When last we wrote, we were just beginning to reflect on the global upheaval encapsulated in the COVID-19 pandemic and the new urgency to confront systemic racism. Some areas of the world have emerged from COVID-19 lockdowns while others are battling new variants with catastrophic consequences. The disparities in vaccine distribution continue to be an urgent problem, along with vaccine hesitancy, building trust between patients and the healthcare system, and establishing access to healthcare for underserved populations. So, while we may be nearing the end of the COVID-19 pandemic, there is much work to be done to tackle the complexities of racial and social justice issues that remain.

On a more positive note, we were thrilled to have three keynote speakers join us at our biennial conference who addressed different parts of the issues of systemic racism and health inequity; we are fortunate that these speakers agreed to elaborate on their talks and continue the conversation here in the newsletter. Dr. Peter Cahn’s How Structural Competency Can Help Dismantle Structural Racism piece in this issue relays key points of his talk on racial constructs in medical practice. He focuses on how interprofessional education can rise to the challenge and educate the next generation of health professionals to combat the structural issues that give rise to medical error and systems neglect.

Tiffany Ledesma, Jessica Brooks, and Elizabeth Svekla illustrated how teamwork and collaboration can have a positive impact on community health via lessons learned from the 10th anniversary of the Philadelphia Water Department’s Green City, Clean Waters initiative. Their piece provides practical guidance for other community organizations hoping to have similar impacts.

Finally, Dr. Ivy Oandasan spoke about how to advance change in complex systems, specifically, in education and healthcare. She spoke with Co-Director, Dr. Brooke Salzman, about how IPE can move beyond simple competencies and focus on readying students for collaborative practice in a more holistic way.

As in past issues, we are thrilled to feature a piece by student champions Jordan Mak and Cat-Trinh Phan (both PharmD candidates at Jefferson) illustrating how incorporating information on social determinants of health can positively impact natural disaster relief leading to a healthier community. Jordan, Cat, Mary Lloyd and Francesca Girone (both Nursing students) all represented Jefferson at this year’s annual Clarion Case Competition, a virtual interprofessional student team event hosted by the University of Minnesota, and reflect on the experience in this edition.

So, while we are slightly more optimistic about the future than when we last wrote, we recognize that seismic changes are necessary to move interprofessional education and practice, and indeed, the world in a positive direction. We at JCIPE are ready for that challenge and we hope you will continue to join us!
JCIPE Update

• The Health Mentors Program (HMP) opened the Spring 2021 semester with online Module 2 Orientation in February, engaging 137 student teams of more than 750 students. Student teams scheduled and conducted a virtual home visit with their Health Mentor throughout the spring semester and gathered for the online IPE Small Group sessions in April to conclude Module 2. 137 teams presented their Module 2 Wellness Presentations during this online session, with the help of 18 facilitators and four co-facilitators.

• HMP also had the pleasure of collaborating with the Jefferson Health Design Lab (JHDL) to create a “design sprint”. Our objective was to refine HMP and attain a more structured alignment of the content delivery with the overall program goals. This was also an opportunity to improve engagement of both students and mentors. Participants involved in this innovative work included the JHDL staff, eight students, three Health Mentors, three faculty/facilitators, and six JCIPE/HMP staff.

• During the spring semester, 182 students from five professions (Medical Imaging and Radiation Sciences, Pharmacy, Physical Therapy, Physician Assistant Studies, Public Health) joined us to practice speaking up for patient safety in our virtual Introductory TeamSAFE workshops, bringing our total participation for 2020-21 to 1,237 learners. This includes the East Falls Occupational Therapy program, which was new to TeamSAFE this past year. We look forward to Speech-Language Pathology and Athletic Training joining us for the upcoming academic year.

• In its second offering as an integrated component of SKMC’s Gateway to Internship course, Advanced TeamSAFE included 148 students from 4 professions in virtual workshops during March 2021.

Next year, all FACT-1 nursing students will join their medical school colleagues in continuing to grow the program!

• JCIPE integrated Alzheimer’s Virtual Interprofessional Training (AVIT) into the Adult-Gerontology Primary Care Nurse Practitioner Master’s specialty curriculum during the spring semester. 25 total students from four professions (Medicine, Nursing Practice, Occupational Therapy, and Pharmacy) participated in the pilot of a new, one-day format, including all three cases showing the spectrum of Alzheimer’s from diagnosis to late-stage illness. We are thrilled to announce that Jeannette Kates, PhD, CRNP, AGPCNP-BC, GNP-BC, Program Director for the Adult-Gerontology Primary Care Nurse Practitioner MSN (Master’s) specialty, joined AVIT as a faculty lead on July 1, 2021. We look forward to expanding AVIT programming by offering simulations at affiliate continuing care retirement community the Hill at Whitemarsh during Summer 2021 under Dr. Kates’ and Dr. Susan Toth-Cohen’s leadership.

• From late fall through early spring, nine students joined us from six professions (Medicine, Nursing, Occupational Therapy, Pharmacy, Physician Assistant/Public Health Dual-Degree, and Population Health) for Enhancing Services for Homeless Populations (ESHP) to explore team-based care for homeless populations in several different settings.

