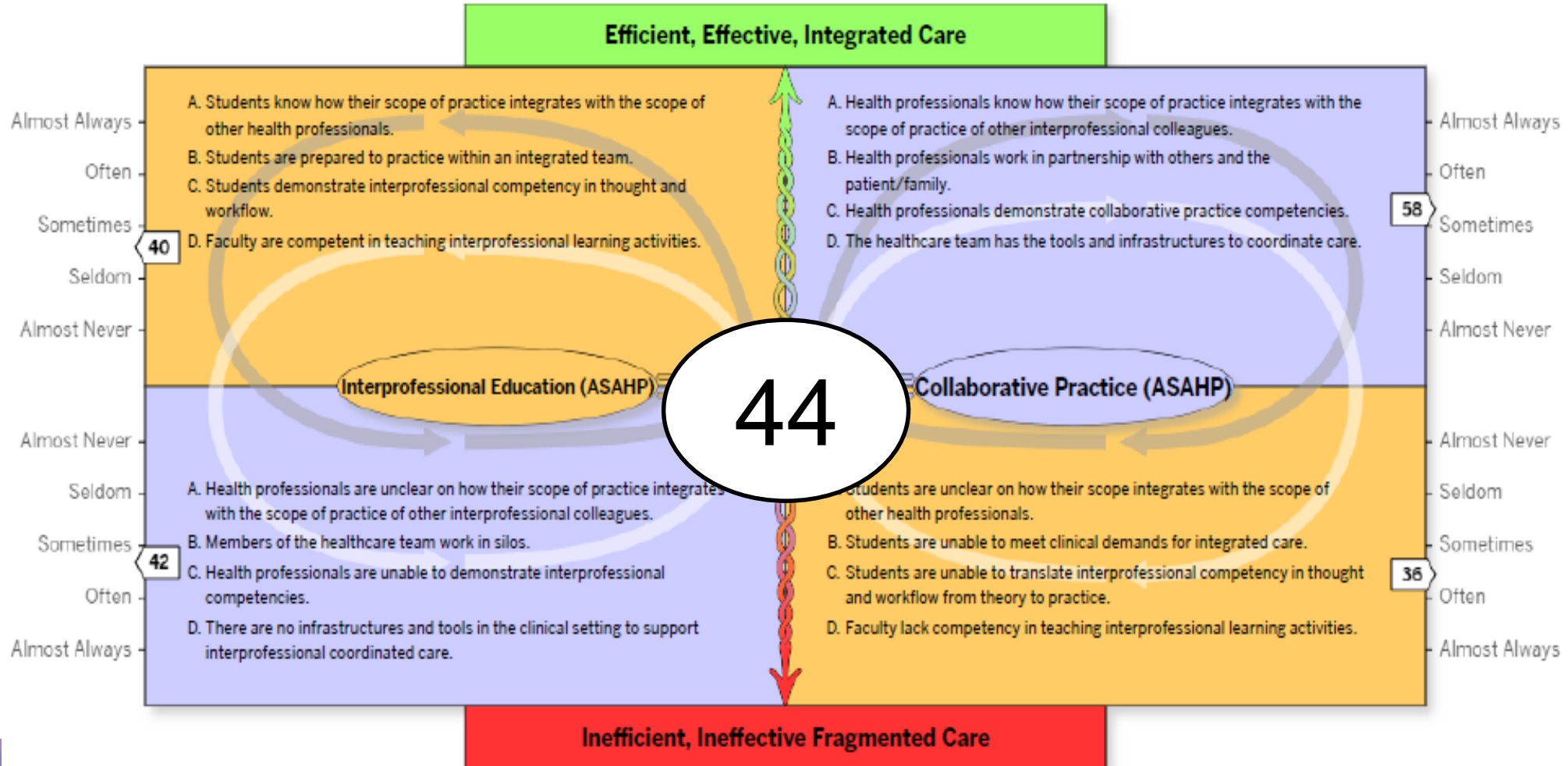
YEARS IN HEALTHCARE SERVICE	
1-5 years	1
6-10 years	0
11-15 years	1
16-20 years	3
21-25 years	4
31-35 years	1
36-40 years	0
+41 years	3

