

▲ Innovating in Teaching Collaborative Practice with a Large Student Cohort at Université de Montréal

Marie-Claude Vanier, BPharm, MSc¹

Pierre-Yves Therriault, PhD²

Paule Lebel, MD, MSc^{3,5}

France Nolin, MSc⁴

Hélène Lefebvre, PhD⁵

Isabelle Brault, PhD⁵

Eric Drouin, MD³

Nicolas Fernandez, PhD⁵

For the Interfaculty Operational Committee for Collaborative Practice Teaching at Université de Montréal*

Université de Montréal implemented an interprofessional education (IPE) curriculum on collaborative practice in a large cohort of students (>1,100) from 10 health sciences and psychosocial sciences training programs. It is made up of three one-credit undergraduate courses (CSS1900, CSS2900, CSS3900) spanning the first 3 years of training. The course content and activities aim for development of the six competency domains identified by the *Canadian Interprofessional Health Collaborative*. This paper describes the IPE curriculum and highlights the features contributing to its success and originality. Among main success key factors were: administrative cooperation among participating faculties, educators eager to develop innovative approaches, extensive use of clinical situations con-

ducive to knowledge and skill application, strong logistic support, close cooperation with health care delivery organizations, and partnership between clinicians and patients. A distinguishing feature of this IPE curriculum is the concept of partnership in care between the patient and caregivers. Patients' representatives were involved in course planning, and patients were trained to become patients-as-trainers (PT) and cofacilitate interprofessional discussion workshops. They give feedback to students regarding integration and application of the patient partnership concept from a patient's point of view. *J Allied Health* 2013; 42(4):e97–e106.

From the ¹Faculty of Pharmacy, ²Faculty of Medicine, School of Rehabilitation (Occupational Therapy program), ³Faculty of Medicine, MD program, ⁴Faculty of Medicine, Department of Nutrition, ⁵Faculty of Nursing, ⁶Faculty of Medicine, Center for Applied Pedagogy in Health Sciences, at the Université de Montréal, Montréal, Canada.

* For the period covered in this article, the Interfaculty Operational Committee for Collaborative Practice Teaching at Université de Montréal included, in alphabetical order: Chantal Besner, Isabelle Brault, Louise Boulanger, Eric Drouin, Vincent Dumez, Raynald Gareau, Fanny Guérin, Paule Lebel, Diane Lefebvre, Marie-Josée Levert, Sue-Ann MacDonald, Julie Ménard, Audrey-Maude Mercier, Josée Montreuil, André Néron, France Nolin, Annie Pullen-Sanfaçon, Louise St-Denis, Pierre-Yves Therriault, and Marie-Claude Vanier.

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Address correspondence to: Prof. Marie-Claude Vanier, Faculty of Pharmacy, Université de Montréal, CP 6128, succursale Centre-ville, Montreal, Quebec, H3C 3J7, Canada. Tel 514-343-6111 x5065, fax 514-343-2102. marie-claude.vanier@umontreal.ca.

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CHALLENGES concerning access to care and health care system performance are growing more acute worldwide (1). To better meet these challenges, *The Lancet's Commission* on health professionals for a new century recommends promotion of *interprofessional education* (IPE) (1). The World Health Organization has also underscored the importance of interprofessional education and collaborative practice in training for the health professions (2). Canadian associations have advanced similar recommendations (3,4). Indeed, aging populations, increased prevalence of chronic illness and coexistence of multiple pathologies require greater efficiency in care delivery (5). Hence, IPE programs are being implemented in universities in Canada (6), in the United-States (7), in Australia (8) and in Europe (9,10).

In light of this situation, in 2008 the Université de Montréal (UdeM) pioneered a pilot project of two IPE activities on collaborative practice across four professions. This project has led to a formal three-course IPE program across ten health and psychosocial sciences professions currently in place. This paper aims to: 1) describe the UdeM Interprofessional Education (IPE) program on

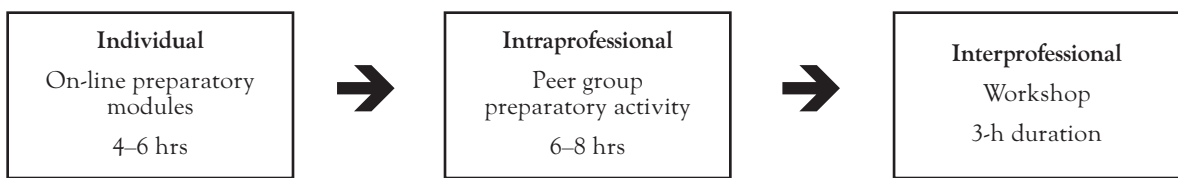


FIGURE 1. Interprofessional Education Continuum.

collaborative practice in partnership with patients and caregivers, and 2) highlight the features of the program that contribute to its success and originality.

