

# Understanding Interprofessional Collaboration: An Essential Skill for all Practitioners

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## ABSTRACT

Health care is undergoing significant transformation to reduce cost while improving quality and client experience. Interprofessional collaboration (IPC) and education are viewed as the best path forward to meet the complex needs of today's clients under new reimbursement models (Moyers & Metzler, 2014). IPC occurs "when multiple health workers from different professional backgrounds work together with patients, families, [caregivers], and communities to deliver the highest quality of care" (World Health Organization [WHO], 2010, p. 7). IPC represents a significant paradigm shift in the way all health care workers provide services (Uhligh & Raboin, 2015). To move toward collaborative care, they must overcome barriers such as a uniprofessional mindset, incompatible organizational priorities, and the lack of focus on teamwork found in traditional health care. Occupational therapy practitioners—through their holistic training and ability to integrate client factors, the environment, and occupations—are equipped to help implement IPC initiatives at their facilities to improve client satisfaction and outcomes. Case examples in this article provide practical suggestions for ways occupational therapy practitioners can apply IPC's four core competencies.

## LEARNING OBJECTIVES

After reading this article, you should be able to:

1. Identify the benefits of IPC
2. Contrast IPC with traditional care
3. List the barriers to and core competencies of IPC
4. Identify occupational therapy's unique tools to help implement IPC initiatives
5. Identify three practical steps to promote IPC initiatives

## INTRODUCTION

The need for change in the U.S. health care system to deliver sustainable, high-quality, affordable care for all people is well known. The Institute for Healthcare Improvement (IHI; 2016) recommends that interventions be in line with the "Triple

Aim," which is to improve the health of populations, improve the experience of care, and lower per capita costs. To reflect this aim, the Centers for Medicare & Medicaid Services (CMS; 2010) created new reimbursement models. These payment models are forcing health care professionals to fundamentally change the way they provide care (Moyers & Metzler, 2014). The traditional medical model, which dominates health care delivery, focuses interventions on specific body parts or systems (Brandt, 2015a). Brandt explains that the medical model is the basis of fee-for-service payment systems that have escalated health care costs. Though unintended, focusing on the medical model has also led to fragmented care, as no single provider has the skills necessary to meet all of clients' health care needs (Brandt, 2015b). Thus, a new focus on interprofessional collaboration (IPC) is now seen as the best path forward to move health care toward client-centered care (World Health Organization [WHO], 2010).

## IMPORTANCE OF IPC TO OT PRACTITIONERS

To remain viable under the new value-based reimbursement models, occupational therapy practitioners must learn how to partner with other disciplines to provide coordinated care across the health care system (CMS, 2010, 2014, 2015; Moyers & Metzler, 2014). A paradigm shift from traditional care to interprofessional collaborative care has several benefits. According to WHO (2010), collaborative care optimizes health services, strengthens health systems, and improves health outcomes and client satisfaction. Collaborative care also increases health care providers' job satisfaction and retention and promotes sustainable programs (Uhligh & Raboin, 2015).

IPC is a global movement in health care and education. In 2010, the WHO published a 64-page document entitled, *Framework for Action on Interprofessional Education and Collaborative Practice*. Targeting policy makers and educators, this document details collaborative practice's status around the world and identifies strategies to promote teamwork to prepare health care workers to be "collaborative practice ready" (p. 7). In 2011, an expert panel published *Core Competencies for Interprofessional Collaborative Practice* to support educators in training students to work effectively as members of the clinical team (Interprofessional Education Collaborative, 2016). Many educational institutions are incorporating interprofessional education into their curricula (National Center for Interprofessional Practice and Education, 2015). The Accreditation Council for Occupational Therapy Education (ACOTE®) includes standard B.5.21,

requiring students to effectively work in an interprofessional manner (ACOTE, 2013).

**UNDERSTANDING INTERPROFESSIONAL COLLABORATION**

**Defining IPC**

The WHO defines interprofessional collaboration as, “when multiple health workers from different professional backgrounds work together with patients, families, [caregivers], and communities to deliver the highest quality of care” (2010, p. 7). Uhlig and Raboin (2015) noted that collaboration occurs when two or more people come to an understanding that neither could have come to on their own. New energy, excitement, and insight result in a plan that better matches the client’s needs. Interprofessional collaboration’s goal is client and family engagement in the care plan that translates into a sharper focus on treating the whole person and not just diseases and body functions.