• Student Hotspotting concluded its 2020-21 year in April (coinciding our Wrap Up with the JCIPE Conference!). 75 total students (from Jefferson, Harvard, Johns Hopkins, and Northeastern PA) and 38 total advisors participated this year, working with 17 patients (our most ever!). In addition to our recurring programming, we offered two new Essentials Workshops this year, on Motivational Interviewing and Trauma-Informed Care (and our 3 external teams participated in our workshops for the first time!).

• 137 students from 6 professions (Couple & Family Therapy, Medicine, Occupational Therapy, Pharmacy, Physical Therapy, and Physician Assistant Studies) participated in Team Care Planning, conducting a discharge planning meeting for acute stroke patient Reverend Walker in partnership with our ever-talented standardized patients and caregivers. We look forward to piloting a new maternal health case currently under development this coming year.

• The Jefferson Teamwork Observation Guide (JTOG) App has a total of ~3,610 users (~2,190 more users since our last report). We are undergoing another round of App and dashboard upgrades with a focus on revamping and further improving our dashboard functions. The paper-based version of the JTOG tool was made available for licensing to external users and the App version is estimated to be available later this year.

• JCIPE’s Racial and Social Justice Taskforce continued its work, holding discussions with rotating leaders each month, creating a diversity statement to be used in all JCIPE programs next year and beginning work on a self-study template to guide standardized, close examination of all program content relative to diversity, equity and inclusion (DEI). Issues of DEI were also incorporated into two recent faculty development offerings. Additional work at the center level will take place during strategic planning later this fall.

NAP Public Policy Principles

1. All Americans should have affordable health care.
2. Health care should include prevention as a core strategy, not just cure strategy.
3. Primary care should be the starting point for coverage, but other services need to be added.
4. Health care should encompass physical, behavioral, and social health.
On the afternoon of Friday, September 19, 2008, Brian Sinclair maneuvered his wheelchair to a community health center in Winnipeg, Manitoba. Center staff were familiar with Mr. Sinclair, a 45-year-old First Nations (Canadian indigenous) man and double amputee with chronic illnesses. He complained of pain and requested assistance with the catheter bag he used. A physician and nurse examined him and recommended that he go to a nearby acute care hospital to have his catheter changed in a sterile environment. Mr. Sinclair agreed. The physician gave him a letter to share with the emergency department explaining the reason for his visit, which he placed in his pocket (Brian Sinclair Working Group, 2017).

When Mr. Sinclair arrived at the emergency department, an aide greeted him and inquired about his illness but, for some reason, did not enter his case into the triage system. Mr. Sinclair sat quietly in the waiting room as his symptoms worsened. At 4:00 am Saturday, a nurse noticed the sleeping Mr. Sinclair. She checked his wrist, and, not seeing a wristband, assumed he had been discharged and was waiting for a ride or was a homeless person seeking shelter. Mr. Sinclair was still in the waiting room Saturday afternoon when other patients alerted a guard that he had vomited. Environmental services staff cleaned up the vomit, but no one informed the health professionals (Brian Sinclair Working Group, 2017).

At midnight on Saturday, a patient approached the guard concerned that Mr. Sinclair had not moved in hours. The guard said he was probably intoxicated. The patient insisted, so the guard went over to Mr. Sinclair and discovered that he was unresponsive. He wheeled Mr. Sinclair to the nursing staff, who declared him dead, the letter from the physician still in his pocket. Seventeen staff members had observed Mr. Sinclair during the 34 hours he waited for care, but none offered to help. An autopsy revealed a bladder infection had led to sepsis. It found no drugs or alcohol in his system (Puxley, 2014).

In the case of Mr. Sinclair, any proponent of interprofessional collaborative practice could identify lapses in team performance. Failures in communication prevented crucial information from reaching the appropriate health professionals. Some members of the hospital staff may not have fully understood the scope of their and their colleagues’ roles. Fellow patients exhibited more respect for Mr. Sinclair’s dignity than the clinicians who encountered Mr. Sinclair.

But if health professions educators focus on fixing just the aspects of team dynamics, they still allow the underlying effects of structural racism to persist, which conditioned most of the people who encountered Mr. Sinclair to see him as someone unworthy of care. I use ‘structural racism’ specifically to avoid judging the mindset of any individual health professional (Hardeman et al., 2016). All the staff in the emergency department may have been free of personal animus toward indigenous peoples; yet, they inhabited a structure, built up over time and continuously reinforced, that caused them all to judge Mr. Sinclair in the same way: undeserving.

For interprofessional education to meet its ultimate goal of improving wellbeing, it needs to be attentive to the adverse impacts of structural racism on health. Structural competency asks the clinician to consider not just the person presenting in front of them, but also the historic, social, economic, and environmental context in which they are embedded (Metzl & Hansen, 2014). Take Mr. Sinclair for example. A standard health history for his case would look like Figure 1.

A more complete health history would widen the lens to include the full trajectory...
that brought him to the emergency department that Friday afternoon. These are not immediately visible to the clinicians but can be solicited through more in-depth interviewing. A simplified version of Mr. Sinclair’s story might look like Figure 2 on page 3.

Finally, the external structures that shaped his life would appear. These forces are harder to see and may not be apparent even to Mr. Sinclair (Neff et al., 2020). (See Figure 3).