Survey Results

- Survey responses were aggregated
- **Mean scores** were calculated for *each quadrant* (score ranging from 0-100)
- **Overall score** generated, indicating how well the *polarity is managed*
“efficient, effective, integrated care”
to
“inefficient, ineffective, fragmented care”

Survey Results - Polarity Map[®]

Interprofessional Education (ASAHP) AND Collaborative Practice (ASAHP)



Survey Results

Positive Results Being Experienced As a Result of Focusing on Interprofessional Education (ASAHP)

0-39 = **Danger**, 40-60 = **Risky**, 61-100 = **Good/Great**

Students know how their scope of practice integrates with the scope of other health professionals.



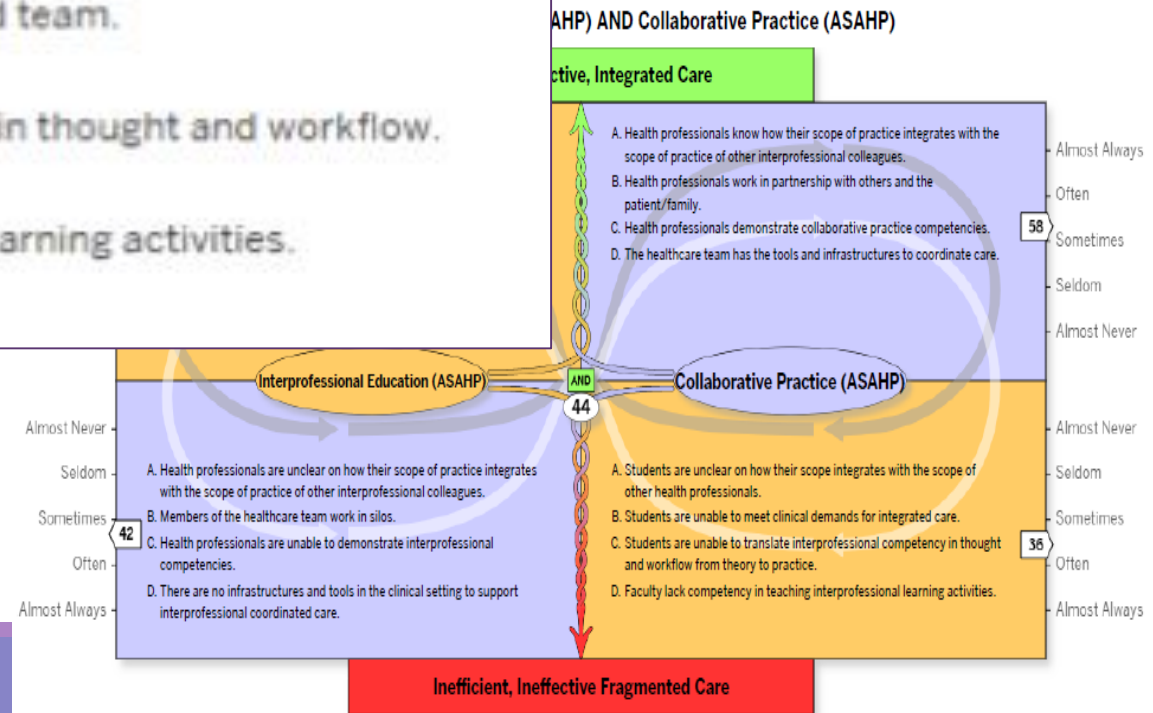
Students are prepared to practice within an integrated team.



Students demonstrate interprofessional competency in thought and workflow.



Faculty are competent in teaching interprofessional learning activities.



Survey Results

Positive Results Being Experienced As a Result of Focusing on Collaborative Practice (ASAHP)

0-39 = **Danger**, 40-60 = **Risky**, 61-100 = **Good/Great**

Health professionals know how their scope of practice integrates with the scope of practice of other interprofessional colleagues.



