



**ASSOCIATION OF SCHOOLS OF
ALLIED HEALTH PROFESSIONS**

**2018 ASAHP Summit on
Healthcare Workforce Readiness
for Interprofessional
Collaborative Practice**

**Saturday, July 28, 2018
Minneapolis, Minnesota**

2018 ASAHP Summit on Healthcare Workforce Readiness for Interprofessional Collaborative Practice

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2018 ASAHP Summit on Healthcare Workforce Readiness for Interprofessional Collaborative Practice

The Association of School of Allied Health Professions (ASAHP) hosted the 2018 ASAHP Summit on Healthcare Workforce Readiness for Interprofessional Collaborative Practice in Minneapolis, Minnesota on Saturday, July 28, 2018 from 12:00 - 5:00 pm. It was structured as a pre-conference session to the Nexus Summit, sponsored by the National Center for Interprofessional Practice and Education, which was held at the same venue.

The focus of the ASAHP Summit was “Sustainable Collaborative Health Care through Education-Practice Partnerships” and brought together leaders from academia and practice to mutually explore the current realities of both environments and the interdependent relationship between them. The outcomes of the Summit are co-created action steps and several outputs for dissemination.

Summit Objectives

- Exploring Interprofessional Education and Collaborative Practice through a New Lens
- Developing Polarity Thinking™ Mindset & Skills
- Mapping Interprofessional Education (IPE) and Collaborative Practice (IPCP) Interdependent Realities
- Identifying Global & Local Action Needed to Create and Sustaining Education-Practice Partnerships

Facilitators

The keynote speakers/facilitators for the meeting were Tracy Christopherson, MS, BAS, RRT and Michelle Troseth, MSN, RN, FNAP, FAAN from MissingLogic, LLC who engaged participants in activities using Polarity Thinking™ to help understand the interdependencies between interprofessional education and collaborative practice (IPECP) and determine critical action steps for education and practice settings toward a sustainable interprofessional workforce.



Background

There is a growing body of evidence to suggest that interprofessional education (IPE) can improve student attitudes toward interprofessional practice and enhance their team-based knowledge and skills.^{1,2} The importance of context as it relates to the continuum of learning from foundational to continuing professional education and the impact of interprofessional education and collaborative practice on the quadruple aim (improved patient outcomes, improved patient experience, improved clinician experience, and reduced cost) is less well understood.³ Identification of this gap has led to recent calls for greater alignment and coordination among education and healthcare delivery systems.^{3,4} For example, one of the conference recommendations from the Josiah Macy Jr Foundation was a call to “develop broadly based coalitions to align education and clinical practice” and they went on to suggest that these coalitions, “must help inform the operational design of the education-practice interface.”⁴ Others have suggested that this alignment and collaboration is a critical component in efforts to improve health and health system outcomes.⁵

One method that may assist in achieving or improving coalitions around interprofessional education and collaborative practice is Polarity Thinking™. Polarities represent interdependent pairs of what appear to be different, opposing or conflicting values or perspectives.^{6,7} Polarity Thinking™ is the systematic process for examining, understanding and leveraging polarities. Johnson created a Polarity Map® which identifies the two interdependent values or perspectives and the positive and negative aspects of each.⁸ Action steps serve to strengthen each pole and early warnings identify signs that one pole is being over-emphasized to the neglect of the opposite pole.⁹ As Wesorick noted, “some of the most haunting issues facing leaders in healthcare are not problems that will ever be solved but polarities that must be managed.”¹⁰ The first step in this management is to determine how well the interdependent values are leveraged in order to reach a “greater purpose” (a desired outcome that neither pole can reach alone).⁹ This can be done through a Polarity Assessment™ survey tool, that asks relevant stakeholders to identify, based on their observations and experience, how often they observe positive and negative outcomes associated with each identified pole.

Using a Polarity Thinking™ approach may provide a better understanding how IPE and IPCP can be leveraged to achieve efficient, effective and integrated care. The ASAHP Summit provided an opportunity to conduct a pilot research study that explored the tension between interprofessional education and collaborative practice as a polarity to be managed rather than a problem to be solved.

What is Polarity Thinking™?