**Multidisciplinary Care vs. IPC**

It is important to distinguish between traditional multidisciplinary care and interprofessional collaboration; multidisciplinary is not the same as working interprofessionally. To be truly interprofessional, team members must promote mutual respect, trust, shared decision making, equal voices, and familiarity with each other’s roles (Canadian Interprofessional Health Collaborative, 2010). Based on Uhlig and Raboin’s (2015) work, Table 1 demonstrates some of the differences between traditional multidisciplinary care and interprofessional collaborative care.

Interprofessional collaborative care requires practitioners to shift their work patterns to allow time to meet, often daily and as a group with the client to address the client’s concerns,

needs, and goals. Although getting all care providers in the same room at the same time with the client and family to discuss and plan the client’s care makes sense, it is extremely difficult to do within many traditional health care settings.

**Barriers to IPC**

Barriers to IPC include a uniprofessional mindset, organizational challenges, and lack of training in teamwork. Understanding these barriers is the first step toward collaborative care.

*Uniprofessional Mindset*

Although the concept of working interprofessionally has been around for 40 years, until very recently a uniprofessional mindset has dominated health care education and delivery (Brandt, 2015a). As an example, note the use of medical jargon unique to most disciplines. The existence of educational silos for each discipline is well documented (Newhouse & Spring, 2010). Disciplines tend to provide health care services parallel to one another. The result is that the average hospital client sees individual providers all day long, each providing interventions and education from their own perspective with little thought about how their interventions might integrate with other providers’ interventions and education.

*Organization Environment and Priorities*

Organizational barriers also contribute to the lack of collaboration in health care. The fee-for-service payment model has been one of the biggest contributors to parallel rather than interprofessional care. Payment systems are set up to reward one-to-one care and professional productivity. As a result, schedules revolve completely around giving practitioners one-to-one time with clients.. In addition, many clients experience inconsistency in

**Table 1: Contrasts Between Traditional Care and IPC**

<b>Traditional Care</b>	<b>Collaborative Care</b>
All team members are not present.	All team members are present.
Located in conference room or hallway (“meat” of discussion and plan here)	The “meat” of team conversation and plan formulation includes the client.
A select few do most of the talking.	A team member (often not the physician) facilitates the conversation.
When the client is in the room, the pace is brisk and does not include all voices. Medical jargon is used.	Everyone on the team has a role, voice, and space to contribute to the conversation. Everyone understands the language used.
Hierarchical undertones are present. Physicians direct, disciplines report, clients and family are informed.	Physicians participate, professionals confer, clients and families are engaged in the conversation.
Focus is on disease, treatment, and tasks.	Focus is on people, needs, and goals.
Whispered side conversations occur. The client is “talked about” in third person.	Few side conversations occur, resulting in transparency. Care progress is discussed.
Uniprofessional notes are taken. Parallel interventions occur.	Care plan is jointly developed with the client. Professionals collaborate on interventions.
Who will do what is assumed. Task delegation by team members is not reviewed or summarized.	Safety checklists are often used. The plan is summarized for the team, including the client.

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**Table 2: Core Competencies for Interprofessional Collaborative Practice** (IPEC, 2016, p. 10)

<b>Competency One:</b> Values/Ethics	Work with individuals of other professions to maintain a climate of <i>mutual respect</i> and <i>shared values</i> .
<b>Competency Two:</b> Roles/Responsibilities	Use the knowledge of one's own role and those of other professionals to appropriately assess and address the health care needs of clients and to promote and advance the health of populations.
<b>Competency Three:</b> Interprofessional Communication	Communicate with clients, families, communities, and professionals in health and other fields in a responsive and responsible manner that supports a team approach to the promotion and maintenance of health and the prevention and treatment of disease.
<b>Competency Four:</b> Teams and Teamwork	Apply relationship-building values and the principles of team dynamics to perform effectively in different team roles to plan, deliver, and evaluate client/population-centered care and population health programs and policies that are safe, timely, efficient, effective, and equitable.

the staff providing their care due to changes in hospital census. When census is high, hospital policy may mandate that when all other beds are full, clients be sent to open beds on floors that do not specialize in those clients' needs. Thus, those clients' physicians may work with a completely different staff. If census is low, hospital policy often requires managers to float staff to other floors or to send staff home. In this situation, clients rarely have the same nurse, respiratory therapist, occupational therapist, or physical therapist for more than 2 days in a row. Given these organizational forces, it is difficult for the same interprofessional team to meet consistently with the client and family to coordinate clients' care.