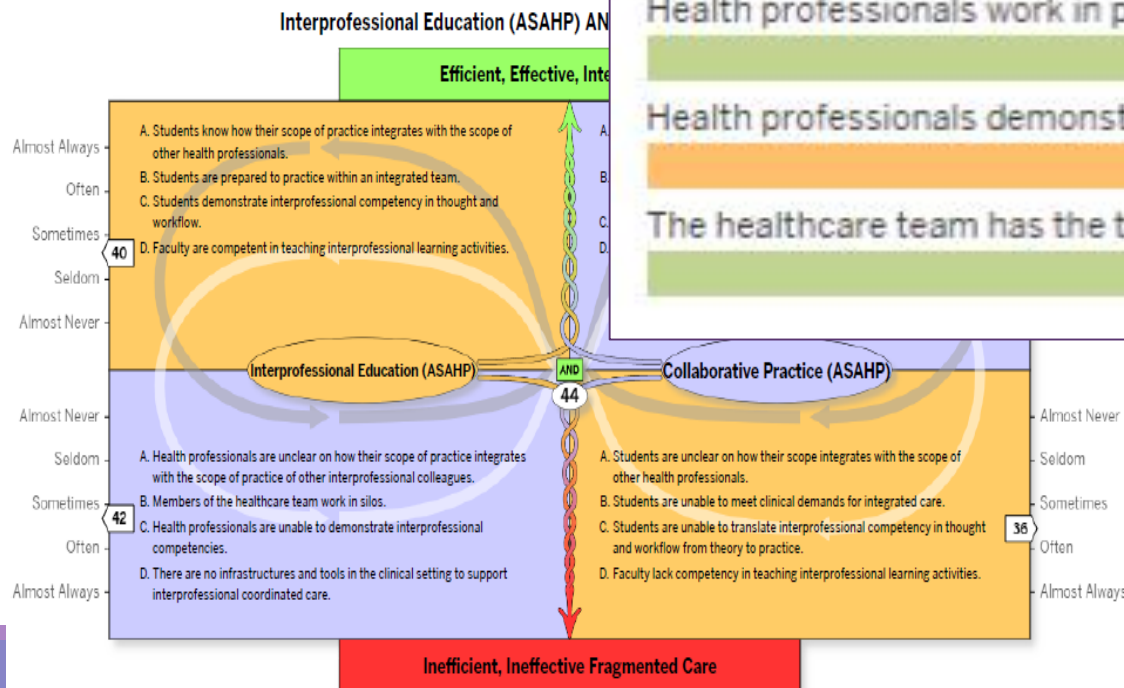
Health professionals work in partnership with others and the patient/family.



Health professionals demonstrate collaborative practice competencies.



The healthcare team has the tools and infrastructures to coordinate care.

