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| **Attitudes Toward Health Care Teams**
  developed by Heinemann, Schmitt & Farrell

Seamless Care Student ID:__________

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<td>Physicians, as a rule, are team players</td>
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Attitudes (continued)
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<td>13.</td>
<td>The give and take among team members help them make better patient care decisions</td>
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<td>Having to report observations to the team helps team members better understand the work of other health professionals</td>
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### Attitudes Toward Health Care Teams developed by Heinemann, Schmitt & Farrell

Seamless Care Student ID:__________

<table>
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<th>Attitude</th>
<th>Scale</th>
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Attitudes Toward Health Care Teams
developed by Heinemann, Schmitt & Farrell

Seamless Care ID: _____________

1. Working on teams unnecessarily complicates things most of the time ................. 0  1  2  3  4  5
2. The team approach improves the quality of care to patients ............... 0  1  2  3  4  5
3. Team meetings foster communication among team members from different disciplines ............ 0  1  2  3  4  5
4. Physicians have the right to alter patient care plans developed by the team ............. 0  1  2  3  4  5
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Attitudes (continued)
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Return the completed form to: Seamless Care, Dalhousie University Room C123, 5849 University Avenue

Or fax to: 494-6291 Atten: Tanya Matheson
## Evaluation Plan

<table>
<thead>
<tr>
<th>Evaluation Element (Kirkpatrick Model)</th>
<th>Student Learners</th>
<th>Faculty</th>
<th>Patients</th>
<th>Clinical Sites</th>
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<tr>
<td>1. Reaction</td>
<td>Focused Reflective Exercise&lt;sup&gt;1&lt;/sup&gt; Post-Intervention Focus Group&lt;sup&gt;2&lt;/sup&gt;</td>
<td>Focused Reflective Exercise&lt;sup&gt;1&lt;/sup&gt; Post-Intervention Focus Group&lt;sup&gt;2, 2a&lt;/sup&gt;</td>
<td>Semi-Structured Interview&lt;sup&gt;3&lt;/sup&gt;</td>
<td>Semi-Structured Interview&lt;sup&gt;4&lt;/sup&gt;</td>
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<tr>
<td>2a. Modification of attitudes/perceptions</td>
<td>RIPLS&lt;sup&gt;5a&lt;/sup&gt; AHCTS&lt;sup&gt;5a&lt;/sup&gt;</td>
<td>RIPLS&lt;sup&gt;5b&lt;/sup&gt; AHCTS&lt;sup&gt;6b&lt;/sup&gt;</td>
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<tr>
<td>2b. Knowledge and skill acquisition</td>
<td>Self-efficacy (IPL competencies)&lt;sup&gt;7a&lt;/sup&gt;</td>
<td>Self-efficacy (IPL competencies)&lt;sup&gt;7b&lt;/sup&gt; Knowledge&lt;sup&gt;7c&lt;/sup&gt;</td>
<td>Self-efficacy for Managing Chronic Disease 6-item Scale&lt;sup&gt;8&lt;/sup&gt;</td>
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<tr>
<td>3. Behavioural change</td>
<td>SYMLOG Group Process Assessment&lt;sup&gt;9&lt;/sup&gt;</td>
<td>SYMLOG Group Process Assessment&lt;sup&gt;9&lt;/sup&gt;</td>
<td>Semi-Structured Interview&lt;sup&gt;3&lt;/sup&gt;</td>
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<tr>
<td>4a. Change in organizational practice</td>
<td>SYMLOG Group Process Assessment&lt;sup&gt;9&lt;/sup&gt;</td>
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<td>Semi-Structured Interview&lt;sup&gt;4&lt;/sup&gt;</td>
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<tr>
<td>4b. Benefits to patients/clients</td>
<td></td>
<td></td>
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1. **Focused Reflective Exercise**: Led by the Integrative Preceptors (IP’s), each student team will complete a short survey (8-10 questions with rating scales) following each team meeting to assess how the group is functioning, what IPL is occurring and its effectiveness, how the teams are being patient-centred and observed outcomes for the patient. The structured reflective exercise was chosen over the option of requiring students and preceptors to maintain a reflective journal as there it is more time-manageable and less content sensitive (confidentiality), while still providing useful information. Students and IP’s will also use the observations recorded in these brief surveys for the focus-group meetings that will be held at the end of the intervention.

2. **Post-Intervention Focus Group**: The project’s Evaluation Coordinator will hold focus groups with the student teams and their IP’s and Disciplinary Preceptors (DP’s) immediately following the intervention to gauge their reactions to the intervention, impact on learning and on patients. There will be 4 focus groups with two teams meeting together to share observations across patient groups (i.e. a team assigned to diabetics would meet with a group assigned to a frail elderly patient).
2a. A focus group interview will also be held with Faculty (DPs and IPs) following the experience to reflect on the experience. The draft outline of this focus group is appended (see Appendix 1).

3. **Semi-Structured Interview with Patients**: The project’s Evaluation Coordinator will conduct a semi-structured interview with patients immediately after the intervention and three months after the intervention ends. The interview will include questions that will measure the patient’s satisfaction with the intervention and also about their own self-care management abilities.

3a. **Semi-structured interview with primary care team members:**

4. **Semi-Structured Interview with Selected Clinical Site Staff**: The project’s Evaluation Coordinator will conduct semi-structured interviews with various clinical staff members (sample to include clinical and administrative staff members) immediately following the intervention to measure their reaction to the intervention on their collaborative practice, and to indicate what changes the intervention might lead to for the site as well as their observations about its impact on patient outcomes. The draft questions for this interview are appended (Appendix 2).

5a. **The Readiness for Inter-professional Learning Scale (RIPLS) (Students)**: The RIPLS was developed by Parsell and Bligh (1999) based on the desired outcomes of shared learning. Two versions of the scale exist: V1, the published scale is 19 items in length, and has three subscales of Teamwork and Collaboration, Professional identity and Roles and Responsibilities. Reported Cronbach’s alpha coefficient for this scale is .89. Construct validity also has been reported (Parsell, Stewart and Bligh, 1998). Horsburgh, Lamdin and Williamson reported its use with health professional students (2001). Currently, researchers across the UK, Europe, Australia and New Zealand and Canada are reporting its use. Hall and Weaver are currently using the scale to examine attitudes to inter-professional care in Palliative Care fellows. A modified 26-item scale is available, and the authors suggest its use in current research. The original scale items are incorporated, and three additional subscales are identified, including patient centeredness, uniqueness of discipline and a separation of the teamwork and collaboration subscales. We will use the 26-item scale, and have received permission to do so. The scale will be administered before and following the intervention, and at three months post intervention (Appendix 3).

5b. **The Readiness for Inter-professional Learning Scale (RIPLS) Faculty**: In cooperation with the authors of the scale, we have modified the original RIPLS, V1 19-item scale, to collect data on Faculty attitudes toward inter-professional learning. We are currently in discussions as to whether it is appropriate to utilize the two subscales of teamwork and collaboration and Professional identity only. The scale will be administered before and following the intervention, and at three months post intervention (Appendix 3). The draft of this modified scale is attached (Appendix 4).

6a. **The Attitudes to Health Care Teams Scale (AHCTS) Students**: This 20-item scale (Heinemann, Schmitt, Farrell and Brallier,1999) was developed to measure attitudes to health care teams. The scale has been validated and contains two subscales: Quality of care/Process, and Physician centrality. Concurrent Validity has been assessed. Internal Consistency, using Cronbach’s alpha, is reported as .83 for Quality of Care/Process, and .68 for Physician centrality. The authors have granted permission for us to use the scale. Permission and the scale are appended (Appendix 5). The scale will be administered before and following the intervention, and at three months post intervention.
6b. **The Attitudes to Health Care Teams Scale (AHCTS) Faculty:** The same scale as in 6a will be utilized for Faculty. The scale will be administered before and following the intervention, and at three months post intervention.

7a. **Self-Efficacy Measure of Inter-Professional Practice Competencies for Students:** Measures of self-efficacy have been widely used and validated in the general educational, health education and psychology literature. The concept, developed originally by Bandura (1977), describes the individual's perceptions of his/her ability to execute a certain skill or task. Measures of perceived self-efficacy have been shown to predict the difficulty of tasks undertaken, and the intensity and duration of effort in these tasks. Self-efficacy perceptions, while relatively stable, are modifiable; the two most effective approaches to modification have been through experience, followed by learning through observation of others. The scale we will use, we have developed based on the identified core competencies in the literature, as well as the requirements of the experience as we envision it. The scale is 15 items in length. The scale will be pilot tested, for face and content validity and clarity, and its test-retest reliability will be assessed prior to its use. The scale will be administered before and following the intervention, and at three months post intervention. A draft of the scale is appended (Appendix 6).

7b. **Self-Efficacy Measure of Inter-Professional Practice Competencies Customized for Faculty:** The Faculty self-efficacy scale is a 15-item scale that has been designed to reflect their expected tasks we expect the Integrated and Discipline preceptors to encounter. Although the latter group will have less interaction with the entire team than the integrated preceptors, the competencies will be important in their role as well. The scale will be pilot tested and refined prior to its use, similarly to the scale for learners. The scale will be administered before and following faculty development, immediately following the intervention, and at three months post intervention. A draft of the scale is appended (Appendix 7).

**WE SEEM TO HAVE A QUESTION OF WHETHER THE SELF-EFFICACY MEASURE WILL BE USED FOR FACULTY DEVELOPMENT, I.E. IN PLACE OF THIS NEEDS ASSESSMENT INSTRUMENT: 7c. Knowledge test for Faculty.** To assess the knowledge and skills of Faculty with regard to the inter-professional competencies, a needs assessment will be conducted prior to the Faculty development intervention. Following the intervention, an assessment of knowledge and skills will also occur. The development of the needs assessment is proceeding, and will follow accepted approaches. Similarly, the design of the post intervention assessment is still under consideration.

8. **Self-efficacy for Managing Chronic Disease 6-Item Scale.** To assess the change in patients' self-management skills, this questionnaire will be self-administered before and after the 8-week intervention, and will be included in the three-month follow-up interview about self-management. This 6-item scale covers domains that are common across many chronic diseases: symptom control, role function, emotional functioning, and communication with physicians. The scale has been validated in 605 patients with chronic diseases; the internal consistency of the scale is .91.

9. **SYMLOG (System for the Multiple Level Observation of Groups):** SYMLOG will be administered as a pre- and post-intervention test to assess team behavioural change in student learners and preceptors. SYMLOG testing looks at task orientation, friendliness and dominance within a team. The SYMLOG research base contains over 1,000,000 profiles drawn from applications in twelve languages, in forty countries, on six continents. SYMLOG, developed by Robert F. Bales “demonstrates that intentional team training and development' produces team values consistent with high functioning teams.” The IP’s will integrate the individual and team profiles pre-test outcomes in their mentoring and tutoring of student participants. Based on the differences in pre- and post-testing of team behaviour, the program will investigate the feasibility of continued use of the SYMLOG assessment post 2007.
<table>
<thead>
<tr>
<th>Outcomes of IPE (Modified Kirkpatrick Model)</th>
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<th>Faculty</th>
<th>Patients</th>
<th>Clinical Site</th>
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<tr>
<td><strong>1. Reaction</strong></td>
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<td>-Team Reflective Exercise⁴</td>
<td>-Post Semi-Structured Interview³</td>
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<td>-Post- Intervention Focus Group²</td>
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<td><strong>2a. Modification of attitudes/ perceptions</strong></td>
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<td>-RIPLS For Faculty/Preceptors⁵</td>
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<td>-Attitudes Toward Health Teams⁶ (ATHCT)</td>
<td>-Attitudes Toward Health Teams ⁶a (ATHCT)</td>
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<td>-Perceived Self-Efficacy For Facilitating Interprofessional Learning for Faculty⁸ - Perceived Self-Efficacy For Facilitating Interprofessional Learning for Integrative Preceptors⁹</td>
<td>-Patient Self-Management Scale ¹⁰</td>
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<td><strong>4b. Benefits to patients/clients</strong></td>
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1. Team Reflective Exercise:

Authors: Karen Mann, Greta Rasmussen, Hope Beanlands & the project team.

Purpose: The scale has been designed to assess the key functions of an interprofessional student team and to assess the effectiveness of the team’s learning together. It has been designed with four purposes: 1) to help students reflect on their experience; 2) to help the interprofessional facilitators’ to identify areas of strengths and weakness in the team’s work; 3) to provide information to the project team regarding the implementation of the project, and 4) to measure change in the group over time.

Scale construction: this 10 item rating scale has been developed based on the identified core team competencies in the interprofessional education literature and the team effectiveness literature.

Administration: this team reflective exercise is completed after each team meeting with or without the participation of an interprofessional facilitator or preceptor.

Scoring: students respond individually to each question using flash cards on a five point scale. The team negotiates final ratings and the responses are recorded in the scale. The score of each item is the number circled. Scores in the latest administration are compared to previous administrations. Change scores in each item are calculated and provide information for both interprofessional facilitator and for educational planning. Each item can be monitored over time.

Comments: The structured reflective exercise was chosen over the option of requiring students and preceptors to maintain a reflective journal as there it is more time-manageable and less content sensitive (confidentiality), while still providing useful information.

2. Post- Intervention Focus Group: Evaluation Staff will hold focus groups with the student teams and IP’s and Disciplinary Preceptors (DP’s) immediately following the intervention to gauge their reactions to the intervention, impact on learning and on patients. There will be focus groups with students and Faculty (DPs and IPs ). Students who can not attend a focus group will be allowed to arrange for an interview.

3. Semi-Structured Interview with Patients: Evaluation Staff will conduct a semi-structured interview with patients immediately after the intervention and three months after the intervention ends. The interview will include questions that will measure the patient’s satisfaction with the intervention and also about their own self-care management abilities.

4. The Readiness for Inter-professional Learning Scale (RIPLS) (Students). The RIPLS was developed by Parsell and Bligh (1999) based on the desired outcomes of shared learning. Two versions of the scale exist: V 1 , the published scale is 19 items in length, and has three subscales of Teamwork and Collaboration, Professional identity and Roles and Responsibilities. Reported Cronbach’s alpha coefficient for this scale is .89. Construct validity has also been reported (Parsell, Stewart and Bligh, 1998). Horsburgh, Lamdin and Williamson reported its use with health professional students (2001). Currently, researchers across the UK, Europe, Australia and New Zealand and Canada are reporting its use. Hall and Weaver are currently using the scale to examine attitudes to inter-professional care in Palliative Care fellows. A modified 26-item scale is available, and the authors suggest its use in current research. The original scale items are incorporated, and three additional subscales are identified, including patient centeredness, uniqueness of discipline and a separation of the teamwork and collaboration subscales. We will use the 29-item scale, and have received permission to do so. The scale will be administered before and following the intervention, and at three months post intervention.
5. Readiness for Interprofessional Education Learning Scale (RIPLS) for Faculty/Preceptors

Authors: Karen Mann, Judy McFetridge-Durdle & Maria Sarria and the project team. Adapted with permission from the Readiness for Interprofessional Learning Scale (Parsell & Bligh, 1999)

Purpose: To measure readiness for facilitating interprofessional learning by exploring faculty/preceptors’ attitudes and perceptions towards shared learning.

Target population: This instrument has been designed for university faculty in the health professions involved or to be involved in interprofessional learning; and preceptors/interprofessional facilitators that are or will be involved in facilitating interprofessional learning.