Educational Approach

The adoption of *Competency-based education* (CBE) has encouraged all involved with the IPE program to revisit concepts used in their respective professions, with particular attention paid to identifying relevant teaching practices. Thus, the CSS courses (*Collaboration en Sciences Santé*) are student centered experiential learning activities (11) that form a continuum from general concept acquisition moving progressively to clinical applications.

The IPE program is made up of three one-credit undergraduate courses (CSS 1900, CSS 2900, CSS 3900) spanning the first 3 years of training offered within the following professional training programs: audiology, medicine, nursing, nutrition, occupational therapy, pharmacy, physiotherapy, psychology, social work, and speech therapy. The courses are mandatory in all programs except psychology, where it is offered as an optional course. During the 2012–2013 academic year alone, 3,600 students were enrolled in the IPE program courses.

A unique feature of this IPE program is that patients are involved in every step of program planning and development and are gradually involved as trainers in pedagogical activities. This is consistent with our view that patients and caregivers should be viewed as full-fledged members of the health care delivery team. In 2010, the Faculty of Medicine created a Faculty Bureau of Expertise on Patient Partnership (FBEPP). Its Director sits on the Interfaculty Operational Committee meetings. Delegated patients from the Bureau participate in interfaculty courses planning and educational material production. The Bureau is responsible for recruitment and training of patients acting as co-facilitators in IPE workshops. These patients live with a chronic illness, demonstrate an acceptance of their health condition and are eager to constructively share their experience.

The three CSS courses include the same three-stage process of progressive competency development (Fig. 1). In the individual stage, students complete 4- to 6-hour on-line training modules to acquire basic concepts regarding other professions, partnership with patients and collaborative practice. This allows all professions

to work and progress within the same knowledge base. In the intraprofessional stage, students work in peer group sessions, to identify specific features of their profession they will enact in the ensuing interprofessional workshop. This leads to development of self-confidence by consolidating one's own professional identity and expertise. In the interprofessional stage, they experiment interprofessional collaboration through a 3-hour workshop. This third stage allows students to start experiencing interprofessional practice and contributes to a more global vision of care.

The course content and activities aim for development of the six competency domains identified by the *Canadian Interprofessional Health Collaborative: National Interprofessional Competencies Framework* (3):

1. Role clarification
2. Team Functioning
3. Collaborative Leadership
4. Interprofessional Conflict Resolution
5. Interprofessional Communication
6. Patient-centered care (that we transformed into a concept of Partnership with patients and their family)

All four core competencies from the Interprofessional Collaborative Practice in the U.S. (12) are also covered by our course content, as shown in Table 1. Specific educational content of the three CSS courses is also presented in Table 1.

As students advance in the continuum toward becoming clinicians, they are called upon to apply the interprofessional collaboration concepts in increasingly complex clinical situations in the interprofessional workshop segment of the courses. Figure 2 illustrates the continuum and focus for each IPE workshop.

In the first IPE course (CSS1900) students are introduced to other professions and basic concepts of partnership with patients and their family. Interprofessional workshop includes small group ($n=10$) and plenary discussions among classes of 50 mixed students from the 10 participating programs. Prior to the workshop, students are asked to reflect on their own experience as a patient, or a relative's experience, and assess the level of partnership experimented in those care situations. The workshop allows students to share their care experiences amongst themselves and with a patient-as-trainer. They are also asked to share information about their professions based on an assignment

previously completed intraprofessionally to better know their own profession.

The second IPE course (CSS2900) focuses on clarification of professional roles and the application of collaborative practice principles using a video of an interprofessional meeting and a case study involving Child Care in ambulatory setting. This course features in-class experiences designed to foster collaboration skill integration. Interprofessional workshop is divided in two parts. The first part is a plenary of 50 students, seated in subgroups of 10. Following the projection of a video illustrating an interprofessional meeting, students are asked to identify and discuss in small group factors facilitating and impeding successful interprofessional meeting.

A plenary discussion follows where factors observed are paralleled with the CIHC interprofessional competencies framework. After the plenary session, small teams ($n=10$) move to smaller classrooms with their facilitator(s) to discuss the case study. They are asked to identify the case study patient and her parents' needs, identify actions required and which person(s) could best take responsibility for each action. For the year 2012–2013, recruitment allowed adding a patient-as-a trainer to cofacilitate with the health professional in half of the groups.