The benefit of structural competence is that it reorients health care away from treating patients’ symptoms after they become sick to identifying root causes that prevent sustainable health (Bourgois et al., 2017). This is not to say that Mr. Sinclair bears no responsibility for the decisions he made before arriving in the emergency department, only that he inhabited a world that constrained his choices. As an analogy, think of currency: we are free to attempt to pay for retail items in the United States with euros, but customs, policies, and rules of exchange make that option unreasonable. In the same way, the rules of structural racism are not written down, but they still determine how resources and opportunities are distributed.

Interprofessional collaborative practice can be particularly helpful in building the structural competence needed to dismantle structural racism. Health professionals engaged in effective teamwork are already attuned to systems-level dynamics. They know how to identify underlying barriers in communication, hierarchy, and role clarity to put the patient and family at the center of care. Interprofessional collaborative practice has not embraced anti-racism as an explicit focus, but it takes only a widening of the lens to perceive how structural forces like racism negatively impact the health of the patient. For instance, one emergency department confronted a dispiriting roster of patients with substance use disorder in acute distress. They would admit them, stabilize their condition, and then release them back into the community only for the cycle to repeat (Messac et al., 2013). A sustainable intervention would require interprofessional coordination at multiple levels: strengthening the coordination between intensive care and outpatient social services to connect patients to resources before they need emergency care, establishing an institutional partnership with legal services to help patients qualify for housing assistance and career development programs, and leveraging multiple professional associations to lobby for more public investment in treating substance use disorders.

A coordinated team alone cannot be expected to counteract hundreds of years of ingrained disadvantages, but team members can use their interprofessional voices to conceive and advocate for more equitable systems. Seeing systems is a strength of interprofessional collaborative practice, though traditionally the analysis has been limited to the clinical environment. To promote more lasting health that takes into account the full context of people’s lives, interprofessional teams will need to consider how to extend their roles into community and policy arenas. The sheer scope of structural flaws that need to be repaired may overwhelm a clinical team already fully occupied with patient care. Fortunately, the first step toward incorporating an anti-racist orientation into interprofessional collaborative practice involves only a shift in outlook. Too often, health care team members see “frequent flyers” like Mr. Sinclair as solely responsible for the condition of their health. Nurturing a deeper understanding of the structures that shape patients before they present themselves in a clinical setting helps counteract the blame-the-victim mentality. Structural competence highlights that we all exist in a web of social and historical forces, giving impetus to interprofessional teams to use their collaborative skills to address the pernicious effects of structural racism on health.

References


Dismantling


Figure 3
Hosted by the Center for Health Interprofessional Programs, University of Minnesota, the CLARION National Interprofessional Case Competition is designed to give healthcare students an interprofessional teamwork experience. In 2021, JCIPE sent a strong team consisting of two pharmacy students, Jordan Mak & Cat-Trinh Phan, and two nursing students, Francesca Girone & Mary Lloyd, to represent Jefferson. Our team successfully developed an innovative solution proposal to build a better healthcare system by conducting a root-cause analysis of a fictionalized event. Over the course of the project, our team formed a strong relationship, which culminated in a presentation and a pitch to a panel of judges representing leaders in various healthcare professions. To address the needs of real patient populations in modern society, we utilized the University of Minnesota Earl E. Bakken Center for Spirituality and Healing Well-Being Model that includes six dimensions: health, relationships, security, purpose, community, and environment. The competition was held virtually on Zoom over two days. The first day included a kick-off address and a healthcare-themed escape room activity with participants from other schools. On the second day, teams presented their proposals privately to the judges. Four finalists were selected for a final presentation to all participants and the competition concluded with an awards ceremony for the 1st, 2nd, and 3rd place winners.

The Case: Weathering the Storm
As climate change continues to increase the frequency and intensity of Atlantic hurricanes, families like the fictitious (but representative) Rivera family from the case are displaced from their homes. Natural disasters like hurricanes, forest fires, and droughts force swaths of people to migrate from low-resource systems to avoid injuries, disease, malnutrition, vector-borne illness, and death; the consequences of such catastrophes must be mitigated with contemporary solutions, especially within the healthcare sector.

The Proposal: Many Hearts, One Home
Millions of people navigate the American healthcare system each day, but as it is highly complex, those most in need may find it difficult to access the care available. Our team conducted a Needs Assessment to determine the issues and barriers that families like the Riveras may face when trying to protect their livelihoods. By focusing on our Core Values, we developed our proposal, Many Hearts, One Home, to provide holistic care to displaced families who have experienced a natural disaster, by assessing clients’ individual needs and coordinating educational workshops to acclimate them to a new environment. After determining our SMART objectives with a comprehensive logic model, our team decided on a three group, one team model consisting of the Outreach, Operational, and Educational groups in order to offer workshops addressing both general and specific needs. With a bilingual case manager focused on the families, we would be able to create a custom curriculum for the displaced Puerto Rican population in Orange County, Florida. We would also be able to offer an intimate community and safe space for these families, following them closely to ensure that they met their personal, social, and health goals.

Our proposal included an executive summary, an implementation timeline, partnership identification, grant funding, and a budget design. Our team spent dozens of hours together examining how to execute an impactful, yet affordable, program for our target population; this required a substantial understanding of both the patient perspective and the roles of all the members on an interprofessional healthcare team. We utilized this project as an opportunity to reach out to our resourceful faculty, and even got to glean wisdom from interviewing a social worker. Over the course of a semester, our team members learned population health concepts and how important different and unique professional perspectives are, so we can provide the best care for our future patients.