Scale construction: This scale is an adaptation of the Readiness for Interprofesional Learning Scale. Dr. Karen Mann in cooperation with Glennys Parsell and John Bligh modified the 19 item original RIPLS to collect data on faculty/preceptors’ attitudes towards interprofessional learning. This new scale consists of 15 items.

Sample: The pilot sample consisted of 31 university faculty/preceptors of the Health Professions at Dalhousie University, Halifax, Nova Scotia.

Reliability: Reliability was checked using the internal consistency method; the alpha coefficient obtained was 0.82. Consecutive studies resulted in Cronbach’s alpha coefficient of 0.88 and 0.90.

Factor Analysis: A principal component, varimax rotation factor analysis was conducted which yielded two factors: Factor 1: items 1, 2, 3, 5, 6. Factor 2: items 12, 13, 14, 15.
Administration: The scale will be administered before and following the intervention, and at three months post intervention. This instrument has been pilot tested and results are still under analysis.

6. Attitudes Towards Health Care Teams for Students and Preceptors

Authors: Gloria Heinemann, Madeleine Schmitt, Michael Farrell.

Purpose: To measure attitudes and bias against or in favor of health care teams.

Target population: This instrument has been designed for students and faculty in the health professions.


Reliability: face, expert and concurrent validity checked. This instrument has been extensively used in the U.S and Canada and there are version with 28, 20 and 21 items. We have permission from the author to use the 20 item version.

Factor Analysis: Factor 1: Quality of Care (alpha coefficient 0.83); Factor 2: Physician Centrality (Alpha coefficient 0.63)
**Administration:** The scale will be administered before and following the intervention, and at three months post intervention. This instrument has been pilot tested and results are still under analysis.

**7. Self-Efficacy Measure of Inter-Professional Practice Competencies for Students**

**Authors:** Karen Mann, Judith McFetridge Durdle, Maria Sarria and the Project team.

**Purpose:** To assess the student’s perceptions of his/her ability to execute skills and tasks as they relate to interprofessional practice. The scale evaluates the students’ level of personal efficacy or their belief that they can successfully execute behaviors necessary to produce desired outcomes.

**Target population:** This instrument has been designed for pre-licensure students in the health professions involved or to be involved in interprofessional learning.

**Scale construction:** This scale has been developed based on the interprofessional education and self-efficacy literature. Measures of self-efficacy have been widely used and validated in the general educational, health education and psychology literature. The concept, developed originally by Bandura (1977), describes the individual’s perceptions of his/her ability to execute a certain skill or task. Measures of perceived self-efficacy have been shown to predict the difficulty of tasks undertaken, and the intensity and duration of effort in these tasks. Self-efficacy perceptions, while relatively stable, are modifiable; the two most effective approaches to modification have been through experience, followed by learning through observation of others. This scale has 16 items.

**Sample:** The pilot sample consisted of 190 students of the health professions at Dalhousie University, Nova Scotia, Canada who attended a compulsory session on interprofessional learning. The disciplines represented in the sample where Kinesiology (35), Pharmacy (25), Nursing(17), Dentistry(14), Human Communication Disorders (14), Medicine (12) and Dental Hygiene(11).

**Reliability:** Scale reliability was checked using the internal consistency method. The Cronbach’s alpha coefficient obtained was 0.96. Consecutive studies resulted in Cronbach’s alpha values of 0.90, 0.95 and 0.96.

**Scoring:** The score of each item is the number circled from 1-10, where 1 reflects low confidence and 10 reflects high confidence in the ability to execute skills and tasks that relate to interprofessional practice.

**Factor Analysis:** A principal component, varimax rotation factor analysis was conducted which yielded four factors: Factor 1: items 2,3,4,5. Factor 2: items 6,10,11,13. Factor 3: items 9,8,16. Factor 4: items 1,7,14,15.

**Administration:** The scale will be administered before and following the intervention, and at three months post intervention.

**8. Perceived Self-Efficacy for Facilitating Interprofessional Learning for Faculty**
Authors: Karen Mann, Judith McFetridge-Durdle, Maria Sarria and the Project team.

Purpose: To allow potential or current faculty to rate their perception(s) of their ability to execute the tasks that are required to facilitate interprofessional learning.

Target population: This instrument has been designed for university faculty in the health professions involved or to be involved in facilitating interprofessional learning. These faculty members have predominantly non-clinical roles.

Scale construction: This scale has been developed based on the interprofessional and self-efficacy literature. Measures of self-efficacy have been widely used and validated in the general educational, health education and psychology literature. The concept, developed originally by Bandura (1977), describes the individual’s perceptions of his/her ability to execute a certain skill or task. Measures of perceived self-efficacy have been shown to predict the difficulty of tasks undertaken, and the intensity and duration of effort in these tasks. Self-efficacy perceptions, while relatively stable, are modifiable; the two most effective approaches to modification have been through experience, followed by learning through observation of others. This scale has 15 items.

Sample: The original sample consisted of 65 faculty/preceptors of the Health Professions at Dalhousie University, Halifax, Nova Scotia.

Reliability: Reliability was checked using the internal consistency method. The alpha coefficient obtained was 0.97.

Factor Analysis: A principal component, varimax rotation factor analysis was conducted which yielded two factors: Factor 1: items 6, 8, 11, 12, 13, 14, 15. Factor: items 1, 2, 3, 4, 5, 7, 9, 10.

The scale will be administered before and following faculty development, immediately following the intervention, and at three months post intervention. This instrument has been pilot tested and results are still under analysis.
10. **Patient Self Management Scale**

This instrument has been adapted from the Canadian Occupational Performance Measure, a well-established measure with excellent psychometric properties. The adaptation was made by members of the Project Team to accommodate the work of interprofessional teams with patients. It is an individualized measure where patient and the Student Team together can set goals to develop: skills to deal with their chronic condition, skills to continue normal living, and skills needed to deal with emotions. The patient has to rate his confidence on attaining those goals, the importance of those goals and the satisfaction on working on those goals.

**Administration:** This scale will be administered before the intervention, immediately following the intervention and three months after intervention.

11. **Audio Recordings:**
To better capture the interprofessional team exchanges in a natural setting, the research team will have access to conversations by the student interprofessional team. For this purpose, a tape recorder is lent to each team with instructions to audiotape two of their team meetings at their discretion.

12. **Observations:**
For trustworthiness and reliability, this study will take into consideration not only methodological triangulation and data triangulation but also theory triangulation and investigator triangulation. For this purpose, data collection will include unstructured observations aiming to capture participant’s reactions to the experience and identify benefits of the experience for students and patients.

13. **WebCT discussions:**
Students and preceptors online electronic discussions in WebCT (Dalhousie University’s course management system) will be analyzed as another source of project data. WebCT is a password-protected course management system, which is run from one of Dalhousie University’s computer servers. WebCT is an educational space for learning aids such as web pages with resource information and an electronic discussions area where students and preceptors may exchange information, ask questions and discuss topics pertaining to the research project. Participants may access WebCT with a computer which is connected to the Internet and an Internet browser, such as Internet Explore. All students at Dalhousie University are provided with an email account and access to computers if they do not have a computer of their own. Student teams are encouraged to use WebCT to exchange ideas and work on behalf the patient, as an alternative to face-to-face meetings.
Seamless Care

Self-Management of Chronic Health Conditions

The journey of learning to self-manage a chronic health condition can be both complex and challenging. We know that the thoughts people have about their chronic health condition can greatly determine what happens and how people handle their health challenges day-to-day. People who have learned self-management skills in the following three main categories are usually considered to be “good self-managers”. (Lorig, K. at el, 2004).

The three main categories of skills are:
1. Skills needed to deal with the chronic condition;
2. Skills needed to continue normal living or lives;
3. Skills needed to deal with emotions.

Skills needed to manage the chronic condition include:
1. medication management
2. exercise
3. nutrition
4. symptom management such as fatigue, pain, shortness of breath, nausea etc.
5. accessing medical services
6. managing communication with health care providers

Skills needed to continue normal living or lives include:
1. self-care
2. home-making
3. home maintenance
4. work/employment
5. volunteerism
6. social activities

Skills needed to deal with emotions:
1. goals and expectations;
2. sadness
3. frustration
4. anger and uncertainty
5. change in relationships
Seamless Care

Patient Goal Setting Exercise

There are three main categories of skills that patients need to manage their chronic health condition. These include skills needed to deal with the chronic condition, skills needed to continue normal living or lives, and skills needed to deal with emotions.

Have each patient identify one goal from each of the three skill areas:
1. Skills needed to deal with the chronic condition;
2. Skills needed to continue normal living or lives; and,
3. Skills needed to deal with emotions.

This goal can be set by identifying with the patient, something that the patient:
1. needs to do;
2. wants to do; or,
3. is expected to do.

Have the patient rate on a scale of 0 to 10 their:
1. confidence to achieve the goal;
2. importance of achieving the goal; and,
3. his/her current level of satisfaction with ability to perform the action related to the goal.

Identifying three patient goals and obtaining a pre-intervention measure will enable the generation of a pre-intervention score of 0-30 for each goal.

This exercise is also completed at the end of the eight week interprofessional education intervention. The pre and post intervention goal setting and measures of confidence, importance and level of satisfaction will generate three sets of scores for each goal at two different points in time. A change score (pre-intervention minus post-intervention) can be generated for each dimension of the goal for each patient. Each patient would have a total of nine change scores. The change scores will then be used for further statistical analysis.

Following the completion of the post intervention measures, students are encouraged to share the pre-intervention measures with the patient and talk about any changes which may have occurred.
# Seamless Care Goal Measurement Template

Patient: ______________________

<table>
<thead>
<tr>
<th>Goal</th>
<th>Pre-intervention Date</th>
<th>Post-intervention Date</th>
<th>Change Score</th>
<th>Total Change Score</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Confidence</td>
<td>Importance</td>
<td>Satisfaction</td>
<td>Importance</td>
</tr>
<tr>
<td>Illness Management</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Normal ADL</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emotional Management</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient: ___________________</td>
<td>Date: ________________</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-------------------------------</td>
<td>--------------------------</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Goal Statement</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ways to accomplish goal</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Short Term Action Plan</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Implementation of Plan</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Monitor Results</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Change Plan (if necessary)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Results (Reward)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
New Instruments

### Readiness for Interprofessional Learning Scale (RIPLS) for Faculty/Preceptors

<table>
<thead>
<tr>
<th>Item</th>
<th>Rating Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Learning with other students will increase the students' ability</td>
<td>Agree, Disagree</td>
</tr>
<tr>
<td>2. Shared learning will help clarify the nature of the patient's</td>
<td></td>
</tr>
<tr>
<td>3. Sharing learning with other health care students will enhance</td>
<td></td>
</tr>
<tr>
<td>4. Learning with health care students before entering clinical</td>
<td></td>
</tr>
<tr>
<td>5. Learning with health care students before working in clinical</td>
<td></td>
</tr>
<tr>
<td>6. Patients would ultimately benefit if health care team</td>
<td></td>
</tr>
<tr>
<td>7. We were patient-centred in our work</td>
<td>Agree, Disagree</td>
</tr>
<tr>
<td>8. We communicated effectively among the team members</td>
<td>Agree, Disagree</td>
</tr>
<tr>
<td>9. We showed respect, as a team, for all professions</td>
<td>Agree, Disagree</td>
</tr>
<tr>
<td>10. It is not necessary for undergraduate health care students</td>
<td>Agree, Disagree</td>
</tr>
</tbody>
</table>

**Instructions:**

- Date _______________________
- # of team members present __________
- Team Code __________

**TEAM REFLECTIVE EXERCISE**

<table>
<thead>
<tr>
<th>Number</th>
<th>Statement</th>
<th>Rating Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>We identified what the team members needed to learn</td>
<td>Agree, Disagree</td>
</tr>
<tr>
<td>2.</td>
<td>We communicated effectively among the team members</td>
<td>Agree, Disagree</td>
</tr>
<tr>
<td>3.</td>
<td>We learned from each other</td>
<td>Agree, Disagree</td>
</tr>
<tr>
<td>4.</td>
<td>We resolved any problems in working together as a team</td>
<td>Agree, Disagree</td>
</tr>
<tr>
<td>5.</td>
<td>We learned from each other</td>
<td>Agree, Disagree</td>
</tr>
<tr>
<td>6.</td>
<td>We collaborated on meeting the patient's needs</td>
<td>Agree, Disagree</td>
</tr>
<tr>
<td>7.</td>
<td>We showed respect, as a team, for all professions</td>
<td>Agree, Disagree</td>
</tr>
<tr>
<td>8.</td>
<td>We were patient-centred in our work</td>
<td>Agree, Disagree</td>
</tr>
</tbody>
</table>

**Ideas for improving our team work:**

_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

**Return the completed form to:**

Ms. Tanya Matheson  
Room C123, 5849 University Avenue, Halifax, NS B3H 4H7  
Fax: 494-2278

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### Self-Efficacy Measure of Interprofessional Practice Competencies for Students

1. Working with other students from different professions to form a team.
2. Working with other students from different professions to develop a realistic appropriate care plan.
3. Working with other students from different professions to understand our respective roles in an interprofessional team.
4. Working with other students from different professions to understand the benefits to patients of team care.
5. Helping students from different professions to understand the benefits to patients of team care.
6. As a group, discuss and rate how your team has worked together since the last team meeting.

**Instructions:**

Using the following scales, please rate your confidence in your ability to carry out some aspects of your role as a student for interprofessional learning: 1 represents very low confidence in your ability to carry out this task, whereas 7 represents high confidence.

<table>
<thead>
<tr>
<th>Low Confidence</th>
<th>High Confidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 2 3 4 5</td>
<td>6 7 8 9 10</td>
</tr>
</tbody>
</table>

---

### Self-Efficacy Measure of Interprofessional Practice Competencies for Faculty/Preceptors

1. Working with other students from different professions to form a team.
2. Working with other students from different professions to develop a realistic appropriate care plan.
3. Working with other students from different professions to understand our respective roles in an interprofessional team.
4. Working with other students from different professions to understand the benefits to patients of team care.
5. Helping students from different professions to understand the benefits to patients of team care.
6. As a group, discuss and rate how your team has worked together since the last team meeting.

**Instructions:**

Using the following scales, please rate your confidence in your ability to carry out some aspects of your role as a preceptor for interprofessional learning in a scale from 1 (Low confidence) to 7 (High confidence).

<table>
<thead>
<tr>
<th>Low Confidence</th>
<th>High Confidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 2 3 4 5</td>
<td>6 7 8 9 10</td>
</tr>
</tbody>
</table>
*Adapted Patient Self-Management Scale

In the box below, please identify your goal to manage your chronic condition.

Patient goal statement:

Please mark on the line below your level of confidence in achieving this goal.

0 10
no confidence complete confidence

Please mark on the line below the level of importance you place on achieving this goal.

0 10
no importance extreme importance

Please mark on the line below your level of satisfaction with your ability to achieve this goal.

0 10
no satisfaction complete satisfaction

*Adapted with permission XXXXXX
Directions: Please mark on the line below your level for each of the following areas.

Goal to deal with the chronic condition

Confidence

Importance

Level of satisfaction
Seamless Care Patient Goal Setting Exercise:

There are three main categories of skills that patients require to manage their chronic health condition. These include skills needed to deal with the chronic condition, skills needed to continue normal living or lives, and skills needed to deal with emotions.

Have each patient identify one goal from each of the three skill areas:
1. Skills needed to deal with the chronic condition;
2. Skills needed to continue normal living or lives; and,
3. Skills needed to deal with emotions.

