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Editorial

Laying 'the groundwork' for a post-licensure interprofessional education initiative in Qatar

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INTRODUCTION

Interprofessional education (IPE) has been recognized by the World Health Organization (WHO) as one potential approach for improving health care delivery and outcomes[1]. The premise is that effective IPE can lead to more effective collaborative practice among health professionals from different disciplines. This in turn can lead to better health care delivery. IPE has been shown in the literature to be associated with increased patient satisfaction, better health outcomes, shorter hospital stays, improved staff morale, and a range of other benefits[1−3]. In addition, successful examples of IPE initiatives from around the world demonstrate that IPE and collaborative practice can be beneficial to health care in a variety of contexts[1].

Interprofessional Education and Interprofessional Practice (IPE & IPP)

Interprofessional Education is often used to indicate training opportunities for health care students and health care professionals to engage in and learn more about working together to promote improved healthcare outcomes. More recently, however, it has become helpful to differentiate between training of healthcare professionals in their post-secondary work (e.g., undergraduate work) prior to becoming full-time healthcare professionals in practice settings. Thus IPE has become associated with pre-licensure post-secondary education while Interprofessional Practice (IPP) has become associated with post-licensure practice settings. The difference lies primarily in the manner in which training is implemented and in the barriers or challenges encountered. D'Amour and Oandason, for example, discuss the systemic factors that exist in interprofessional education and those that exist in collaborative practice[4]. Although an understanding of the linkage between IPE and IPP is crucial[1,5], it is helpful to look each environment independently and determine the contexts into which IPE or IPP is being implemented.

Interprofessional practice settings include populations of healthcare workers who may or may not have had the opportunities provided by IPE. The challenges of developing a culture of IPP in post-licensure settings often include a population of healthcare professionals who have not had the IPE opportunities and who work in a healthcare cultural context that is only beginning to engage in IPP.

This paper explores the development of a strategy for the implementation of IPP into an existing healthcare system. In 2013, the Qatar Academic Health System (QAHS) approved funding for the development of an integrated IPE project for post-licensure health care professionals working with QAHS members. The purpose of this paper is to discuss the initial stages of development of this project.

Local context

In Qatar, IPE is gaining increasing popularity. The national health strategy recognizes IPE as one potential tool to strengthen health care service delivery[6]. Furthermore, the recent formation of the

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QAHS is a working example of the importance placed on interdisciplinary collaboration. The QAHS consists of the major public health care providers, Hamad Medical Corporation (HMC), Sidra Medical and Research Center, and the Primary Health Care Corporation (PHCC), the Qatar Biobank for Medical Research (QBMS), and the major health care education institutions: the University of Calgary in Qatar (UCQ), Weil-Cornell Medical College (WCMC), College of the North Atlantic Qatar (CNAQ), and Qatar University. Many of the QAHS members are currently involved in a range of collaborative IPE initiatives, which clearly sends the message is that IPE is being integrated into health care education in Qatar.

The formation of the Qatar Interprofessional Health Council (QIHC) in 2009 signaled the commitment to IPE across healthcare delivery in education institutions in Qatar. The QIHC membership consists of representatives from each of the healthcare educational institutions (CNAQ, UCQ, WCMC, QU) as well as representation from the healthcare system (Sidra, HMC). The QIHC's strategic aims include the leadership of collaborative practice in IPE and IPP in Qatar.

Necessary conditions (the groundwork)

Freeth et al. suggest that laying 'the groundwork' is an essential first step in developing IPE. The authors say that important planning must take place before IPE curriculum development, staff development, and implementation[7]. Greenfield, et al. found six factors that impact the likelihood of successful implementations of IPP: (1) Site receptivity, (2) team issues, (3) leadership, (4) impact on healthcare relations, (5) impact on quality and safety issues, and (6) institutional embededness[8]. Of these, 1–3, and 6 can impact the ability to lay an effective groundwork. Site receptivity, team issues, and embededness refer to the local context and establishing stakeholder engagement. Leadership refers to the idea of establishing champions within the local context. Laying an effective groundwork must take into account the local context and ways in which to engage and motivate sustainable change. Implementing IPP requires a team that understands the context into which IPP is being deployed and the resources required to conduct the implementation. The availability of resources plays a crucial role in laying the groundwork. We can consider these to be the necessary minimum conditions under which a successful IPP initiative may occur.

Thus the necessary conditions in the local context of Qatar that constitute the groundwork can be stated as:

1. Stakeholder Engagement,
2. Role of Champions,
3. Implementation Team,
4. Resource Allocation.

These four components, discussed in the following sections, are essential to the development and implementation of a sustainable culture of IPP in post-licensure settings.

Stakeholder engagement

The drive in Qatar to create a world-class health care system, and all of the associated initiatives to develop the health system, has facilitated the initial stages of the QAHS IPE initiative. The inclusion of IPE in the Qatar National Health Strategy and the QAHS' strategic goals has also ensured that the 'political arena'[7] is prepared to support IPE.