The Takeaway: The Meaning of Social Work
Jordan Mak
A major takeaway from this experience was learning about the integral role of a social worker in coordinating care. As our team started to create our proposal, we realized that an essential piece of our program involved case management and social work.

When we started to assign roles for who would accomplish the objectives of the program, we learned that none of us were very familiar with the responsibilities and day-to-day tasks of a case manager and social worker. After reaching out to our faculty advisor, he was able to connect us with Stephanie Nickerson, a licensed social worker in the Department of Case Management at TJUH. Meeting with Stephanie helped to broaden our knowledge about social work. Her feedback was instrumental in how we ultimately decided to design our proposed program, which featured a case manager who coordinated an interprofessional team in supporting displaced families.

This experience taught me to continue learning about the many different roles in healthcare. The CLARION competition has reinforced what I have learned through participating in previous JCIPE programs, that providing comprehensive care takes a team and each member’s contribution is valuable.

The Takeaway: The Health of a Community
Cat-Trinh
As our team consisted of two different professions, we were able to discuss our understanding of patient-centered care as Jefferson students. We were able to tap into professionals from other spaces to understand their approach as well. However, the concepts that really pulled this project through to the end were from our team’s background in population health. Two of our team members had experience in population health courses, which allowed our proposal to take a tangible shape, as we defined our desirable outcomes and utilized popular models to create a full-fledged program.

An awareness of the patterns of human behavior was also essential in understanding what the displaced Puerto Rican population in Florida might need and what communities and resources could be accessible to them; this led to significant decisions in aspects such as which partnerships we considered pursuing and how to most effectively build rapport among our target population.

The CLARION competition emphasized the importance of being culturally competent and the meaningfulness of being a healthcare provider that serves the local community. This opportunity reminded me how to step into the shoes of a patient once again and how empathy can lead to an in-touch professional career.
Meet an IPE Student Champion from Thomas Jefferson University
Krista Garrison, MS Occupational Therapy, Class of 2021

Briefly describe your work with/related to JCIPE:
From Fall 2019-January 2021, I had the opportunity to be a graduate assistant (GA) for JCIPE. This experience gave me the opportunity to be involved in a variety of programs. My main projects included working with Team Care Planning, the TeamSAFE program and mainly Hotspotting. My work with Team Care Planning involved analyzing and preparing data from previous sessions. These sessions involved interprofessional groups of students creating discharge planning for a case study with simulated actors. After data collection, I would cultivate the data to identify themes and results from the student experiences. As for my work with TeamSAFE, I was able to assist with preparation for all in-person sessions. When we made the shift to virtual learning, I was a part of the supportive staff for the transition, and I was also engaged in TeamSTEPSS training. This training allowed me to analyze the student sessions to collect data on the usage of TeamSTEPSS verbiage and techniques. Lastly, I was involved in the behind the scenes work for the Hotspotting Program. Aside from assisting with the Kick Off and Wrap Ups each year, I was able to dive deeper and be a part of the Hotspotting research. I was a part of a subcommittee that helped to revise and streamline the pre- and post-outcome measure administered to student participants in Hotspotting which was implemented in Fall 2021. Additionally, I was able to be involved in Hotspotting poster analysis to identify themes and outcomes over the years of the program. This data is currently being put together for a manuscript, which is very exciting! Through all of these experiences and the additional small projects I was able to assist in, I have learned so much about the importance of research and education for interprofessional teams!

What excites you about this work?
The exciting part about working with JCIPE is working behind the scenes with a goal in mind to improve interprofessional education and collaboration! Interprofessionalism is imperative in healthcare; therefore, being behind the scenes to assist with kick starting programs throughout health professionals’ education is an amazing opportunity. As a student myself, I have enjoyed taking part in some of the programs offered, and am so thankful for the opportunity to be involved in the research aspect of JCIPE as well!

What have you learned that was new?
Throughout my work with JCIPE, I have learned so much about interprofessional practice; however, what stands out most to me is the impact of forms of communication we practice, such as TeamSTEPSS. Educating students on utilizing clear, open and effective communication is one way of ensuring safe practice throughout careers and I have found myself utilizing this technique in my own clinical fieldworks.

Why is IPE/CP important to you?
Interprofessional education is important to me because it is the first of many steps in creating safe, high quality, client-centered care. All members of the team play a vital role and working collaboratively with the entire team helps to provide the best care possible for individual clients.

How do you think you will apply your IPE/CP learning to your future role?
As a future occupational therapist, I will be part of many health care teams. These experiences in IPE will apply to daily interactions with colleagues in order to create the best quality care for my clients. In working with JCIPE and taking part in the programs, I have obtained a skillset in effective communication, leadership, client-centered care, and implementing evidenced-based practice. I look forward to taking these skills into my future career!

Welcome to the 2020-2021 Student Hotspotting Wrap-Up!

Hotspotting Faculty Director Dr. Tracey Earland and the JCIPE team lead the 2020-21 Hotspotting cohort (75 students and 38 advisors, from Jefferson, Harvard, Johns Hopkins, and Northeast PA) through its virtual Wrap Up event in April.