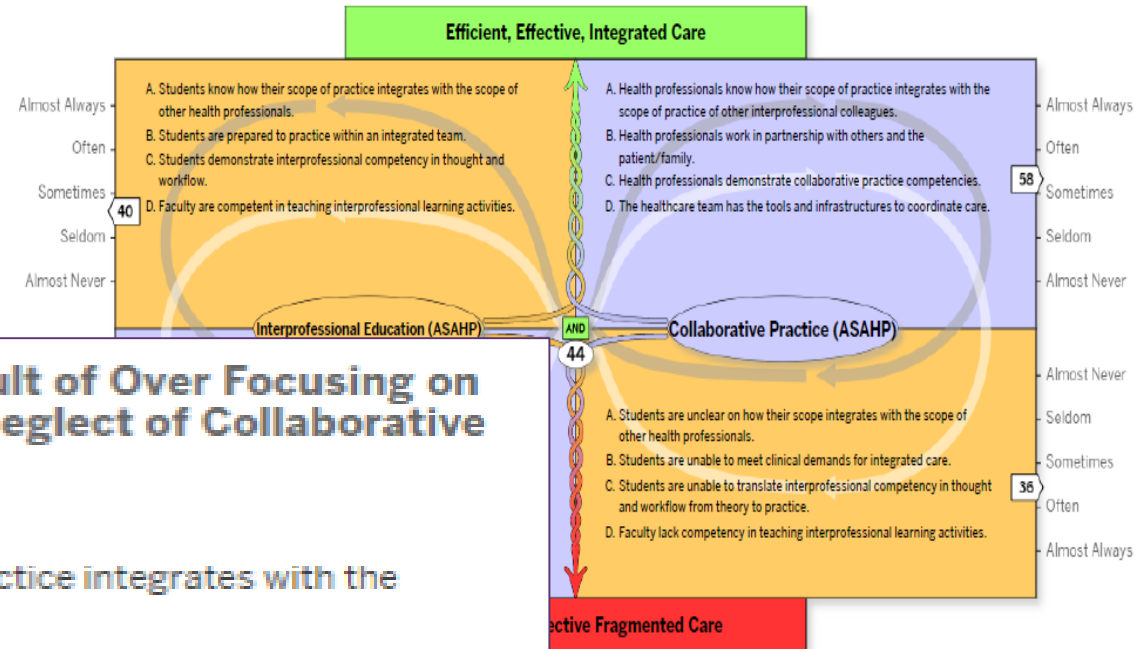


Survey Results



Survey Results

Interprofessional Education (ASAHP) AND Collaborative Practice (ASAHP)



Negative Results Being Experienced As a Result of Over Focusing on Interprofessional Education (ASAHP) to the Neglect of Collaborative Practice (ASAHP)

0-39 = **Danger**, 40-60 = **Risky**, 61-100 = **Good/Great**

Health professionals are unclear on how their scope of practice integrates with the scope of practice of other interprofessional colleagues.



Members of the healthcare team work in silos.



Health professionals are unable to demonstrate interprofessional competencies.



There are no infrastructures and tools in the clinical setting to support interprofessional coordinated care.



Summit Activities

- ▶ 18 participants
- ▶ **Participants:**
 - ▶ **Learned** about **polarity mapping**
 - ▶ **Reviewed** the **pre-conference survey** findings

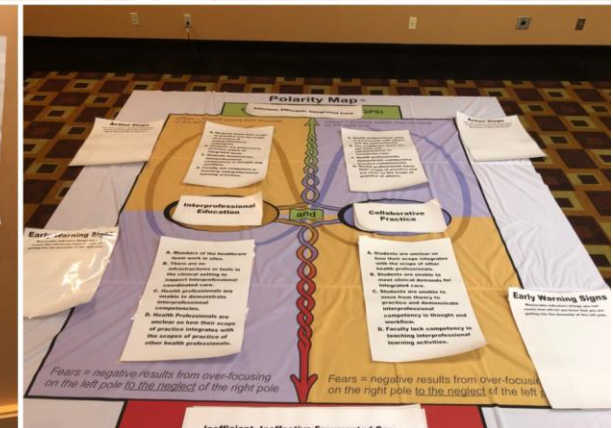
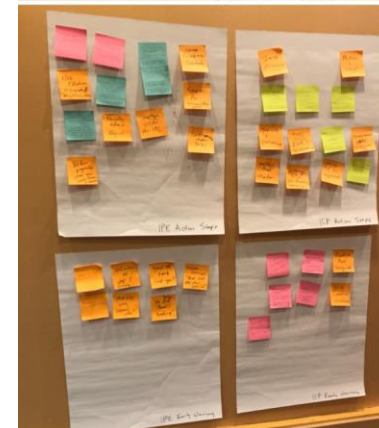


Small groups: Action steps & early warnings generated

Large group: Small group ideas discussed & additional ideas generated

Summit Activities

- ▶ All **data** from the small and large group work was **transcribed**
- ▶ **Action steps** and **warning signs** identified in large group were **categorized** into **major themes**
- ▶ **Themes** were **reviewed** by two additional researchers; the **language** and **categories** were **further defined** by consensus