### Teamwork

The other barrier to IPC is lack of teamwork. Until recently, many health care professionals were not taught interprofessional teamwork skills when they were in school. In addition, traditional health care education and practice have been based on hierarches that limit communication (Eppich, 2016). Nursing and therapy staff may not feel that the physician welcomes their opinions. Therapy staff may not feel that nurses respect them, or vice versa. Research on health care teamwork reveals a tribal mentality, with rampant stereotypes and hierarches affecting interactions (Braithwaite et al., 2016). Braithwaite et al. (2016) concluded that workplace culture, not individual personalities or group characteristics, was the biggest contributing factor to difficulties with teamwork. Clearly, IPC involves more than communicating with one other. IPC requires acknowledging the uniprofessional education most health care providers received and how that education influences their language and attitudes. Financial pressures on health care organizations for productivity and efficiency can also have a negative impact on IPC. Many organizational policies and priorities must change to support a collaborative model. Finally, organizations must examine their workplace culture and determine whether hierarchies and stereotypes are

barriers to IPC. Fortunately, professional organizations have begun working together to find ways of helping health care providers overcome these barriers by identifying IPC's four core competencies.

### IPC Core Competencies

The Interprofessional Education Collaborative (IPEC) began as an organization of six national associations of schools of health professions in 2009 with the stated goal "to help prepare future health professionals for enhanced team-based care of clients and improved population health outcomes" (IPEC, 2016, p. 1). The American Occupational Therapy Association (AOTA) was one of nine institutional members added to the collaborative in February 2016. The IPEC has identified IPC's four core competencies—Values/Ethics, Roles/Responsibilities, Interprofessional Education, and Teams and Teamwork—are designed to build on discipline-specific competencies to help professionals engage to improve individual and population health outcomes (IPEC, 2016). See Table 2 for a description of each competency.

IPC's four core competencies provide basic guidelines to promote client-centered care, but putting these guidelines into practice within a traditional health care setting can be quite challenging.

### TOOLS TO PROMOTE IPC INITIATIVES

Although IPC's focus is on teamwork with shared leadership, practitioners with knowledge of collaborative practice are needed to promote IPC initiatives. The *Occupational Therapy Practice Framework: Domain & Process, 3rd Edition (Framework; AOTA, 2014)* and the Person-Environment-Occupation (PEO) Model (Law et al., 1996) equip occupational therapy practitioners to support IPC initiatives.

IPC promotes focusing on the whole person. Looking back at the comparison of traditional and collaborative care in Table 1, note the focus on the person's needs and goals. Occupational therapists are adept at assessing client factors (AOTA, 2014).

Practitioners can identify the client's roles, values, beliefs, and routines to ensure that the interprofessional team's care plan is client centered. As health care professionals are being called to move beyond the traditional medical model's focus on body parts and functions, occupational therapy practitioners can help team members view client needs from a more holistic perspective, which includes performance skills and patterns. This viewpoint allows the occupational therapist to help the team understand how the client's motor, process, and social skills converge with the client's habits, routines, roles, and rituals to affect health outcomes. In addition, the occupational therapist's ability to assess and identify environmental and contextual factors influencing the client and family can also help the team create an effective care plan that aligns with the client's goals and needs (AOTA, 2014).

Although most occupational therapy practitioners have been trained to recognize their distinct contributions to the interprofessional team to help meet client needs, it is important to note how the *Framework* can also be used to address barriers to interprofessional team collaboration.

### Promoting IPC Initiatives Using the PEO Model

The PEO Model can be useful in identifying and addressing barriers to IPC.

