ALIGNING INTERPROFESSIONAL EDUCATION AND COLLABORATION IN PRACTICE

using promising regional experiences for international exchange

,

PERCEPTIONS AND EXPERIENCES OF THE ICF

a report on the ICF needs focus groups

This is the first of three documents to be produced by INPRO partners to develop ICF-based tools and practices and ICF education.

The aim of study was to collect the perceptions and experiences of lecturers in universities of applied sciences and professionals of rehabilitation centres on the needs, challenges, and opportunities of the ICF to facilitate the use of the ICF as an interprofessional and person-centred tool for education and practice. The data was collected by focus groups in June 2021. A total of 228 statements were identified from 51 participants from 4 countries. The qualitative content analysis was carried out using the New World Kirkpatrick Model. Based on it the distribution of the statements was as follows: Level 1 (Reaction) 8%, Level 2 (Learning) 27%, Level 3 (Behavior) 41% and Level 4 (Results) 24%

Resulting in recommendation to education, professionals and organisations. It is important to focus on Level 3 that looks if they are utilizing what they learned at work (e.g., change in behaviors). It would lead to improving collaboration and quality of care. Level 4 (Result) should be the primary goal of all learning. It determines if the learning had a sustainable, positive impact on the organization.

Authors

J. Paltamaa, Adjunct professor, PhD., pt, Jamk University of Applied Sciences, Finland

J. Ritsilä, Senior Lecturer, Jamk University of Applied Sciences, Finland

M. Neubauer, St. Poelten University of Applied Sciences, Austria

U. Hemetek, PhD., Dietitian, , St. Poelten University of Applied Sciences, Austria

C. De Weerdt, MSc, AP University of Applied Sciences. Belgium

I. Aerts, MSc, AP University of Applied Sciences. Belgium

E. van Lingen, Msc., physiotherapist, Revalidatie Friesland, The Netherlands

S. Jorna-Lakke, PhD., Hanze University of Applied Sciences, Groningen, The Netherlands

The authors wish to acknowledge the INPRO project consortium for participating in the focus group discussions. In alphabetical order:

- AP University of Applied Sciences and Arts Antwerp, Belgium
- Coronaria Rehabilitation and therapy services (Coronaria Contextia Ltd), Finland
- Hanze University of Applied Sciences, Groningen, The Netherlands
- Jamk University of Applied Sciences, Jyväskylä, Finland
- Moorheilbad Harbach Gesundheits- & Rehabilitationszentrum, Austria
- Rehabilitation Centre Revalidatie Friesland, The Netherlands
- St. Poelten University of Applied Sciences, Austria

Project number: 621428-EPP-1-2020-1-NL-EPPKA2-KA

Start date: Jan 1, 2021

End date: Dec 31, 2023

Date: October 31, 2023

Creative Commons: Attribution-ShareAlike 4.0 International (CC BY-SA 4.0)

The European Commission's support for the production of this publication does not constitute an endorsement of the contents, which reflect the views only of the authors, and the Commission cannot be held responsible for any use which may be made of the information contained therein.

Table of Contents

Table of Contents 2
1. Introduction 3
2. The aim of the ICF focus groups 3
3. Methods 4
3.1. Data collection 4
3.2. Data analysis 4
4. Implementation of the focus groups 6
4.1. Participants of the focus groups 6
4.2. Focus group in Austria 8
4.3. Focus group in Belgium 9
4.4. Focus group in Finland 9
4.5. Focus group in the Netherlands 10
5. Results 10
5.1. Description of focus group materials 10
5.2. Analysis based on Kirkpatrick levels 13
5.2.1. The New World Kirkpatrick Model Level 1: Reaction 14
5.2.2. The New World Kirkpatrick Model Level 2: Learning. 15
5.2.3. The New World Kirkpatrick Model Level 3: Behavior 15
5.2.4. The New World Kirkpatrick Model Level 4: Results 15
6. Discussion 16
6.1. Perceptions and experiences 16
6.2. Tips for successful learning processes of the ICF education and clinical practice 19
7. Conclusion 20
References 21
Appendices 23

1. Introduction

The pressure on the European health care system is increasing considerably: more elderly people and patients with chronic diseases in need of care, a diminishing work force and health care costs continuing to rise (World Health Organization, 2020). Several measures to counteract this are proposed, such as reduction of the length of stay in hospitals or rehabilitation centres by improving **interprofessional and person-centred collaboration** between health and social care professionals (Martin et al., 2020).

Competencies in interprofessional cooperation are essential for graduating health and social professions. Although there is a lot of attention for **interprofessional education and collaborative practice (IPECP)**, there is a gap between competence levels of future professionals and the levels needed in rehabilitation practice (World Health Organization, 2010).

The use of a common language in interprofessional collaboration is very important. The World Health Organization (WHO) **International Classification of Functioning, Disability and Health**, known more commonly as ICF (World Health Organization, 2001), has been chosen by the INPRO consortium as the linking model for interprofessional collaboration and structuring the wishes and needs of a client. Implementing collaborative learning on person-centred clinical reasoning with a focus on functioning according to the ICF in higher educational institution (HESI) and clinical practice leads to educational and organizational challenges (Madden & Buddy, 2019, Reed et al., 2005).

The aim was to collect the perceptions and experiences of HEI lecturers and professionals of rehabilitation centres about the use of the ICF. This collection could be used as a basic for further development in each country to facilitate the use of the ICF in IPECP. Each country organised a focus group. The outcomes from each country were sent to Jamk University of Applied Sciences (UAS), where the qualitative content analysis was carried out using the New World Kirkpatrick Model. This document provides an overview of the implementation of the focus groups and results.

2. The aim of the ICF focus groups

The ICF focus groups were organised in the INPRO project to discover the perceptions and experiences of HEI lecturers and professionals of rehabilitation centres about the use of the ICF. The assumption was that all the participants had some knowledge about ICF, whether they had gained the information from formal or informal sources.

Perceptions and experiences included information on the needs, challenges, and opportunities of the ICF to facilitate the use of the ICF as an interprofessional and person-centred tool for education and practice. The intent was that the focus groups could provide input for the development of the ICF in

Moorheilbad HARBACH | fh/// st.pölten | Revalidatie Friesland | jamk University of Applied Sciences | Coronaria | AP University of Applied Sciences and Arts Antwerp | Hanze University of Applied Sciences Groningen | Co-funded by the Erasmus+ Programme of the European Union

the INPRO project. The results of the focus groups were used when developing ICF-based Tools and practices and ICF Education.

3. Methods

3.1. Data collection

The focus groups were organized nationally by ICF Working Group / Steering group members in each partner country in June 2021. It could be held in the national language or in English, but the results were collected in English. It was supposed that all the invited participants of the focus groups have some knowledge of ICF.

To collect the data a focus group was held in each country, led by two supervisors, one from the HEI and one from the work field partner. The model and structure of the discussion was developed at Jamk UAS. It included the follows:

- a recap of the basics of the ICF development in INPRO Work Package 5
- a discussion on the following questions: the factors affecting the ICF implementation and needs to be addressed in the future, both in HEI´s and clinical practice
- a plan for further development in each county to facilitate the use of the ICF as interprofessional education in HEIs and interprofessional collaboration in practice.

Each partner nominated focus group leaders who had a key role of leading this task and compile a national report. The focus group participants filled in the informed consent. Research was conducted in such a way that the dignity and autonomy of human research participants is respected. Based on the ethical review system for research in Finland, no ethical review by an ethics committee is needed (Jamk 422125, April 19, 2023).

All data was gathered in an online meeting with all responsible specialists (from the HEIs and work field) to share results of the focus group and discuss needs for further developments. The protocol and data collection templates were discussed within the partners and are annexed as invitation letter (appendix 1), instructions (appendix 2) and data collection template (appendix 3).

3.2. Data analysis

A qualitative content analysis based on a Grounded theory method (Makri & Neely, 2021) was carried out. The answers recorded in the Word template were broken down into statements (concerning sentences or phrases). They were entered into an Excel spreadsheet in which the columns indicated the country (Austria, Belgium, Finland or the Netherlands) and the partner (HEI, work field or both) that provided the comment. The statements were marked according to whether they were reported as a challenge, an opportunity or a future challenge related to the use of ICF.