Polarities can also be referred to as paradoxes, wicked problems, chronic tensions, dilemmas, etc. Advancing these types of descriptions and/or concepts into an emerging field for study and applying them in healthcare is underway. To understand the co-

existence of interdependent pairs, the understanding of their nature, the ability to take simultaneous action and recognize when course correction is needed, as well as measure outcomes over time is referred to as Polarity Thinking™.¹³

Polarities represent interdependent pairs of values or perspectives that appear to be competitive or oppositional but need each other over time to achieve a greater purpose.⁸

Polarities are an energy system. The two interdependent values create a dynamic tension that always exists. We often experience the energy as “negative” tension. The tension can be negative and/or positive, depending on how we understand and approach it. Polarities are like gravity, they cannot be seen, but they are present and because of the energy flow are 100% predictable. The energy flow is unavoidable, unsolvable, indestructible, unstoppable, and leverage-able.

How Can We Differentiate Between a Problem and Polarity?

A critical first step is to know how to recognize if an issue at hand is a problem, polarity or both.

PROBLEMS	POLARITIES
<ul style="list-style-type: none">• Not ongoing, end-point exists• Solution: present independent alternatives• Stands alone• No need to include alternatives for the solution to work	<ul style="list-style-type: none">• Ongoing, no end-point• Manage together with interdependent alternatives• Cannot stand alone• Alternatives need each other to optimize the situation over time

Because problems have an end-point, it results in “either-or” thinking and a single action. An example of this is: “Do we start an IPE Program or not?” The answer is yes or no.

Polarities are ongoing and have no end-point, resulting in “both-and” thinking and simultaneous actions. An example of this is: “Should we focus on recruitment or retention of staff?” The answer is both, because this is ongoing and over-focusing on one at the neglect of the other will not assure adequate, quality staff at over time.

Sometimes, an issue is a problem *and* a polarity. An example of this is clinician burnout; it is a problem to be addressed *and* it represents the polarity of individual factors and system factors to manage overtime to assure clinician well-being & resilience is sustainable.

Interprofessional Education (IPE) and Interprofessional Collaborative Practice (IPCP): A Crux Polarity

The effort to implement sustainable IPE curriculums has been going on for nearly 50 years. There has also been effort to create IPCP environments, especially more recently as the healthcare delivery system transitions to value-based care models.

IPE and IPCP fit the characteristics of a polarity as they represent an ongoing and persistent challenge. Neither one can stand-alone; IPE & IPCP need each other! The pattern has been to address IPE and IPCP from one point of view (education or practice) and because they are a polarity, we can predict that the greater purpose will not be sustained without attention to both.

It is important to note that poles in a polarity do not collapse or integrate into one element. They remain separate but bound together in an interdependent relationship. Both poles need to be strong for the greater purpose to be achieved and sustained.

“As the energy crosses between the two poles it separates them. This reflects the reality that the **two poles never collapse into one**. They are always differentiated. As the energy wraps around each of the poles, it **holds them together as an interdependent pair**. This reflects the reality that the two poles come as a set and need each other over time. They are always connected”

Dr. Barry Johnson
Creator, Polarity Maps and Principles

The 2018 ASAHP Summit Planning Committee established a theme of *Healthcare Workforce Readiness for Interprofessional Collaborative Practice*. It posed the question; does ASAHP continue to address the longstanding challenges in the same way? Or does ASAHP take a different approach by exploring IPE and IPCP through a new lens, obtaining real-time assessment data from participants, exploring simultaneous action steps for education and practice to advance efficient, effective and integrated care.

ASAHP chose that later with a facilitated workshop on “Sustainable Collaborative Health Care through Education-Practice Partnerships”, as well as publishing this summit report with recommendations for future research and work. A team of health professionals from the ASAHP Leadership Development Program collaborated in the assessment of Summit outcomes

The Summit was announced in Spring 2018 to ASAHP members and other stakeholders through targeted electronic mailings and social media. The announcement included a registrant link and participants were not charged a registration fee to attend.

Pre-Summit Survey

Registrants received an email in June 2018 inviting them to complete a survey in preparation for the ASAHP Summit. In addition, within the survey they were asked to indicate their consent to allow their responses to be included in this study. All responses were anonymous. The IPE/ICP polarity assessment survey is a context specific version of the Polarity Assessment™ Instrument developed by Dr. Barry Johnson and Polarity Partnerships, LLC, Auburn, CA.