Action Steps and Early Warnings

Action Steps

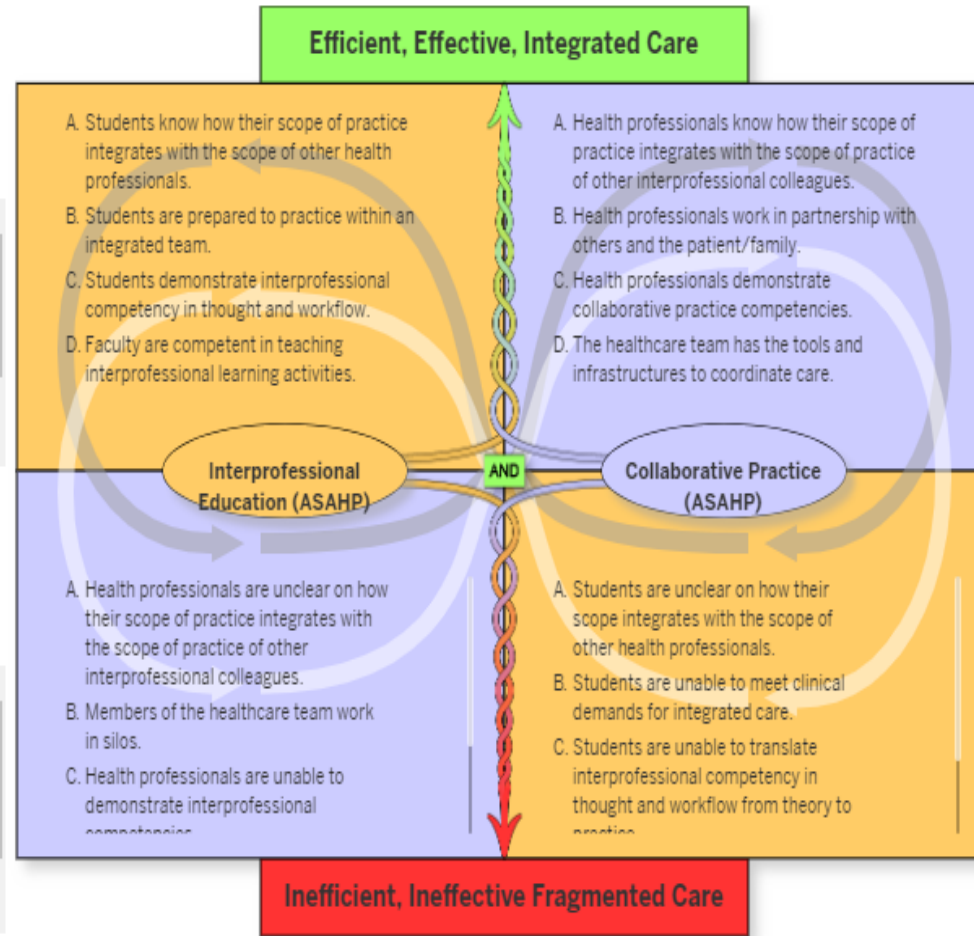
How will we gain or maintain the positive results from focusing on this left pole? What? Who? By when? Measures?

1. Implement a Faculty/Preceptor Development Program
2. Build Practice Education Partnership Infrastructure
3. Enhance Didactic IPE Education
4. Implement an IPE Assessment Process

Early Warnings

Measurable indicators (things you can count) that will let you know you are getting the downside of this left pole.

1. Students report "That was a great IPE event last year".
2. Students respond "Great site but no collaboration"
3. Preceptors ask "What is IPE?"
4. Clinical cynicism – talk about in the classroom, but not like that in



Action Steps

How will we gain or maintain the positive results from focusing on this right pole? What? Who? By when? Measures?

1. Secure Resources that support ICP
2. Institute Team Development Program
3. Develop Practice-based IPE Opportunities
4. Implement an IPCP Assessment