This goal can be set by identifying with the patient, something that the patient:
1. needs to do;
2. wants to do; or,
3. is expected to do.

Have the patient rate on a scale of 0 to 10 their:
1. confidence to achieve the goal;
2. importance of achieving the goal; and,
3. his/her current level of satisfaction with their ability to perform the action related to the goal.

Identifying three patient goals and obtaining a pre-intervention measure will enable the generation of a pre-intervention score of 0-30 for each goal.

This exercise is also completed at the end of the eight week interprofessional education intervention. The pre and post intervention goal setting and measures of confidence, importance and level of satisfaction will generate three sets of scores for each goal at two different points in time. A change score (pre-intervention minus post-intervention) can be generated for each dimension of the goal for each patient. Each patient would have a total of nine change scores. The change scores will then be used for further statistical analysis.

Following the completion of the post intervention measures, students are encouraged to share the pre-intervention measures with the patient and talk about any changes which may have occurred. This exercise will be repeated at 3 months post intervention.
Patient Self-Management Scale:

The student team, in collaboration with the patient/family, will identify three self-management goals. Have the patient/family mark each line with a pen, indicating their present level of confidence etc. This self-management scale will be completed three times by the patient/family, before and after and three months following the end of the student team intervention.

In the box below, please identify your goal to manage your chronic condition.

Patient goal statement 1:

Please mark on the line below your level of confidence in achieving this goal.

<table>
<thead>
<tr>
<th>0</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>no confidence</td>
<td>complete confidence</td>
</tr>
</tbody>
</table>

Please mark on the line below the level of importance you place on achieving this goal.

<table>
<thead>
<tr>
<th>0</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>no importance</td>
<td>extreme importance</td>
</tr>
</tbody>
</table>

Please mark on the line below your level of satisfaction with your ability to achieve this goal.

<table>
<thead>
<tr>
<th>0</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>no satisfaction</td>
<td>complete satisfaction</td>
</tr>
</tbody>
</table>
In the box below, please identify your goal to manage your activities of everyday living.

Patient goal statement 2:

Please mark on the line below your level of confidence in achieving this goal.

0 10
no confidence complete confidence

Please mark on the line below the level of importance you place on achieving this goal.

0 10
no importance extreme importance

Please mark on the line below your level of satisfaction with your ability to achieve this goal.

0 10
no satisfaction complete satisfaction
In the box below, please identify your goal to deal with your emotions.

Patient goal statement 3:

Please mark on the line below your level of confidence in achieving this goal.

<table>
<thead>
<tr>
<th>0</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>no confidence</td>
<td>complete confidence</td>
</tr>
</tbody>
</table>

Please mark on the line below the level of importance you place on achieving this goal.

<table>
<thead>
<tr>
<th>0</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>no importance</td>
<td>extreme importance</td>
</tr>
</tbody>
</table>

Please mark on the line below your level of satisfaction with your ability to achieve this goal.

<table>
<thead>
<tr>
<th>0</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>no satisfaction</td>
<td>complete satisfaction</td>
</tr>
</tbody>
</table>

This Patient Self-Management Scale has been *adapted from the Canadian Occupational Performance Measure (COPM).
Seamless Care Goal Measurement Template

<table>
<thead>
<tr>
<th>Goal</th>
<th>Pre-intervention Date</th>
<th>Post-intervention Date</th>
<th>Change Score</th>
<th>Total Change</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Confidence</td>
<td>Importance</td>
<td>Satisfaction</td>
<td>Confidence</td>
</tr>
<tr>
<td>Illness/Symptom Management</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Normal ADL</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emotional Management</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

This template can be used to keep a record of my patient’s goals and the patient’s measures for each goal.
Perceived Self-Efficacy for Facilitating Interprofessional Learning for Faculty.

Please use the scale to indicate your confidence in your ability to carry out the following aspects of your role as a preceptor for interprofessional learning in a scale of 1-10, where 1 represents very low confidence in your ability and 10 represents high confidence in your ability. For your reference interprofessional team refers to a team made up of individuals from different professions.

1. Helping students from my profession to form a team.  
1 2 3 4 5 6 7 8 9 10  
(Low Confidence) (High Confidence)

2. Helping students from my profession to resolve problems in an interprofessional team.  
1 2 3 4 5 6 7 8 9 10  
(Low Confidence) (High Confidence)

3. Helping students from my profession to develop a realistic appropriate patient care plan.  
1 2 3 4 5 6 7 8 9 10  
(Low Confidence) (High Confidence)

4. Helping students from my profession to understand their respective roles in an interprofessional team.  
1 2 3 4 5 6 7 8 9 10  
(Low Confidence) (High Confidence)

5. Helping students from my profession to understand the benefits to patients of team care.  
1 2 3 4 5 6 7 8 9 10  
(Low Confidence) (High Confidence)

6. Explaining and discussing the objectives of interprofessional learning.  
1 2 3 4 5 6 7 8 9 10  
(Low Confidence) (High Confidence)

7. Interacting with clinicians and/or faculty members* from other professions and disciplines than my own.  
1 2 3 4 5 6 7 8 9 10  
(Low Confidence) (High Confidence)

8. Providing feedback to an interprofessional team on their function and work as a team.  
1 2 3 4 5 6 7 8 9 10  
(Low Confidence) (High Confidence)

9. Providing feedback to individual team members of an interprofessional team on their function and work on the team.  
1 2 3 4 5 6 7 8 9 10  
(Low Confidence) (High Confidence)

10. Helping clinical sites understand an interprofessional team’s role in a clinical setting.  
1 2 3 4 5 6 7 8 9 10  

11. Helping the patient to understand the objectives of the interprofessional learning.
   (Low Confidence)                           (High Confidence)

12. Evaluating the quality of the work of an interprofessional team.
   (Low Confidence)                           (High Confidence)

13. Evaluating the degree to which an interprofessional team has achieved its goals.
   (Low Confidence)                           (High Confidence)

14. Helping students to evaluate the quality of their work as an interprofessional team.
   (Low Confidence)                           (High Confidence)

15. Helping students to evaluate the degree to which they have met their objectives in an interprofessional team.
   (Low Confidence)                           (High Confidence)
“Seamless Care”
Interprofessional Education

Perceived Self-Efficacy for Facilitating Interprofessional Learning for Integrative Preceptors.

Please use the scale to indicate your confidence in your ability to carry out the following aspects of your role as a preceptor for interprofessional learning in a scale of 1-10, where 1 represents very low confidence in your ability and 10 represents high confidence in your ability. For your reference interprofessional team refers to a team made up of individuals from different professions.

1. **Helping students from different professions to form a team.**
   1 2 3 4 5 6 7 8 9 10
   (Low confidence) (High confidence)

2. **Helping students from different professions to resolve problems in an interprofessional team.**
   1 2 3 4 5 6 7 8 9 10
   (Low confidence) (High confidence)

3. **Helping students from different professions to develop a realistic appropriate patient care plan.**
   1 2 3 4 5 6 7 8 9 10
   (Low confidence) (High confidence)

4. **Helping students from different professions to understand their respective roles in an interprofessional team.**
   1 2 3 4 5 6 7 8 9 10
   (Low confidence) (High confidence)

5. **Helping students from different professions to understand the benefits to patients of team care.**
   1 2 3 4 5 6 7 8 9 10
   (Low confidence) (High confidence)

6. **Explaining and discussing the objectives of interprofessional learning.**
   1 2 3 4 5 6 7 8 9 10
   (Low confidence) (High confidence)

7. **Interacting with clinicians and/or faculty members* from other professions and disciplines than my own.**
   1 2 3 4 5 6 7 8 9 10
   (Low confidence) (High confidence)

   * Clinicians and/or faculty members may be from any of the health professions.

8. **Providing feedback to an interprofessional team on their function and work as a team.**
   1 2 3 4 5 6 7 8 9 10
   (Low confidence) (High confidence)
9. Providing feedback to individual team members of an interprofessional team on their function and work on the team.
   1 2 3 4 5 6 7 8 9 10
   (Low confidence) (High confidence)

10. Helping clinical sites understand an interprofessional team's role in a clinical setting.
    1 2 3 4 5 6 7 8 9 10
    (Low confidence) (High confidence)

11. Helping the patient to understand the objectives of the interprofessional learning.
    1 2 3 4 5 6 7 8 9 10
    (Low confidence) (High confidence)

12. Evaluating the quality of the work as an interprofessional team.
    1 2 3 4 5 6 7 8 9 10
    (Low confidence) (High confidence)

13. Evaluating the degree to which an interprofessional team has achieved its goals.
    1 2 3 4 5 6 7 8 9 10
    (Low confidence) (High confidence)

14. Helping students to evaluate the quality of their work as an interprofessional team.
    1 2 3 4 5 6 7 8 9 10
    (Low confidence) (High confidence)

15. Helping students to evaluate the degree to which they have met their objectives in an interprofessional team.
    1 2 3 4 5 6 7 8 9 10
    (Low confidence) (High confidence)
Capital Health Research Ethics Board
“Category A” Submission

TITLE:
“Seamless Care: An Interprofessional Education Project for Innovative Team-Based Transition Care”

RATIONALE

Health system reform demands new approaches to patient care that make effective use of limited resources while maximizing patient health and well-being. Government, health system administrators, clinicians and academics are increasingly interested in teams based interdisciplinary care, which has been shown to improve patient outcomes, reduce re-admissions to acute care and lower cost to the health care system. Currently, health professionals are educated largely in isolation of each other. Each health profession has its own unique knowledge base and culture of values and attitudes— in fact, the health professions are sometimes referred to as silos, operating beside but apart from each other (Gyamarti, 1986; Carpenter, 1995; Casto and Julia, 1994; Barr, 2000; Engel, 2000) Patients are better served when health professionals transcend these barriers to work cooperatively. (D’Amour & Oandasan, 2004)

Interprofessional education is an educational activity in which interaction takes place between learners from various professions, with the purpose of improving their working collaboration and their impact on the health and well-being of their clients (Zwarenstein et al, 1999). The goals of interprofessional education include enhancing the understanding of other professional roles and responsibilities, reinforcing collaborative competence, effecting change, and improving services (Barr, 2003; Parsell & Bligh, 1999). The potential benefits of interprofessional education consist of facilitation of interprofessional communication, encouragement of reflective practice, promotion of more effective working relationships, and promotion of holistic patient care (Pirrie, Wilson, Harden, & Elsegood, 1998). The literature highlights the importance to involve patient or “service users” as co-participants and in the design, delivery and evaluation of interprofessional education, but reported examples are few (Barr, 2002) this study addresses that gap.

At present, there is no reliable evidence on the effectiveness of pre-licensure interdisciplinary education. The lack of evidence does not mean that interprofessional education is ineffective, but rather may indicate that the intervention is difficult to evaluate (Oandasan et al, 2004). Furthermore, the present practice of educating students in silos, offers little opportunity for students from different health profession programs to interact and work together in an ‘authentic’ setting.

In 2003 the First Ministers’ Accord on Health care renewal highlighted the importance of appropriate planning and management of health care human resources to ensure Canadians have now and in the future access to the health providers they need. The Interprofessional Education for Collaborative Patient-Centred Practice initiative is one component of the Pan-Canadian
Health Human Resource Strategy. “Seamless Care: An Interprofessional Education Project for Innovative Team-Based Transition Care,” is one of eleven studies of interprofessional education awarded funding with the purpose to promote change in the way health professionals are educated.

The primary purpose of this study is to evaluate “Seamless Care,” an innovative model of interprofessional education in a clinical setting, designed to prepare pre-licensure health professional learners from Dalhousie University to become competent collaborative practitioners and foster the attitudes and skills that promote positive, synergistic interdisciplinary care while facilitating patient transition from acute care to the community. The secondary purpose of this study is to increase understanding of interprofessional education in a clinical setting.

BACKGROUND

There is a lengthy history of Interprofessional Learning (IPL) at Dalhousie, beginning with an inter-disciplinary “sexuality week” in the 1970’s that involved faculty members in medicine, nursing and theology. Other early grass-roots efforts included the development and delivery of IPL modules in breastfeeding and HIV/AIDS. The groundswell of active IPL and inter-Faculty cooperation at Dalhousie led to a major study of IPL readiness among 12 health professions in 1995-96 (Mann, McIntyre, Ryding, Banks & Rigby, 1997).

This study laid the basis for our current IPL program. Since 1997, Dalhousie’s Faculties of Dentistry, Medicine and Health Professions have required students to take part in IPL modules to discuss contemporary health and health care issues and build skills for interprofessional practice. Participation is mandatory and the IPL modules supersede all other regularly scheduled classes. The learning objectives of these modules are to: 1) learn and develop skills and strategies for working effectively to address complex problems and issues with other professionals, colleagues and clients/consumers/patients; and 2) develop an awareness of, and respect for, the expertise, roles and values of other professionals, colleagues and clients/consumers/patients.

Through this experience, Dalhousie students are “learning together to work together.” Through extensive evaluations and reflective practice exercises, students have indicated that the IPL modules have helped them: 1) become aware of their professional roles in relation to other health professionals; 2) develop skills in working in interprofessional teams; and 3) develop skills in managing complex health care problems.

Dalhousie’s IPL program is administered by the Tri-Faculty Interprofessional Academic Advisory Committee (Tri-IPAAC) and includes representatives from 22 health professions located in 13 academic units, including the professional programs which are participating in this project: dental hygiene, dentistry, nursing, medicine, and pharmacy. Tri-IPAAC has functioned solely with grant-funding and in-kind support and has been bolstered by the strong voluntary participation of its composite academic units. The Tri-IPAAC infrastructure provides an excellent institutional base to support the extension of the current IPL program to a clinical setting. Over 2,500 students per year attend the mandatory IPL modules (often 850 students in a single day!), and over 60 faculty members and scores of volunteers are trained to deliver and facilitate these sessions. Tri-IPAAC has been planning to extend the IPL program to distributed
modules for clinical students, but resources had prevented the launch of this critical addition to the IPL initiative. Funding from Health Canada’s initiative Interprofession Education for Collaborative Patient-Centred Practice will allow us to meet this goal. (Appendix A: letter Health Canada)

“Seamless Care: An Interprofessional Education Project for Innovative Team-Based Transition Care” has the following partners:

**Dalhousie University**

**Faculty of Medicine:** The Faculty of Medicine has been a member of Tri-IPAAC since its inception. Dr. Karen Mann, Director of the Division of Medical Education, is one of the two principal investigators for this project and she serves on the project’s Steering Committee and chairs the Management Committee. Additionally, Dr. Richard (Sam) Rowe, the Associate Dean of Undergraduate Medicine, serves on the project’s Steering Committee and is the present Chair of Tri-IPAAC.

**School of Nursing, Faculty of Health Professions:** The School of Nursing was one of the founders of Tri-IPAAC. Dr. Judith McFetridge-Durdle, Associate Professor and Principal Co-investigator for the project, will serve as the Co-Chair of this project’s Steering Committee. Professor Lucille Wittstock, Assistant Professor and Associate Director of Undergraduate Student Affairs, serves on the Steering Committee.

**School of Dental Hygiene, Faculty of Dentistry:** The School of Dental Hygiene has been a member of Tri-IPAAC since its inception. Dr. Joanne Clovis, Professor in the School serves on the Steering Committee.

**Faculty of Dentistry:** The Faculty of Dentistry has been a member of Tri-IPAAC since its inception. Dr. Helen Ryding, Professor and Associate Dean, has served as Chair of Tri-IPAAC and is a member of this project’s Steering Committee.