In the third IPE course (CSS3900), students are exposed to complex Elderly Care situations in two different stages of hospitalization of a patient from an ethnic minority who suffered a stroke and is newly diagnosed with diabetes. Students are called upon to integrate role clarification and care delivery partnership through simulations in small interprofessional groups ($n=10$), whose outcome is to produce an Interprofessional Intervention Plan (IIP). As for CSS2900, half of the groups were facilitated both by a health professional and a patient-as-trainer for the year 2012–2013.

Learning Goals and Outcomes

Main goal of our IPE curriculum is to prepare students to become good collaborators, ready to efficiently integrate interprofessional teams during their clinical placements and in their future career. Ultimately, we wish them to become agents of change in clinical and community settings, contributing to transform healthcare practice towards a collaborative practice in partnership with patients and their families.

CSS courses are pass or fail courses. In order to succeed, students must satisfactorily complete all educational activities. Demonstration of collaboration competency during the 2nd and 3rd year interprofessional workshops is assessed by direct observation by the facilitators. Behaviors observed are: 1) General attitudes as a team member; 2) Interprofessional communication; 3) Helpfulness to team to reach goal. Level of competency is assessed using 3 categories: does not meet expecta-

tions, meets expectations, surpasses expectations. Names of students who do not meet expectations are communicated to professors responsible for the course in each profession program. The professor assesses the situation and requires additional work from students, depending on the importance and the nature of the underdeveloped competency.

Each course is evaluated by students via online questionnaires. Globally, interprofessional workshop is highly valued by students. Intraprofessional preparatory activities' appreciation is variable between programs. Harmonizing these intraprofessional activities is one of our short-term goals. One frequent students' comment is they would like to have all professions represented in their small group discussions. Because of the different cohort sizes for each profession, this is not possible. When allocating small groups, we try to insure at least one student from psychosocial sciences will be included in each group. We also favor allocation of at least one student from rehabilitation professions. Facilitators are given a facilitating guide specifying important messages related to each profession and are expected to insure these messages will be discussed. This is especially important for professions not represented in the small discussion groups.

One of the most interesting outcomes measured for the first time this academic year is the increase of 2nd year and 3rd year students' confidence level towards their interprofessional interactions and their participation to an interprofessional meeting in a clinical setting. A pre-post assessment of self-reported confidence level on a 10-point numerical scale revealed a major improvement in proportions of students reaching a confidence level greater than 7. Changes between before and after course completion were as follows for interacting with other professionals during clinical placement (CSS2900: 34% before vs 68,1% after) (CSS3900: 61,4% vs 91,1%) and for participating in an interprofessional meeting (CSS2900: 28,9% before vs 63,8% after) (CSS3900: 52,9% vs 88,1%).

Other main findings for students' reported learning and course appreciation for academic year 2012–2013 are reported in Table 2. Informal comments received from clinical placements supervisors confirmed that students are more knowledgeable of other professions when they arrive in the clinical settings. They are also more confident in interacting with other professionals and identify more easily the other professionals that should be consulted or involved in individual patient's care situations.

Governing Structure

In order to integrate the three IPE courses across the 10 participating programs, a dedicated governing structure was implemented. An Interfaculty Executive Commit-