The survey included two parts. The first part consisted of demographic questions asking respondents to identify their profession, role, work setting, years of healthcare service and highest level of education obtained. The demographic data are listed below:

PROFESSION	
Athletic Trainer	2
Care Manager	1
Nurse	1
Physical Therapist	3
Physician	1
Speech-Language Pathologist	3
Other	4

SETTING	
Academic	9
Practice	0
Academic and Practice	6

HIGHEST LEVEL OF EDUCATION	
MS	4
PhD	9
MD	1
Doctorate of Practice	1

ROLE	
Dean	1
Director	1
Executive	2
Faculty	6
Professor	2
Other	3

YEARS IN HEALTHCARE SERVICE	
1-5 years	1
6-10 years	0
11-15 years	1
16-20 years	3
21-25 years	4
31-35 years	1
36-40 years	0
+41 years	3

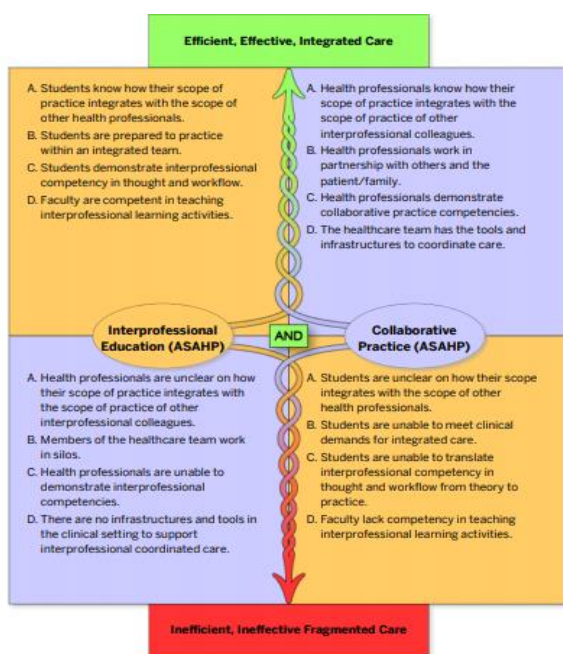


Figure 1: A visual of the Polarity Map®

The second part of the survey was developed based on a Polarity Map® that identifies the positive outcomes associated with a focus on interprofessional education and collaborative practice respectively and the negative outcomes associated with over-focusing on either interprofessional education or collaborative practice.¹³ This IPE/ICP Polarity Map® was developed by two experts in this methodology (Tracy Christopherson & Michelle Troseth) and is based on current literature in interprofessional education and collaborative practice.¹⁻⁷

From this map, sixteen Likert-type scale questions (4 for each quadrant in the polarity) were developed asking respondents to indicate the frequency with which they experienced or observed the situations or behaviors described on the following scale: almost never, seldom, sometimes, often, and almost always. Each of the responses for the positive quadrants are assigned point values as follows: almost never = 0 points; seldom = 25 points; sometimes = 50 points; and almost always = 100 points. The negative poles are inversely scored (e.g. almost never - 100 points). From these responses, each quadrant was assigned an average score from 0-100 and an overall aggregated score from 0-100 (the average of the scores from all 4 quadrants) was generated to indicate how well on the continuum from “inefficient, ineffective, fragmented care” to “efficient, effective, integrated care” participants believed this polarity was managed.

Summit Activities

Summit participants (n=18) convened to engage in a facilitated interactive session.

1. Opening Keynote: “Exploring Interprofessional Education and Collaborative Practice through a New Lens”

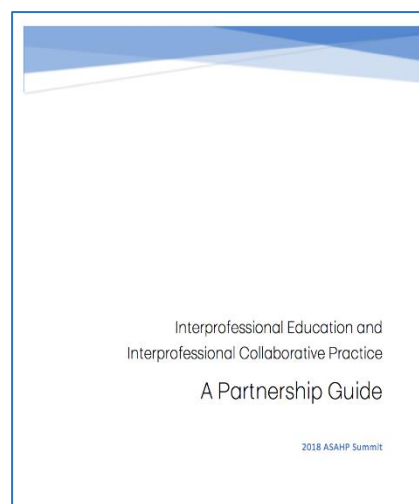
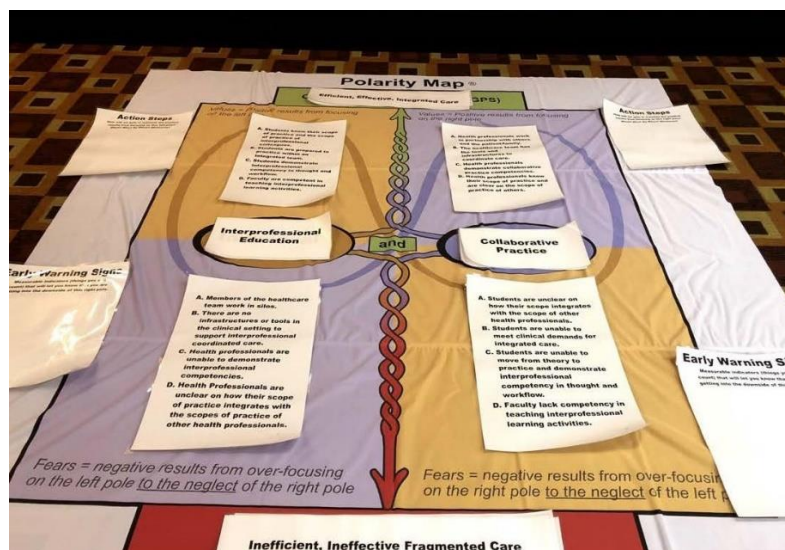
Participants received a dynamic keynote on current trends in IPE/ICP and an introduction to seeing IPE/ICP through a polarity lens. This was followed by education on the principles of polarities, the Basic Polarity Map® and a review of the pre-summit assessment findings.