Early Warnings

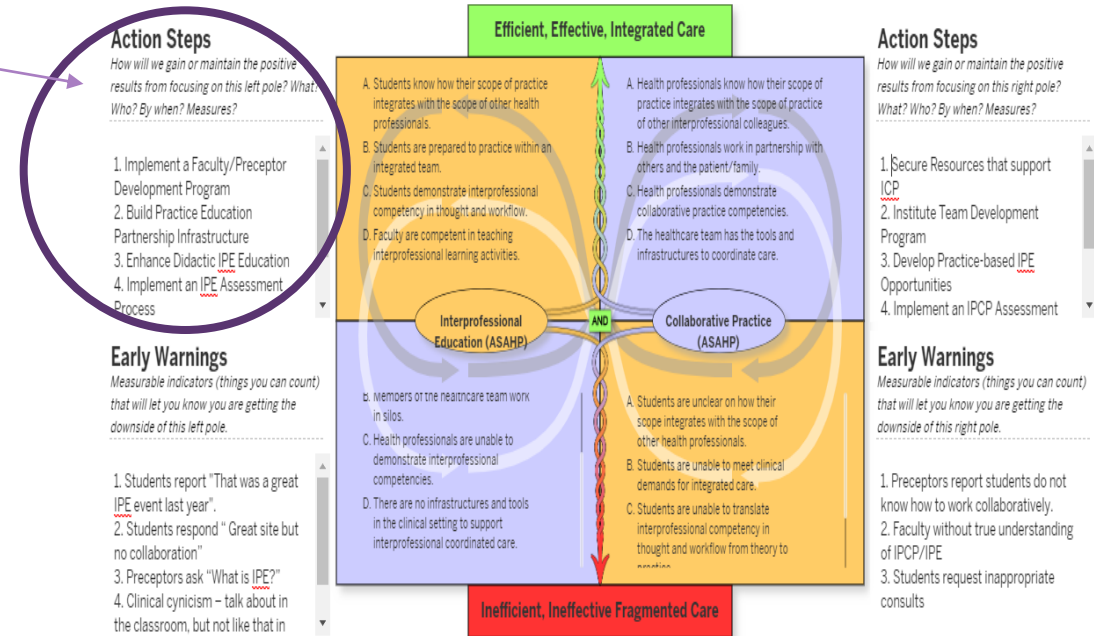
Measurable indicators (things you can count) that will let you know you are getting the downside of this right pole.

1. Preceptors report students do not know how to work collaboratively.
2. Faculty without true understanding of IPCP/IPE
3. Students request inappropriate consults

Results - IPE Action Steps

IPE Action Steps

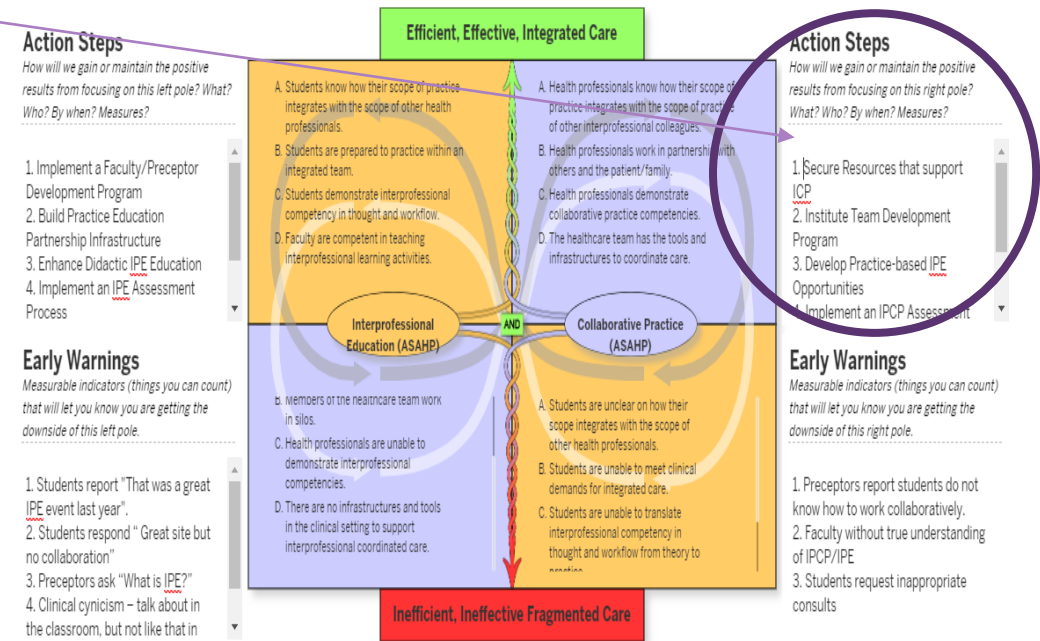
- ▶ Implement *faculty/preceptor development* program
- ▶ Build *Practice Education Partnership* infrastructure
- ▶ *Enhance didactic education*
- ▶ Implement *IPE assessment process*
- ▶ Secure *institutional commitment*