TABLE 1. IPE Courses Content

Level of Competency and Course Main Themes

Main Course Content	Pedagogical Approach	CIHC Related Core Competencies	AIHC Related Core Competencies
Discovery (Beginner level)			
CSS1900—Discovering other professions and partnership in care	On-line module	Patient/client/family/community-centred	Values/Ethics for inter-professional practice
Partnership in care	Intraprofessional discussion Interprofessional discussion (small group n=10 and plenary n=50)		
General principles of teamwork	On-line module	Team functioning	Teams and teamwork
Meeting facilitation	On-line module	Team functioning; Inter-professional communication	Teams and teamwork
Discovering other professions (training, certification, practice settings)	Intraprofessional assignment to describe own profession. Interprofessional discussion to share information (small group n=10 and plenary n=50)	Role clarification	Roles/Responsibilities
Application (Intermediate level)			
CSS2900—Role clarification	On-line survey	Team functioning	Values, Teams and teamwork
Attitudes versus IP learning and IP collaboration	On-line module	Role clarification Team functioning	Roles/responsibilities Teams and teamwork
Professional practice		Role clarification	Roles/responsibilities
Professional role and responsibilities	Intraprofessional discussion Interprofessional small group discussion aiming at role clarification in a pediatric case study (n=10)		
CIHC National Interprofessional competency framework	Individual reading Intraprofessional discussion Interprofessional plenary discussion (n=50)	All core competencies	
Interprofessional meetings: facilitating factors and impeding factors	Video and Interprofessional plenary discussion (n=50)	Interprofessional communication Team functioning Interprofessional conflict resolution Collaborative leadership Patient/client/family/community-centred	Interprofessional communication Teams and teamwork, Values/Ethics
Partnership in care with patients and their family	Interprofessional small group discussion aiming at role clarification in a pediatric ambulatory care case study (n=10)	Patient/client/family/community-centred; role clarification, team functioning	Values/Ethics Roles/Responsibilities, Teams and teamwork
Integration (Intermediate level)			
CSS3900—Collaborative practice and Interprofessional Intervention plan (IIP)	On-line module	Interprofessional communication; Role clarification; Team functioning; Conflict resolution	Interprofessional communication; Teams and team work; Roles/Responsibilities; Values/Ethics
Roles clarification and negotiation	Intraprofessional discussion		
Interprofessional Intervention Plan			
Conflict prevention and resolution	Interprofessional small group discussion (n=10) aiming at role clarification in a geriatric case study involving hospitalization and home return preparation	Interprofessional communication; Role clarification; Team functioning; Patient/client/family/community-centred; interprofessional Conflict resolution; Collaborative leadership.	Interprofessional communication; Teams and team work; Roles/Responsibilities; Values/Ethics in inter-professional practice
Roles clarification and negotiation			
Interprofessional Intervention Plan			
Partnership in care			
Continuity in care			

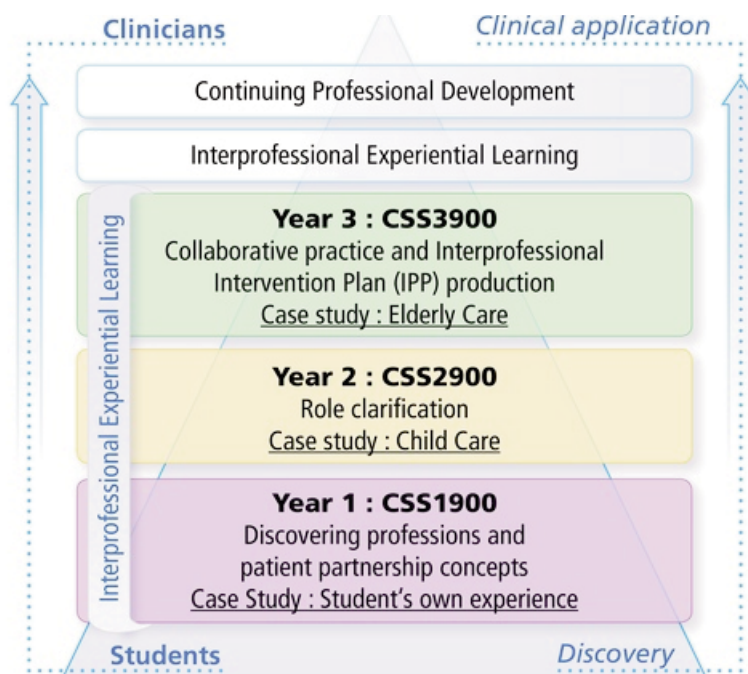


FIGURE 2. Three Stage Process of Progressive Competency Development.

tee (IEC) and an Interfaculty Operational Committee (IOC) were created to develop and administer IPE courses and other related activities (interprofessional fieldwork learning and continuous professional development). The governing structure of the IPE program is presented in Figure 3.

The Executive Committee (IEC) is composed of Deans from the participating faculties and of the president and vice-president of Operational Committee. The Operational Committee (IOC), aside its president and vice-president, is composed of at least one educator (academic or instructor) from each participating program as well as the director and a representative of the Faculty Bureau of Expertise on Patient Partnership (FBEP).

Educators delegated to sit on the Operational Committee as IPE Representatives, jointly carry out IPE program management and development of pedagogical tools to encourage program evolution. Representatives of the Bureau of Expertise on Patient Partnership contribute to all aspects of IPE program development but especially to integration of patients-as-trainers in interprofessional workshops and development of content related to partnership in care. Education technology support was provided by the Center for Applied Pedagogy in Health Sciences (CAPHS) of the Faculty of Medicine.