Teamwork (Really Does) Make the Dream Work! Lessons Learned from Implementing Citywide Infrastructure with Interdisciplinary Teams

The City of Philadelphia is celebrating the 10th anniversary of its ambitious 25-year Green City, Clean Waters plan. It was the first endeavor of its kind, as the City proposed a primarily nature-based approach to meet regulatory requirements associated with decreasing the amount of polluted water entering creeks and rivers in Philadelphia. The forward-looking Green City, Clean Waters reimagined stormwater management as a visible investment in public areas such as sidewalks, parkland, and vacant lots, as well as other spaces in neighborhoods across the City.

Because the Philadelphia Water Department (PWD) is tasked with implementing this plan (although it owns very little land), partnerships and teamwork took on a new meaning for the Department. The plan required PWD to step outside of its standard operations to construct green infrastructure, which required expanding its capacity for team-building and collaboration. At the official start of the program in 2011, the team responsible for Green City, Clean Waters comprised approximately 10 staff that were predominantly engineers; today, the team is a staff of over 75 members, who incorporate specialties in urban planning, landscape architecture, public affairs, environmental science and more.

Teamwork and collaboration went well beyond the interdisciplinary teams that formed internally, too; teaming up with those that own and operate the land that the City targeted for green stormwater infrastructure (GSI) was (and still is) mission critical. Collaboration with the private sector, non-profits and city agencies, like Philadelphia Parks and Recreation and the Streets Department, in addition to the School District of Philadelphia and neighborhood communities, required partnership at all levels and during every phase of each project.

We learned that the key to success in the first ten years of the program is in creating teams that are composed of various disciplines, and not only one specialty; for example, when planners, designers, and community outreach specialists come together, the outcomes are most sustainable. The ability to have flexibility, and to tap into specialty backgrounds within a solid team, improves the process and ultimately the outcomes. The below list summarizes some of the most important takeaways we’ve learned through a decade of multidisciplinary collaboration, which we believe are universal across sectors.

First, let’s cover one of our projects to see how the lessons learned translate into the real world:

The American Street Improvement Project is a collaboration between multiple city agencies that has resulted in the largest single contribution to publicly owned GSI, as well as many other improvements along the corridor that help support both the neighborhood and business communities. The project originated when the Streets Department and Water Department recognized that they were both interested in removing the historic train tracks that were in the middle of the street along this commercial corridor, in order to facilitate their own improvements; together they were able to apply for and received over $5M in funding to support the project. The funders were particularly supportive of this project because it would deliver multiple benefits (Lesson 4).

The funding meant the project could move forward, but it also had short deadlines associated with it. The project management team created a stakeholder group early on to facilitate communication and make space for everyone to be heard. Working together along the way meant that input was included upfront and the design was completed within the required timeframe (Lessons 1, 2, and 3). The group responsible for maintenance was also included in the design process, and special considerations were included for access of maintenance vehicles in order to make future maintenance easier (Lesson 5). The management team held public meetings at various stages in the design process and along this corridor; this gave community members the ability to provide their input and ultimately led to their support of the project (Lesson 6). One community group made it clear that their priority was increasing the greening of the corridor, and collaboration with this group eventually led to additional green space being added to the project (Lesson 7). The project also allowed the Water Department to test out a new incentive we have been working on with private property owners (Lesson 8). Although the process of working with the private properties was new, standard materials were proposed in the design to make it easier to work with and maintain (Lesson 9). The team was ultimately awarded the Innovative Transportation Solution award from WTS Philadelphia and they were able to celebrate their accomplishments together at a special event. The completion of one project prepared the team to take on the next challenge more collaboratively (Lesson 10)!

Our Top 10 Lessons of Interdisciplinary Teamwork:

1. Keep an open dialogue with all of the parties involved in a project. Anticipate potential conflicts as early as possible. Figure out the weaknesses and issues in your projects and partnerships early on and address them head on. The sooner you are transparent and honest about issues you may face at a later date, the more respect you will gain in the eyes of your team member, partner or community member and the less energy, time and money you will waste in trying to fix the problem, when it may be too late. Projects always run more smoothly if challenges are addressed quickly and directly.

2. Take time to make sure everyone is on the same page. The benefits of a multidisciplinary team are manyfold, particularly once everyone’s roles are clear. Sometimes the engineers need the planners to get them out of a potentially endless comment loop, while other times the planners need a reality check from engineers about the proposed location (siting) of the planned project.

3. Get feedback from different team members at every stage. The outreach specialists and designers need feedback from the maintenance staff to ensure the upfront investments in time, money and talent are not short-lived. Maintenance is a long game. Request feedback.

4. Sell a project from multiple angles. If the city agencies and partners see what’s in it for them, collaboration is undoubtedly smoother.
5. Think about the entire life cycle of a project from the beginning to end. It’s not just about the planning, design, and construction; once the infrastructure is in the ground, it needs to be maintained in perpetuity and maintenance can be complicated. Being clear about what can and cannot be maintained needs to be a regular topic of conversation early on.

6. Building trust within teams is critical to success. Whether with internal or external partners, it’s important to create opportunities for trust-building outside of seeing the task through.

7. Listen! Listen! Listen to your partners. Find out their priorities. Give them what they want/need and they will help you with your wants/needs. Find ways to align your priorities and be ready to compromise, if you want to be partners for the long haul.

8. When creating a new program, allow space for mistakes and recognize the need for flexibility in the development stage. Giving a program the space it needs to form also allows time to develop partnerships and adjust to include partners’ needs and perspectives along with your own.