Results – IPCP Action Steps

IPCP Action Steps

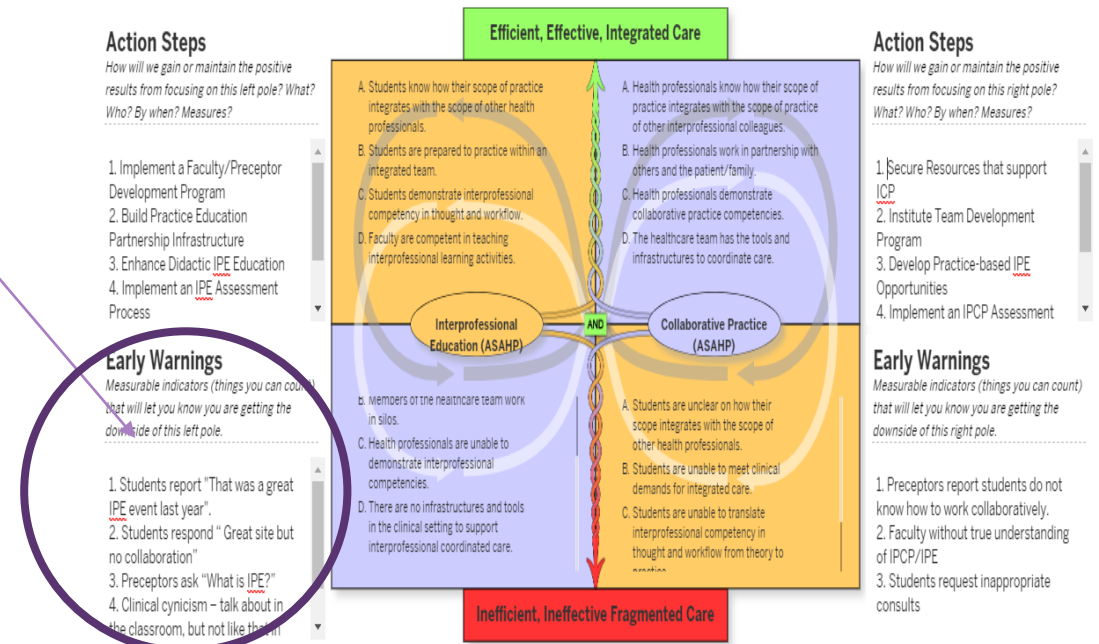
- ▶ Secure *resources* that *support IPCP*
- ▶ Institute *team development program*
- ▶ Develop *practice-based IPE opportunities*
- ▶ Implement an *IPCP assessment process*
- ▶ Establish *structural support* for *IPCP*



Results – IPE Early Warnings

IPE Early Warnings

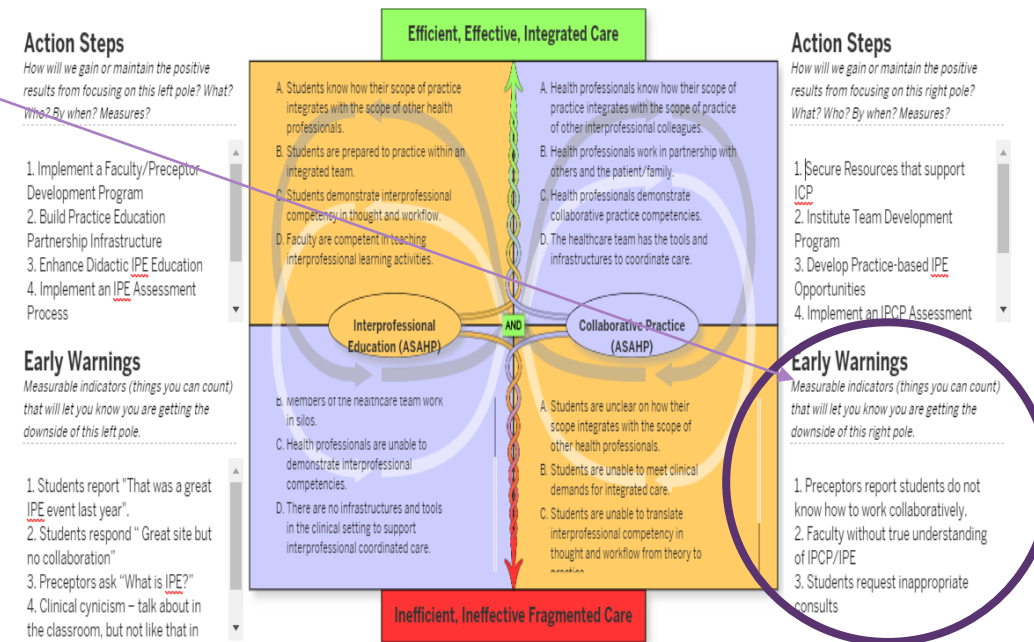
- ▶ Examples of **lack of IPE integration & clinical experience opportunities**
- ▶ Evidence of **learning needs**, particularly with preceptors
- ▶ Evidence of **resistance**