2. Mapping the IPE/ICP Interdependent Realities

The group collectively reviewed the IPE/ICP poles in a Polarity Map®. The group had an opportunity to validate the content in the map and relate it to their current work environment/setting.

Next the participants broke into four workgroups to identify key action steps and early warning signs for each quadrant in the polarity. Following individual table work, participants gathered in a collective large group and discussed the action steps necessary to achieve the positive outcomes of each pole and the early warning signs to indicate an over emphasis on one pole to the neglect of the other. As participants were sharing their action steps and early warning signs, open dialogue continued to clarify experiences and offer different perspectives to generate meaningful recommended actions.



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3. Global & Local Action on Creating and Sustaining Education-Practice Partnerships

The summit concluded with a call for global *and* local action to establish education-practice partnership infrastructures. Participants were given the *Interprofessional Education and Interprofessional Collaborative Practice Partnership Guidebook*. Participants reviewed the guidebook together via facilitated discussion. Topics such as key considerations on establishing IPE/ICP partnership infrastructures, essential skills, managing crux polarities within IPE/ICP partnerships were discussed. Meeting templates, a meeting agenda example, and references were also reviewed collectively.

Data Analysis

Interprofessional Education and Interprofessional Collaborative Practice Polarity Assessment

Interprofessional education and interprofessional collaborative practice polarity assessment scores were auto-calculated. The responses provided metrics for how the individuals completing the survey observe or experience the positive and negative outcomes of the polarity. The results are visually represented in the form of a Polarity Map® (Fig. 2) and include the mean score for each quadrant in the polarity and the overall mean score for how well the polarity is managed utilizing the collective perspective of the respondents with a maximum score being 100.⁹ An overall mean score was calculated by adding the means from all four quadrants and dividing by four⁹.

When a polarity is being well-managed the overall score is between 80 and 100.⁹ The observations and experiences of the outcomes in the polarity is demonstrated by the scores in each positive and negative quadrant. The final score for each item is a mean of answers/ratings from all respondents for each specific item. The final score yields a positive value between 0 and 100 for items in the positive quadrants and conversely a negative value from -100 to 0 for items within the negative quadrants. These item scores indicate to what degree each specific outcome within the quadrant is experienced by the respondent. The mean was computed for the three items collectively within each separate quadrant of the polarity under study. The more frequently the outcomes were experienced across the respondents, the higher the score in the upper quadrants and the lower the score in the lower quadrants. A high score in the upper quadrants indicates the positive outcomes represented in the quadrant are experienced often or always. The reverse is true for the negative outcome experiences. If the scores are high in the lower quadrants, then the negative outcomes are seldom or almost never experienced by the respondents.

Interactive small and large group exercises

All data generated from the small and large group work at the ASAHP Summit were transcribed. Using this transcript, the action steps and warning signs that were generated for both IPE and IPCP were grouped and categorized into major themes. These themes were reviewed by two additional researchers to further strengthen the results through investigator triangulation. Any disagreements relative to what data was to be included in each category and how the categories were described were resolved through discussion and consensus.

Results

The IPE/ICP polarity assessment results generated from the survey are displayed visually within a Polarity Map® (Fig. 2) and show the overall score for how well the polarity is being managed and the mean for each of the positive and negative outcome quadrants. Each quadrant is made up of four items from the IPE/ICP polarity assessment. The mean for each of the individual items is also displayed in a bar graph format (Fig. 5).