**College of Pharmacy, Faculty of Health Professions:** The College has participated in Tri-IPAAC since its inception. One of its faculty members, Professor Susan Mansour is the most recent past-Chair of Tri-IPAAC. Prof. Mansour, Assistant Professor and Associate Director of Undergraduate Education, is a member of this project’s Steering Committee. (Appendix B: letters of support from academic partners)
Capital District Health Authority, Halifax Regional Municipality:

Capital District Health Authority (CDHA) is the clinical partner for this project. The largest academic health centre and teaching hospital in Atlantic Canada, CDHA provides core health services to 395,000 residents, or 40 per cent of the population of Nova Scotia and tertiary and quaternary acute care services to residents of Atlantic Canada. Specialized adult health services are provided to a referral population from the rest of the province and to residents of New Brunswick and Prince Edward Island. 8,500 staff are employed within Capital Health. Dr. Andrew Padmos, Vice President, Research & Academic Affairs of Capital Health, serves as co-chair of the project’s Steering Committee (please see Appendix B: Capital District Health Authority Executive Endorsement). Five of Capital Health’s clinical sites will be directly participating in the project and each of these will designate a representative to serve on the Steering Committee (please see Appendix B: Clinical Sites’ Letters of Support). The sites were chosen for their strong collaborative care/ patient-centered practice models, and include:

The Centre for Health Care of the Elderly (CHCE) is a multi-service, interdisciplinary Capital Health program based primarily in the Veteran’s Memorial Building of the Queen Elizabeth II Health Sciences Centre. The cornerstone of care is interdisciplinary comprehensive geriatric assessment, treatment and education of frail older persons and their families. CHCE services include Geriatric Day Hospital (includes a Fall Clinic), Geriatric Assessment Unit, Geriatric Restorative Care, Progressive Care Unit, Geriatric Ambulatory Care/Memory Disability Clinic and satellite clinics throughout the province.

The Endocrinology Clinic and the Diabetes Management Centre are located in the Queen Elizabeth II Health Sciences Centre and are staffed by endocrinologists, nurses, dieticians, social workers, psychologists, podiatrists, and physiotherapists. Multi-service, interdisciplinary care for patients with diabetes is provided from the access point in the emergency department to acute care units, rehabilitation, and 6 months post discharge. The Diabetes Case Management Team (consisting of three advanced practice nurses) works collaboratively with healthcare teams and community primary care providers to identify best management strategies and to facilitate comprehensive follow-up plans for patients. The Diabetes Management Centre works with the Diabetes Care Program of Nova Scotia to track patient data, and to identify local and provincial management trends.

The Capital Health Integrated Palliative Care Service, in collaboration with its health care service delivery partners, serves patients who suffer from incurable illnesses which are expected to progress to death. A consensus-based model, developed by the Canadian Hospice Palliative Care Association in consultation with experts across the country, guides practice based on patient and family needs, creates a shared vision, and sets the stage for a consistent and standardized approach to patient and family care. Patients may be seen early or late in the illness. An interdisciplinary team provides care across care settings, including home, in-patient consultation, in-patient unit, outpatient clinics and long term care. Care is focused on patient/family-centered assessments with a view to identifying and addressing issues in the physical, psychological, social and spiritual domains. Efforts are made to facilitate coordinated care among primary and consultant caregivers and across cross care settings.
The Acute Stroke Program is based at the Halifax Infirmary site. About 350 people annually are admitted to the in-patient service because of stroke or transient ischemic attack. These individuals receive coordinated, evidence-based, patient and family-centered care from a multidisciplinary team comprising expertise from food and nutrition services, medicine, nursing, occupational therapy, physiotherapy, speech-language pathology, and social work. About 500 people annually are seen in the Neurovascular Clinic which focuses on optimizing prevention therapies in individuals at high risk of stroke. (Appendix B: Letter of Support from Clinical Partners)

The Physical Medicine and Rehabilitation Division is located on the corner of Summer Street and University Avenue. The Rehab Centre, in partnership with our clientele and their communities, provides quality service in the areas of physical rehabilitation. We work with persons who have physical and associated disabilities to develop their potential through specialized rehabilitation programs and services.

The Division of Gastroenterology at Dalhousie University functions in a multidisciplinary role in close cooperation with colleagues in the Department of Surgery and the Department of Nursing. The Division provides secondary and tertiary care to patients with gastrointestinal diseases in both Nova Scotia and the Atlantic Provinces at large. The Division provides expertise in liver disease for the entire Atlantic Region and it is the coordinating centre for liver transplantation for patients from this area. Nine of the 11, clinical members are hospital based at either the Victoria General Hospital or the New Halifax Infirmary Sites. There are currently also two community-based members.

The Hypertension Clinic is a primary and secondary cardiovascular risk reduction Capital Health Program based in the Dickson Building at the V.G. Site of the Queen Elizabeth II Health Sciences Centre. The focus of care is interdisciplinary, risk reduction of patients with hypertension with the goals of optimizing quality of life, primary and secondary prevention of cardiovascular events, and promoting self-management through education about the medical condition, medications and lifestyle changes. The interdisciplinary team consists of registered nurses, a specialty nurse practitioner and general internists who provide comprehensive assessment, treatment, and education of persons with hypertension and their families. There is a close affiliation with the Heart Failure Clinic. The team also educates other health care providers to ensure appropriate diagnosis, testing and evidence-based management.

Northwood Care located in Halifax, Nova Scotia, Northwoodcare Incorporated is the largest long term care facility in Eastern Canada. Northwood’s three buildings - the Towers, the Manor and the Centre - offer a wide range of living options. Northwood Centre provides 24-hour nursing care for residents requiring continuous supervision. A number of floors are devoted to the care of people with Alzheimer Disease and other forms of dementia. The Centre is also home to the Northwood Community Centre, the Harbourview Bar and Lounge as well as a wide range of programs and services. Northwood offers both independent living and assisted living options for residents living in the Manor.

To address the interests of clients, we asked health associations, who include strong patient inclusion as part of their organizational mandates, to identify patient representatives to serve on the project’s Steering and Management Committees (Appendix C: Steering and Management
Committees). Three provincial health organizations involved with patient advocacy, education and support have agreed to participate in the project: the Nova Scotia chapter of the Canadian Diabetes Association, the Nova Scotia division of the Heart & Stroke Foundation of Canada, and the Gerontology Association of Nova Scotia (Appendix D: Health Organizations’ Letters of Support.) As well, we asked the Capital Health Integrated Palliative Care Service to identity a palliative care patient representative to serve on the Steering Committee. To minimize any oversight with respect to our selection of patient representation, a Capital Health Authority Patient Representative staff person will also be a member of the Steering Committee, which provides broad governance to the project. Patient centeredness will be further reinforced through the guiding principle of this teaching intervention: that is, everyone involved in the intervention is ultimately accountable to patients and their families.

**Duration of Study**

Seamless Care is a 34-month development and evaluation pilot project beginning in June 2005 and ending March 31, 2008. Between January to April 2006 and 2007, teams of students will work in clinical settings under the guidance of clinical Integrative Preceptors and with support of academic faculty Discipline Preceptors. As each January to April intervention involves different types of evaluations for each type of participant, it is anticipated that for 2006 and 2007:

- Patients will be involved in this study for a maximum of 6 months
- Students will be involved in this study for a maximum of 8 months
- Patient families will be involved in this study for a maximum of 6 months
- Integrative Preceptors will be involved in this study for a maximum of 8 months
- Discipline Preceptors will be involved in this study for a maximum of 8 months
- Clinical sites will be involved in this study for a maximum of 4 months

Evaluations are outlined in Appendix F: Evaluation Plan and Instruments’ Description.

**Numbers of Participants to be Recruited**

The study will take place at 8 clinical sites of the Capital District Health Authority in Halifax Nova Scotia. The sites are: Centre for Health of the Elderly, Endocrinology Clinic and the Diabetes Management Center, Heart Failure Clinic, Capital Health Integrated Palliative Care Services, the Acute Stroke Program, Physical Medicine and Rehabilitation Center, The Hypertension Clinic, Northwood and the Gastroenterology Service. Over two years, approximately 16 patients/families, 64 to 80 students and a minimum of 30 preceptors/faculty will take part in this study. Additionally, 20 clinical sites’ administrative/clinical staff will participate in this study.
PROCEDURES
The project consists of three teaching interventions, which focus on the student learners, the educators (clinical Integrative Preceptors and academic faculty Discipline Preceptors), and the patient. The goals are as follows:

- **Student Learners**: Develop core competencies in interprofessional learning and patient-centred collaborative practice in the course of facilitating patient transition from acute care to home or continuing care
- **Faculty/Preceptors**: Prepare faculty to act as preceptors for student teams and participants in interprofessional learning. It includes the development of training materials and approaches.
- **Patients**: Improve patient self-management
- **Program Evaluation**: Evaluate all aspects of the project, including outcomes for all participants.

I. Student Intervention

For the first intervention period, Jan to April 2006, eligible students will be consented once ethics approval is received from Capital Health Research Ethics Board. For the second intervention period, Jan to April 2007, eligible students will be consented by the Project Director once they self-identify their interest to participate following student information sessions, which will be held in September and October 2006. Students will be asked to consent to maintain confidentiality of patient information, participate in team and other project activities, respect policies of clinical site, help facilitate patient transition care from hospital to home or continuing care, participate in project evaluation activities, and to report any change of address and any change that may change/limit their participation. Following a needs assessment, the student team intervention will start with a half-day project orientation and workshop on team function and management issues. From January to April, 2006, when a participating site identifies an appropriate patient volunteer, 32 to 40 students will participate in one eight-week clinical placement. Each of eight clinical placements will consist of a team of 4 or 5 students (32 to 40 students per year, for a total of 64 to 80 students over 2 years). Please refer to the flowchart appended (Appendix E: Dalhousie University Interprofessional Intervention) Each student team will consist of 1 nursing student, 1 medical student, 1 dental and/or dental hygiene student, and 1 pharmacy student - all in their senior year of pre-licensure study. [Boxes D & E on the Flowchart]

The students who volunteer for this program will receive an orientation to the project early in their senior year, so that they will be ready for the call to assemble as a team as eligible patients are identified and consent to participate. For a fuller understanding of this intervention, the flowchart diagram outlines the teaching intervention, which is described below, from the time of patient identification to the final discharge report and care plan prepared by each interprofessional student team.

Each interdisciplinary student team will care for a patient from one of the five patient groups: the frail elderly, those with heart failure, acute stroke, or diabetes, or requiring palliative care [Box A]. Patients eligible for the IPL intervention will be identified in collaboration with the five practice sites. The total number of patients involved in the project will be approximately 16 (2
From each practice site each year. If a patient withdraws from this project and the Integrative Preceptor is in agreement, the student team for the patient who has withdrawn may decide to work with another patient for the balance of the team’s eight-week clinical placement. [Boxes A & B on the Flowchart]. Each student team will work with one patient/family to facilitate the patient’s transition from acute care to home with the goal of empowering patients to assume a central role in managing their illness. Once the patient is discharged from the hospital, the team members will plan follow-up meetings with the patient/family.

After the initial post-discharge consultation with the patient, student teams and their Integrative Preceptor and academic Discipline Preceptors may meet face-to-face or via teleconference to discuss the results of the consultation and to plan further care. We believe that it is important to incorporate alternate means of communication into the project, as it is likely that ‘real life’ transition care will permit limited face-to-face team encounters. Both the student learners and their Integrative Preceptor will complete brief surveys that capture their reflections on how the team is functioning. The number of home visits during the 8 week clinical rotation will be determined by the student team and their Integrative Preceptor in collaboration with the patient. At the end of the eight-week rotation, patients will have the opportunity to confer with the student teams and their Integrative Preceptors and Discipline Preceptors. The student team will also provide a jointly-prepared case report to the primary care provider, such as a family physician, if one is identified.

Throughout, students and preceptors will use WebCT, a password-protected web-based course management system, to supplement face-to-face meetings with time- and place-independent asynchronous electronic communication (www.webct.com). Patient information will not be exchanged or stored on WebCT. Within WebCT, participants may view educational materials, evaluation instruments, and other resources, access schedules, arrange meetings with team members and preceptors, send and receive email, attend to administrative issues and generally discuss all non-patient aspects of the program.

As part of their preparation, students will participate in ongoing formal and informal educational interventions by their Preceptors and the Faculty Development Coordinator before and during their 8-week clinical placement, addressing issues such as team management, conflict resolution, patient self management, and building community relationships.

The evaluation component of the student experience is a key component of the study. The Readiness for Interprofessional Practice (RIPLS), the Attitude Towards Health Care Teams (ATHCT) and the Self Efficacy Measure for Interprofessional Practice Competencies will be administered before, after and three month after the intervention. During the intervention, observations by the Evaluation Coordinator, and review of structured reflections on group process will be conducted with the aid of an instrument called Team Reflective Exercise. Following the intervention, students will participate in a focus group. Additionally, we will request students to keep a personal journal of their experiences during the study. The objective is to create a space where students can reflect on their interprofessional learning. At the end of the 8-week experiences students will be invited to share their journals with the research team. Sharing the journal will be voluntary.
Students who volunteer to participate, may change their mind without negative consequence. A student may stop participating in one of two ways. The student may:

1. Continue as a member of the student team but not participate in the evaluation part of the study, such as complete the online surveys or participate in a focus group with other students, OR
2. Stop participating as a member of the student and not complete the evaluations.

If the student continues as a member of the student team, but does not complete the evaluation component of the study, doing so will not affect the student’s academic coursework as long as he or she continues to working as a member of the student team and completes assigned tasks other than evaluations. Should the student cease all participation in this project, the Project Director will meet with the student’s academic program representative to development alternative means for the student to gain course credit, if necessary.

At the end of the Patient Intervention the Student team prepare a report to be sent to the family physician. Another report is sent to Seamless Care. A report template has been designed for data collection consistency and facilitate this task for the student teams.

II. Preceptors/Faculty Intervention

As noted, two categories of preceptor will be involved in the intervention. The Integrative Preceptor (IP) will play a key role in the success of the project. The IP will be the link between the student team, the patient, and the clinical site. (Each clinical site will choose the IP for their site.) The Integrative Preceptor (IP) will be responsible for mentoring the student team about interprofessional practice for assessment of team function.

For the first intervention period, Jan to April 2006, Integrative Preceptors will be consented by Project Director once ethics approval is received from Capital Health Research Ethics Board. For the second intervention period, Jan to April 2007, eligible Integrative Preceptors will be consented by Project Director once they express interest to participate after being approached by the Director or Head of their site between September and November 2006.

Integrative Preceptors will be asked to consent to mentor and guide students, participate in Faculty/Professional Development activities, interact regularly with the Faculty Development Coordinator, and participate in the project evaluation. As well, the IP will agree to, after the treating physician has made first contact with the patient, explain the study to and obtain consent from the patient and/or family, and, throughout the students 8-week clinical team placement, act as the patient’s advocate and monitor patient’s comfort level with the team and intercede as necessary.