Results - IPCP Early Warnings

IPCP Early Warnings

- ▶ Evidence that *practitioners* are *not collaborating*
- ▶ Program *faculty* without true *understanding* of *IPE/IPCP*
- ▶ *Preceptors* report that *students* are *unable to work collaboratively*
- ▶ Evidence of *resistance*



Discussion

For 50 years we have been striving to
implement and *sustain IPE* and *IPCP*
and we have *not accomplished* sustainable results!

- ▶ The energy pattern between the IPE/IPCP poles is predictable
- ▶ We know if we continue to approach IPE and IPCP from a problem solving logic, over time failure is 100% guaranteed

Discussion

- ▶ Preconference survey data suggests:
 - ▶ the *IPE/IPCP polarity* is *not being managed well*
 - ▶ *positive outcomes* of *either pole* are **not experienced** *frequently or consistently*
- ▶ Together, preconference survey data with Action Steps and Early Warnings generated at the ASHAP Summit:
 - ▶ demonstrate what can be **learned locally** and **nationally** when we look at **IPE/IPCP** through a **polarity lens** and when **stakeholders come together** to assess their current realities and engage in dialogue!
 - ▶ *Even with this small N*

Discussion

To achieve and maintain the experience of the **positive outcomes** of both **IPE/IPCP**:



simultaneous action is required

- ▶ An infrastructure that utilizes a **practice and education partnership** can bring stakeholders for both poles together to create action plans that serve to achieve the greater purpose of the Quadruple Aim.



Summary

- The **managing** the *interaction* between **IPE** and **IPCP** is *hard!*
- This *polarity* is *not a problem* to be solved; IPE and IPCP have to be *managed together*
- *Strong partnerships* between *educational programs* and *practitioners* must be created
- **ACTION STEPS:** *Consider mapping your own organization!*

Thank you! Questions?

ASAHP Leadership Development Team

- ▶ Elizabeth Adams, PhD, CCC-A - eadams@southalabama.edu
- ▶ Anthony Breitbach, PhD, ATC - anthony.breitbach@health.slu.edu
- ▶ Lisa Dutton, PT, PhD - lldutton@stkate.edu
- ▶ Patricia Talbert, PhD - patricia.talbert@howard.edu

- ▶ **Mentor:** Andrew Butler, PhD - andrewbutler@gsu.edu

For more information on Polarity Thinking in healthcare go to: www.missinglogic.com

- ▶ Tracy Christopherson - tracy@missinglogic.com
- ▶ Michelle Troseth - michelle@missinglogic.com

Participant Biggest Learning (AHA!) Moments

- ▶ IPE/IPCP is really a polarity in many institutions/organizations.
Hopefully 5 years
- ▶ from now we won't be there!
- ▶ Focus on the “both/and”
- ▶ Not all points of tension are problems to be fixed
- ▶ The importance of attending to both sides of a polarity
- ▶ New way to understand problems/challenges
- ▶ Polarity theory, model and mapping
- ▶ That polarity applies to personal issues, too
- ▶ It was interesting to experience the broadening of dialectic integration models to organizational practices