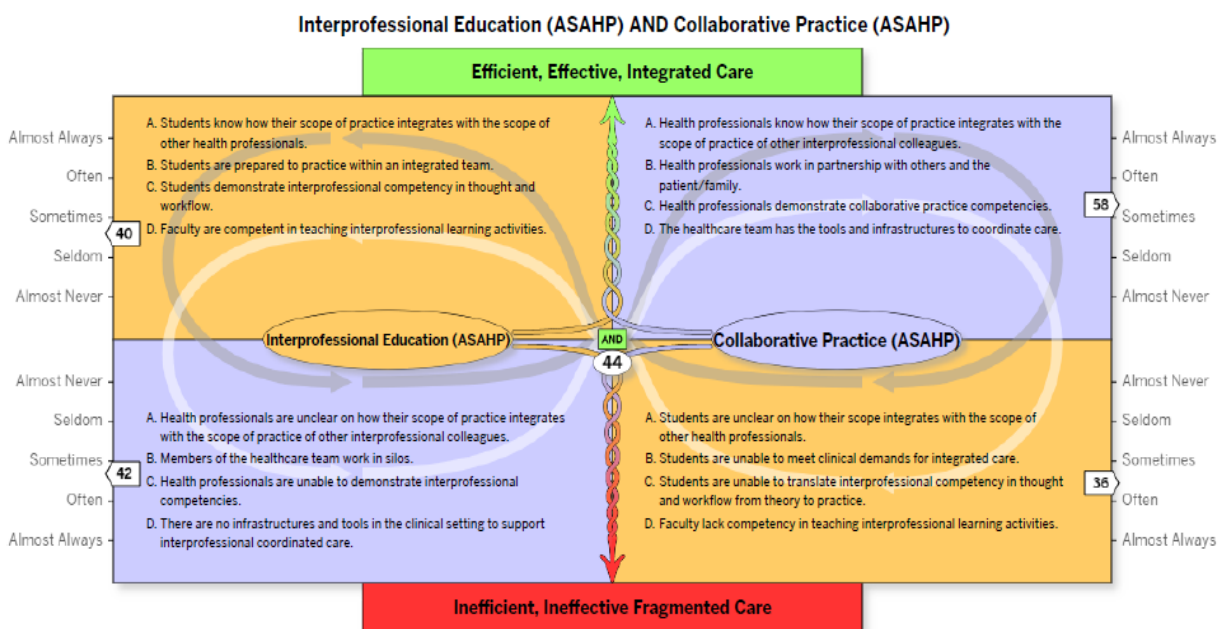


Figure 2: ASAHP Interprofessional Education and Collaborative Practice Polarity Assessment Results

The overall positive quadrant score for the IPE pole (upper left quadrant) is the mean of the four items in the quadrant. The IPE positive outcome quadrant score is 40 out of 100, the mean score for the positive outcomes of IPCP is 58, the downside (negative outcomes) quadrant of the IPCP pole (lower left quadrant) score is 36, and the downside (negative outcomes) of the IPE quadrant (lower right quadrant) is 42. The overall polarity score indicating how well the polarity is being managed is shown in the circle in the middle of the Polarity Map®. The polarity assessment™ scale for how well a polarity is managed is shown in Figure 3. The overall mean score for the IPE/ICP polarity is 44, which shows this polarity is not being well managed and there is a risk of experiencing the greater of inefficient, ineffective, fragmented care.

Polarity Summary

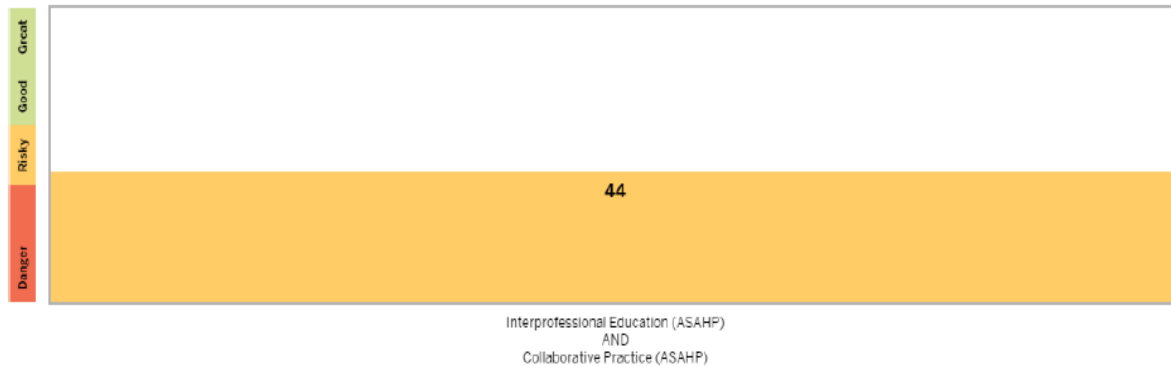


Figure 3: Polarity Assessment Scale 0-39= Danger; 40-59=Risky; 60-79 = Good; 80-100= Great