One of the first steps undertaken to lay 'the groundwork' for this project was to identify and meet with key stakeholders in order to gain approval and support. Initial meetings were held with members of the QIHC, who then acted as gatekeepers by identifying and providing introductions to other key stakeholders within HMC. Meetings were held with stakeholders from Medicine, Nursing, Pharmacy, and Allied Health and feedback was sought on the overall project direction as well as the practicalities of implementation. In general, stakeholders from all levels of health care, from the front lines to senior leadership, were supportive of development. In essence, the drive for an improved health care system has begun to create a culture of openness to change in many respects. However, the drive for system development also has a downside; several stakeholders were unable to commit time or other resources to the project due the number of other initiatives currently under way.

Two key decisions came out of this consultation process: first, to focus initial development on HMC only. This decision was based on undertaking a project that was reasonable in scope. Second, project development would focus on the four key focus areas identified by the QAHS: oncology, endocrinology, cardiovascular disease, and neuroscience. This would ensure that the project was addressing the

health needs of the country. Involving the stakeholders in the planning and decision making process was insightful as it provided an insider's view of the system and also seemed to facilitate buy-in and political support.

Role of champions

Champions can aid project efforts by facilitating dissemination of knowledge, acting as project advocates, helping to build relationship between stakeholders, and gaining consensus[9]. Several champions were already in place prior to the commencement of the current project. For example, QIHC members provided key introductions, shared information with relevant stakeholders, provided insider information about the structure of services and current forms of education, offered feedback on initial plans, and provided resources. Several of these individuals played a key role in getting the project off the ground.

Champions typically come from the following areas: clinical, managerial, and executive[9]. Members of the QIHC filled the role of champions from the managerial and executive areas, but lacked clinicians. Engaging clinicians as IPE champions can help provide an important perspective and promote bottom-up development[7]. A group of educators who will receive training and help to facilitate IPP workshops has been identified. Several of these clinicians have expressed a strong interest, and have previous experience, in IPE. Other clinicians, who complete the initial workshops and are interested in maintaining their involvement, will receive follow up support to facilitate their potential role as champions.

One of the difficulties in developing champions at the managerial and executive levels has been the heavy workloads already being managed by these individuals. One strategy that seems to have worked was to offer key people the opportunity to become part of the project leadership team, therefore giving them a more tangible stake in the planning, development, and delivery of the project.

Implementation team

The ongoing need to build and maintain relationships across organizations is the key foundation of developing the implementation team[7]. Development of the implementation team for the current project is ongoing. Members from Medicine, Nursing, and Pharmacy have been included in order to provide a multidisciplinary perspective and to facilitate the identification of champions, communications and recruitment. Several individuals from other professional backgrounds, including Education, Medical Simulation, and Sociology, have also been included in order to increase the diversity of the team. The team includes several individuals with sufficient seniority or delegated authority to effect change[7].

Putting a team together is the first step, but based on the current experience, building a cohesive team is a challenge. Scheduling meetings, commitment to the initiative, preconceived notions about the nature of IPE, interpersonal conflict and group dynamics can all present challenges to effective teamwork[7]. Several of these issues have arisen in the current project and the majority of planning has been done in one-to-one meetings between the lead and various team members or in sub-groups. Future efforts will attempt to build the cohesiveness of this team and ensure that members learn 'with, from and about' each other in parallel to the IPE initiative being developed.

Resource allocation

Financial and human resources are necessary to support the "development, delivery, and evaluation" of IPE initiatives (p.57)[7]. The project lead was given release by UCQ from a portion of his teaching load in order to oversee the project. This was essential initially due to the extensive consultation process and significant amount of time required to arrange and attend meetings and lay 'the groundwork'. The release time continued to be essential during subsequent phases of the project due to delays in hiring project staff.

The QAHS provided generous funding for the current project. Financial resources were approved to hire staff, purchase equipment, rent office/training space, and cover other operational and capital expenses. However, an initial delay in the release of funds, combined with a lengthy hiring process, resulted in a significant delay in the procurement of contracts for project staff. Regular consultation between the project lead and the QAHS was important in revising timelines, adapting initial plans and preparing for subsequent phases. The development and engagement of the implementation team was also valuable in mitigating the lack of human resources.

CONCLUSION

Some of the groundwork has been laid. Extensive consultations have helped to secure political support from the executive levels of the organization, and the drive for improved healthcare services in the country has created open-mindedness for quality improvement projects. Resources have been secured both in terms of dedicated time for the project lead as well as financial support. Champions from managerial and executive levels have been identified, and relationships with these individuals have been developed. Initial members of the implementation team have been brought into the project and work with these individuals is in progress. Although much work has been done, the groundwork will foreseeably have to continue throughout the life of the project. Ongoing consultations to report on outcomes and promote continued political support, advocating for continued funding and developing sustainable practices, identifying and building the capacity of champions from the clinical level, and working to ensure the development of an engaged implementation team are all necessary to increase the likelihood of success for this and other IPE initiatives.

COMPETING INTERESTS

Both authors have reviewed and agree with the contents of the manuscript and there are no conflicts of interest to report.

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AUTHOR CONTRIBUTIONS

The first author wrote the original draft of this article. He was responsible for undertaking the majority of the legwork involved with this project (e.g., identifying and developing relationships with stakeholders, liaising with the funding agency, attending meetings, etc.) The second author conceived the project and submitted the initial funding application. He offered ongoing support throughout the groundwork process and made substantial revisions of the article.

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