With respect to this project, responsibilities of the Integrative Preceptor are to:

1. Mentor and guide students.
2. Provide or direct students to additional resources or support, as necessary
3. Participate in Faculty/Professional Development activities
4. Interact regularly with the project’s Interprofessional Facilitator regarding progress of the student team
5. Contact the project Interprofessional Facilitator regarding concerns about the student(s)
6. Participate in the project evaluation
7. Explain the study and obtain consent from eligible patients and/or their family.
8. Act as the patient’s advocate and monitor patient’s comfort level with the student team and intercede as necessary

In addition to the Integrative Preceptor guiding a student team, each student on the team will have access to a discipline-specific faculty preceptor or Discipline Preceptor. Each academic program (e.g. Dentistry) will choose the Discipline Preceptor (DP) for their program. Responsibilities of the Discipline Preceptor are to:
9. mentor and guide students from their particular discipline
10. provide or direct students to additional resources or support, as necessary
11. interact regularly with the project’s Faculty Development Coordinator regarding progress of the student team
12. contact the project Interprofessional Facilitator regarding concerns about the student
13. participate in the project evaluation, which will include evaluation of student teams using specified instruments, completion of questionnaires concerning preceptor’s experiences with the project and participation in interviews. (Informed consent will be sought for this participation.)

The DPs will serve as a resource for the students for clinical questions and patient care specific to their discipline. The DPs will also be chosen for their ability to model and support strong interprofessional competencies, and their willingness to work with students in interprofessional learning experiences.

Following a needs assessment based on needs as perceived by preceptors and identified in the literature, the Preceptor Teaching Intervention will be designed to support Integrative Preceptors (IPs) and Discipline Preceptors (DPS) in their role to foster collaborative team skills and guide the student team as it works with the patient to increase their capacity to self-manage his/her disease. IPs and DPS will receive an orientation on their role, expectations, resources, and student team evaluation. To prepare the IPs and DPS, the Interprofessional Facilitator will facilitate ongoing coaching sessions on key topics such as team management, conflict resolution, and patient self-management.

The evaluation component of the preceptor intervention includes completion of a modified version of the readiness for interprofessional learning survey (RIPLS). This questionnaire will be pre-tested and analyzed for reliability and validity. Preceptors’ perceptions of their experience will be gained through a focus group interview.

Patient Intervention
At the time a patient is admitted to or treated by one of the participating clinical sites, the clinical site will determine if the patient meets eligibility criteria to participate in this project. After the treating physician makes first contact with a patient, the IP will explain the study to and obtain consent from the patient and/or family. Throughout the student team’s clinical placement, the IP will act as the patient’s advocate and monitor patient’s comfort level with the team and intercede as necessary. The clinical site will then notify the Project Director who in turn will contact the members of the student team, the team’s IP and DPs, the Interprofessional Facilitator and the Evaluation Coordinator, and arrange a meeting with the student team and their IP and DPs. At this meeting, students will be briefed about the patient’s case history, will share their own discipline’s perspectives on patient care and identify learning needs. Students will then conduct follow-up study (library research, etc.) and meet with their IP to begin to develop an integrative transition care plan. Soon after the first meeting with the patient, the student teams will administer the Patient Self Management Scale. The scale is an adaptation from the Canadian Occupational Performance Measure (COPM), a widely used instrument with excellent psychometric properties. It is an individualized measure where patient and the student team together can set goals to develop skills in the following areas: skills to deal with their chronic condition, skills to continue normal living, and skills needed to deal with emotions. The patient has to rate his confidence on attaining those goals, the importance of those goals and the satisfaction on working on those goals. The student teams will then develop and implement a transition care plan with the guidance of both the IP and the DPs.

When the patient is discharged from the hospital, the team members will monitor and follow-up how the patient/family is doing in terms of ability to manage the illness. [Boxes I, J and L on the Flowchart] For some patients, meetings with four to five students and their preceptor, as well as members of their hospital care team or primary health care providers, may prove overwhelming; thus it may be that these encounters occur with students singly or in pairs (with disciplinary supervision as required).

The evaluation component of this intervention includes a pre-test, post-test and three month post intervention interviews with the patient/family. The interview will be developed to reflect the intervention developed by each site as part of the study.

RESEARCH PLAN

PURPOSE OF THE STUDY

This study will evaluate the effectiveness of Seamless Care: An Interprofessional Education Project for Innovative Team-Based Transition Care,” an innovative model of Interprofessional education in a clinical setting. A secondary purpose is to increase understanding of interprofessional education in a clinical setting.
RESEARCH QUESTIONS

General Questions
1. Is Seamless Care: An Interprofessional Education Project for Innovative Team-Based Transition Care an effective educational intervention? What are the outcomes for learners, faculty/preceptors, and patients?
2. What social, educational and organizational or other elements of this intervention made this project successful or not? What other factors facilitated or hindered the intervention?

Specific questions
3. How does involvement in this collaborative educational experience affect learners’ and preceptor/faculty’s perceptions of the value of interprofessional learning?
4. What is the nature of the relationship of Integrative Preceptor and Discipline Preceptors with the student team? How do such relationships impact on the team performance?
5. Is interprofessional collaboration an effective model for patients who are making the transition from hospital to home or community?
6. What organizational, educational and social or other obstacles do participants (learners, faculty/preceptors, and patients) encounter?
7. What are the lessons learned from the first year that may inform the second year?
8. What are the lessons learned from the project as a whole for interprofessional learning?

SUBJECT SELECTION

This study involves the selection of three types of subjects: students, faculty and patients.

I. Student Subjects
This study will choose a non probability sample of student, preceptor/faculty and patients using the technique of purposive sampling. Through this method the research team purposively choose participants for the sample, based on specific a priori criteria. To be eligible to participate in the program, student must be in his/her senior year in the Faculty of Dentistry, School of Dental Hygiene, School of Nursing, Collage of Pharmacy, or Faculty of Medicine. Purposive sampling was chosen due to the importance the literature has given to team balance in interprofessional teams. Eight to ten students from each academic program will be chosen each year. Further selection was deemed important to minimize student attrition and each academic program determined the selection criteria:
a) In the Faculty of Dentistry and School of Dental Hygiene, student volunteers will be selected from those who have a good academic standing, are motivated, and who demonstrate strong organizational and time management skills as assessed by the program in didactic, clinical and professionalism records.
b) In Medicine, student volunteers will be selected according to the timing of their request (first come - first served).
c) In Nursing, student volunteers will be selected from those interested individuals who have demonstrated good academic standing.
d) In Pharmacy, application from interested individuals will be screened based in the following criteria: interest, experience external to curriculum, plan for handling extra workload, ability to place the student within Halifax Metro for the clinical placement.
To compensate ambiguity and logistical inconvenience as well as to formally recognize student participation, all students will receive a memory stick containing project information (this devise is for students to keep) and an honorarium of $150.00. Additionally, students who have completed the 8 week interprofessional experience will be awarded a certificate of completion. The certificate of completion has the logo of Dalhousie and Capital Health and is signed by the principal investigators of the project and the Integrative Preceptor at the participating clinical site.

II Preceptor/Faculty Subjects

A. Integrative Preceptor (IP)
Each clinical site will choose the IP for their site. Selection criteria will include someone who:

- expresses interest in precepting a team of student
- has experience in working and liaising with patients/families
- has experience with clinical teaching
- is willing to participate in the faculty development activities that are part of the project.

B. Discipline Preceptors:
Each academic site will choose the Discipline Perceptor (DP) for their program. Selection criteria will include someone who:

- has experience with teaching students
- has relevant clinical experience
- expresses interest in precepting students working in an interprofessional team
- is willing to participate in the project’s faculty development activities
- is willing to collaborate with other preceptors as part of the team’s learning
- holds a current and relevant license to practice in Nova Scotia

III Patients Subjects
There are five patient groups represented in this project: diabetes patients, stroke patients, the frail elderly, palliative care recipients, and patients with heart failure. These five groups were invited to participate because the clinical sites where patients receive treatment for these conditions have well-established collaborative care models. This was considered essential for the patients and student learners participating in the project, as their learning will be supported by well-established patient-centered clinical settings and professionals. The eligibility criterion is a patient who will be in transition care and who will be discharged from the hospital to home or continuing care. The exclusion criterion is a patient with cognitive disabilities unable to participate in this educational intervention as assessed by the site. Participating sites are:

1. Capital Health: Centre for Health Care of the Elderly (CHCE)
2. Capital Health: Endocrinology Clinic and the Diabetes Management Centre
3. The Hypertension Clinic
4. Capital Health: Heart Failure Clinic
5. Northwood Care
IV. Family Members
Selection criterion is any individual designated by the patient to facilitate the process of giving/receiving information about his/her condition and his/her experience with the student teams.

V. Clinical Sites’ Staff:
Two key staff from each participating clinical site will be identified by the Integrative Preceptor. Because of their involvement with the day to day life of the project, they will be invited to participate to share and their perceptions of the impact of this project on the site’s organizational processes and culture.

RESEARCH DESIGN AND METHODOLOGY

This is an evaluative research study. Evaluative research is defined as the systemic and empirical data collection to examine and judge accomplishment and effectiveness of a program (Patton, 2002). Considering “Seamless Care” is a pilot program in its first year and is funded by the government, there are many questions to be answered, many audiences to reach such as program funders, scholars, researchers, academicians and participants; and there are many purposes to accomplish. The two main purposes of this study are:
1. To evaluate the effectiveness of “Seamless Care.
2. To contribute to fundamental knowledge and theory on interprofessional education and collaborative patient centered practice.
All these factors have impacted on the design and methodology decisions.

This study attempts to evaluate the program as a whole. Therefore, a model of pre, during and post intervention measures will be used to evaluate the program. The research questions are multiple and diverse in nature; therefore, both qualitative and quantitative methodologies will be used.

Quantitative methods will be used to measure outcomes and determine change, compare frequencies and means, and explore associates among the variables. Quantitative data will be collected from pre-tested validated tests, surveys and interviews. Reliability of each instrument will be reported using the internal consistency method. Validity will also be assessed with a focus on construct validity.

Qualitative research will be used to explore what the experience mean to participants, and their perceptions and beliefs. These measures are better captured through qualitative study. This methodology is particularly oriented toward exploration and discovery. While the
interprofessional teams are in the clinical setting a naturalistic inquiry design will attempt to document the day to day reality of the program and its participants.

To better evaluate the program as a whole, and also counteract the fact that each source of data has strengths and weaknesses, multiple methods of data collection will be used. For trustworthiness and reliability this study will take into consideration not only methodological triangulation and data triangulation but also theory triangulation and investigator triangulation.

Data collection will include open ended interviews, observations, event sampling, participants’ reflective exercises, focus groups, taped phone interviews (only to participating students not physically present in Halifax during focus group sessions), audio tape recording of team meetings, validated scaled instruments such as surveys and questionnaires, analysis of WebCT online discussions. The list of all the instruments included in the evaluation plan is appended. Appendix. F: Evaluation Plan and Description of Instruments.) Careful attention has been given to the sources of data to answer the research questions. A list of the instruments and its relationship to each research question is appended (Appendix G: Research Question and Respective Data Collection Tool)

DATA ANALYSIS

Data will be collected from learners, preceptors, patient, their families, and clinical sites’ staff. To assess the outcomes of the program for learners, preceptors and patients and families, the Kirkpatrick (1967) Hierarchy of Levels of Evaluation model was chosen. This model describes four levels of outcomes to measure: Participants’ reaction, learning (knowledge and skills), behavior, and impact on organizations and clients. The Kirkpatrick model has been used in published evaluations of interprofessional learning (CAIPE, 2002.)

Quantitative data from all test scores will be analyzed and reported using descriptive statistics in the first and second year. Other comparative correlation analyses will be performed (Pearson’s R) to evaluate the relationships among participant groups.

Qualitative data will be analyzed with an inductive design, which consists of allowing the important analysis dimensions to emerge from patterns found. Qualitative data from questionnaires will be broken down into meaningful units and assigned to categories. Categories will be grouped and themes identified and interpreted. Combined results attempt to answer the research questions to produce a descriptive written account of the participants, context and outcomes and themes that emerged regarding the model of interprofessional education proposed by “Seamless Care: An Interprofessional Education Project for Innovative Team-Based transition Care.” The selection bias of participants will be taken into consideration in data analysis and the principle of keeping the finding in context will be reinforced throughout the study.

A meta-evaluation exercise will be conducted at the end of the study will highlight the strengths and weakness of the evaluation and will provide insights into the limitations and opportunities for evaluation in interprofessional education.
This study attempts to contribute to the literature in the field of interprofessional education by designing and validating five new instruments:

1. The Self Efficacy Measure of Interprofessional Practice Competency for Students.
2. Perceived Self Efficacy for Interprofessional Practice for Integrative Preceptors.
3. Perceived Self Efficacy for Interprofessional Practice for Faculty.
4. The Readiness for interprofessional Practice for Preceptors.
5. Team Reflective Exercise.

For this purpose, a sub-study will be conducted in the first year to refine these tools and determine reliability and validity of these instruments.

To validate these instruments students from the health professions not participating in Seamless Care will be invited to complete one survey: the Self Efficacy measure for Interprofessional Practice Competencies. Preceptors/Faculty members will be invited to complete two surveys: The Readiness for Interprofessional Learning Scale (RIPLS) and the Self Efficacy Measure for Interprofessional Practice Competencies.

Students will be reached through the Tri-faculty Interprofessional Academic Advisory Committee (Tri-IPAAC) interprofessional learning sessions. They will be invited to complete the appropriate survey at the end of their session. Approximate time that students will be involved in the study is 5 minutes. Some Faculty members will be reached in the above mentioned sessions, and will be invited to participate. Faculty/preceptors not involved in the Tri-PACC sessions will be invited to participate, via email/university mail. They will receive an introductory letter and a copy of the survey. The study will target a sample of 50 faculty members in total for this specific purpose.

For the purpose of validating the Self-Efficacy Measure for Students, a minimum of 85 students per Tri-IPAAC interprofessional learning session will be required for a total of 255 students. Approximately 250 students attend each of the 3 sessions at a Tri-IPAAC interprofessional learning module for a total of approximately 750 potential participants.

The instruments will be administered during a Tri faculty Interprofessional Academic Advisory Committee IPL module (Tri-IPAAC) at which time students from different programs meet to work together to learn about interprofessional education. Before being asked to complete the Self-Efficacy Scale, students will be made aware of the purpose of the survey and that completing the survey is voluntary. Students will be requested to disclose their professional affiliation and sex. To ensure confidentiality, students will be asked to deposit the survey in a collection bin placed at each of the two exit doors at the end of the session. Factorial and reliability analyses will be performed to assess the psychometric properties of the instruments.

As a second validation stage, experts in the field of Interprofessional Education will be contacted, and asked to comment on each instrument in relation to its purpose, and to identify any theoretical lagoons in the scale and advise on the interpretation of the data arising from the items; we will ask that the items be rated to the degree they measure what they are suppose to
measure, rather than other phenomenon. Results will be taken into consideration for further refinement of the scales.

6. Benefits and Harms and How Benefits Outweighs the Harm?

Students—Benefits: Students gain new skills such as providing patient care as part of a collaborative interdisciplinary team and learning about patients needs as the patient transitions from hospital to home or continuing care. Harms: It is possible that some students may feel emotionally touched by the exposure to the patient’s challenges and realities. It is possibly that some conflict-resolution challenges will arise in the course of the interprofessional teamwork. There are risks of discomfort with the clinical site assignment, with the patient assignment, and with the information provided. Reduction of Risk: To reduce this risk, students will have the support and guidance of both the Integrative and Discipline Preceptors to resolve conflict and provide support. Benefits of the study are extremely important because these are skills required of health professionals. Beyond the benefit to the individual student, there will be benefits in terms of new understanding and interprofessional education.

Faculty/Preceptors—Benefits: The Integrative and Discipline Preceptors will have the opportunity to participate in programs to develop skills and knowledge in precepting interprofessional student teams. They will benefit directly, in terms of new skills and knowledge acquired personally, and indirectly, through new knowledge gained. Harms: Minimal risk is anticipated in the Faculty/Preceptor role. Reduction of Risk: Preceptors will have access to and support of the Faculty Development Coordinator throughout the project.