#### Person

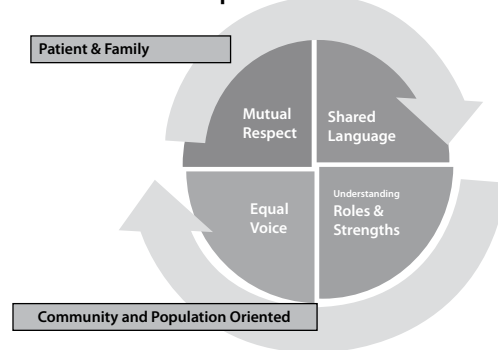
According to Law et al. (1996), focusing on the person allows the occupational therapy practitioner to recognize the continuous, evolving, dynamic nature of people or groups and what motivates them. This perspective is also valuable when working toward IPC. As previously noted, embedded in IPC's first competency is mutual respect and equal voice. An occupational therapist can analyze the dynamics of the group (i.e., the team) and identify areas where values, beliefs, and understanding of each other's roles may be negatively impacted by hierarchies, stereotypes, or basic misunderstandings and lack of communication.

#### Environment

Occupational therapists can also identify environmental factors that affect the team. For example, is the physical environment conducive to meeting together? Do the disciplines interact during breaks, such as lunch, or do they remain separate, due to lack of space or some other reason? Are the clients treated by the same team in the same location to promote easy communication? What about the temporal environment? How do the nursing, psychiatry, and therapy work schedules affect the team members' consistency? The virtual environment can be another challenge. Does the electronic medical record ease or impede reading notes from each discipline? The cultural environment is one of the biggest influences on IPC (Eppich, 2016; Uhlig & Raboin, 2015). Does the institution support sharing ideas from all staff members?

**Figure 1. Core of Interprofessional Collaboration**

### Core of Interprofessional Collaboration



Adapted from IPEC, 2016

#### Occupation

Based on Law et al.'s (1996) definition of occupation, the occupational therapist can analyze the clusters of activities and tasks in which the IP team engages to meet the client's health care needs. For example, would it be more beneficial to the client to have the entire team participate in the physician's daily rounds? Could the task of weekly team-care plan meetings be held in the client's room with the caregiver present?

Finally, the occupational therapist can assist the IP team in reflecting on all these factors and evaluate their level of occupational performance or quality of meeting the client's needs and goals as a team.

Moving to a collaborative care model is not a simple task; instead, a multitude of dynamic factors are involved. Many of these factors can be categorized, analyzed, and addressed using the *Framework*'s tools and the PEO Model, making occupational therapy practitioners well equipped to promote IPC initiatives.

#### PRACTICAL STEPS TO PROMOTING IPC INITIATIVES

Figure 1 depicts the core concepts adapted from IPEC (2016). Keeping these concepts in mind helps occupational therapy practitioners work collaboratively. Start by employing these core concepts with co-workers and clients/caregivers, and then expand to the community and targeted populations.

The following case examples and suggestions for applying IPC's core competencies are based on experiences leading interprofessional collaboration initiatives in an inpatient rehabilitation facility over the past year. Uhlig and Raboin (2015) noted three important notions to keep in mind when working toward collaborative care. First, collaborative care should not be considered a program to be implemented; instead, it emerges as a result of cultivating the core concepts into a setting. It should be viewed as a cultural change. Second, each facility is different; therefore, the way professionals best collaborate may look different. For example, some facilities have moved to interprofessional weekly rounds, whereas other

facilities have daily team huddles. Finally, there is a spectrum of collaboration—transitioning from traditional to collaborative care takes about 12 to 18 months. Any movement toward collaboration is helpful.

### **Competency One: Values/Ethics, and Identify Existing Areas of Mutual Respect**

Ulig and Raboin (2015) recommend beginning work toward collaborative care by identifying where mutual respect already exists. Note good working relationships among professionals in which genuine mutual respect results in excellent client care. Communicate what you have observed to these professionals, and invite them to a meeting to reflect and build on what they have already accomplished. Perhaps an interprofessional group already meets to discuss issues and methods for quality improvement. This group can be a good place to introduce IPC and its benefits. Then invite others to partner with you to move toward collaborative care. Include those with decision-making power (e.g., physiatrists, charge nurses, directors) in the meeting so the group can act easily on ideas to improve collaboration. The best way to involve these decision makers is to help them see the link between IPC and improving client outcomes and client satisfaction.