Co-funded by the Erasmus+ Programme of the European Union

The New World Kirkpatrick Model (Kirkpatrick & Kirkpatrick,2016) was used to structure the content of the statements by two investigators (J.P. & J.R.). First, the investigators familiarised themselves with New World Kirkpatrick Model, discussed the evaluation principles and agreed on a methodology. They conducted a literature search on the Kirkpatrick model and found many publications. The search results are not reported here, but the studies were used for discussion. Secondly, they performed the content analysis alone by deciding at which level of the New World Kirkpatrick Model each statement was directed. They focused on understanding the meaning of statement by identifying themes and underlying concepts. Thirdly the solutions were discussed, and the level of the New World Kirkpatrick model was agreed upon. In the case that the principal investigators did not agree, it was possible to use a third investigator to solve it. An example of the Excel data sheet is in appendix 4. The whole data is stored in the European Commission Funded Research (OpenAIRE) database (Zenodo) *https://doi.org/10.5281/zenodo.10518466*

The New World Kirkpatrick Model is a training evaluation strategy to be used in formal and informal training, whether it is classroom training, e-learning, or any type of modality in which individuals gain knowledge or skills. The model was created in the 1950s by Dr. Donald Kirkpatrick and has been stated as the most used training evaluation model in the world. The newest version of the model, introduced in 2009, modernizes the four levels of the model. (Kirkpatrick & Kirkpatrick, 2016, 4−5)

Kirkpatrick & Kirkpatrick (2016) emphasizes that too often trainings are evaluated only from the “effectiveness” point of view, which does not focus on the transfer of learning and whether the knowledge is implemented on the job. That is why the transfer of learning to behaviour and subsequent organizational results were added to the New World Kirkpatrick Model as well as the value of training to the organization (Kirkpatrick & Kirkpatrick, 2016, 5−7).

The New World Kirkpatrick Model is divided into four levels and the levels were used as categories for a Grounded theory driven data analysis.

1) The New World Kirkpatrick Model Level 1: Reaction

It figures out the learners´ experiences about the topic, whether it is positive or negative or relevant to their jobs. This immediate reaction determines how invested they will be learning the following levels (Kirkpatrick & Kirkpatrick, 2016, 10−11).

In the ICF focus groups, the focus of discussion was not one specific training or education module alone. Therefore, in the data analyses, the statements that expressed participant’s immediate reaction of ICF, enthusiasm to use ICF, or reasons not to use ICF, were classified into this first level.

2) The New World Kirkpatrick Model Level 2: Learning

On this level the learner´s knowledge about the topic increases and the knowledge, skills, attitudes, and commitment to the learned topic is present. The knowledge of the topic learned could be measured e.g., by an exam. The statements that show Level 2 Learning are such as: “I know it”, “I believe this will be worthwhile to do” or “I can do it”. (Kirkpatrick & Kirkpatrick, 2016, 15−16).

In the focus group data analyses, the statements indicating understanding ICF as a concept, knowing the structure, ICF-language, and ICF-tools, were classified into this second Level.

Moorheilbad HARBACH · fh st. pölten · Revalidatie Friesland · jamk University of Applied Sciences · Coronaria · AP University of Applied Sciences and Arts Antwerp · Hanze University of Applied Sciences Groningen · Co-funded by the Erasmus+ Programme of the European Union

3) The New World Kirkpatrick Model Level 3: Behavior

The level describes the differences in the participant´s behavior at work after learning. For most learners, this Level offers the truest evaluation of learning's usefulness. In this level the learners have started to properly utilize what they have learned (Kirkpatrick & Kirkpatrick, 2016, 13−14).

The first question in the focus groups was: What are the main challenges that make it difficult to implement ICF in your own work? In the focus group data analyses, the statements including the use of ICF or interprofessional collaboration in practical work, such as client situations, documentation, goal setting, and communication, were classified into this Level three.

4) The New World Kirkpatrick Model Level 4: Results

The primary goal of all learning is at this Level. This level does not focus on small individual areas of learning but rather on productive organisational effectiveness and can be related to the delivery of a product or service to the marketplace. It can take months or years to manifest this Level. It is a culmination of countless efforts of people, departments, and environmental factors (Kirkpatrick & Kirkpatrick, 2016, 12).

One of the focus group questions discussed was: How to use ICF in the future? In the ICF focus groups data analyses, statements describing the outcomes or benefits of ICF use the results or benefits of the use of ICF in organisations were classified into this Level four.

4. Implementation of the focus groups

4.1. Participants of the focus groups

Four online focus groups were organized, one in each country (Table 1). In one country the discussion with the HEI – group and the working field persons was organised at a different time because of schedule problems. The total number of participants was 51, of which 33 were lecturers from HEIs and 18 professionals from working field.

Moorheilbad HARBACH | fh/// st.pölten | Revalidatie Friesland | jamk University of Applied Sciences | Coronaria | AP University of Applied Sciences and Arts Antwerp | Hanze University of Applied Sciences Groningen | Co-funded by the Erasmus+ Programme of the European Union

Table 1. Implementation and participants (n=51) of the ICF Focus Groups.

Country		Austria	Belgium	Finland	The Netherlands
Date		June 7, 2021	June 8,2021	June 10, 2021	June 7, 2021
Duration		90 minutes	120 minutes (HEI) & 90 minutes	90 minutes	90 minutes
Moderators		Michaela Neubauer (STP) Ursula Hemetek (STP)	Claudia De Weerdt (AP) Ingrid Aerts (AP) Eline Van Dooren & Malou Roo Garcia (students)	Jaana Ritsilä (Jamk) Nita Savolainen (Coronaria)	Sandra Jorna-Lakke (Hanze) Ellen van Lingen (RF)
Number of participants	HEI	5 (STP)	13 (AP)	6 (Jamk)	9 (Hanze)
	working field	3 (MoHa)	3	4 (Coro)	8 (RF)
	total	**8**	**16**	**10**	**17**

AP = AP UAS; Coro = Coronaria Rehabilitation and therapy services; Hanze = Hanze UAS; Jamk = Jamk UAS; MoHa = Moorheilbad Harbach Gesundheits- & Rehabilitationszentrum; RF = Rehabilitation Centre Revalidatie Friesland; STP = St. Poelten UAS
HEI = Higher Education Institution

Background information from the participants as well as informed consent was gathered by a Webropol questionnaire. Information on participants' previous ICF experience is available for a total of 38 out of 51 participants (Table 2). Half of them have acquired their ICF knowledge through several channels (degree education, life-long learning, training in a workplace and/or studying independently). Four participants had acquired their ICF knowledge only through self-study. Average self-evaluated enthusiasm for the ICF framework was 7,6 (range 2–10) on a scale of 1–10 (1= I am not; 10= I am very).

Moorheilbad HARBACH · fh st.pölten · Revalidatie Friesland · jamk University of Applied Sciences · Coronaria · AP University of Applied Sciences and Arts Antwerp · Hanze University of Applied Sciences Groningen · Co-funded by the Erasmus+ Programme of the European Union

Table 2. Background information on focus group participants ICF experience (38 out of 51).

Duration (years)	Have known of the ICF framework n (%)	Have used the ICF framework in education or Social and Health care n (%)
1–3 years	6 (16)	11 (29)
4–6 years	8 (21)	11 (29)
7–9 years	6 (16)	5 (13)
10 years or over	18 (47)	11 (29)

4.2. Focus group in Austria

The focus group was moderated by the leaders from St. Poelten UAS in Austria. Michaela Neubauer moderated the discussion. Ursula Hemetek took notes and filled in the data collection form. The higher education participants (n=5) were from St. Poelten USA and professionals (n=3) from Moorheilbad Harbach (MoHa).

Online discussion was organized via Teams. Most of the participants also participated in the 5.1. task and completed the ICF Basic course. Because it was a small group the leaders decided that it is more valuable for all of them to share and connect the experiences of practice and education. They did not separate in breakout-sessions and discussed everything in a plenary setting.

The focus group was implemented as follows:

- 15 minutes introduction and experience with ICF of all participants
- 5 minutes to fill in questionnaire
- 10 minutes padlet on main challenges
- 60 minutes discussion on main challenges and questions
- 5 minutes to fill in questionnaire
- 10 minutes padlet on main challenges
- 60 minutes discussion on main challenges and questions

A padlet was created for the participants to fill in their general statements about their "3 main challenges that make it difficult to implement ICF in your own work / organization."

Filling in the questionnaire was difficult for some of them, because for teachers and professionals who do not work with ICF the answer option: "no use of ICF" was not given. Only 1-3 years could be chosen.

A higher number of participants was the target, but two STP participants were absent due to illness and one MOHA participant was 30 minutes late.

Co-funded by the Erasmus+ Programme of the European Union

4.3. Focus group in Belgium

The focus group was moderated by the leaders from AP UAS in Belgium. The introduction was done by Ingrid Aerts and the conversation was led by two students during their internship. The summary and the end of the discussion was led by Claudia De Weerdt. In Belgium they had two separate meetings: one with HEI and with working field due to scheduling difficulties. The higher education participants (n=13) were from the AP UAS and three professionals from clinical practice participated the working field group. At the beginning the links was given to the participants to fill in the informed consent.

All the suggested information from the instruction was given. At the beginning of the focus group, they opened a Jamboard where the participant's three challenges were written. During the conversation the Jamboard was also used to pick out a challenge and talk about that topic.

The discussion with the HEI – group and the work field persons were organized at a different time because of schedule problems.

4.4. Focus group in Finland

The focus group was moderated by the leaders from Jamk UAS and Coronaria in Finland. The introduction was done by Jaana Ritsilä (Jamk UAS). The conversation of the HEI group was moderated by Jaana Ritsilä and the rehab centre group by Nita Savolainen (Coronaria). They took notes and filled in the data collection form. The higher education participants (n=5) were from Jamk UAS and professionals (n=4) from Coronaria.