Patients—Benefits: Patients who participate will have the benefit of a student team working with them to assist in making the transition to home. They may benefit directly through acquiring new skills and managing their health condition. Harms: Patients may find interacting with a student team overwhelming or tiring. They may feel unable to undertake the suggestions made by the team. There is potential of a breach of confidentiality. Patients may find visits to their home tiring. Reduction of Risk: Student teams will, at all times, be supervised by their Integrative and Discipline Preceptors. This will ensure the appropriateness of the plan developed and its implementation. The Integrative Preceptor will act as a liaison and advocate for the patient and the team, and can assist in any assist in any clarification, etc. The patient’s confidentiality will be maintained for all patient-related communications (Appendix G: Coding System). The Benefits to the patient may potentially be both direct, through greater satisfaction and greater confidence, knowledge and skills in management of his/her illness. There may also be an indirect benefit to patients as their transition needs are better understood.

Family—Benefits: Family may gain greater understanding, knowledge and skills regarding their family member’s transition from the acute to home or community settings. Harms: Families may experience some discomfort at having a team of students interact with their family member. They may also experience some discomfort with answering questions posed related to the experience. Reduction of Risk: The Integrative Preceptor will act as a liaison with the patient and family should any concerns arise.
Clinical Sites—Benefits: The sites have the benefit of introducing students to their model of collaborative care. They will benefit potentially from participation in a pilot model of interprofessional education that may inform care at their site. Harms: There may be some discomfort at answering interview questions about the pilot intervention and their experience with it. Reduction of Risk: There will be close cooperation between the sites, the Faculty Development Coordinator and the Evaluation Coordinator to ensure prompt attention to any problems or concerns.

In sum we believe that, while some risks exist, participants and sites potentially may benefit substantially, both through direct increase in knowledge and skills, and indirectly through the new knowledge and understandings contributed to the field.

Disclosure of Financial Compensation

No patient or faculty/preceptor will receive financial compensation. However, the participating Capital Health District Authority clinical sites and Dalhousie University academic programs will be compensated for the time their clinicians or faculty members (Integrative Preceptors and Discipline Preceptors) participate in this project to pay for release time, as necessary. In addition to each of the five sites identified in #13, the participating academic programs (Faculty of Dentistry, School of Dental Hygiene, Faculty of Medicine, School of Nursing, and College of Pharmacy) will be compensated for the time their faculty members participate in this project for release time, as necessary. Students will be compensated for the logistical inconvenience and time spend in the development and pilot of this project.
REFERENCES

Capital Health Research Ethics Board

Ethics Approval Submission Form

Instructions:
All questions must be answered on this form, or the submission will be returned. Submission must be typed, in 12 pt font. Refer to the Guidelines for Submission Form for more detailed information.

Research Team:

1. Project Title: "Seamless Care: An Interprofessional Education Project For Innovative Team-Based Transition Care"
1a. Title for Public Release (if different from above): "Seamless Care Interprofessional Education"

2. Print Name of Principal/Qualified* Investigator: Karen V. Mann, Ph.D

Signature: Date: 2005/11/04
(Principal/Qualified Investigator) (yyyy/mm/dd)

*Note: According to Division 5 Health Canada regulations, one “qualified investigator” must be identified as medically responsible for a clinical trial. A QI refers to a physician or dentist (in the case of a drug to be used for dental purposes only) in good standing of a professional medical or dental association.

3. Please Indicate All Institutional Appointments:

☐ Dalhousie ☑ Capital Health ☐ IWK ☐ Other

If Other please indicate where:

3. Institution, Department and Division:
Karen Mann, Division of Medical Education - Faculty of Medicine.

5. Mailing Address: Seamless Care Interprofessional Education, Dalhousie University, c/o Greta Rasmussen, Project Director, Room C123, 5849 University Ave. Halifax, NS B3H 4H7

6. Phone:
Principal Investigators:
(902) 494-1884 (Karen V. Mann),

7. Fax: (902) 494-2278

8. Email: karen.mann@dal.ca

9. Associate Investigators (if applicable):
*These signatures confirm that the co-investigators have read the proposal and agree to participate in the research described in this protocol.

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<thead>
<tr>
<th>Name</th>
<th>Div/Dept.</th>
<th>Signature*</th>
<th>Affiliation</th>
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1. Joannne Clovis PhD, Dip. DH  
   School of Dental Hygiene, Faculty of Dentistry

2. Blye Frank PhD  
   Faculty of Medicine, Division of Medical Education

3. Susan Mansour, BSc, MBA  
   College of Pharmacy, Faculty of Health Professions

4. Ruth Martin Misener, RN, NP, MN, PhD(c)  
   School of Nursing, Faculty of Health Professions

5. Greta Rasmussen, BAA (IT), MEd  
   Tri-Faculty Interprofessional Academic Advisory Committee

6. Richard (Sam) Rowe, MBBS, MAEd, FRCPC  
   Faculty of Medicine, Undergraduate Medical Education; Dept. of Medicine, Div. of Endocrinology CDHA

7. Helen Ryding, BDS MSc, FACD  
   Faculty of Dentistry

8. Joan Versnel, MScOT, PhD  
   School of Occupational Therapy, Faculty of Health Professions

9. Lucille Wittstock, MN, RN  
   School of Nursing, Faculty of Health Professions

Note: A 10th co-applicant, Lynn McIntyre, MD, MHSc, FRCPC, Faculty of Health Professions, recently decided to withdraw as co-applicant as she relocated to Alberta, making active participation in this project very difficult. Dr. McIntyre will continue to consult and collaborate on this project.

10. If PI is not a Capital Health staff member, identify a Capital Health staff member who is an associate investigator and who has accepted overall clinical responsibility for risks related to the research:

    **Signature:** ______________________________  **Date:** 2005/11/04 (yyyy/mm/dd)
    
    **Print Name:** Karen V. Mann, Ph.D
    
    (CH Staff Member and Associate Investigator)

11. If PI is a trainee, identify associate investigator at Capital Health who has reviewed the
protocol and accepted overall responsibility to supervise the conduct of this research:

Signature: ___________________________ Date: ________________

(Associate Investigator) (yyyy/mm/dd)

Print Name: n/a

(Associate Investigator)

12. Name of contact research coordinator (if applicable): Greta Rasmussen, Project Director

Mailing address: Room C123, 5849 University Avenue, Halifax, Nova Scotia B3H 4H7

Phone number: (902) 494-3004

Fax number: (902) 494-2278

Email: Greta.Rasmussen@Dal.ca

13. Site(s) where research will be conducted:
   1. Centre for Health of the Elderly (CHCE)
   2. Endocrinology Clinic and the Diabetes Management Center
   3. Heart Function Clinic and Transplantation Clinic
   4. Capital Health Integrated Palliative Care Services
   5. Acute Stroke Program

14. Study Sponsor (if funded): Health Canada - Health Care Strategies, Policy Contribution Program. (Appendix A)

15. Does the study involve the use of an investigational drug/device or an approved drug/device for a new indication?

☐ YES ☒ NO

If YES, then a copy of the “Letter of No Objection” from the Therapeutics Product Directorate of Health Canada is required as part of the submission.

16. Does your study require the services or support of any department/division other than the PI’s own?

☒ YES ☐ NO

If YES, provide a letter of support from the Head of the impacted department/division. Please note that “Letters of Support” are not required from departments providing “Fee for Service Agreements”.

17. Does the study involve the use of a recombinant gene (DNA) therapy?

☐ YES ☒ NO

If YES, then the study must also be approved by the Capital Health BioSafety Committee.
Compensation/Financial Interest:

1. Will subjects be provided with any compensation (financial or other) over and above reimbursement for expenses?
   - YES   ☒ NO

   If YES, please detail. If subjects are to receive amounts beyond simple reimbursement of expenses (based on receipts), please explain why you think that the amount is not enough to induce individuals to participate for monetary reasons.

   Detail/explanation: No patient, or faculty/preceptor will receive financial compensation. However, in appreciation of participation in this project, each student who consents to take part will be offered an honorarium in the form of a $150.00 gift certificate to a Dalhousie University Bookstore. The participating Capital Health District Authority clinical sites and Dalhousie University academic programs will be compensated for the time their clinicians or faculty members (Integrative Preceptors and Discipline Preceptors) participate in this project to pay for release time, as necessary. Similarly each program will be compensated for the time the preceptors spend the program. (Faculty of Dentistry, School of Dental Hygiene, Faculty of Medicine, School of Nursing, and College of Pharmacy)

   For Students: With the exception of Nursing, each academic department has assigned a means of credit for the "Seamless Care" elective experience.

   1. In Nursing: The Seamless Care elective will contribute to academic credit for course N4260 for those nursing students whose clinical site placement with Seamless Care corresponds with their clinical placement for N4260 Community Placement. Otherwise, nursing students will not receive academic credit.
   2. In Medicine: the Seamless care elective will be one of the options students may chose to fulfill the mandatory Continuing and Preventive Care Unit (course number 4003)
   3. In Dentistry: "Seamless Care" will be an elective with credit for alternative clinical experience.
   4. In Dental Hygiene: Seamless Care will be an elective with credit for alternative clinical experience.
   5. In Pharmacy: Seamless Care will be an elective with credit for placement experience

2. Will any fee (e.g. finder's fee) be paid to individual(s) or organization(s) for finding subjects for this study?
   - YES   ☒ NO

   If YES, please provide details:
3. Does any investigator or the CDHA have a financial or proprietary interest in the research and/or the product under investigation, or in the company sponsoring the research?

☐ YES  ☒ NO

If YES, please provide details:

Research Protocol Information:

1. Planned start date: December 1, 2005  Planned end date: March 30, 2008

Subjects: Provide number of subjects to be studied (both local and in total). Also provide justification here for any exclusion criteria that appear to violate the principle of inclusiveness (e.g., upper or lower age limits, exclusion of women):

The study will include 5 types of subjects:
1. STUDENTS: 32 to 40 per year (for a total of 64 to 80 over 2 years).
2. PRECEPTORS: There will be a minimum of 5 Integrative Preceptors per year (for a total of 10 over two years); and 10 Discipline Preceptors, which responsibilities are share so there may be more (for a total of 20 over two years).
3. PATIENTS: 8 per year (for a total of 16).
4. FAMILY MEMBERS: Patients may involve family members at their discretion.
5. CLINICAL SITES' STAFF: 2 per site (for a total of 10)

2. Standard of Care: For research involving therapies, procedures and interventions, what is the standard of care at Capital Health for the patient population?

1. Following treatment in the Acute Stroke Program, the standard of care is a discharge plan that is medically appropriate and agreeable to the patient and family. Once the patient leaves the unit, medical responsibility for the patient passes to another physician. If the patient is discharged to the community this physician is the patient's family doctor.
2. Following treatment in the Centre for Health of the Elderly, the standard of care is a discharge plan that is medically appropriate and agreeable to the patient and the family. The discharge plan does not usually include a home visit. However, if the patient cannot leave his/her home to go to the hospital, it is possible (but uncommon) for a geriatrician or a Registered Nurse to visit the home. The home assessment includes evaluation of physical function, cognition, medical illness, and family dynamics.
3. Following treatment in the Capital Health integrated Palliative Care Services, the standard of care is a discharge assessment and care plan with follow up in conjunction with primary care providers and other specialist care providers to optimize the patient and families' quality of life, supportive care and decision making.
4. Following Treatment in the Diabetes Management and Transplantation Clinic, some patient are followed by: GP, VON, Home Care NS, Diabetes Case Managers (nurses, dietitians, SW, psychologist, podiatrist) Endocrinology Teams (Specialist physicians and nurse/dietitian teams),
Internal medicine physicians, multiple specialist in multiple field such as nephrology, neurology, cardiology, ophthalmology, CV teams.

5. Following treatment in the Heart Function Clinic, the discharge order is made and a standard of teaching is conducted according to the service in the hospital. Discharge requests are reviewed by the Director of the Clinic and Dr. Jonathan Hewlett. An appointment is made for the patient by the clinic, and efforts are made to see him/her as soon as possible. Physician and nurse see the patient at the appointment. If the patient is over standard and is unstable, the patient may be phoned by staff to see how she/he is doing and to determine if the patient should be flagged for earlier appointment.

4. How will participation in this project potentially change or add to the standard of care for a patient? In the Acute Stroke Program, the Centre for Health of the Elderly, and the Heart Function Clinic, the intervention carried out by the student team, will add to their assigned patient's standard of care. Each student team will consist of 1 nursing student, 1 medical student, 1 dental and/or dental hygiene student, 1 pharmacy student. Each student team will work with one patient/family to facilitate the patient's transition from acute care to home or continuing care with the goal of enhancing the patient's self-efficacy and decision-making. Following discharge from the hospital the student team will assess the patient/family at home and support the patient's self management behaviors. Team assessment in the patient's home is not the standard of care in these units. In the Integrated Palliative Care Service, and the Diabetes Management Clinic the research intervention will not change the standard of care.

5. Identify any additional visits, procedures, or data collected for the purposes of the research project only.

1. Organizational Structure: A Steering Committee has been set up to provide broad direction and government to the project. The committee are composed of academic representation, including the 5 participating academic programs (dental hygiene, dentistry, medicine, nursing, and pharmacy), the 5 clinical sites, 5 student representatives from each participating academic program, Dental hygiene; and representatives from nongovernment organizations (Heart & Stroke Foundation, Gerontology Association, Diabetes Association). Consumer and patient are also represented (refer to appendix C: Steering Committee Membership.) A Management Committee (a sub-group of the Steering Committee) with the assistance of the Project Director, who will oversee the day-to-day operations of the Project, is responsible for the operational planning and implementation with respect to clinical and academic aspects of the Project. Also, the research project has established offices at Dalhousie Medical Education Division and 4 staff have been hired (Project Director, Evaluation Coordinator, Faculty Development Coordinator, and Secretary-assistant).

2. Data collected: This study will collect data on students, faculty and patients/family and clinical sites. Following the Kirkpatrick Model of outcomes of
interprofessional Education data on: Reaction, Modification of attitudes and perceptions, knowledge and skills acquisition, behavioral change, change in organizational practice and benefits to the patients/clients will be collected. The full data collection plan is identified in Appendix F: Evaluation Plan and Instrument Description and Appendix G: Research Question and Data Collection Tools.

3. The patients will participate in a maximum of 3 home post discharge visits during the study. Generally these visits will be in the patient’s home. The primary care provider in the community may be involved in these visits.

4. For confidentiality a coding system has been develop (Appendix H: Coding System)

5. Notification to all potential physicians on call in each participating site will be given in a timely fashion (Appendix I: Notification Letters to Potential “Physicians on Call” at CDHA)

6. Safety monitoring: Is there an independent Data and Safety Monitoring Board?
   - YES
   - NO

7. When are safety analyses planned by the DSMB or by the sponsor? n/a

8. When will summary reports be available to the Capital Health Research Ethics Board? Please describe.
   - Note: In addition to SAEs, all safety summary reports should be provided to the REB. A summary report is requested on at least an annual basis, at the time of annual approval.
   - Description: A summary report will be available to the Research Ethics Board in December 2006 and December 2007.