### **Challenge Negative Narratives**

Pay attention to narratives that impede collaboration, and challenge them. For example, a young occupational therapist noted that the nursing staff did not listen or care about implementing a bowel and bladder plan the team had agreed to, based on the fact that the nurse had not started the program the day after it was discussed. For another occupational therapist, who had 27 years of experience, the narrative of nurses not caring about carrying over an intervention sounded familiar. However, this therapist decided not to believe that narrative and called a quick huddle with herself, the nurse, and the nurse practitioner. It turned out that the bowel program had not been initiated yet because the order had not been changed regarding the time the client was to receive the suppository. This issue was quickly resolved, and the interprofessional team implemented the care plan as discussed.

### **Competency Two: Roles/Responsibilities**

#### **Promote Understanding of Each Other's Roles and Responsibilities**

A good place to start is asking how well co-workers, clients, and caregivers understand each other's roles and responsibilities. Does the respiratory therapist (RT) who just arrived to do a breathing treatment with the client understand the role of the occupational therapist currently working with the client? Does the client understand how the occupational therapist's interventions integrate with the RT's interventions? Would it be helpful to initiate a conversation among the occupational therapist, the client, and the RT to discuss how the respiratory treatments may affect the ability of the client to participate in valued

occupations? This conversation can also be very helpful when the nurse gives the client a medication during an occupational therapy intervention. Engaging the nurse and the client in a discussion on how the medication may affect the client's routines and performance of occupations enlightens all.

Another suggestion is to create a bulletin board with pictures of staff members and a description of their role in helping the client (Vanderzalem, Hall, McFarlane, Rutherford, & Paterson, 2013). Caregivers and clients can use this bulletin board to clarify their understanding of staff roles and direct their questions to appropriate team members.

Hosting an interprofessional journal club is another excellent way for staff to gain a better understanding of each other's roles and responsibilities. For example, respected professionals from each discipline were asked to bring an evidence-based article from their profession on current strategies in treating stroke. All the professionals shared their role in treating a client who had a stroke and commented on at least one thing other disciplines could do to help them in their role.

### **Competencies Three and Four: Interprofessional Education, and Teams and Teamwork**

Interprofessional communication and teamwork are closely related. Underlying these competencies are the core principles of equal voice, shared language, transparency, and team problem solving.

### **Equal Voice**

One of the easiest ways to move toward collaborative care is by communicating with the client. It is important to realize that many clients desire to be "good patients" and believe this entails not questioning the professionals who are caring for them. Clients need to hear that they have an equal voice in their care. It can be amazing to discover what clients do and do not understand by simply asking, "What do you hear me saying to you?" This question allows the practitioner to identify and correct misconceptions the client has about the goals and purpose of their work together. Another way to promote equal voice is to honor the client's verbal and nonverbal communication. For example, one day an occupational therapist noted that the client seemed to hesitate when the nurse gave her a stool softener to drink. The therapist asked the client, "Do you feel that you need that?" The client said, "No." After a discussion with the nurse and client, it was determined that the client did not need to take the medication. The therapist later asked the client whether she would have said anything to the nurse on her own, and the client said, "Probably not." It is important to remember how little power clients can feel in the hospital environment.

As another example, a client's wife had spent the night with the client and told the occupational therapist that she had not slept well because the night staff had left a light on. A few minutes later, when the night nurse entered to introduce the day shift nurse, the occupational therapist took the

opportunity to mention in front of the client, his wife, and the nurses that the light had been a problem. The nurse assured the client's wife that she could turn off the light, showed her how to do so, and acknowledged that this issue would be good feedback for the staff. Had the occupational therapist not said anything, the wife may have continued to feel powerless and the nursing staff would have remained unaware of such a simple issue affecting client satisfaction. Ask yourself whether this type of transparent conversation is welcome at your facility. A culture of transparency and equal voice is cultivated when staff are encouraged and trained to discuss issues openly with those involved.

### Communication and Teamwork

Many facilities use a whiteboard posted in the client's room to list staff names, precautions, and transfer status. It is important to remember that HIPPA regulations do not apply to information the client consents to share. If the client is agreeable, a list of specific daily or weekly goals (e.g., "walk to the bathroom every time," "get rid of tubes," "have a bowel movement") can be posted so everyone entering the room can assist in helping the client meet those goals.