In order to include a student voice, the Operational Committee set-up the Interprofessional Student Council (ISC) as a consultative body made up of students from participating programs. The principal mandate of the Student Council is to provide opinions on relevant subjects pertaining to the IPE program and pilot differ-

ent pedagogical projects. Likewise, in order to favor exchanges between the Operational Committee and the student council, the president of the latter sits on the former. Some members of the Student Council participate in the Operational Committee subcommittees working on development or updating of teaching materials or specific issues.

The synergetic development of collaborative practices between academic teaching and health care networks is supported by regular interaction with the Committee on Collaborative Practices and Interprofessional Training (CCPIT) within the Integrated University Network for Healthcare (IUNH) of the UdeM (see Fig. 3). In order to facilitate information sharing and concerted project development, some members of the University Network Committee are also members of the operational committee and the Bureau on Patient Partnership.

Similarly, more than half of the health professional facilitators involved in the IPE workshops are also practicing clinicians. This ensures continuity between students' training and interprofessional collaborative practice as it is experienced in health care and social service institutions. Furthermore, the existence of these links has led to agreement on common vocabulary for interprofessional collaboration among all partners, which in and of itself directly supports collaborative practice development. This interdependency between the education network and the health care network allows better response to population needs and ensures development of socially relevant competencies (1,13).

TABLE 2. Interprofessional Workshops Outcomes Assessment by Students

Course	Items Assessed	% of Respondents Agreeing or Strongly Agreeing
CSS1900 (n=1056)	Students' learnings	
	Small group discussions allowed me to better understand other professions' training and their practice setting	93,0%
	Discussions allowed me to identify advantages of interprofessional collaboration in a professional setting	81,7%
	Discussions allowed me to recognize importance of shared clinical decision-making (including patient, family and professionals)	84,8%
	I now have a better understanding of the concept of partnership in care with the patient and his family	88,7%
	After this course, I am now considering using the partnership in care approach in my future practice.	94,1%
	Course organisation	
	Mixed professions small group discussion favored exchanges between students	90,0%
	Workshop climate was stimulating and respectful	93,8%
	Patients' contribution	
	Co-facilitation by a healthcare provider and a patient was relevant	93,0%
	Patient's shared experience and comments enriched the discussion	91,2%
	Presence of a patient allowed a more concrete illustration of the concept of partnership in care	90,5%
CSS2900 (n=1108)	Students' learnings	
	Plenary discussion allowed me to better understand factors insuring a successful interprofessional meeting	84,4%
	Small group discussion helped me to better understand roles and responsibilities of other professions.	89,2%
	Small group discussion helped me position the patient and his family as an essential member of the care team.	86,6%
	Course organisation	
	Topics discussed in the workshop were adapted to my training level	89,9%
	Information in the case study were useful for discussion on roles, responsibilities and task-sharing	89,1%
	Workshop climate was stimulating and respectful	93,3%
	Patient's contribution (n=599) <i>N.B. Assessed only by students with a patient in their group</i>	
	Co-facilitation by a healthcare provider and a patient was relevant	85,4%
	Presence of a patient allowed me to better integrate the concept of partnership in care	81,7%
	Patient's participation prompted me to allow more importance to the case study patient's and her family point of view when prioritizing clinical interventions.	77,5%
	Healthcare provider tutor and patient co-facilitator interventions were complementary	84,2%
	Patient's comments and retroaction enriched the discussion	85,1%
	Presence of a patient is a plus value to the workshop	86,8%
CSS3900 (n=925)	Students' learnings	
	Small group discussion helped me to better grasp the health problems and impact of the sickness on the case study patient	89,8%
	Small group discussion helped me to better understand the necessity of role and responsibilities clarification between members of a care team	93,2%
	Small group discussion gave me a better vision of what is an interprofessional intervention plan (IIP)	86,3%
	Small group discussion allowed me to experiment care planning in a collaborative practice approach in partnership with a patient and his caregivers	87,7%
	After this workshop, I better understand related issues of integrating patients in care decision making process	87,8%
	I believe creating a partnership in care with patients and their caregivers is essential	96,4%
	Course organisation	
	Topics discussed in the workshop were adapted to my training level	92,8%
	Informations in the case study were useful for simulation of an interprofessional meeting	93,9%
	Workshop climate was stimulating and respectful	96,6%
	Patients' contribution <i>N.B. Assessed only by students with a patient in their group</i>	
	Co-facilitation by a healthcare provider and a patient was relevant	89,8%
	Presence of a patient allowed me to better integrate the concept of partnership in care	84,6%
	Patient's participation prompted me to allow more importance to the case study patient's point of view when prioritizing clinical interventions.	82,7%
	Healthcare provider tutor and patient co-facilitator interventions were complementary	88,1%
	Patient's comments and retroaction enriched the discussion	89,1%
	Presence of a patient is a plus value to the workshop	91,3%