9. Ultimately, however, a large program must transition to standardization to make it possible to manage the program at the citywide scale. Successful standardization relies heavily on the previous lessons being followed and helps to advance trust, because the other team members feel secure in what will be built in the future.

10. Finally, have fun together as a team! It’s amazing how people from different walks of life and professional disciplines accomplish more together when they are creative, relaxed and/or simply enjoying each other’s company. Create opportunities to make collaborations successful!

As we continue our journey of making Philadelphia’s waterways cleaner and our city greener, we look forward to engaging with more disciplines that also promote health and an improved standard of living for all communities. Health and water are intertwined and the potential synergies and opportunities for collaboration are endless.

Meet an IPE Faculty Champion from Thomas Jefferson University
Emily Scopelliti, PharmD, BCPS / Associate Professor of Pharmacy Practice

Briefly describe your work with/related to JCIPE:
I proudly work with JCIPE as a facilitator for Introductory and Advanced TeamSAFE programs and as an advisor for the Hotspotting program. In these roles, I work with students to strengthen communication skills and teamwork to promote patient safety as well as provide guidance for an interprofessional student team as they navigate the healthcare system and community resources to assist patients with complex health and social needs.

What excites you about this work?
I am excited about the opportunities that JCIPE offers healthcare professional students, as they develop essential skills needed to participate as an effective member of an interprofessional team. As an advisor and facilitator in the Hotspotting and TeamSAFE programs respectively, I have the good fortune of collaborating with inspiring and enthusiastic students and colleagues from diverse backgrounds. These innovative programs promote faculty and student development and allow participants to learn from and with each other in a way that deepens their understanding and respect for the vital roles that each individual plays on the collaborative team.

Why is IPE/CP important to you?
High quality patient-centered care is at the core of IPE and CP. As a clinical pharmacist in an outpatient practice, I have directly experienced the importance of communication and collaboration in achieving optimal patient outcomes. As an educator, I have come to understand the importance of innovative and realistic educational experiences to assist future healthcare professionals in becoming “practice-ready.” Student participation in collaborative learning opportunities through IPE breaks down the walls between traditionally isolated educational experiences of individual healthcare professions and allows students to transition to the patient care environment with a clear understanding of collaborative practice.

Accelerating Interprofessional Trailblazing

After the JCIPE conference, our co-director, Dr. Brooke Salzman, sat down with Dr. Ivy Oandasan to learn more about her and her work. We highlight some of the conversation with Dr. Oandasan, a leader in IPE based in Canada, below:

Getting Started in IPE:
Dr. Oandasan started as a research investigator for the University of Toronto, Department of Family Medicine; she says she “kind of stumbled into” IPE when she replied to a call for a literature review of evidence for Health Canada (the Canadian federal government equivalent to the US Department of Health and Human Services).

This initiative, to look for evidence to improve team-based care in health care, took place in 2004 when the Canadian government foresaw a workforce shortage in the next decade (there’s still a shortage today). Dr. Oandasan started by developing a conceptual framework linking interprofessional education and interprofessional practice. She believed that, “If we were going to advance teamwork in healthcare, then we could not just look at changing the education of healthcare professionals; we needed to link the outcomes of our educational programming with models of care that support those whom we graduate that are competent to work interprofessionally; to drive interprofessional
education and interprofessional practice change, there needs to be evidence continually gathered to demonstrate improved health outcomes for both patients and the system as a whole.”

She highlighted that one of the challenges faced in advancing interprofessional education and practice is that our current educational and healthcare systems are based on old paradigms of science-based learning and hospital-based care. Once she reviewed the evidence, she realized that a major cultural shift away from the old paradigms to a more holistic, humanistic, and systems-based approach was needed.

“The interprofessional research we, as a community conduct, helps us advocate for policy reform, which in turn drives practice change. If researchers in interprofessional education and practice can join forces to continue to show evidence of positive impact, the evidence will continue to influence decision-makers, who in turn can make the policy changes needed. Ultimately in time, the hope is that a new cultural norm will be in place with team-based practice, as the way all people receive care.”

**Challenges with Advancing IPE:**

Dr. Oandasan addressed how to advance change in complex systems. She states, “One of the things we’ve learned in making change happen in complex systems is that we live in a world where multiple systems (health, cultural, political, etc.) are always at play interacting and shifting, reacting and always changing. The trick is when trying to advance change, you should have a common set of principles or “simple rules” that can apply to any system. If collaboration is a principle of how things work in a system must work, if it spreads within the system, it can permeate how the system operates in general. If systems interact, then in time and if nurtured, collaboration will influence other systems and so on. For example, if we focus on interprofessional education in the education system and graduate learners with principles grounded in collaboration – our hope is that they will enter the practice system using a collaboration-principled approach, which positively influences patient care. So if equity is a principle or value we believe is important, then it should be seen in how we teach, the way we practice, and the way we govern. Overarching principles can help shape the systems we work within at micro, meso and macro levels. If a system values collaboration and it is getting results, look to the leadership, as likely their behavior exemplifies the desired values in action. The culture of an organization reflects its values and permeates through it. For example, the culture can be seen in an organization’s vision statement, in their hiring policies, in their organizational structures modelled in the behavior of its employees. If you don’t see collaboration in action within an organization or system, the culture of the organization/system likely needs to shift.”