In May 2016, Walter Eppich, MD, MEd, gave a presentation on interprofessional communication's challenges and opportunities. Eppich noted that individual competency does not equal team competency. He went on to explain that competent clinicians can form incompetent teams because of social and cultural issues. The key to team competency is fostering psychological safety, which is the belief that one will not be punished for speaking up, admitting to mistakes, or giving ideas (Eppich, 2016). Hearing all voices requires creating an environment of psychological safety. This requirement is not as easy as it sounds and can take time, but the key is valuing all voices and being appreciative when people do speak up, even if all don't agree. Stating that everyone involved is fallible and needs each other is also important. Another key is setting aside time for safe reflection on the group's work as a team. After a client has been discharged, most facilities do not allow time for clinicians to debrief to discuss what went well and what could have been improved. Although not reimbursed by insurance, time devoted to debriefing could be valuable in improving outcomes.

Geographical location and scheduling for staff consistency must also be addressed. For example, the clients on a team were located on any one of four halls and had different nurses and one of two psychiatrists. As a result, a nurse sometimes had to communicate with up to 26 different professionals when addressing her five clients' needs. That same nurse could have a different set of clients the next day. The occupational therapy/physical therapy team could have 10 different clinicians to locate and communicate with to meet each client's needs. Obviously, this system would limit communication and teamwork. The other challenge was lack

of consistency. It was not uncommon for an occupational therapist or physical therapist to be sent to work on the acute floors or to be sent home if the census was low. Thus, the clients might not have been seen by the same therapists for more than a few days at a time.

Taking the time to analyze these geographical and organizational factors and the reasons for them has helped the team move toward assigning clients to specific hallways and scheduling consistent nurses and therapy practitioners. However, being sensitive to different disciplines' needs is also important. For example, a full team of clients with spinal cord injuries may be too high acuity for one nurse.

When making changes, another key to success has been to employ the Plan-Do-Study-Act Model (Institute for Health Improvement, 2017). After a core group representing all professionals willing to meet weekly was established at our facility, each meeting started with a very honest discussion. As the facilitator, the occupational therapist ensured that everyone's perspective was heard and that everyone had an equal voice. During the discussion, it was helpful to paraphrase and check understanding with all the participants and write their comments for all to see. This process helped team members recognize some hierarchies and make changes to diminish them. Each meeting started and ended on time. The last 20 minutes or so was devoted to finalizing an action plan to be completed by the next meeting. Several attendees commented that they felt energized by the meeting because they "actually did something and not just talked." The occupational therapist usually encouraged the group to start small, trying the plan with one client or one team. Sometimes the team agreed to start small, but sometimes they decided to implement full scale immediately. The timing of weekly meetings gave the team the opportunity to "study" the results while the plan was fresh, make adjustments, and move forward. This approach has kept the momentum going.

### CONCLUSION

Health care is undergoing significant changes that impact health care providers, including occupational therapy practitioners and challenge them to look at new models of service delivery. Interprofessional collaboration is viewed as one of the best models to improve quality of care and client satisfaction while reducing costs. IPC represents a significant paradigm shift away from traditional multiprofessional medical care. Collaborative care requires practitioners to adjust their uniprofessional mindset and organizational priorities and to gain communication and teamwork skills. Mutual respect, understanding roles and responsibilities, interprofessional communication, and teamwork are the four core competencies needed for interprofessional collaboration. Occupational therapy practitioners have the knowledge and skills necessary to promote IPC initiatives that incorporate these competencies. ①