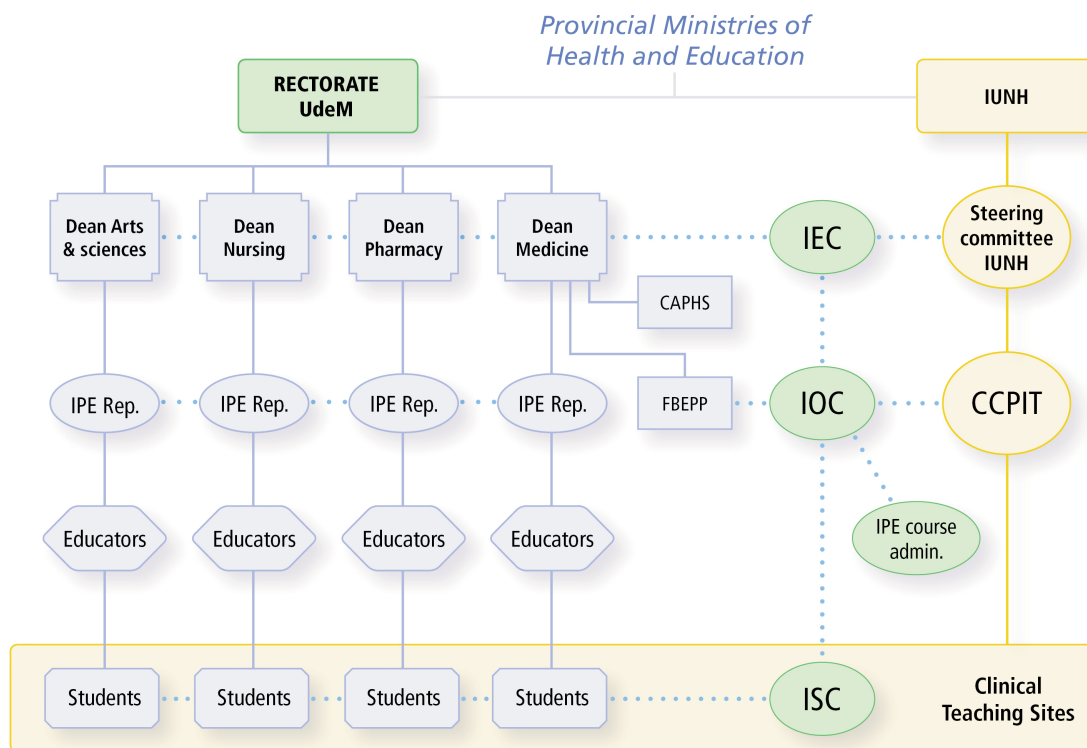


FIGURE 3. Governing structure of UdeM IPE Program. IEC, Interfaculty Executive Committee; IOC, Interfaculty Operational Committee; ISC, Interfaculty Students Council; CAPHS, Center for Applied Pedagogy in Health Sciences; FBEPP, Faculty Bureau of Expertise on Patient Partnership; IUNH, Integrated University Network for Healthcare; CCPIT, Committee on Collaborative Practices and Interprofessional Training.

Key Factors for Success

According to a survey of 10 American and Canadian universities, the principal factor conducive to successful IPE implementation is administrative cooperation among participating faculties and availability of educators who are convinced and eager to develop innovative approaches and convince other educators and instructors to adopt new approaches (14). Extensive use of clinical situations conducive to knowledge and skill application, close cooperation between teaching institutions and health care delivery organizations and partnership between clinicians and patients were factors that were integral to the UdeM experience.

Chief among the challenges involved in IPE implementation is program sustainability with regards to resources and financing. Logistical challenges that arise from the multiplication of students enrolled in the same course are also challenges that needed to be addressed. The integration of the patient as a full member of the health care delivery team and teaching team constitutes in and of itself a paradigm shift, generating a unique set of logistical challenges. This section describes how each of these challenges were met and how this has led to innovative insights about IPE.

SUSTAINABILITY

From the moment the pilot project was implemented in 2008–2009, the program’s long-term survival has constituted an ongoing concern for people from each of the participating programs, as well as for the deans of the four faculties. The vision, creativity and flexibility of the deans, vice-deans and all educators involved, combined with the staunch support from the University Vice-rectorate, has allowed implementation of IPE mandatory courses in 9 out of the 10 training programs. Table 3 presents relative proportions of students from each participating program.