The focus group was implemented as follows:

- 15 minutes introduction
- 45 minutes small group discussions: one small group (a) for HEI lecturers' and (b) for working field professionals
- 30 minutes summary discussion all together

The focus group was recorded. It was analysed by Nita Savolainen, who was a student at Jamk UAS at the same time. She wrote her thesis on it for master's degree Programme in Health Promotion "ICF-model as a facilitator of interprofessional collaborative practice" (Finnish language). A Finnish article based on the results has been written "The benefits and challenges of ICF in promoting interprofessional cooperation". It has been published in the Finnish journal named Kuntoutus (The Finnish Journal of Rehabilitation) 2023; 46(2): 46-52.

Moorheilbad HARBACH
fh st.pölten
Revalidatie Friesland
jamk University of Applied Sciences
Coronaria
AP University of Applied Sciences and Arts Antwerp
Hanze University of Applied Sciences Groningen
Co-funded by the Erasmus+ Programme of the European Union

4.5. Focus group in the Netherlands

The focus group was moderated by the leaders; Sandra Jorna-Lakke from Hanze University of Applied Sciences in the Netherlands (Hanze) and Ellen van Lingen from Revalidatie Friesland (RF). The higher education participants (n=9) were lecturers from different schools of Hanze (School of health care studies, School of nursing and School of social studies comprising Social Work and Psychology). Eight professionals form RF were physiotherapy (n=1), dietetics (n=3), nursing (n=2), psychology (n=1), social work (n=1).

To allow Hanze and RF participants to exchange views with each other, one hybrid session was organised online, with Hanze teachers participating in the session discussing in Teams as a group and at the same time there was a simultaneous online connection with a group of professionals meeting at the RF. There was a PowerPoint presentation on INPRO at the start.

The focus group was

- 15 minutes introduction
- 60 minutes group discussions: one group (a) for HEI lecturers per TEAMS and (b) life for professionals at RF
- 30 minutes summary discussion all together

5. Results

5.1. Description of focus group materials

A total of 228 statements were identified, with a 16−38 % distribution across countries (Figure 1). The average distributions by type of organisation was as follows: HEIs 37%, work field 32% and both 31% (Figure 2). There we differences between counties. It was similar in Belgium (respectively 34%, 15%, 51%) and the Netherlands (respectively 28%, 28%, 44%). in Austria, most of the comments were from work life (respectively 34%, 45%, 21%). In contrary to Finland where the results highlight a division between either HEI (50%) or work life (44%), with only 6% common to both. This difference between countries may be due to different ways of drawing focus groups and reporting the results. Due to the small numbers, they are indicative, and no further analysis is not made on the basis of who expressed the statement.

Moorheilbad HARBACH
fh/// st.pölten
Revalidatie Friesland
jamk University of Applied Sciences
Coronaria
AP UNIVERSITY OF APPLIED SCIENCES AND ARTS ANTWERP
Hanze University of Applied Sciences Groningen
Co-funded by the Erasmus+ Programme of the European Union

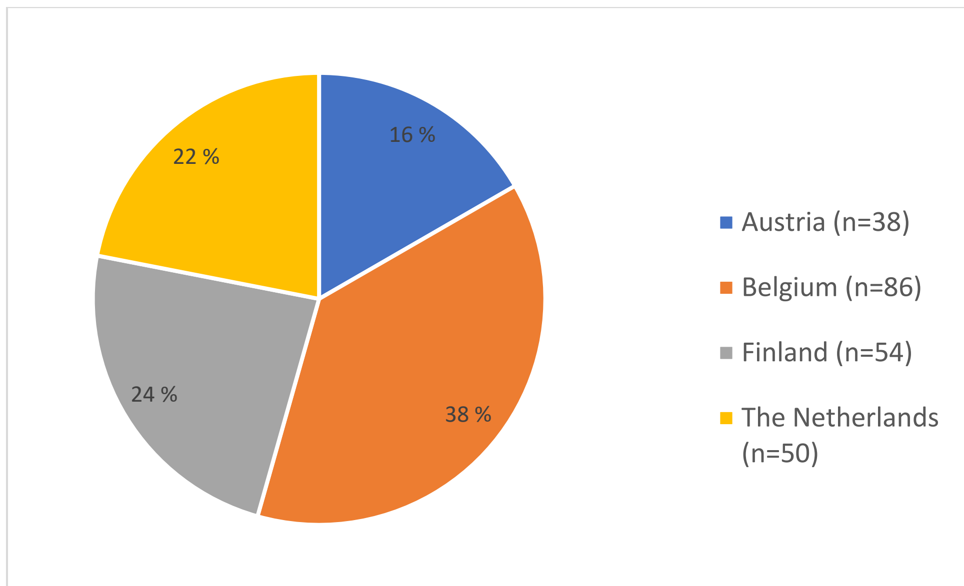

Figure 1. Distribution of the identified statements (n=228) per country.

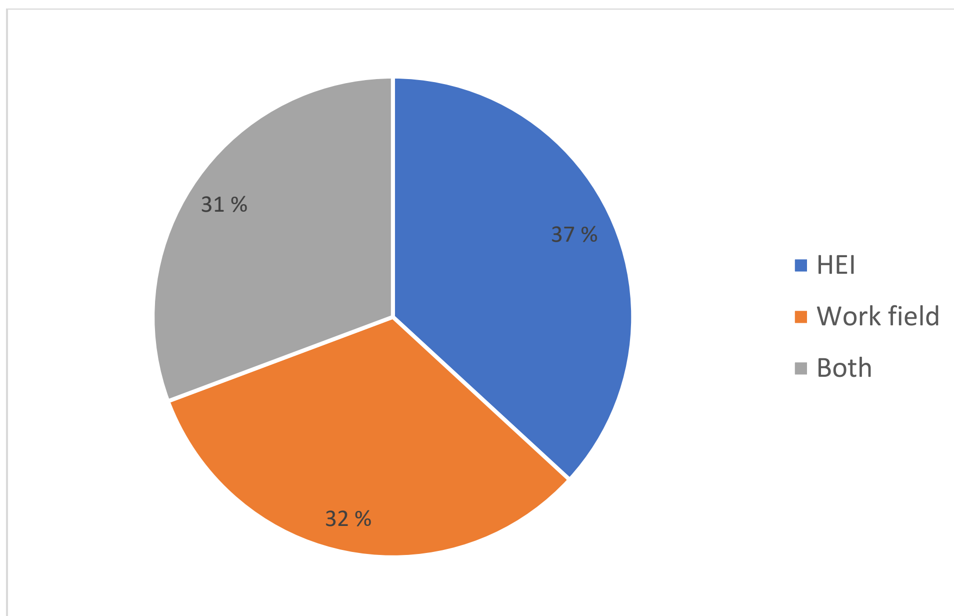

Figure 2. Distribution of the identified statements (n=228) per field (HEI, work field or both) who made the comment.

Over half of the statement were considered a challenge that make difficult to implement the ICF (Figure 3). In addition, some possibilities were also seen for using the ICF in interprofessional collaboration and some future perspective. There were differences between countries (Figure 4). Belgium and Finland had the highest proportion of comments focusing on future, respectively 18%

Co-funded by the Erasmus+ Programme of the European Union

and 11%. While almost two thirds of the statements concerned challenges in the Netherlands and Austria, respectively 69% and 68%.

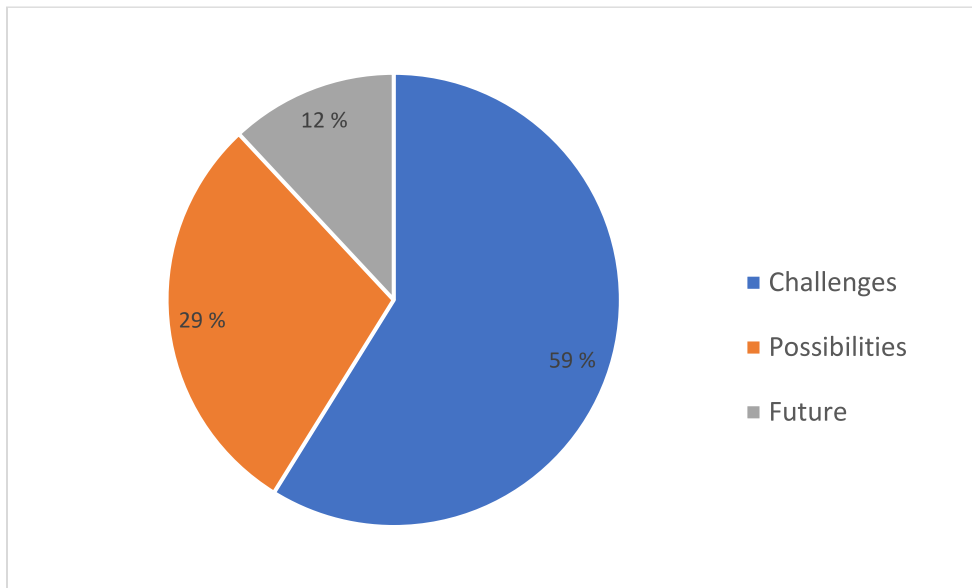

Figure 3. Statements depending on whether ICF was seen as a challenge, a possibility or had potential for future use.