9. Follow-up care: In the case of treatment studies, what procedures are planned to ensure provision of follow-up care at the end of the study or if the study is terminated prematurely? Prior to the end of the intervention period, the student team will communicate in writing with the primary care provider, such as a family physician, if one is identified

10. Has/Will this protocol been/be submitted for approval to another local Research Ethics Board (e.g., Dalhousie, IWK)?
    - YES
    - NO

    If yes, provide the Board’s name, date of submission, and a copy of the final approval letter:

11. Has this protocol been previously reviewed by either a local or external peer review process?
    - YES
    - NO

    If yes, provide the name of the funding agency or committee and date. Please provide copies of any written comments. Health Canada

12. Does anything in the protocol or the contract limit your ability to notify research subjects, other investigators, physicians, the REB, regulatory agencies or the scientific community of newly identified risks during the conduct of the study?
    - YES
    - NO
If yes, please provide details:

13. Does anything in the protocol or the contract limit your ability to publish the results?  
☐ YES  ☒ NO

If yes, please provide details:

**Informed Consent Process:**

Please provide a step-by-step description of the informed consent process including the following information:

1. **Who is the proposed subject population?**
   1. STUDENTS in their senior year of Dalhousie undergraduate programs Dentistry, Medicine, Nursing and Pharmacy. The Seamless Care intervention will be publicized to students in each program. Students will be invited to volunteer to participate in the intervention. Each faculty has specified criteria for selecting students from the list of students volunteers.
   a) In the Faculty of Dentistry and School of Dental Hygiene, student volunteers will be selected from those who have a good academic standing, are motivated, and who demonstrate strong organizational and time management skills as assessed by the program in didactic, clinical and professionalism records.
   b) In the Faculty of Medicine, student volunteers will be selected according to the timing of their request (first come - first served).
   c) In the School of Nursing, student volunteers will be selected from those interested individuals who have demonstrated good academic standing.
   d) In the College of Pharmacy: application from interested individuals will be screened based on the following criteria: interest, experience external to curriculum, plan for handling extra workload, ability to place the student within Halifax Metro for the clinical placement.

2. **PRECEPTORS**
   a) Discipline Preceptors: Faculty members from the Dalhousie Faculties of Dentistry and Medicine, the Schools of Nursing and Dental Hygiene, and the College of Pharmacy will be invited to participate as Discipline Preceptors based on the following criteria: has experience with teaching students, has relevant clinical experience, expresses interest in precepting students working in an interprofessional team, is willing to participate in the project’s faculty development activities, is willing to collaborate with other preceptors as part of the team’s learning, holds a current and relevant license to practice in Nova Scotia.
   b) Integrative Preceptors: clinicians could be chosen to be Integrative Preceptors based on the following criteria: expresses interest in precepting a team of students, has experience in working and liaising with
patients/families, has experience with clinical teaching, is willing to participate in the faculty development activities that are part of the project.

3. PATIENTS: subjects will be patients from one of the 5 collaborative practice clinical sites, who will be in transition care and their discharge plan includes going home or to continuing care. The participating collaborative practice sites are: The Centre for Health of the Elderly, Endocrinology Clinic and the Diabetes Management Center, Heart Function Clinic, Capital Health Integrated Palliative Care Services, the Acute Stroke Program.

4. FAMILY MEMBERS: any individual designated by the patient to facilitate the process of giving/receiving information about his/her condition.

5. CLINICAL SITES' STAFF: key staff members, who are considered to have observed the intervention's impact on the site's organizational structure and processes, will be invited to participate.

2. How will they be identified?

1. STUDENTS:
The Seamless Care intervention will be publized to students in each program. Students will be invited to attend an informational session to learn about the study.

a) In Pharmacy after the information session, they will accept applications on a specific application form (Appendix J). Applications will be reviewed by Susan Mansour, Associate Director, Undergraduate Education, Harriet Davies, Coordinator Clinical Education and Rita Caldwell, Director of the College.

b) Medicine, after an information session, Dr. Richard Rowe will accept expressions of interest and will fill available openings in order of application.

c) In Nursing, following an information session, interested students will self identify. Dr. Lucille Wittstock, Associate Director, Undergraduate Student Affairs will review eligibility.

d) In Dentistry and Dental Hygiene, following an information session, students will be asked to provide an indication of interest. Associate investigators, Dr. Joan Clovis, Associate Professor and Dr. Helen Ryding, Associate Dean of Academic Affairs will review applications.

Then students will be invited to participate by each academic department based on eligibility criteria.

2. PRECEPTORS:

a) Integrative Preceptors will be identified by the Directors/Head of their clinical site based on the following criteria: express interest in precepting students, has experience in working and liaising with patient/families, has experience with clinical teaching, and is willing to participate in the faculty development activities that are part of the project.

b) Discipline Preceptors will be identified by their academic program based on the following criteria: experience teaching students, relevant clinical experience, express interest in precepting students working in an interprofessional team, is willing to participate in the project faculty
development activities, is willing to collaborate with other discipline
preceptors as part of the team's learning, and holds a current and relevant
license to practise in Nova Scotia.
3. PATIENTS: at the time a patient is admitted or treated by one of the
participating sites, the treating physician in consultation with the Director
or Head of the site and/or the Integrative Preceptor will determine if the
patient meets eligibility criteria to participate in this project.
a) In the Acute Stroke Program: eligible patients will be those whose
Discharge Plan includes going home or the home of a friend and will be
identified in the Stroke Team Rounds that take place twice a week.
b) The Heart Function Clinic: eligible patients will be determined by
physicians at that site with the final approval of Dr. Jonathan Howlett,
Medical Director, Heart Function & Transplantation Clinic.
c) The Endocrinology Clinic and Diabetes Management Center: Patients
will be identified by the Diabetes Case Management, the Diabetes
Management Centre Staff and the Endocrinology Clinic Staff. These will
forward description of eligible patients to the Integrative Preceptor who will
make the final decision.
d) The Centre for Health Care of the Elderly: patients will be identified by
geriatricians with the final approval of Dr. Laurie Mallery, Head of the Unit.
e) Integrated Palliative Care Services: patients will be identified by
physicians of the Division of Palliative Care with the final approval of Dr.
Paul McIntyre, Head of the division.
4. FAMILY MEMBERS: will be identified by the patients.
5. CLINICAL SITES' STAFF: Key staff members at each site will be
identified by the Integrative Preceptor.

3. Who will initially approach the potential subjects for informed consent to
participate?
1. STUDENTS from Dental Hygiene, Dentistry, Medicine, Nursing, and
Pharmacy, who express interest in participating (as identified in Informed
Consent Process, Question 2, 1. STUDENTS), will be approached by
Greta Rasmussen, Project Director and Associate Investigator.
2. PRECEPTORS:
   I) Discipline Preceptors will be approached as follows:
   a) In Dentistry: Dr. Helen Ryding, Associate Investigator.
   b) In Dental Hygiene: by Dr. Joan Clovis, Associate Investigator will
      approach the potential Discipline Preceptors.
   c) In Nursing: Dr. Judy McFetridge Durdle, 2nd Principal Investigator.
   d) In Medicine: Dr. Richard Rowe, Associate Investigator.
   e) In Pharmacy: Susan Mansour, Associate Investigator.
   II) Integrative Preceptors will be approached by the Director of the clinical
       site
3. PATIENTS: will be approached by the treating physician at each
   clinical site.
4. FAMILY MEMBERS: will be approached by the Integrative Preceptor.
5. CLINICAL SITES' STAFF: will be approached by the Integrative
   Preceptors or site director or his/her designate.
NOTE: It is the policy of the REB that patients should not be approached by ‘strangers’ who know their health care circumstances.

3. Who will be involved in the consent procedure?
1. STUDENTS: After initial approach as detailed in the previous question and if the potential subject agrees to participate, Seamless Care staff will be involved in the consent procedure.
2. PRECEPTORS: After initial approach as detailed in the previous question and if the potential subject agrees to participate. Seamless Care Staff will be involved in the consent procedure.
3. PATIENTS: After initial approach as detailed in the previous question and if the potential subject agrees to participate. Seamless Care Staff will be involved in the consent procedure.
4. FAMILY MEMBERS: After initial approach as detailed in the previous question and if the potential subject agrees to participate. Seamless Care Staff will be involved in the consent procedure.
5. CLINICAL SITES: After initial approach as detailed in the previous question and if the potential subject agrees to participate. Seamless Care Staff will be involved in the consent procedure.

In the identified subject population, do you anticipate any limitations to the procedure for consent (e.g., blindness), or to the capacity to consent, (e.g., dementia)?

☐ YES  ☒ NO

If yes, please describe the informed consent method you will use to take any limitations into account. If participants may lack the competency to consent, or the capacity to consent may change during the course of the study, please explain:

5a) How will the participant’s competency be determined?

5b) Who will be approached for consent? (see the Institution’s policy on consent)

6. What will occur should the capacity of the participant to give informed consent changes during the study? NOTE that the consent procedure should be reflected in the consent form. Cognitive competence is an eligibility requirement. Cognitive ability will be assessed by the Integrative Preceptor. If the capacity to provide informed consent changes during the study, the subject will be withdraw from the study.

Other Ethical Issues:

1. Is this a placebo-controlled study?  ☐ YES  ☒ NO

If yes, provide a justification for using a placebo instead of a standard therapeutic agent with reference to Article 7.4 of the Tri-Council Policy Statement on the Ethical Conduct for Research Involving Humans.

☐ a) There is no standard treatment.
b) Standard therapy has been shown to be no better than placebo.

c) Standard therapy has been shown to provide no net therapeutic advantage.

d) Effective treatment is not available due to cost constraints or short supply.

e) A population of patients is refractory to standard care and no standard second-line therapy exists for them.

f) The treatment being tested is an “add-on” treatment to standard therapy that all subjects in the trial will receive.

g) Patients have provided an informed refusal of standard therapy for a minor condition that will not lead to any undue suffering or irreversible harm.

Please justify your above selection(s):

2. Identify any other potential ethical issues in the design or conduct of the project and provide an explanation for how you have found a resolution for these issues (e.g., justification of safeguards and benefits if it is a high risk project; any deviation from standard scientific methodology). In the case of students, "Seamless Care" is part of a university course and a research study. Most students who volunteer to participate will receive credit for participation. If a student decides to withdraw from the research component, it will not affect the student academic standing. Also it will be emphasized to students that participation in the research study (no participation in data collection) is voluntary and that they are free to withdraw. Withdrawing from the research component of this project will not affect any coursework to which "Seamless Care" is attached.

Research Summary:

Provide a 1-2 page summary in non-expert terminology of the research project. This following information is requested:

1. Background and rationale of the research project. Why is this research important?

2. Hypothesis to be tested or question to be asked:

3. Methods of the study (including the design):

4. Outcome measures and how they will be analyzed to test the hypothesis:
5. What are the proposed benefits? What are the potential harms? How do the benefits outweigh the harms?
## APPENDIX G: Research Questions and Respective Data Collection Tools.

<table>
<thead>
<tr>
<th>SEAMLES CARE RESEARCH EVALUATION QUESTIONS</th>
<th>DATA COLLECTION TOOLS TO ANSWER QUESTIONS</th>
</tr>
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</table>
| 1. Is Seamless Care: An Interprofessional Education Project for Innovative Team-Based Transition Care an effective educational intervention? What are the outcomes for learners, faculty/preceptors, and patients? | RIPLS  
Self Efficacy Scale for Students  
Self Efficacy Scale for Preceptors  
ATHCT  
Interviews  
Focus Groups  
Online discussions  
Journals  
Group/Team Reflective Exercise  
Self Efficacy Scale for Managing Chronic Disease |
| 2. What social, educational and organizational or other elements of this intervention made this project successful or not? What other factors facilitated or hindered the intervention? | Observations,  
Questionnaires  
Focus groups  
Interviews  
Online discussions  
Journals  
Group/Team Reflective Exercise |
| 3. How involvement in this collaborative experience affect learners and faculty’s perception of the value of interprofessional learning? | RIPLS  
ATHCT  
Self Efficacy Scale for Students  
Self Efficacy Scale for Preceptors  
Interview  
Focus Groups  
Self Efficacy Scale  
Online discussions  
Group/Team Reflective Exercise |
| 4. What is the nature of the relationship of Integrative Preceptor and Discipline Preceptors with the teams? How that impact on the team performance? | Observation  
Interview  
IP evaluation of the team  
Event sampling  
Focus Groups  
Online discussion  
Group/Team Reflective Exercise |
| 5. Is interprofessional collaboration an effective model for patients who are making the transition from hospital to home or community? | Observation  
Interviews  
Focus Group  
Online discussions  
Group/Team Reflective Exercise  
Self Efficacy Scale for Managing Chronic Disease |
| 6. What organizational, educational and social or other obstacles do participants (learners, faculty/preceptors, and patients) encounter? | Interviews  
Observations  
Focus Groups  
Online discussions  
Group/Team Reflective Exercise |
| 7. What are the lessons learned from the first RIPLS | |

Version 7
| year? | Self Efficacy Scale for Students  
|       | Self Efficacy Scale for Preceptors  
|       | ATHCT  
|       | Interviews  
|       | Journals  
|       | Focus Groups  
|       | Online discussions  
|       | Group/Team Reflective Exercise  
|       | Self Efficacy Scale for Managing Chronic Disease  

| 8. What are the lessons learned from the second year? | RIPL  
|                                                   | Self Efficacy Scale for Students  
|                                                   | Self Efficacy Scale for Preceptors  
|                                                   | ATHCT  
|                                                   | Interviews  
|                                                   | Journals  
|                                                   | Focus Groups  
|                                                   | Self Efficacy Scale for Managing Chronic Disease  

Version 7
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<td></td>
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</tr>
</tbody>
</table>
Research Summary

1. Background and rational of the research project. Why is this research important?
Health system reform demands new approaches to patient care that make effective use of limited resources while maximizing patient health and wellbeing. Government, health system administrators, clinicians and academics are increasingly interested in team-based interdisciplinary care, which has been shown to improve patient outcomes, reduce re-admissions to acute care and lower cost to the health care system. Currently, health professionals are educated largely in isolation from each other. Each health profession has its own unique knowledge base and culture of values and attitudes- in fact, the health professions are sometimes referred to as silos, operating beside but apart from each other (Gyamarti, 1986; Carpenter, 1995; Casto and Julia, 1994; Barr, 2000; Engel, 2000;.) Patients are better served when health professionals transcend these barriers to work cooperatively. (D’Amour & Oandasan, 2004) Seamless Care offers a model of interprofessional education designed to foster the attitudes and skills that promote positive, synergistic interdisciplinary care. Seamless Care is an educational intervention to prepare pre-licensure health professional learners from Dalhousie University to become competent collaborative practitioners by creating an innovative model of care for patients with key health conditions who are transitioning from acute care to the community. The project builds on Dalhousie’s well-established Interprofessional Learning program by extending it to the clinical realm.

The Seamless Care project will consist of two-8-week clinical placements (January-April of 2006 and January-April 2007) of students of Dentistry, Dental Hygiene, Medicine, Nursing and Pharmacy. The project model is integrated within the existing curricula and within the health professional students’ existing clinical time. In this project, student teams will be guided to help patients develop the necessary knowledge, skills and self-efficacy to better deal with disease-related problems and to collaborate with their health care professionals and the health care system. We also expect that interprofessional transition care will yield other patient benefits in terms of satisfaction, improved rehabilitative outcomes, and reduced readmissions.