The infinity loop in the IPE/ICP Polarity Map® (Fig. 2) is a visual representation of the movement of the energy or tension that naturally exists between the two poles and where the tension is between the poles based on the assessment results. The gray infinity loop in Figure 2. represents an example of a well-managed or leveraged polarity with the positive outcomes for each pole being experienced almost always. The white infinity loop represents the results from the IPE/ICP polarity assessment and indicates the energy is sitting between the lower half of the upper quadrant and the upper half of the lower quadrant. This indicates the positive outcomes of focusing on IPE and IPCP are only experienced sometimes and the negative outcomes from lack of focus on both poles are experienced sometimes as well. Based on the responses the energy is sitting a little higher on the IPCP pole indicating the positive outcomes of this pole are experienced more frequently than the positive outcomes of the opposite pole. To increase and maintain the experience of the positive outcomes of both the IPE and IPCP poles simultaneous action and vigilance is required.



The Polarity Map® includes a place to indicate the action steps necessary to achieve or strengthen the positive outcomes of each pole and the warning signs that will occur when, there is not enough emphasis on a pole or there is over emphasis on the opposite pole. The map in Figure 4. captures the action steps and early warning signs for the IPE/ICP poles as identified by ASAHP Summit participants.

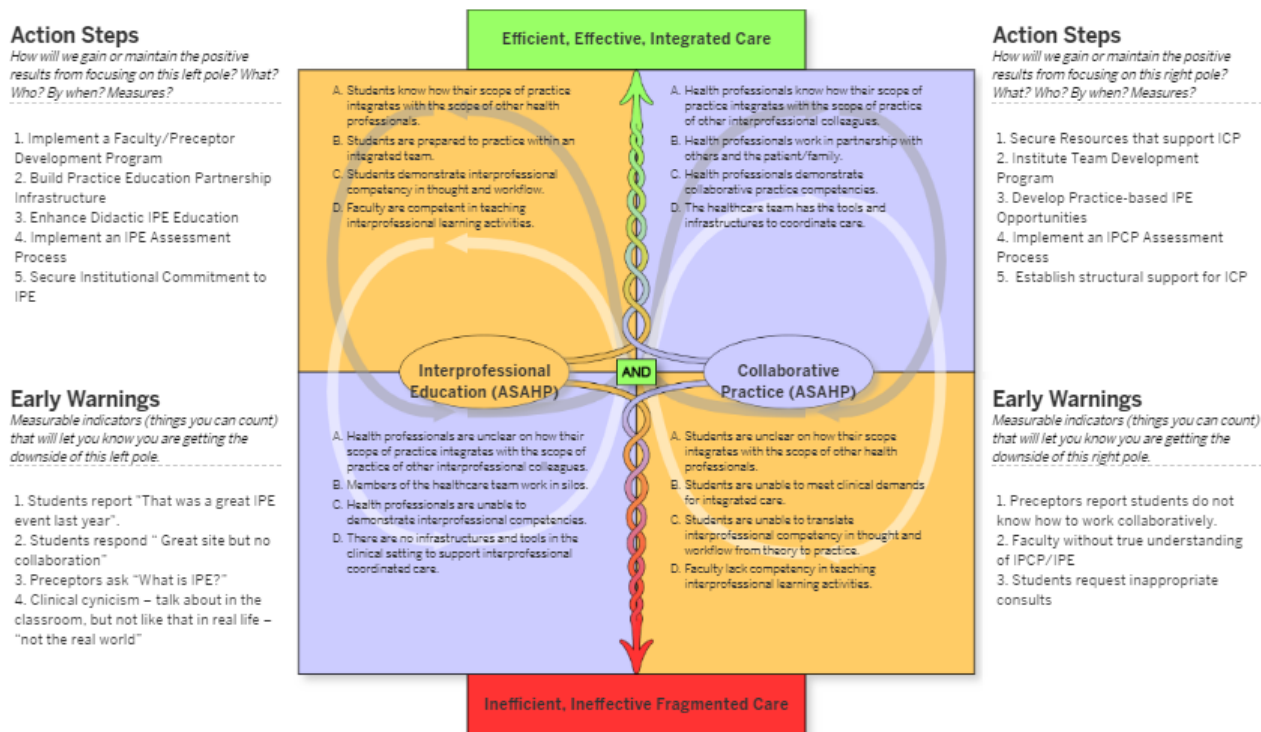


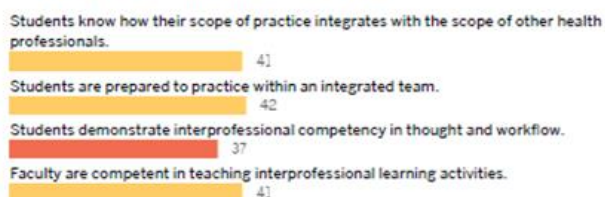
Figure 4: ASAHP IPE/ICP Polarity Assessment results and action steps and early warning signs

Action steps related to IPE include actions related to faculty/preceptor development, strengthening partnerships, enhancing didactic education, implementing assessment processes, and securing institutional support. For ICP, action steps included development of resources, instituting a team development program, developing practice-based IPE opportunities, implementing assessment processes, and establishing structural supports.

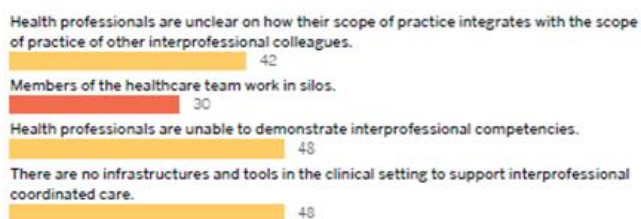