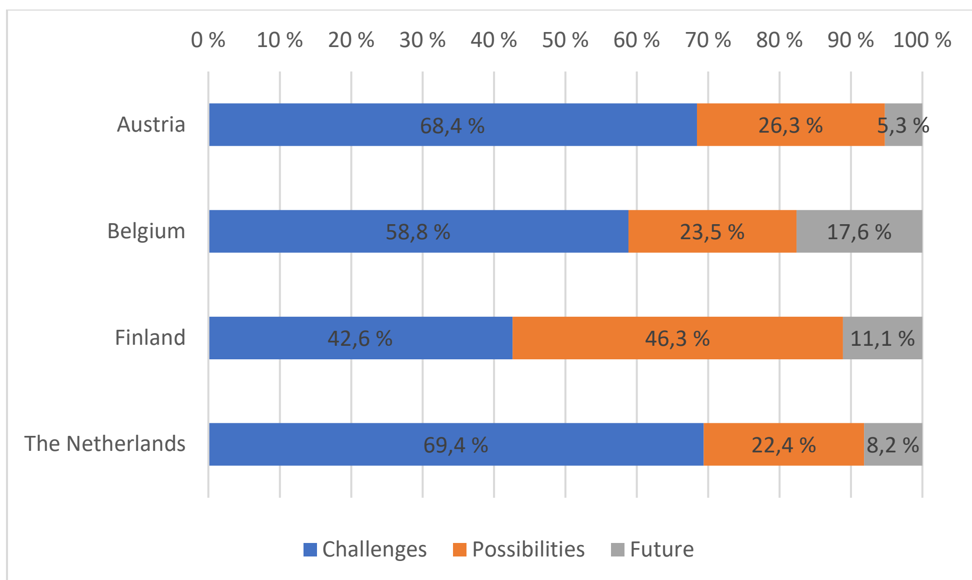

Figure 4. A challenge, a possibility or a future statements by country.

HARBACH
fh st.pölten
Revalidatie Friesland
jamk University of Applied Sciences
Coronaria
AP University of Applied Sciences and Arts Antwerp
Hanze University of Applied Sciences Groningen
Co-funded by the Erasmus+ Programme of the European Union

5.2. Analysis based on Kirkpatrick levels

The main content analysis were made by the New World Kirkpatrick Model Levels. Most of the statements (41%) were at Level 3 (Behavior) and only 8% was at Level 1 (Reaction) (Figure 5). The results can be viewed from two directions, both based on the New World Kirkpatrick Model Levels and by country (Figure 6 and 7). Most of the reactions came from Austria, although their total number of statements was lower than in other countries. In Austria, 18% of statements were Reactions (Level 1), while in other countries the Level 1 distribution ranged between 5–9%. For Level 4 (Results), the Netherlands had the lowest number of statements (4%), while the other countries ranged from 22–45%, with the highest proportion in Austria.

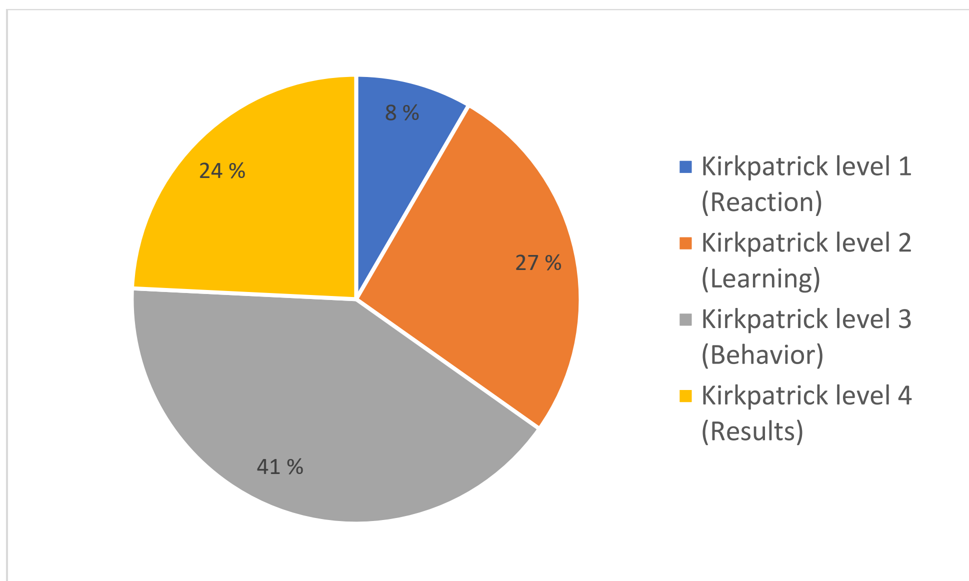

Figure 5. Distribution of the identified statements (n=228) per the New World Kirkpatrick Model Levels.

Co-funded by the Erasmus+ Programme of the European Union

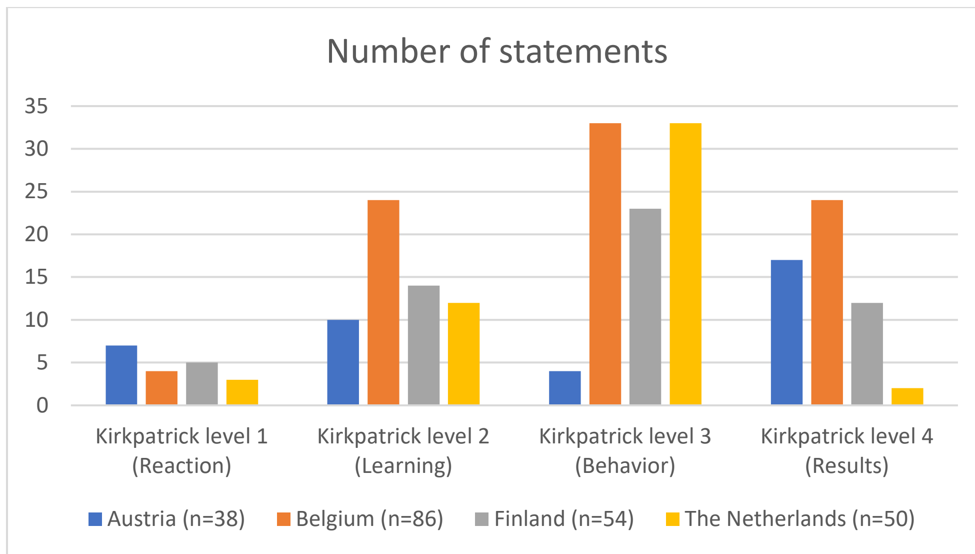

Figure 6. Number of statements in each of the New World Kirkpatrick Model Level by country.

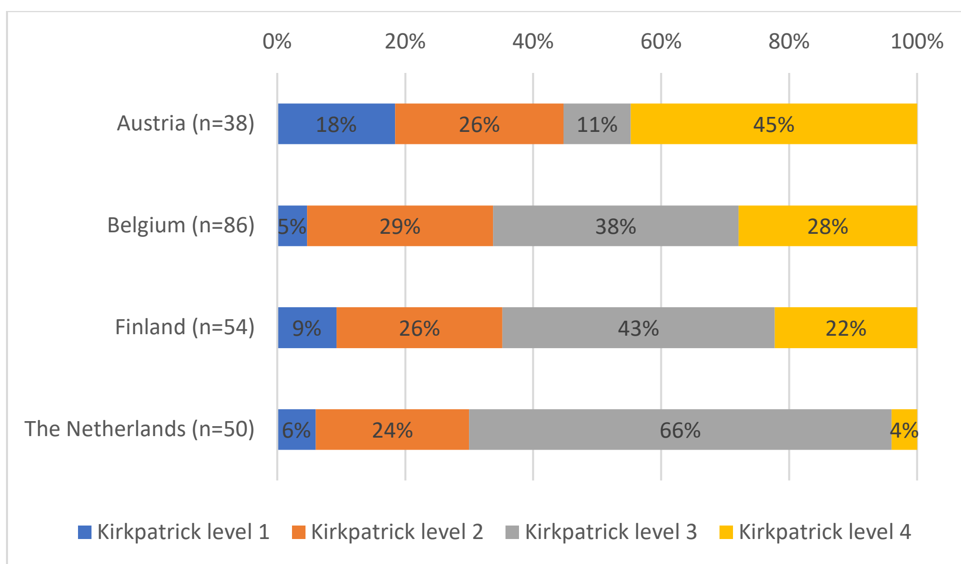

Figure 7. Distribution of the New World Kirkpatrick Model Levels by country.

5.2.1. The New World Kirkpatrick Model Level 1: Reaction

Overall, 8% of the statements (Figure 5) expressed the immediate reaction of ICF on interprofessional collaboration, enthusiasm to use ICF or reasons not to use ICF. Examples of the statements of the focus groups as challenges to use ICF are:

HARBACH
fh st.pölten
Revalidatie Friesland
jamk University of Applied Sciences
Coronaria
AP University of Applied Sciences and Arts Antwerp
Hanze University of Applied Sciences Groningen
Co-funded by the Erasmus+ Programme of the European Union

"Fear of greater workload."