This study has two purposes:
1. To evaluate the effectiveness of “Seamless Care: An interprofessional Education Project for Innovative Team-Based Transition Care”
2. To increase understanding of interprofessional education in a clinical setting

2. Research Questions
   General Questions
   1. Is Seamless Care: An Interprofessional Education Project for Innovative Team-Based Transition Care an effective educational intervention? What are the outcomes for learners, faculty/preceptors, and patients?
   2. What social, educational and organizational or other elements of this intervention made this project successful or not? What other factors facilitated or hindered the intervention?
   Specific questions
   3. How does involvement in this collaborative educational experience affect learners’ and preceptor/faculty’s perceptions of the value of interprofessional learning?
   4. What is the nature of the relationship of Integrative Preceptor and Discipline Preceptors with the student team? How do such relationships impact on the team performance?
5. Is interprofessional collaboration an effective model for patients who are making the transition from hospital to home or community?
6. What organizational, educational and social or other obstacles do participants (learners, faculty/preceptors, and patients) encounter?
7. What are the lessons learned from the first year that may inform the second year?
8. What are the lessons learned from the project as a whole for interprofessional learning?

3. Major Activities
The study includes:
1. A student intervention: This consists of educational modules on interprofessional knowledge and skills, and a clinical placement with the goal of learning about interprofessional collaborative care in the course of facilitating patient transition for acute care to home or continuing care.
2. A faculty intervention: The goal is to prepare faculty to act as preceptors for student teams and participants in interprofessional learning. It includes development of training materials and approaches.
3. A patient intervention: The goal of this intervention is to improve patient self-management.
4. A Program Evaluation: To evaluate all aspects of the project, including outcomes for all participants.

4. Methodology and Design
The project is a pilot program to test an educational intervention. The project will involve mixed methods: both qualitative and quantitative data will be collected, before, during, and after the intervention. A single group design has been selected for the pilot project.

5. Outcomes measures and how they will be analyze to test the hypothesis:
Qualitative and quantitative methods will be employed and will include pre and post interviews, observation, participant journals, event sampling, focus groups and a validated instruments such as the “Readiness for Interprofessional Learning Scale” for faculty and students that will be administered pre and post intervention.
Data will be collected from learners, faculty, patient, their family and the clinical sites’ staff. The reported outcomes of Interprofessional Education in participants will be analyzed according the Kirkpatrick model of Interprofessional Education outcomes: reactions, change in attitudes/perceptions, knowledge skills, changes in individual behavior, changes in organizational behavior, and benefits to the patients.

6. Benefits and Harms and How Benefits Outweighs the Harm?
Students--Benefits: Students gain new skills in collaborative team care and in understanding patient needs in transition to home or community care. Harms: It is possible that some students may feel emotionally touched by the exposure to the patient’s challenges and realities. It is possibly that some conflict-resolution challenges will arise in the course of the interprofessional teamwork. There are risks of discomfort with the clinical site assignment, with the patient assignment, and with the information provided. Reduction of Risk: To reduce this risk, students will have the support and guidance of both the Integrative and Discipline Preceptors to resolve conflict and provide support. Benefits of the study are extremely important because these are skills required of health professionals. Beyond the benefit to the individual student, there will be benefits in terms of new understanding and interprofessional education.
**Faculty/Preceptors—Benefits:** The Integrative and Discipline Preceptors will have the opportunity to participate in programs to develop skills and knowledge in precepting interprofessional student teams. They will benefit directly, in terms of new skills and knowledge acquired personally, and indirectly, through new knowledge gained. **Harms:** Minimal risk is anticipated in the Faculty/Preceptor role. **Reduction of Risk:** Preceptors will have access to and support of the Faculty Development Coordinator throughout the project.

**Patients—Benefits:** Patients who participate will have the benefit of a student team working with them to assist in making the transition to home. They may benefit directly through acquiring new skills and managing their health condition. **Harms:** Patients may find interacting with a student team overwhelming or tiring. They may feel unable to undertake the suggestions made by the team. There is potential of a breach of confidentiality. Patients may find visits to their home tiring. **Reduction of Risk:** Student teams will, at all times, be supervised by their Integrative and Discipline Preceptors. This will ensure the appropriateness of the plan developed and its implementation. The Integrative Preceptor will act as a liaison and advocate for the patient and the team, and can assist in any clarification, etc. The patient’s confidentiality will be maintained for all patient-related communications (Appendix G: Coding System). The **Benefits** to the patient may potentially be both direct, through greater satisfaction and greater confidence, knowledge and skills in management of his/her illness. There may also be an indirect benefit to patients as their transition needs are better understood.

**Family—Benefits:** Family may gain greater understanding, knowledge and skills regarding their family member’s transition from the acute to home or community settings. **Harms:** Families may experience some discomfort at having a team of students interact with their family member. They may also experience some discomfort with answering questions posed related to the experience. **Reduction of Risk:** The Integrative Preceptor will act as a liaison with the patient and family should any concerns arise.

**Clinical Sites—Benefits:** The sites have the benefit of introducing students to their model of collaborative care. They will benefit potentially from participation in a pilot model of interprofessional education that may inform care at their site. **Harms:** There may be some discomfort at answering interview questions about the pilot intervention and their experience with it. **Reduction of Risk:** There will be close cooperation between the sites, the Faculty Development Coordinator and the Evaluation Coordinator to ensure prompt attention to any problems or concerns.

**In sum** we believe that, while some risks exist, participants and sites potentially may benefit substantially, both through direct increase in knowledge and skills, and indirectly through the new knowledge and understandings contributed to the field.
Readiness for Interprofessional Learning Scale (RIPLS) for Faculty/Preceptors

Instructions: Please check the box with the response that best reflects your beliefs.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
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<tbody>
<tr>
<td>1</td>
<td>Learning with other students will help health professions students to become a more</td>
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<td></td>
<td>effective member of a health care team.</td>
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<td>2</td>
<td>Patients would ultimately benefit if health care students worked together to solve</td>
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<td></td>
<td>patient problems.</td>
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<td>3</td>
<td>Shared learning with other health care students will increase the students’ ability to</td>
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<td>understand clinical problems.</td>
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<td>4</td>
<td>Learning with health care students before qualification would improve relationships</td>
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<td>after qualification.</td>
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<td>5</td>
<td>Communication skills should be learned with other health care students.</td>
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<td>6</td>
<td>Shared learning will help students to think positively about other professionals.</td>
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<td>7</td>
<td>For small group learning to work, students need to trust and respect each other.</td>
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<tr>
<td>8</td>
<td>Team-working skills are essential for all health care students to learn.</td>
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<td>9</td>
<td>Shared learning will help students to understand their own limitations.</td>
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<tr>
<td>10</td>
<td>It is not necessary for undergraduate health care students to learn together.</td>
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<td>11</td>
<td>Clinical problem-solving skills can only be learned with students from ones own discipline.</td>
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<tr>
<td>12</td>
<td>Shared learning with other health care students will help them to communicate better</td>
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<td></td>
<td>with patients and other professionals.</td>
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<td>13</td>
<td>I would welcome the opportunity to work on small-group projects with other health care</td>
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<td>professionals.</td>
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<td>14</td>
<td>Shared learning will help clarify the nature of patient problems.</td>
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<tr>
<td>15</td>
<td>Shared learning before qualification will help students become better team workers.</td>
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</table>

Return the completed form to: Seamless Care, Dalhousie University
Room C123, 5849 University Avenue

Or fax to: 494-6291 Atten: Tanya Matheson
Self-Efficacy for Managing Chronic Disease 6-Item Scale

We would like to know how confident you are in doing certain activities. For each of the following questions, please choose the number that corresponds to your confidence that you can do the tasks regularly at the present time.

1. How confident are you that you can keep the fatigue caused by your disease from interfering with the things you want to do?
   - not at all confident
   - totally confident
   1 2 3 4 5 6 7 8 9 10

2. How confident are you that you can keep the physical discomfort or pain of your disease from interfering with the things you want to do?
   - not at all confident
   - totally confident
   1 2 3 4 5 6 7 8 9 10

3. How confident are you that you can keep the emotional distress caused by your disease from interfering with the things you want to do?
   - not at all confident
   - totally confident
   1 2 3 4 5 6 7 8 9 10

4. How confident are you that you can keep any other symptoms or health problems you have from interfering with the things you want to do?
   - not at all confident
   - totally confident
   1 2 3 4 5 6 7 8 9 10

5. How confident are you that you can do the different tasks and activities needed to manage your health condition so as to reduce your need to see a doctor?
   - not at all confident
   - totally confident
   1 2 3 4 5 6 7 8 9 10

6. How confident are you that you can do things other than just taking medication to reduce how much you illness affects your everyday life?
   - not at all confident
   - totally confident
   1 2 3 4 5 6 7 8 9 10

Note: This scale is free to use without permission as indicated by the Stanford Patient Education Research Center
Readiness for Interprofessional Learning Scale for Students

**Instructions:** Mark the box with the response that best reflects your beliefs.

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<tr>
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<td>6</td>
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<tr>
<td>7</td>
<td>Learning with health care students before qualification would improve relationships after qualification.</td>
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<tr>
<td>8</td>
<td>Communication skills should be learned with other health care students.</td>
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<tr>
<td>9</td>
<td>Shared learning will help me to think positively about other professionals.</td>
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<tr>
<td>10</td>
<td>Shared learning with other health care students will help me to communicate better with patients and other professionals.</td>
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<tr>
<td>11</td>
<td>I would welcome the opportunity to work on small-group projects with other health care students.</td>
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<tr>
<td>12</td>
<td>Shared learning will help to clarify the nature of patient problems.</td>
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<tr>
<td>13</td>
<td>Shared learning before qualification will help me become a better team worker.</td>
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<tr>
<td>14</td>
<td>I don't want to waste my time learning with other health care students.</td>
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<tr>
<td>15</td>
<td>It is not beneficial for undergraduate health care students to learn together.</td>
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<tr>
<td>16</td>
<td>Clinical problem-solving skills should only be learned with students from my own department.</td>
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<tr>
<td>17</td>
<td>The function of nurses and therapists is mainly to provide support for doctors.</td>
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<tr>
<td>18</td>
<td>There is little overlap between my future role and that of other healthcare professionals.</td>
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<tr>
<td>19</td>
<td>I would feel uncomfortable if another health care student knew more about a topic than I did.</td>
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<tr>
<td>20</td>
<td>I have to acquire much more knowledge and skills than other health care students.</td>
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<tr>
<td>21</td>
<td>I'm not sure what my professional role will be.</td>
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<tr>
<td>22</td>
<td>I will be able to use my own judgment a lot in my professional role.</td>
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<tr>
<td>23</td>
<td>Reaching a diagnosis will be the main function of my role.</td>
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<tr>
<td>24</td>
<td>My main responsibility as a professional will be to treat my patient.</td>
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<tr>
<td>25</td>
<td>I like to understand the patient's side of the problem.</td>
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<tr>
<td>26</td>
<td>Establishing trust with my patients is important to me.</td>
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<tr>
<td>27</td>
<td>I try to communicate compassion to my patients.</td>
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<tr>
<td>28</td>
<td>Thinking about the patient as a person is important in getting treatment right.</td>
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<tr>
<td>29</td>
<td>In my profession you need skills in interacting and cooperating with patients.</td>
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</tr>
</tbody>
</table>
Self-Efficacy Measure of Interprofessional Practice Competencies for Students

Instructions: Using the following scales, please rate your confidence in your ability to carry out some aspects of your role as a student for interprofessional learning: 1 represents very low confidence in your ability and 10 represents high confidence in your ability. For your reference interprofessional team refers to a team made up of individuals of different professions.

1. Working with other students from different professions to form a team.
   [1 2 3 4 5 6 7 8 9 10]
   (Low confidence) (High confidence)

2. Working with other students from different professions to resolve problems in the team.
   [1 2 3 4 5 6 7 8 9 10]
   (Low confidence) (High confidence)

3. Working with other students from different professions to develop a realistic appropriate patient care plan.
   [1 2 3 4 5 6 7 8 9 10]
   (Low confidence) (High confidence)

4. Working with other students from different professions to understand our respective roles in an interprofessional team.
   [1 2 3 4 5 6 7 8 9 10]
   (Low confidence) (High confidence)

5. Working with other students from different professions to understand the benefits to patients of team care.
   [1 2 3 4 5 6 7 8 9 10]
   (Low confidence) (High confidence)

6. Understanding and discussing the objectives of interprofessional learning.
   [1 2 3 4 5 6 7 8 9 10]
   (Low confidence) (High confidence)

7. Interacting with students from other professions and disciplines than my own.
   [1 2 3 4 5 6 7 8 9 10]
   (Low confidence) (High confidence)

8. Providing feedback to an interprofessional team on our function and work as a team.
   [1 2 3 4 5 6 7 8 9 10]
   (Low confidence) (High confidence)

9. Providing feedback to individual team members of an interprofessional team on their function and work on the team.
   [1 2 3 4 5 6 7 8 9 10]
   (Low confidence) (High confidence)
10. Helping clinical sites understand an interprofessional team's role in a clinical setting.
   1 2 3 4 5 6 7 8 9 10
   (Low confidence) (High confidence)

11. Helping the patient to understand the objectives of the interprofessional learning.
   1 2 3 4 5 6 7 8 9 10
   (Low confidence) (High confidence)

12. Evaluating the quality of the work as an interprofessional team.
    1 2 3 4 5 6 7 8 9 10
    (Low confidence) (High confidence)

13. Evaluating the degree to which an interprofessional team has achieved its goals.
    1 2 3 4 5 6 7 8 9 10
    (Low confidence) (High confidence)

14. Learning together cooperatively with students from other professions.
    1 2 3 4 5 6 7 8 9 10
    (Low confidence) (High confidence)

15. Communicating effectively with other members of an interprofessional team.
    1 2 3 4 5 6 7 8 9 10
    (Low confidence) (High confidence)

16. Interacting with teachers and preceptors from other professions and disciplines than my own.
    1 2 3 4 5 6 7 8 9 10
    (Low confidence) (High confidence)
TEAM REFLECTIVE EXERCISE

Date: _______________ # of team members present: ______ IP present (Y or N) _____ Team Code: T01

Instructions: Please allow time at the end of each team meeting, with or without your Integrative Preceptor, to complete this Team Reflective Exercise. For each team, there should be one completed form; therefore, the team should select a recorder whose responsibilities include returning this form to the Seamless Care office.

As a group, discuss and rate how your team has worked together since the last team meeting and in today’s meeting.

The rating scale is 1-5, where 1 is a low rating of your work together in an area, and 5 is a high rating.

<table>
<thead>
<tr>
<th>Since our last meeting*</th>
<th>Little or not at all</th>
<th>Some-what</th>
<th>Very well</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. we identified what the team members needed to learn</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2. we communicated effectively among the team members</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3. we divided the tasks effectively among the team members</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4. we resolved any problems in working together as a team</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5. we learned</td>
<td>a. from each other</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>b. about each other</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>c. with each other</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>6. we collaborated on meeting the patient’s needs</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>7. we were patient-centred in our work</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>8. we accessed resources effectively</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>9. we showed respect for all professions</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>10. we met our team objectives</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

*For the Seamless Care project, a meeting is defined as an occasion when people actively communicate together, such as a face-to-face meeting, a teleconference or video conference, and an online real-time chat.

Ideas for improving our team work

________________________________________________________________________________________________

________________________________________________________________________________________________

________________________________________________________________________________________________

Other comments:___________________________________________________________________________________

________________________________________________________________________________________________

________________________________________________________________________________________________

Return the completed form to: Ms. Tanya Matheson
Seamless Care IPE, Dalhousie University
Room C123, 5849 University Avenue, Halifax, NS B3H 4H7
Fax: 494-6291