**From Preparing to Practicing:**

Dr. Oandasan described how to move education to the next level from preparing students to practice collaboratively to them actually practicing collaboratively. She states, “As educators, we’re nurturing seeds that grow. When we grow a flower as educators, we hope that the flower ends up in a home that appreciates it and helps it continue to grow. But if the home doesn’t put effort into nurturing it, it will not flourish. This analogy reflects the work we have been doing in interprofessional education. We are producing graduates who are skilled in being collaborators for care. Our practice system needs to value what we are producing and capitalize on strengths. Education and practice must work together. Real system change is not possible without shifts in education and practice together. Proficiency opens the door to the practice world, but mastery comes through ongoing support in the workplace.”

**Interprofessional Collaborative Practice and Competencies:**

Dr. Oandasan commented on the principles of an organization and how they shape the practice environment, and how those principles relate to competencies in interprofessional collaborative practice. She stated that the interprofessional competencies currently defined in the US and/or Canada have been helpful in advancing interprofessional education. “You’re seeing people who have acquired these competencies and they are now leading interprofessional education and care movements… that’s inspiring; it means that the IPE competencies are being put into action. My hope is that the more people we train using our interprofessional education models, the more agents of change we set loose into our health and education systems. They will be the practitioners who carry out the principles of collaboration we have instilled in them, and when enough of them are out there, they will be the ones in leadership roles that will shift our systems at micro, meso and macro levels. I think we’re doing it. It will take time and if nurtured, collaboration will influence the systems we work within. I think we’re doing it. It will take time and if nurtured, collaboration will influence the systems we work within.”

**Confidence and Competence to Provide Interprofessional Care:**

Dr. Oandasan described confidence as an output of interprofessional education, which is as important as competence. “As interprofessional educators, our role has been in teaching and assessing interprofessional competencies to prepare health care providers to enter practice. Our expectation is that those who complete training are competent interprofessionally. But is competence the end goal? Given that competence can be assessed objectively, one can be deemed competent yet still not feel confident to do it. We might teach interprofessional communication skills to our learners and they could pass an exam but in the real world will they actually use their communication skills?

When you look at the confidence literature, there are different constructs that make up the concept of confidence. For educators, self-concept is one layer of confidence. It reflects a belief about oneself based upon the collective beliefs or reactions by others. For example, a health professional could say: ‘I practice in a team-based way because everyone around me reinforces me when I do and I keep doing it because everyone around me practices in this way.’ As educators we have an opportunity to nurture health professionals’ self-concept of being a collaborator. In my way of thinking, learners will feel more confident to act collaboratively if it is a normative behavior they see day in and day out.

Self-efficacy is another construct related to confidence, that relates to an “I can do this” attitude. You may not do it perfectly, but you have enough trust in yourself that you will try. So an example would be in the interprofessional communication skills we teach. A learner might ace a communication simulation, but in real life, even if they have the skill set, will they actually put their skills to the test? Do we ask how confident [students] are in their interprofessional abilities and ask them to what extent they would carry out the skills in a different context with different people? I think self-efficacy comes when our learners are given multiple opportunities to apply the skill in different contexts. So that’s part of this need for repetitive exposure, practicing these skills, and then putting them in situations where they may actually fail, and they might actually not do it right or feel very hesitant to even try. We’re giving them opportunities to fail in order for them to build their confidence to try.”

Dr. Salzman: “The construct of self-confidence is tricky, just because I feel like many of the students and trainees I work with, who may not self-report high confidence levels, are very reflective and more concerned about their performance, versus some of the people who are most confident, I really wish would potentially be more self-aware.”

Dr. Oandasan: “That’s part of that notion of guided self-reflection that we can use, too, helping the learner be able to see what they don’t. So, what would be the role of the educator? If I saw that I had a learner who is having difficulty with power and hierarchy, what is the intervention that I need to do as a teacher? I need to give them more opportunities where they actually become self-confident. At the end of the day, if they’re not going to voice a contrary opinion and
somedbody's going to die, then I failed as an educator. As an educator, it's my role to coach them to develop their own sense of self-concept using my feedback and the feedback of others in order to gain confidence. The opposite holds true as well for the "cowboys" who are overconfident. We need to help them with their development of self-concept and use feedback frequently and effectively. We owe it to our learners to not just expect competence...we owe it to them to support their self-confidence which includes self-concept and self-efficacy. I think we owe it to them as educators to ensure that they are really ready to practice collaboration in unknown and challenging situations. Are they prepared with both confidence and competence?"

**Intersectionality of Interprofessional Education and Racial and Social Justice:**

Dr. Oandasan was asked to elaborate more on the role of IPE in teaching about issues of equity, diversity, and inclusion. She stated that "Interprofessional education is a teaching approach. If equity is a foundational principle embedded across health professions programs, then the use of interprofessional education (teaching about, from, and with each other) needs to be in service of equity. Equity could be the outcome at the end of the day. Whenever there's a moment in the course where there's dissension or difference, or people are storming in their small groups, I'm like, 'Yeah, this is good. Take a deep breath. It's about people being able to voice their different perspectives in order for us to get to the best possible outcome. We need to hear everyone's voice and everyone needs to feel that they can voice their opinion and be heard.'"