"The ICF is often perceived only as a selection of codes (code jungle)."

"The handbook has been found too expensive for students to purchase."

"From this perspective ICF become not a patient centred approach but a classification system approach. "

It seemed, that reactions mentioned in Kirkpatrick and Kirkpatrick (2016, 11, figure 2-1), i.e., engagement, relevance and customer satisfactions, did not occur in the focus group discussions.

5.2.2. The New World Kirkpatrick Model Level 2: Learning.

Overall, 27% of the statements (Figure 5) indicated understanding ICF as a concept, knowing the structure, language, and tools of ICF or international collaboration. In the focus groups, the participants mentioned challenges as:

"While learning ICF (in school) there is a lot of confusion around coding."

"And some don't know what ICF is."

"To get a grip of the ICF might cost a lot of time."

5.2.3. The New World Kirkpatrick Model Level 3: Behavior

Overall, 41% of the statements described the differences in the participant´s behavior after ICF learning (Figure 5). In this Level the learners have started to properly utilize what they have learned. The statements including the use of ICF on interprofessional collaboration in practical work, such as client situations, documentation, goal setting and communication were classified into this category.

Examples of the statements are:

"ICF information should be brought into a practical level."

"It takes a while before everyone wants to start working with it."

"The time you have should be spent more on the patient than on filling in the ICF chart. This would take away the focus of the treatment."

5.2.4. The New World Kirkpatrick Model Level 4: Results

Overall, 24 % of the statements were classified as a Result (Figure 5). One of the focus group questions discussed was "How to use ICF in the future?". Results can be seen as a leading indicators and desired outcomes based on Kirkpatrick and Kirkpatrick (2016, 11, figure 2-1). In the ICF focus

Moorheilbad HARBACH | fh/// st.pölten | Revalidatie Friesland | jamk University of Applied Sciences | Coronaria | AP University of Applied Sciences and Arts Antwerp | Hanze University of Applied Sciences Groningen | Co-funded by the Erasmus+ Programme of the European Union

groups data analyses the following statements described the results or benefits of the use of ICF or interprofessional collaboration and were classified into this category.

Here are some examples of the statements:

> *"We need a decision that this will be the framework"*
>
> *"We need a continuum, what ICF issues are good to study in the early stages of studies, what in the middle phase and in the advanced stage."*
>
> *"The implementation of ICF is an initiative of the medical management in order to have a solid and understandable structured system."*

6. Discussion

6.1. Perceptions and experiences

The ICF focus groups were organised in the INPRO project to discover the perceptions and experiences of HEI lecturers and professionals about the ICF. The assumption was that all the focus groups participants had some knowledge about ICF, whether they had gained the information from formal or informal sources. Kirkpatrick & Kirkpatrick (2016, 5) mentions three reasons for evaluating training programs: to improve the program, to maximize transfer of learning and to demonstrate the value of training. All these three viewpoints were reasons for organizing ICF focus groups. Firstly, the focus groups were supposed to give understanding how ICF is perceived and experienced in the participants´ organizations. Secondly, they were planned to give information on how ICF skills are used in practice. And thirdly, they supposed to give answers on how to improve ICF education in HEI or clinical practice.

The Grounded theory driven data analysis was chosen to categorize the challenges and needs of learning and using ICF in interprofessional practice. The New World Kirkpatrick Model (Kirkpatrick & Kirkpatrick, 2016) was used to categorise the statements. Even though the participants of the focus groups were not trained in one specific training program of ICF, but rather gained their ICF knowledge through different kinds of formal and informal learning situations, the New World Kirkpatrick Model was used because the focus of learning was the same: the use of ICF in interprofessional practice.

There were relatively few reactions, but they were mainly negative or questioning. The reactions given were used to explain reasons for avoiding using the ICF. It seemed that these negative reactions raise from insufficient knowledge of the ICF framework or uncertainty of what opportunities ICF can offer. The engagement and relevance of the ICF was not aware.

Based on the New World Kirkpatrick Model, the primary goal of all learning is at the Level 4, (Results). It does not focus on small individual areas of learning but rather on productive organizational effectiveness and can be related to the delivery of a product or service to the marketplace. It can take months or years to manifest this level. It is a culmination of countless efforts

Moorheilbad HARBACH | fh/// st.pölten | Revalidatie Friesland | jamk University of Applied Sciences | Coronaria | AP University of Applied Sciences and Arts Antwerp | Hanze University of Applied Sciences Groningen | Co-funded by the Erasmus+ Programme of the European Union

of people, departments, and environmental factors. (Kirkpatrick & Kirkpatrick, 2016, 12.) In our data, one fourth of statements was in this Level. We believe that ICF education should also aim for sustainable results at the organisational level.

Based on our literature search, during the last 15 years several studies focusing on interprofessional learning / education in social and healthcare have used the Kirkpatrick model as a framework or as an analysing structure of the search terms "*Kirkpatrick & health & education*". These studies show that typical educational outcomes are often on Level 1 (Reaction) or Level 2 (Learning) whereas positive outcomes related to the Level 3 (Behavior) or Level 4 (Result) seem to be less.

Examples of this trend can be recognized e.g., in a scoping review of interprofessional education to chronic illness for health professional (McCabe et al., 2021), the review of using information and communications technologies in the delivery of interprofessional education (Curran et al., 2015) and a focused review about the components of interprofessional education programs in neonatal medicine (Parmekar et al., 2022). The same issue can be recognized in the online MOOC course "Take the Lead of Healthcare Quality Improvement", which leaves the Level 4 out from the study model and evaluation procedure (Reese et al., 2021).

However, in our study we found a slightly different result from the literature. We found that 65% of the statements was in the Levels 3 and 4. However, there were differences between the countries. In relation to the total number of the statements, Austria had the highest number of reactions (18%), but also the lowest number of Level 3 (Behavior) and 4 (Result) statements (56%). In other countries, the number of Level 1 (Reactions) ranged from 5−9% and the number of Level 3 and 4 statements ranged from 66−70% (see Figure 7). In this context, we cannot analyse the cause of these differences. They may also be due to the way the focus groups are conducted, such as the number of participants or the accuracy of the records. However, we recommend that it would be good to focus on Levels 3 and 4 in the future development of ICF education and clinical practice.

Previous studies support this recommendation. Focusing on the Levels 3 and 4 will be needed more in the future in the field of interprofessional education (Thristlethwaite et al., 2016). Focusing Level 3would lead to improving collaboration and quality of care (Topperzier et al., 2019). However, the Levels 3 and 4 cannot be reached only by developing educational modules and clarifying educational outcomes. Support for behavior change in the organisation and willingness of social and healthcare professionals to apply learned skills and knowledge are vital and can take place on working placements only (Topperzier et al., 2019). In order to measure the Level 4 outcomes, longitudinal studies might be needed for finding out learning persistence and clinical level behavioral chance (Reese et al., 2021).

Mann et al. (2009) conducted a mixed method study of 411 healthcare professionals working with cancer patients and taking part in an interprofessional intervention with 10 offered educational modules. In the post educational questionnaire, the participants were asked to consider what kind of changes they intended to take place after education. The results of the evaluation were analysed using the Kirkpatrick levels of educational outcomes. Participants were satisfied with the education and agreed that the modules led to the acquisition and enhancement of knowledge and skills, producing excellent results of Level 1 and 2 outcomes in clinical practice. Reported changes in Level 3, Behavior, were more common for interprofessional collaboration, but rarer for clinical practice. Overall, the participants reported more changes at an individual level than on an institutional level.

Moorheilbad HARBACH | fh/// st.pölten | Revalidatie Friesland | jamk University of Applied Sciences | Coronaria | AP University of Applied Sciences and Arts Antwerp | Hanze University of Applied Sciences Groningen | Co-funded by the Erasmus+ Programme of the European Union

Changes reported in the follow-up evaluation were remarkably higher than the intended or considered changes described immediately after the education. (Mann et al. 2009.) This leads us to a conclusion that the evaluation must be carried out in the long term.

The factors influencing change after education, both in clinical practice and in interprofessional collaboration, are versatile and should be considered when developing education and clinical use of the ICF (Mann et al. 2009; Thristlethwaite et al., 2016; Topperzier et al., 2019). The results of the Mann et al. (2009) study pointed out that time and workload seem to be the most common barriers to change in both clinical practice and in interprofessional interactions. Another barrier is resistance from other team members, especially those who did not attend the education at all. Similar statements were also expressed in this study. It is important to commit to change, which could be supported, for example, through change-strategies, follow-up questionnaires and reminders. If the professionals are unclear about how to apply new learning immediately after an education, they may just need time in practice to enable assimilation. Feeling supported and encouraged by other team members and especially by managers, is a strong positive factor. (Mann et al. 2009.)