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## REFERENCES

- Accreditation Council for Occupational Therapy Education. (2013). *Standards and interpretative guidelines*. Retrieved from <http://www.aota.org/media/Corporate/Files/EducationCareers/Accredit/Standards/2011-Standards-and-Interpretive-Guide-August-2013.pdf>
- American Occupational Therapy Association. (2014). Occupational therapy practice framework: Domain & practice (3rd ed.). *American Journal of Occupational Therapy*, 68, S1–S48. <http://dx.doi.org/10.5014/ajot.2014.682006>
- Brandt, B. F. (2015a). *Interprofessional education and collaborative practice: Welcome to the “new” forty-year old field*. Retrieved from: <https://nexusipe.org/informing/resource-center/interprofessional-education-and-collaborative-practice-welcome-new-forty>
- Brandt, B. (2015b, October). *The state of the science of interprofessional practice and education*. Keynote speech presented at University of Minnesota, Minneapolis.
- Braithwaite, J., Clay-Williams, R., Vecellio, E., Marks, D., Hooper, T., Westbrook, M., . . . Ludlow, K. (2016) The basis of clinical tribalism, hierarchy, and stereotyping: A laboratory-controlled teamwork experiment. *BMJ Open*, 6, e012467. <http://dx.doi.org/10.1136/bmjopen-2016-012467>
- Canadian Interprofessional Health Collaborative. (2010). *A national competency interprofessional framework*. Retrieved from [http://www.cihc.ca/files/CIHC\\_IPCompetencies\\_Feb1210.pdf](http://www.cihc.ca/files/CIHC_IPCompetencies_Feb1210.pdf)
- Centers for Medicare & Medicaid Services. (2010). *Affordable Care Act update: Implementing Medicare cost savings*. Retrieved from: <https://www.cms.gov/apps/docs/aca-update-implementing-medicare-costs-savings.pdf>
- Centers for Medicare & Medicaid Services. (2014). *Inpatient rehabilitation facility prospective payment system*. Retrieved from: <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/InpatRehabPaymftctsh09-508.pdf>
- Centers for Medicare & Medicaid Services. (2015). *Innovation center home*. Retrieved from <https://innovation.cms.gov/>
- Eppich, W. (2016). *Interprofessional communication: Challenges and opportunities*. Retrieved from <http://intensivecarenetwork.com/interprofessional-communication-challenges-opportunities-walter-eppich-2/>
- Institute of Healthcare Improvement. (2016). *The IHI triple aim*. Retrieved from <http://www.ihl.org/engage/initiatives/tripleaim/pages/default.aspx>
- Institute for Healthcare Improvement. (2017). *Plan-do-study-act (PDSA) worksheet*. Retrieved from <http://www.ihl.org/resources/Pages/Tools/PlanDoStudy-ActWorksheet.aspx>
- Interprofessional Education Collaborative. (2016). *Core competencies for interprofessional collaborative practice: 2016 update*. Retrieved from <http://www.aacn.nche.edu/education-resources/IPEC-2016-Updated-Core-Competencies-Report.pdf>
- Law, M., Cooper, B., Strong, S., Stewart, D., Rigby, P., & Letts, L. (1996). The Person-Environment-Occupation Model: A transactive approach to occupational performance. *Canadian Journal of Occupational Therapy*, 63, 9–23.
- Moyers, P. A., & Metzler, C. A. (2014). Health policy perspectives: Interprofessional collaborative practice in care coordination. *American Journal of Occupational Therapy*, 68, 500–505. <http://dx.doi.org/10.5014/ajot.2014.685002>
- National Center for Interprofessional Practice and Collaboration. (2015). *About IPE*. Retrieved from <https://nexusipe.org/informing/about-ipe>
- Newhouse, R. P., & Spring, B. (2010). Interdisciplinary evidence-based practice: Moving from silos to synergy. *Nursing Outlook*, 58, 309–317.
- Uhlig, P., & Raboin, W. E. (2015). *Field guide to collaborative care: Implementing the future of healthcare*. Overland Park, KS: Oak Prairie Press.
- Vanderzalem, J., Hall, M. D., McFarlane, L., Rutherford, L., & Patterson, S. K. (2013). Fostering interprofessional learning in a rehabilitation setting: Development of an interprofessional clinical learning unit. *Rehabilitation Nursing*, 38, 178–185.
- World Health Organization. (2010). *Framework for action on interprofessional education and collaborative practice*. Retrieved from [http://www.who.int/hrh/resources/framework\\_action/en/](http://www.who.int/hrh/resources/framework_action/en/)

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An Essential Skill for all Practitioners**

**To receive CE credit, exam must be completed by  
June 30, 2019.**

**Learning Level:** Intermediate

**Target Audience:** Occupational Therapists and Occupational Therapy Assistants

**Content Focus:** Category 1: Domain of OT; Category 2: OT Process

1. Which of the following does *not* characterize health care in the United States?
  - A. The Centers for Medicare & Medicaid Services (CMS) has created reimbursement models that support the “Triple Aim.”
  - B. New CMS payment models are forcing health care providers to change the way they provide care.
  - C. The traditional medical model is viewed as the best path forward to meet health care needs.
  - D. The traditional medical model, has led to escalated health care costs and fragmented care.
2. Which statement best represents what occupational therapy practitioners need to understand about interprofessional collaboration (IPC)?
  - A. IPC is a program that can be easily implemented in less than a year.
  - B. IPC supports working in parallel with other professionals.
  - C. IPC is the same as multidisciplinary care.
  - D. IPC is a global movement in health care and education.