**Closing Statement**

Dr. Oandasan concluded her conversation with us by reiterating her belief that, "we need to adopt a systems approach to the way we advance interprofessional education and interprofessional practice. As educators in this field, we may need to put emphasis on confidence for true readiness to practice versus focusing on competence. Helping our learners to have an 'I can do this, I will do this, I am doing it' mentality is a goal which may require new pedagogical approaches. Perhaps explicit ways to teach self-concept and self-efficacy as part of self-confidence in the practice of interprofessional care will help strengthen our health workforce."

She closed with "My hope is that we also use interprofessional education as an example of how equity, diversity, and inclusion is woven into how we teach and what we hope to impact. We need to think about our learners and how equity, diversity, and inclusion impacts their capacity to be collaborators in a culture that is laced with power and hierarchy of professions. I believe we have and are changing the system of healthcare delivery and health professions education. Doing this work takes courageous people who on principle believe it's the way health care should be delivered. It requires us to increase the number of collaborative health care providers in the health system who are confident and competent in their professional roles, who are able to communicate effectively and negotiate and who are comfortable with conflict. We need collaborative leadership. The people we need leading change in fact require our interprofessional competencies. The application of these competencies will create the paradigm shift our system needs and a system our learners and patients deserve."

---

**Meet an IPE Student Champion from Thomas Jefferson University**

**Emily Romano, MD, SKMC, Class of 2021**

**Briefly describe your work with/related to JCIPE:**

I had the opportunity to be involved with JCIPE even before I was a Jefferson student! I spent a year working at the Camden Coalition and got to assist with analyzing Student Hotspotting (SH) surveys. After coming to SKMC, I participated in the Health Mentors program in my first and second years and then went on to join an SH team during my third year. I got to serve as an alumni advisor for an SH team the following year and have since been working on a qualitative study of the SH process with an interprofessional team representing occupational therapy, medicine, and psychology.

**What excites you about this work?**

I have now seen firsthand how interprofessionalism can improve patient care and contribute to the quadruple aim (better outcomes, lower costs, improved patient experience, and improved clinician experience).

**What have you learned that was new?**

Working with JCIPE has given me the space to reflect on my values and commit to putting those values into practice as a physician.

**Why is IPE/CP important to you?**

We have so much to learn from our colleagues in other disciplines. It is crucial to instill this perspective from the very beginning of training.

**How do you think you will apply your IPE/CP learning to your future role?**

Thanks to my work with JCIPE, I am much more likely to seek opportunities to learn from and collaborate with people outside of my own field. I am looking forward to joining new interprofessional teams as I begin my internal medicine residency this summer!
Jefferson Center for Interprofessional Practice and Education (JCIPE) congratulates this year’s interprofessional education (IPE) and collaborative practice (CP) award winners and thanks them for all their efforts to support and advance this work on campus and beyond. Their contributions are immeasurable!

**Excellence in Interprofessional Health Education**

**Jeannette Kates, PhD, APRN, AGPCNP-BC, GNP-BC**
Jefferson College of Nursing
Thomas Jefferson University

**Clinical Educator Award for Excellence in Interprofessional Education**

**Elissa Harmon, RN, DNP, CCRN, PHNA-BC**
Administrative Charge Nurse
Department of Nursing
Thomas Jefferson University Hospital

**Excellence in Interprofessional Collaborative Practice**

**Lauren LaTourette, LSW**
Palliative Care Social Worker
Department of Family and Community Medicine
Sidney Kimmel Medical College
Thomas Jefferson University

**Administrator/Staff Award for Excellence in Interprofessional Education and Collaborative Practice**

**Julie Phillips, PhD**
Academic Commons
Thomas Jefferson University

**Student Award for Excellence in Interprofessional Education and Collaborative Practice**

**Jamie Garden**
Sidney Kimmel Medical College

**Umara N. Iftikhar**
Department of Occupational Therapy
Jefferson College of Rehabilitation Sciences

**Jennifer Jackson**
Department of Physical Therapy
Jefferson College of Rehabilitation Sciences

**Jordan Mak**
Jefferson College of Pharmacy

**Anjali Patel**
Sidney Kimmel Medical College

**Cat-Trinh Phan**
Jefferson College of Pharmacy

**Nick Safian**
Sidney Kimmel Medical College

---

**TeamSAFE: Introductory & Advanced**

**Program Description:** Case-based simulation program that emphasizes patient safety, teamwork & communication through the application of TeamSTEPPS skills.

**Intro** - low fidelity case-based simulation with beginner learners
- October 2020, January 2021
- Zoom
- Articulate Storyline Student & Faculty Materials
- Faculty Training & Mock Sessions

**Advanced** - high-fidelity simulation with complex clinical scenarios & advanced learners
- April 2020, June 2020, March 2021
- Blackboard Collaborate → Zoom
- Faculty training & Mock Sessions

---

*JCIPE Program Assistant Quadira McPherson introduces our TeamSAFE program (and how it moved fully online during the 2020-21 academic year), during our conference presentation “A rapid transition to, and best practices supporting, synchronous online IPE.”*
Collaborative Healthcare: Interprofessional Practice, Education, and Evaluation is a peer reviewed bi-annual publication that aims to disseminate current information and innovative projects advancing interprofessional education, evaluation, research and practice.

Jefferson Center for Interprofessional Practice and Education
130 S. 9th Street, Suite 1839, Philadelphia, PA 19107 • Tel: 215-955-0639 • Fax: 215-503-6284 • Jefferson.edu/JCIPE