In Canada, faculties and schools receive mixed financing coming from student fees and government subsidies, comparable to financing of American public universities. However proportion of government subsidy is higher in Canada than in the US. Since CSS courses are mandatory and imbedded in the different professions curriculum, a stable recurrent income to support development and coordination of these interfaculty courses is generated. Distribution of tuition fees generated income among the 10 participating programs, belonging to four faculties, was a particularly complex problem. An interfaculty agreement signed by Deans

TABLE 3. Relative Proportion of Students from Each Participating Program

Profession*	%
Audiology	2.4%
Medicine	18.1%
Nursing	25.9%
Nutrition	6.3%
Occupational Therapy	8.8%
Pharmacy	13.7%
Physiotherapy	7.7%
Psychology	0.4%
Social Work	11.6%
Speech Therapy	5.0%

*IPE program courses are not mandatory in the Psychology Program. Psychology students are enrolled in a Postgraduate Clinical Doctorate Program in Psychology.

(Arts and Sciences, Medicine, Nursing and Pharmacy) was the first step. This agreement outlines the innovative fund allocation model for the Interfaculty Operational Committee designed to ensure long-term and shared commitment of participating programs and faculties. These funds cover IPE program administration and management, coordinator's salary, clerical support, course material updating and development of new training activities. Deans approve following year's budget framework according to IPE program needs as expressed by the Operational Committee. The Operational Committee president approves expenses within this framework.

The Deans recognize the substantial workload involved in IPE program administration and course development. All participating educators responsible of the CSS courses in their specific program experienced a significant increase in their workload, leading to necessary adjustments. Management and coordination of such courses are very time consuming. The operational budget provides fund allotment of the monetary equivalent of two teaching assistance-ships for the IOC President and one teaching assistance-ship for the IOC Vice-president, providing them with dedicated time for IPE program management. The faculty, or program, whence the occupants of these positions originate, is allotted the funds for the period in which the person is President or Vice-president.

STRONG LOGISTICAL SUPPORT AND PLANNING FOR LARGE COHORTS

The number of programs involved generates sizable student cohorts that simultaneously enroll in the same course i.e. average of 1,300 per course. Responding to this challenge has led to important innovative solutions. To begin with, the Operational Committee meets on a monthly basis and discusses course functioning at an

operational level. The fact that each program is represented at this committee enables swift decision-making.

In order to facilitate student access to the online preparatory modules, efficient centralized coordination of IPE program activities at the Operational Committee level proved to be essential. A coordinator provides support for educators in their teaching tasks. In order to manage all student records, including small group assignment and distribution of assessment results, every program's Student Record manager was networked for efficient sharing of student files.

The impressive size of student cohorts necessitated the availability of a large number of classrooms. In order to deal with this challenge, interfaculty activities were held simultaneously in many pavilions of the main university campus. For example, for the 1st year course, 28 classrooms able to accommodate 50 students each were required. The choice of an evening schedule allowed availability of the requested number of classrooms, difficult to obtain during daytime. For the 2nd and 3rd year courses, students work in smaller inter-professional groups of 11 students. Smaller team learning rooms were easier to obtain during daytime. The student cohort was divided in two and 50 rooms were requisitioned in the morning and in the afternoon of the same day.

The efficient support of educational technology experts was essential to offer quality online learning materials to such a large number of students. The Operational Committee works closely with the team of educational technologists for online support, course content management and learning material development. This team is composed of physicians, computer experts, techno-pedagogical experts and a graphic artist. The relatively small size of the technology team allowed for rapid response rates, leading to efficient problem solving.

HUMAN RESOURCES COMMITMENT

Implementation of an IPE program across such a large number of programs has been successful thanks, primarily, to a group of dedicated and creative educators, fully engaged with the Operational Committee. These educators have been provided "on-loan" from the participating Faculties and the tasks have been officially included in their workload. Coordination and clerical support are keys for running smoothly such an IPE program. A full time coordinator and a full time secretary are supporting the Operational Committee.

Workshop health professional facilitators are practicing clinicians with experience in collaborative practice. They are recruited by Operational Committee members on a *pro rata* basis of the number of students from each profession. Facilitators have access to all e-learning modules and a detailed facilitator's guide. Before being assigned to a group of students, they are

coached by a recruiting educator to ensure they understand the basic structure of the IPE program and main concepts to teach and behaviors to observe.