Ther are some limitations on the analysis. Statements may be comments by individuals - no synthesis of the focus group as expected. In addition, statements were partly disconnected. It was difficult to know if statements were meant as a proposal or a decision. One challenge of the analysis was that the focus group discussions were conducted in different ways in different countries and that the reporting did not follow the instructions given. Thus, it is good to keep the results as indicative and each country should analyse the results based on its own experience.

This study is a good example for ICF users, such as universities and work field, of how the perceptions and experiences of ICF users can be taken into account when promoting the use of ICF. This approach can also be applied more widely to countries other than those in the project, as the ICF is a universal common approach and language.

The practical benefits of the study can be seen in two different ways. Firstly, In the INPRO project, the results of national focus groups were utilised when developing and implementing the ICF-based materials. Secondly, this summary of the results of the focus groups carried out in different countries shows the importance to keep the focus on the Levels 3 (Behavior) and 4 (Result) when developing the use of the ICF. In addition, by using the New World Kirkpatric Model, enthusiasm to use ICF or reasons not to use ICF can be identified (Level 1). The statements indicating understanding ICF as a concept and knowing the structure (Level 2) expressed the level of ICF knowledge. One way to overcome the lack of knowledge is to develop ICF education in HEIs and training in clinical work, as was done during the INPRO project. The ICF-based tools and practices and ICF education material developed in INPRO can be found from INPRO webpage (https://www.inproproject.eu/intranet/). It is important to understand the ICF framework and keep focus on interprofessional and the person-centred use of the ICF.

Moorheilbad HARBACH | fh/// st.pölten | Revalidatie Friesland | jamk University of Applied Sciences | Coronaria | AP University of Applied Sciences and Arts Antwerp | Hanze University of Applied Sciences Groningen | Co-funded by the Erasmus+ Programme of the European Union

6.2. Tips for successful learning processes of the ICF education and clinical practice

ICF education has been developed in many studies, from which tips can be taken to promote the use of the ICF. That includes Learning (Level 2), how to properly utilize what they have learned (Behavior, Level 3) or use of ICF in interprofessional collaboration in organization as a Result (Level 4). The guide of Scholten et al. (2021) offers twelve integrated practical tips to help health and social care educators embed the ICF throughout the curriculum with a view to supporting student learning and ultimately interprofessional and inclusive practice. Moran et al. (2020,7) presented learning activities based on the MAGPIE (Meet, Assess, Goal-Set, Plan, Implement and Evaluate) model including relevant examples of learning activities for tutorial or practice locations. Nguyen et al (2016) developed a new graduate-level course using the ICF to assist health professionals and graduate trainees in rehabilitation. The innovation behind this course is its focus on application of the ICF in research and practice through a combination of peer support and instructor mentorship. The format of the online resource allows for updating of information, and feedback on the utilisation of the software has been used to enhance the student experience. The key issues for the development of online resource were accessibility for students and staff, alignment with the adopted educational approach, consultation with all disciplines, and ease of modification of information and format once published (Jones 2011).

A strong foundation in the principles exemplified by the ICF may encourage involvement interprofessional collaboration and healthcare (Allan et al, 2006). Implementation of ICF-based practices also contributed to a more positive organizational culture (Wong et al, 2023). It is noted that clinical reasoning only appears to occur once the student has applied the framework to assessment in a real situation (Jelsma & Scott 2011). A well-structured training programme can bring about a change in behaviour, which is reflected in a more comprehensive record of patient care (Sagahutu et al. 2020). An ICF informed practice model is proposed to overcome the potential barriers of use such as lack of philosophical grounding, developmental and operational directives, and evaluation methods (Dufour & Lucy, 2010).

Tips for successful learning processes toward to the New World Kirkpatrick Model Level 4 and sustainable future of the ICF education and implementation. Curran et al (2015) presented a modified typology of outcomes with concrete definitions of the levels, that have been originally described by Barr et al. 2005 in a book of Effective interprofessional education, 2005:

1. Reaction = satisfaction to the education
2. Learning = modification of attitudes / acquisition of new skills and knowledge
3. Behavior = behavioral change in practice
4. Results = change in organizational practice and benefits to patients

The Kirkpatrick´s Four Levels of Training Evaluation –publication (2016) includes a few case studies describing successful training protocols used in organizations for successfully reaching Level 4 outcomes.

One of the most important factors for an education success is management´s active commitment to the usefulness of the training. A policy statement set by the management of the organization may

HARBACH fh/// st.pölten Revalidatie Friesland jamk University of Applied Sciences Coronaria AP University of Applied Sciences and Arts Antwerp Hanze University of Applied Sciences Groningen
Co-funded by the Erasmus+ Programme of the European Union

play an important role in engaging employees to an education. If this policy statement indicates level 4 objectives, including an improved profile or status of the organization gained through education and improved client satisfaction, it will motivate the employees (Kirkpatrick & Kirkpatrick, 2016, 168, 188, 203).

The use of carefully planned engagement tools and evaluation methods seem to have an important role in engaging participants to training. Participant´s booking form including individual learning goals and engagement as well as manager´s reasons for supporting the employee with learning is one of the tools used prior to the learning program. Concrete learning goals set both on individual level and on organizational level can have a significant role motivating for training (Kirkpatrick & Kirkpatrick, 2016, 159−161).

The success of an education program can be related to consistent support and targeted evaluation. The guiding self-evaluation questions during a training could include questions like: “As a result of what I´ve learned today, what do I need to start doing?” One of the key elements measuring positive behavioural change can be the questions asked by the manager after several months of the education could be: “What is different now in the way you are working / communicating compared to before the education program?” (Kirkpatrick & Kirkpatrick, 2016,207−210).

The cases highlight recommendations to succeed in education programs. The importance of pre-meetings between the manager and employees is one of the recommendations. If this is lacking, the participants do not understand the value of the training for the organization and the stakeholders. Another recommendation is that the managers should be prepared to organize coaching sessions and on-the-job support after the training. These could be carried out as informal chats, formal team interviews and monitoring sessions to encourage the employees to use both the new skills and knowledge in their daily work (Kirkpatrick & Kirkpatrick, 2016, 216).

7. Conclusion

There was a general trend in the Focus groups' discussions, but there were significant differences between countries. In order to develop the use of the ICF, perceptions and practices should be examined and developed at national level.

Reactions were relatively few and mainly negative. Participants were not engaged in using the ICF because the unawareness of the relevance of the ICF. A change of attitude and the client-centred and interprofessional use of ICF from management to the individual professional is important both in HEIs and clinical practice.

However, outcomes related to the Level 3 (Behavior), or Level 4 (Result) is important. Therefore, it is positive that more than 65% of the statements in the focus groups fell into Levels 3 and 4, which is higher than in previous literature. On-the-job learning is needed to transfer interprofessional skills and learning into practice. Focusing more on Level 3 (Behavior) would lead to improving collaboration and quality of care. Level 4 (Result) should be the primary goal of all learning on the New World Kirkpatrick Model. It must be supported so that the focus is not on small individual areas of learning but rather on productive and sustainable results at the organisational level.

Co-funded by the Erasmus+ Programme of the European Union

References

Allan, C. M., Campbell, W. N., Guptill, C. A., Stephenson, F. F., & Campbell, K. E. (2006). A conceptual model for interprofessional education: the international classification of functioning, disability and health (ICF). Journal of interprofessional care, 20(3), 235–245. https://doi.org/10.1080/13561820600718139

Curran, V., Reid, A., Reis, P., Doucet, S., Price, S., Alcock, L. & Fitzgerald, S. (2015). The use of information and communication technologies in the delivery of interprofessional education: A review of evaluation outcome levels. Journal of interprofessional care. Vol. 29(6), 541-550. https://doi.org/10.3109/13561820.2015.1021002

Dufour, S. P., & Lucy, S. D. (2010). Situating primary health care within the international classification of functioning, disability and health: enabling the Canadian Family Health Team Initiative. Journal of interprofessional care, 24(6), 666–677. https://doi.org/10.3109/13561820903550671

Health Professions Accreditors Collaborative. (2019). Guidance on developing quality interprofessional education for the health professions. Chicago, IL: Health Professions Accreditors Collaborative. Available at: https://healthprofessionsaccreditors.org/wp-content/uploads/2019/02/HPACGuidance02-01-19.pdf (accepted October 31, 2023).

Jelsma, J., & Scott, D. (2011). Impact of using the ICF framework as an assessment tool for students in paediatric physiotherapy: a preliminary study. Physiotherapy, 97(1), 47–54. https://doi.org/10.1016/j.physio.2010.09.004

Jones L. E. (2011). Introducing the ICF: the development of an online resource to support learning, teaching and curriculum design. Physiotherapy, 97(1), 55–58. https://doi.org/10.1016/j.physio.2010.10.001

Kirkpatrick, J.D. & Kirkpatrick W.K. (2016). Kirkpatrick´s Four Levels of Training Evaluation. (4-16, 159-216). Alexandria, Virginia. Association for Talent Development.