Early warnings for IPE included lack of IPE integration and clinical experience opportunities, evidence of learning needs for preceptors, evidence of resistance. Evidence that practitioners are not collaborating, faculty without a true understanding of IPE, preceptors and students unable to work collaboratively, and evidence of resistance were identified early warning signs related to ICP.

The IPE/ICP polarity assessment results indicate actions steps or strategies necessary to achieve or strengthen IPE outcomes at the various institutions represented by respondents are not being taken or are ineffective because the identified positive outcomes in the upper right quadrant such as “students know how their scope of practice integrates with the scope of other health professionals”, “students are prepared to practice within an integrated team”, “students demonstrate interprofessional competency in thought and workflow”, and “faculty are competent in teaching interprofessional learning activities” collectively have a score of 40 out of 100 possible points. The IPCP pole is a little stronger with a collective mean score of 58 out of 100 indicating the positive outcomes are experienced more frequently across the institutions. This indicates some of the action steps or strategies being taken are somewhat effective in achieving the positive outcomes associated with IPCP.

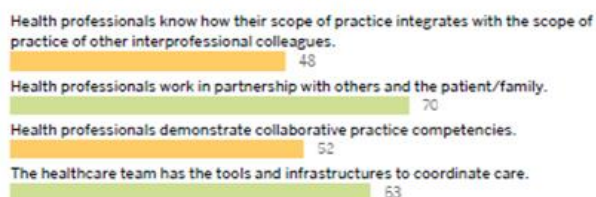
Positive Results Being Experienced As a Result of Focusing on Interprofessional Education (ASAHP)
0-39 = Danger, 40-60 = Risky, 61-100 = Good/Great



Negative Results Being Experienced As a Result of Over Focusing on Interprofessional Education (ASAHP) to the Neglect of Collaborative Practice (ASAHP)
0-39 = Danger, 40-60 = Risky, 61-100 = Good/Great



Positive Results Being Experienced As a Result of Focusing on Collaborative Practice (ASAHP)
0-39 = Danger, 40-60 = Risky, 61-100 = Good/Great



Negative Results Being Experienced As a Result of Over Focusing on Collaborative Practice (ASAHP) to the Neglect of Interprofessional Education (ASAHP)
0-39 = Danger, 40-60 = Risky, 61-100 = Good/Great

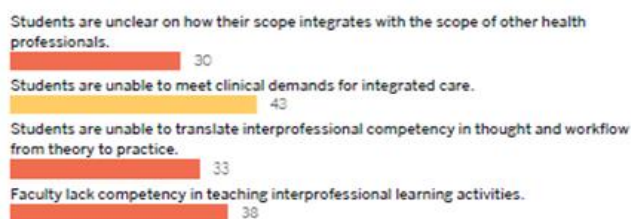


Figure 5: ASAHP IPE/ICP Polarity Assessment individual item level results.