INNOVATION: A NEW VISION OF THE PATIENT-AS-A-PARTNER IN CARE AND IN TEACHING

A distinguishing feature of the IPE program is the concept of partnership in care with the patient and caregivers developed by the Bureau for Patient Partnership, introduced in the CSS courses in 2010. This concept, which calls upon a paradigmatic shift, views “the patient partner [as] a person who is gradually enabled to make free and enlightened health care choices. He is respected in all aspects of his being and he is a full member of his interprofessional team. His ‘life-project’ constitutes the guiding principle according to which clinical decisions are to be made” (*vision of the patient-as-a-partner, FBEPP 2011*). This concept has also evolved to active involvement of patients in the teaching of collaborative practice and partnership in care to health sciences and psychosocial sciences students at UdeM.

With the health professional facilitators from different health and psychosocial professions, Patient-as-trainers are called upon to co-facilitate interprofessional discussion workshops in the IPE program courses. They give feedback to students regarding integration and application of the partnership in care concept from a patient’s point of view. Integration of patients-as-trainers started with a pilot project involving one quarter of the student cohort. The students greatly appreciated their presence and students’ appreciation questionnaires testified to the perceived added value of their involvement. Following success of the pilot project, deployment of patients-as-trainers to all students’ groups is done gradually over a period of 2 to 3 years.

The involvement of the Bureau for Patient Partnership is seen as a catalyst for change in the way health care is delivered. By introducing the patient-as-a-partner in health care and in teaching, it is hoped that a learning community made up of patients, teachers and clinicians will inspire students to enact changes in clinical settings, and position patients as active health care partners.

Discussion

The experience of IPE at UdeM sheds light on a number of benefits as well as the means required to make possible its integration within traditionally separate training programs. Foremost among the benefits is the adoption of a common definition and vocabulary to describe collaborative practice and partnership in care. This has enabled further definition of key concepts associated with collaboration, such as professional identity, role definition, common goal setting and mutual accountability.

Courses appreciation and assessment of learning by our students clearly shows a positive impact on their understanding of collaborative practice and partnership in care, as well as an increase in their confidence level to interact with other professionals. Patients’ contribution to interprofessional workshop is highly valued by the students.

It is also of note that not only students are learning to collaborate before entry into their professional careers, but educators, clinicians and administrators from different faculties and programs are likewise learning to solve problems together for the benefit of enhancing health system performance. Furthermore, the IPE program relies heavily on networking beyond the academic setting. The cooperation with health care delivery organizations and the Integrated University Network for Healthcare-RUIS constitutes an essential ingredient that not only enhances relevance of training outcomes, but also reinforces the trend towards greater interprofessional collaboration in clinical settings.

It is clear that stakeholder representation and coordination within the governing structure has had a large part in IPE program success thus far. An equally important factor has been individual participation of patients-as-trainers and a large number of health care professionals acting as workshop facilitators, willing to review their practice and, on occasion, face difficult questions. This is especially true as the shift is made from patient centered care to partnership in care with patient. Achieving consensus about the need to carry out this paradigm shift has not been easy, and it is by no means completed. Unwavering commitment from University administrators, as well as from educators and students who are acutely aware of patient’s expectations for better health care services has proven to be a driving force.

Conclusion and Future Developments

Stakeholder commitment combined with development of common vocabulary has opened the way for integration of IPE training courses in ten health and psychosocial sciences training programs. The result is that from 1st year training, budding professionals in 10 different professions are being exposed to concepts pertaining to collaborative practice, and they are being taught skills to integrate other professions and patients in their health care decision-making process. At the same time, they are provided with the opportunity to practice their roles and responsibilities in complex interprofessional health care delivery situations.

Challenges still abound but as our experience shows “where there’s a will, there’s a way.” Chief among challenges is the need to meet the needs of a still growing cohort of students. The upcoming introduction of Dentistry, Optometry, Kinesiology and Psychoeducation pro-

grams will require further adaptation of clinical content. Due to the complexity stemming from different professional curricula (up to 14 training programs), it will be crucial that appropriate teaching situations be devised. Recruitment of additional facilitators and providing them with more formal training about IPE and collaborative practice is a priority. Likewise, recruiting and training more patients to act as effective patients-as-trainers in order to expose all students to that enriching experience will be key for IPE program long-term success.

Finally, IPE also needs to be formalized in clinical setting training. This will allow students to further advance along the interprofessional collaboration competency development continuum initiated in our IPE undergraduate program.

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