Madden, R. & Buddy, A. (2019). The ICF has made a difference to functioning and disability measurement and statistics. Disability and Rehabilitation, 41(12):1450-1462. https://doi.org/10.1080/09638288.2018.1431812

Makri, C., & Neely, A. (2021). Grounded Theory: A Guide for Exploratory Studies in Management Research. International Journal of Qualitative Methods, 20. https://doi.org/10.1177/16094069211013654

Mann, K., Sargeant, J. & Hill, T. (2009). Knowledge translation in interprofessional education: what difference does interprofessional education make to practice? Learning in Health and Social Care. 8(3), 154-164.

Martin, J.S., Ummenhofer, W., Manser, T. & Spirig, R. (2020). Interprofessional collaboration among nurses and physicians: making a difference in patient outcome. Swiss Med Wkly. 2010;140:w13062. https://doi.org/10.4414/smw.2010.13062

Co-funded by the Erasmus+ Programme of the European Union

McCabe, C., Patel, K.D., Fletcher, S., Winters, N., Sheaf, G., Valery, J. & McCann, M. (2021). Online Interprofessional education related to chronic illness for health professionals: a scoping review. Journal of interprofessional care. Vol. 35(3), 444-453.

Moran, M., Bickford, J., Barradell, S., & Scholten, I. (2020). Embedding the International Classification of Functioning, Disability and Health in Health Professions Curricula to Enable Interprofessional Education and Collaborative Practice. Journal of Medical Education and Curricular Development, 7. https://doi.org/10.1177/2382120520933855

Nguyen, T., Fayed, N., Gorter, J. W., & MacDermid, J. (2016). Enhancing interprofessional education and practice: Development and implementation of a new graduate-level course using the international classification of functioning, disability, and health. Journal of interprofessional care, 30(3), 385–387. https://doi.org/10.3109/13561820.2016.1139557

Parmekar, S., Shah, R., Gokulakrishnan, G., Gowda, S., Castillo, D., Iniguez, S., Gallegos, J., Sisson, A., Thammasitboon, S. & Pammi, M. (2022). Components of interprofessional education programs in neonatal medicine: A focused BEME review: BEME Guide No. 73. Medical teacher. Vol. 44(8), 823-835. https://doi.org/10.1080/0142159X.2022.2053086

Reed, G. M., Lux, J. B., Bufka, L. F., Trask, C., Peterson, D. B., Stark, S., Threats, T. T., Jacobson, J. W., & Hawley, J. A. (2005). Operationalizing the International Classification of Functioning, Disability and Health in Clinical Settings. Rehabilitation Psychology, 50(2), 122–131. https://doi.org/10.1037/0090-5550.50.2.122

Reese, D., Dolansky, M., Moode, S., Bolden, H. & Singh, M.K. (2021). Quality improvement education innovation: evaluation of Coursera MOOC “Take the Lead on Healthcare Quality Improvement”. Journal of research on nursing. Vol. 26(1-2), 62-78.

Sagahutu, J. B., Kagwiza, J., Cilliers, F., & Jelsma, J. (2020). The impact of a training programme incorporating the conceptual framework of the International Classification of Functioning (ICF) on behaviour regarding interprofessional practice in Rwandan health professionals: A cluster randomized control trial. PloS one, 15(2), e0226247. https://doi.org/10.1371/journal.pone.0226247

Scholten, I., Barradell, S., Bickford, J., & Moran, M. (2021). Twelve tips for teaching the International Classification of Functioning, Disability and Health with a view to enhancing a biopsychosocial approach to care. Medical teacher, 43(3), 293–299. https://doi.org/10.1080/0142159X.2020.1789082

Thistlethwaite, J., Kumar, K., Moran, M., Saunders, R. & Carr, S. (2015). An exploratory review of pre-qualification interprofessional education evaluations. Journal of interprofessional care. Vol. 29 (4), p.292-297.

Topperzer, M.K., Hoffman, M., Roug, L.I., Larsen, H.B, Lausen, B., Schmiegelow, K. & Sörensen, J.L. (2019). Unmet need for interprofessional education in paediatric cancer: a scoping review. Supportive Care in Cancer. Vol 27(10), 3627-3637.

Wong, P. K. S., Kwan, C. L., & Wong, Y. C. (2023). Impact of Implementing New ICF-Based Practices on Staff Valence of Disability Practitioners: An Experience in Hong Kong. International journal of environmental research and public health, 20(2), 1632. https://doi.org/10.3390/ijerph20021632

Moorheilbad HARBACH · fh/// st.pölten · Revalidatie Friesland · jamk | University of Applied Sciences · Coronaria · AP University of Applied Sciences and Arts Antwerp · Hanze University of Applied Sciences Groningen · Co-funded by the Erasmus+ Programme of the European Union

World Health Organization. (2001). International classification of functioning, disability and health: ICF. Geneva: WHO.. https://apps.who.int/iris/handle/10665/42407

World Health Organization. (2010). Framework for Action on Interprofessional Education & Collaborative Practice. the Health Professions Network Nursing and Midwifery Office within the Department of Human Resources for Health. WHO/HRH/HPN/10.3. https://www.who.int/publications/i/item/framework-for-action-on-interprofessional-education-collaborative-practice

World Health Organization. (2020). United Nation's Decade of Healthy Ageing (2021–2030). Geneva: World Health Organization. https://www.who.int/initiatives/decade-of-healthy-ageing

Appendices

Appendix 1. ICF Needs workshop invitation letter

Appendix 2. ICF Needs workshop instructions

Appendix 3. ICF Needs workshop data collection template

Appendix 4. An example analysis sheet.

Moorheilbad HARBACH · fh/// st.pölten · Revalidatie Friesland · jamk | University of Applied Sciences · Coronaria · AP University of Applied Sciences and Arts Antwerp · Hanze University of Applied Sciences Groningen · Co-funded by the Erasmus+ Programme of the European Union

Appendix 1. ICF Needs workshop invitation letter

April 15, 2021
Jamk

ICF FRAMEWORK WITH US TODAY AND TOMORROW – Needs Workshop

What kind of needs do we have to deepen our ICF expertise?
How could we use ICF more for the benefit of our clients?
How could our students learn to use ICF more?

The INPRO –projects invite you to webinar
to discuss the opportunities and needs related to the use of ICF
in our work and teaching in social and health care sector.

The participants in the webinar will be asked to raise up needs related to ICF in their own organization, so that the ICF could be used in a more diverse and professional way.

You have been invited to a webinar because you already know some aspects of the ICF, which means that you can envision with us the needs and the possibilities for the use of ICF in the future. The duration of the webinar is 1.5 hours, and it will take place in May or June 2021.

The needs and perspectives raised in the webinar will be utilized in the following phases of the now launched INPRO project, that aims e.g. developing and implementing ICF training and bringing the ICF skills of students and working life closer together.

Webinar will take place [*add date and time*]

See you on the webinar!

READ MORE ABOUT THE INPRO –PROJECT:
INPRO Interprfessionalism in action! (2021-2023) is an international Erasmus+ - funded project. The project is aligning interprofessional education and collaboration in practice, us ing promising regional experiences for international exchange. One of the aims of the project is to add social- and health care professionals´ and students´ ICF skills training.
The partners are from Austria, Belgium, Finland, and the Netherlands.

Moorheilbad HARBACH · fh/// st.pölten · Revalidatie Friesland · jamk | University of Applied Sciences · Coronaria · AP University of Applied Sciences and Arts Antwerp · Hanze University of Applied Sciences Groningen · Co-funded by the Erasmus+ Programme of the European Union

Appendix 2. ICF Needs workshop instructions

INPRO INTERPROFESSIONALISM IN ACTION
Co-funded by the Erasmus+ Programme of the European Union

May 5, 2021
Jamk

INPRO WP 5.2 ICF Needs Workshop – Instructions

The workshop will be organized nationally by ICF Working Group / Steering group members in each country in May – June 2021. The workshop can be held in your national language or in English, but the results will be collected in English. It is supposed that all the invited participants of the workshop have some knowledge of ICF.

BEFORE THE WORKSHOP

- Plan the workshop according to the methods that suit you the best in order to motivate and inspire the workshop participants for discussion in your own country.
- You do not need to follow these details exactly, however, the documenting instructions need to be followed precisely.
- It is needed that you send one question to the participants in advance. The participants should consider the following question:
  - "Name the three main challenges that make it difficult to implement ICF in your own work / organization."
- You will need at least two leaders in the workshop in order to be able to both lead two separate group discussions (HEI and working life partner) and document the discussions.
- Collect a list of participants (name, organization, occupation).
- Follow the GDPR 6(1c) instructions by keeping the contact details of the participants until the data analysis is completed.