These overall results indicate neither pole is being strongly supported. The individual item mean scores (Figure 5) indicate the strengths and weaknesses in each quadrant. Respondents indicate they experience positive IPCP outcomes more frequently (58) than IPE outcomes (40). The outcomes associated with IPCP experienced most frequently are “health professions work in partnership with others and the patient/family” (70) and “the healthcare team has the tools and infrastructures to coordinate care” (63). When the focus is stronger on IPCP (58) to the neglect of IPE support (40) the negative consequences of the overemphasis on IPCP is experienced in the loss of the positive outcomes of IPE such as “students lack of clarity on how their scope of practice integrates with the scope of other health professionals” (30) and “students unable to translate

interprofessional competencies in thought and workflow from theory to practice” (33) or “lack of faculty competence in teaching interprofessional learning” (38).

Because the IPE is not being strongly and/or consistently supported with the identified action steps, negative consequences are experienced such as “health professionals being unclear on how their scope of practice integrates with the scope of other health professionals” (42), “members of the healthcare team working in silos” (30), “health professionals unable to demonstrate interprofessional competencies” (48) and “lack of infrastructures and tools in the clinical setting to support interprofessional coordinated care” (48).

Discussion

Using the IPE/ICP polarity assessment™ as a diagnostic tool can help academic and practice leaders quantify, visualize and understand the IPE/ICP realities being observed or experienced in education and practice settings today. For 50 years academic and practice leaders have been striving to implement and sustain IPE and IPCP and yet sustainable results at the national level have not been achieved.¹¹⁻¹²

When a challenge is reoccurring or insolvable and the greater purpose cannot be achieved it indicates a polarity exists.¹³ Is the lack of sustainable IPE/ICP outcomes a result of not recognizing IPE and IPCP as interdependent poles in a polarity that requires management, is a question that bears asking?

Pre-summit collective IPE/ICP polarity assessment data suggests the IPE/ICP polarity is not being well managed across the respondent’s institutions and a vicious cycle leading to ineffective, inefficient, fragmented care is occurring. Results also suggest there is a lack of frequent or consistent observation and experience of the positive outcomes associated with both IPE and IPCP indicating the strategies and actions being taken to support both IPE and IPCP are not effective. If IPE/ICP represents a polarity, to reach the greater purpose of effective, efficient and integrated care, the IPE and IPCP positive quadrants require simultaneous support and action.

Examining the strengths and weaknesses at the item level of the IPE/ICP polarity assessment™ gives clarity as to what actions steps need strengthening or prioritization to improve the experience of the positive outcomes of both poles in the polarity and to advance toward the higher purpose⁹. Collectively participants identified action steps to gain or maintain the positive results of focusing on both the IPE and IPCP poles based on their knowledge and experience. Identifying the actions steps can be the first step toward providing an opportunity for academic and practice leaders to examine the effectiveness of these actions through repeat measures of the IPE/ICP polarity.

Early warning signs are identified to increase awareness when the negative consequences of either pole in the polarity are beginning to be experienced. These early warning signs enable organizations to course correct and shift attention.

There were two limitations to this pilot study of the IPE/ICP polarity. The first is there was a small number of survey respondents making it difficult to test the reliability of the instrument. The second is there was minimal response from IPCP practice/industry stakeholders to the survey. Both limitations make it difficult to make any generalizations about the results.

Recently, the National Collaborative for Improving the Clinical Learning Environment (NCICLE) developed the report “Achieving the Optimal Interprofessional Clinical Learning Environment” and Health Professions Accreditors Collaborative (HPAC) published “Guidance on Developing Quality Interprofessional Education for the Health Professions” to help standardize IPE programming across institutions.¹⁴⁻¹⁵

Together, the preconference IPE/ICP polarity assessment™ data along with the action steps and early warning signs generated at the ASAHP Summit demonstrate what can be learned locally and nationally when we look at IPE/ICP through a polarity lens and when stakeholders come together to assess their current realities and engage in dialogue. ASAHP and its industry partners would benefit from replicating the initial study with more balanced participation from a variety of academic and industry/ practice facilities.

Summary

If the polarity of IPE and IPCP is not well understood or managed, the achievement of the greater purpose of effective, efficient, integrated care will not be achieved or sustained.¹³ To achieve and maintain the experience of the positive outcomes of both IPE/ICP leading to the greater purpose, simultaneous action is required. These actions are the dual accountability of both academic and practice leaders.¹³ Implementing an infrastructure that leverages a practice and education partnership can bring stakeholders for both poles together to create action plans and strategies that serve to achieve the desired outcomes of IPE and IPCP and the greater purpose of effective, efficient, integrated care.

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