3. **According to the World Health Organization, which of the following best describes some of the benefits of IPC?**
  - A. It optimizes health services, strengthens health systems, and improves health outcomes and client satisfaction.
  - B. It promotes health provider job satisfaction and retention.
  - C. It is necessary in order to remain viable under value-based reimbursement models.
  - D. All of the above
  
4. **Which of the following is *not* an accurate description of the contrast between interprofessional collaborative care and traditional multiprofessional care?**
  - A. Traditional care focuses on disease/treatment; collaborative care focuses on people's needs/goals.
  - B. Under collaborative care, practitioners use discipline-specific jargon.
  - C. In traditional multidisciplinary care, interventions are parallel.
  - D. With collaborative care, the clients are talked "with"; in traditional care, the client is "talked about."
  
5. **Barriers to IPC include which of the following?**
  - A. Recognizing that many health care professionals do not understand the roles and responsibilities of other professionals
  - B. Sending staff home or floating staff to another floor during low census, disrupting consistency of care
  - C. Identifying stereotypes and hierarchies to promote communication between professionals
  - D. Acknowledging that all members of the team are fallible
  
6. **Which of the following statements about the Interprofessional Education Collaborative (IPEC) is false?**
  - A. IPEC's goal is to help prepare future health professionals for enhanced team-based care and improved population health outcomes.
  - B. The American Occupational Therapy Association is one of IPEC's 15 institutional members, as of February 2016.
  - C. IPEC has identified four core competencies to detect professionals who are not team oriented.
  - D. The core competencies are designed to build on discipline-specific competencies.
  
7. **Which of the following describes one of IPEC's core competencies for health professionals?**
  - A. A health professional works to maintain a climate of mutual respect and shared values.
  - B. A health professional focuses on his or her role and is less concerned about understanding the role of other health professionals.
  - C. A health professional limits communication with other professionals to maintain his or her productivity.
  - D. A health care professional's ability to apply principles of team dynamics is not necessary to deliver efficient, effective, and equitable health care.
  
8. **Which of the following equips occupational therapy practitioners to promote IPC?**
  - A. The use of occupation-based terminology.
  - B. The ability to show respect to the physician by waiting to be asked for feedback on a client's needs.
  - C. The ability to apply the PEO Model to identify issues with team dynamics.
  - D. The ability to use the *Framework* to provide holistic interventions to the client, limiting the need to coordinate with other professionals.
  
9. **When taking steps to implement IPC initiatives, it is important to remember each of the following *except*:**
  - A. Collaborative care emerges from a culture of mutual respect, equal voice, and shared language.
  - B. Collaborative care may look different at each facility.
  - C. Moving toward collaborative care is a process that can take up to 18 months.
  - D. Collaborative care is appropriate in teaching hospitals but will not work in a non-teaching setting.
  
10. **Which of the following is a step an occupational therapy practitioner can take to begin implementing IPC initiatives?**
  - A. Ask clients and caregivers to describe their understanding of the purpose of your intervention.
  - B. Assume that the other professionals understand your role with clients.
  - C. Agree with narratives that professional is not listening or does not want to be a team player.
  - D. When working with a client and another professional enters the room, ask that professional to come back when the occupational therapy session is over.
  
11. **Which of the following is an example of *not* promoting equal voice?**
  - A. Asking a hesitant client if she feels comfortable taking medication
  - B. Ensuring that all individuals in a meeting have been given the opportunity give their opinion
  - C. Choosing to save time by limiting input on the client's care to a select few
  - D. Alerting nursing staff that the client's wife was unable to sleep because a light was left on in his room while both are present
  
12. **Actions that improve teamwork include all of the following *except*:**
  - A. Understanding that competent clinicians can form incompetent teams.
  - B. Fostering a climate of psychological safety; being appreciative when people speak up.
  - C. Understanding that everyone is fallible and makes mistakes.
  - D. Allowing the staff's preferred scheduling without ensuring a consistent team is available to meet the client's needs.