DURING THE WORKSHOP (1,5-2 hours)

- **10-15 min Introduction**
  - Welcome to the workshop!
  - Introduction of the leaders
  - Short introduction of INPRO –project (you can use the English PowerPoint presentation collected by Jaana Paltamaa or make your own in national language)
  - Tell Information about the workshop:
  - Similar workshops are arranged in Austria, Belgium, Finland and the Netherlands to facilitate the use of the ICF as an interprofessional education in higher education institutes and interprofessional collaboration in practice.
  - The data will be analyzed both for ICF education and ICF-based tools and approaches. The data will be collected anonymously and analyzed qualitatively.
  - The discussion in the workshop focuses on NEEDS, the solutions are not on the focus.
  - Short introduction of the workshop participants

Moorheilbad HARBACH · fh/// st.pölten · Revalidatie Friesland · jamk University of Applied Sciences · Coronaria · AP University of Applied Sciences and Arts Antwerp · Hanze University of Applied Sciences Groningen · Co-funded by the Erasmus+ Programme of the European Union

INPRO
Co-funded by the Erasmus+ Programme of the European Union

May 5, 2021
Jamk

- **45 min small group discussions: one small group (a) for HEI lecturers' and (b) for working life professionals**
  - The goal of the webinar is to collect the needs, how to enhance the use of ICF in the future in ICF education and in clinical practice.
  - Collect the answers to the question sent in advance (" 3 main challenges that make it difficult to implement ICF in your own work / organization.")
  - each participant fills hers or his own to a virtual area (e.g. Jamboard, Flinga) or using other means you select.
  - Ask the participants to **fill in the Background questionnaire** (use the link given by JAMK or fill in a paper)
  - Facilitate the participants to discuss the raised topics from pre-collected challenges and emerging topics (if needed, look at the facilitating questions at the end of this document)
  - **Document the discussion** to the given Workshop Data Collection Form
  - Ask the group members to name 1-2 most important areas to be developed in the use of ICF -> bring these to the summary discussion

- **30min Summary discussion all together**
  - One participant from each small group presents their discussion results
  - Discussion all together - **to be documented** to the given Workshop Data Collection Form
  - What are the factors that have an influence on the implementation and utilization of ICF in educational and practical organizations/teams?
  - What kind of needs are there in order to enhance the implementation and utilization of ICF?
  - How to use ICF in future in order to facilitate interprofessional education and collaborative practice?
  - Thank you everyone!

AFTER THE WORKSHOP

- **Submit the data in English** (The Workshop Data Collection Form) to
  - Teams WP 5.2. -> folder Needs Workshop -> Data from the workshop,
  - **before the end of June 2021.**
- JAMK and Coronaria will analyze the data before October.
- The analyzed results will be informed to the members of WP5 Working group, Sustainable board and Advisory board in an online meeting in October in order to share the results of the workshops and discuss needs for further development.

Moorheilbad HARBACH · fh/// st.pölten · Revalidatie Friesland · jamk University of Applied Sciences · Coronaria · AP University of Applied Sciences and Arts Antwerp · Hanze University of Applied Sciences Groningen · Co-funded by the Erasmus+ Programme of the European Union

INPRO
Co-funded by the Erasmus+ Programme of the European Union

May 5, 2021
Jamk

FACILITATING QUESTIONS FOR **ALL THE WORKSHOP LEADERS** (can be used if needed)

- What is the role of attitudes and motivation in the implementation or utilization of ICF?
- How to use ICF in order to facilitate interprofessional collaboration?
- Do you have experiences or plans for using technology with ICF?
- How to add the use of ICF tools by professionals/students in your organization?
- How to support the use of ICF more in documentation?
- How to support the use of ICF in practical client centered work?
- What ICF tools are the most useful in practical client centered work? How to support professionals/students to use them more?
- Is it typical, that the practice organization is using ICF only when a student is at the placement/apprentice? Why? Is there a need for change?
- Is it typical, that professionals/students know ICF in theory, but do not use it in practice? Why? Is there a need for change?
- How to integrate the understanding/use of ICF between students and professionals? Or at the moment of graduation and starting to work as a novice worker?

EXTRA FACILITATING QUESTIONS FOR THE **HEI** WORKSHOP LEADERS (can be used if needed)

- Is ICF included into your curriculum / course descriptions / learning outcomes? Is there a need to add ICF?
- Does the ICF competence broaden / deepen in the course of studies towards graduation? Is there need to use it more?
- Is ICF studied in interprofessional courses / modules? Would you like to do it more?
- Is ICF used in interprofessional thesis / projects? Would you like to do it more?
- Is the use of ICF demanded during practical training / apprenticeship? Should you do that?

EXTRA FACILITATING QUESTIONS FOR THE **PRACTICE** WORKSHOP LEADERS (can be used if needed)

- Does ICF guide the rehabilitation process of a client? How? Should it guide?
- Does the client get benefit or more qualified support if the professionals use ICF? How?
- Does your organization expect a student / novice worker to have ICF competence? Why? If yes, what kind?
- What is the role of leaders /directors/ foremen in the implementation or utilization of ICF? Would you like to change the situation?

Moorheilbad HARBACH
fh st.pölten
Revalidatie Friesland
jamk University of Applied Sciences
Coronaria
AP University of Applied Sciences and Arts Antwerp
Hanze University of Applied Sciences Groningen
Co-funded by the Erasmus+ Programme of the European Union

Appendix 3. ICF Needs workshop data collection template

Workshop data collection form
May 6, 2021 Jamk

INPRO
INTERPROFESSIONALISM IN ACTION

Examples:

Country	Date of the workshop (dd/mm/yyyy)	Duration (minutes)	Workshop leaders	Organization
Finland	*27/4/2021*	*90*	*Jaana Ritsilä*	*JAMK*
			Elina Kuohuva-Ikonen	*CORO*

Participants (NOTE: collect a separate list of names)	
Oganization	Number of participants
JAMK	*9*
Coronaria	*6*

Description of workshop implementation

Other commets

Next page.

Workshop data collection form
May 6, 2021 Jamk

INPRO
INTERPROFESSIONALISM IN ACTION

1. **Startpoint of the small workshop group discussion.**

   List all "3 main challenges that make it difficult to implement ICF in your own work / organization.")" raised up by the workshop participans (pdf from jamboard, a Excel of Word list, ect)

2. **During the workshop discussion.** Notes of the workshop discussion:

3. **During the summary discussion.**

   (a) What are the factors that have an influence on the implementation and utilization of ICF in educational and practical organizations/teams?

   (b) What kind of needs are there in order to enhance the implementation and utilization of ICF?

   (c) How to use ICF in future in order to facilitate interprofessional education and collaborative practice?

Moorheilbad HARBACH
fh/// st.pölten
Revalidatie Friesland
jamk University of Applied Sciences
Coronaria
AP University of Applied Sciences and Arts Antwerp
Hanze University of Applied Sciences Groningen
Co-funded by the Erasmus+ Programme of the European Union

INPRO
INTERPROFESSIONALISM IN ACTION

Appendix 4. An example analysis sheet.

Text from the workshop document (1 entity per line)	Country	Organisation	Section			Kirkpatrick evaluation model				
COMMENT	AUT, BE, FI, NL	HEI, WL, BOTH	Challenges	Possibilities	Future	1 Reaction	2 Learning	3 Behavior	4 Results	na
We read the ICF from top – down, start at the disorders. We would like to start with the patient as a whole person.	NL	WL	x					x		
The way we report in team meetings about the patient isn't in line with ICF	NL	WL	x					x		
Different interpretations of the ICF between studies	NL	HEI	x				x			
The decision that this will be the framework.	NL	BOTH			x				x	
Patient centred care interprofessional targets/aims	NL	BOTH		x				x		
When new employees have no experience with ICF at all, the job training is a lot more difficult and needs more time.	AUT	WL	x						x	
There seem to be very different conceptions of ICF and how it is used in professional settings and how HEIs are going to use it.	AUT	BOTH	x					x		
There is an urgent need of digital tools and documentation systems based on ICF.	AUT	WL	x						x	
Students do not really understand why they are supposed to use codes that are not easy to understand.	AUT	HEI	x			x				
Therefore there is no need to teach the coding.	AUT	HEI	x				x			
ICF has to be taught more practice orientated.	AUT	BOTH			x		x			
It is difficult to teach students something that is not used in	BE	HEI	x				x			
The handbook has been found too expensive for students to	BE	HEI	x			x				
We choose for an open book exam because we think it is not important to learn every detail.	BE	HEI	x						x	
Working with people who indicate that they already know what it is, but rarely or never apply it (correctly).	BE	HEI	x					x		
Integrate ICF into speech therapy coursework in a uniform way (get teachers with noses in the same direction)	BE	HEI	x				x			
Lack of interdisciplinary communication (patient's history is almost always incomplete)	BE	WL	x					x		
If ICF is implemented, there would be a time gain.	BE	BOTH		x					x	
The ICF is often perceived only as a selection of codes	FI	WL	x			x				
ICF information should be brought into a practical level	FI	WL		x				x		
The healthrecors systems do not support the use of codes, the interface for practical work is missing	FI	WL	x					x		
Increasing a common understanding for teachers.	FI	HEI		x			x			
To see the ICF as part of the rehabilitation process - the need is to develop tools, core lists, interview bodies, goal layout, etc.	FI	BOTH		x				x		
Continuum what ICF issues are good to study in the early stages of studies, what in the middle phase and in the advanced	FI	HEI			x				x	