



Making IPE Work: Idea to Actualization

Kimberly A. Udlis^{1*} and Stephanie Stewart²

¹MSN Program Director/Associate Professor of Nursing Bellin College, Green Bay, WI, USA

²Dean of Nursing Bellin College, Green Bay, WI, USA

*Corresponding author: Kimberly A. Udlis, MSN Program Director/Associate Professor of Nursing Bellin College, 3201 Eaton Road, Green Bay, WI 54311, USA, Tel: (920) 433-6624; E-mail: kimberly.udlis@bellincollege.edu

Why Embark on Interprofessional Education?

There is a growing emphasis on interprofessional education (IPE) among nursing and health professions faculty [1]. This movement has been supported by research on teamwork and communication within the health care delivery system, which reports that miscommunication and poor teamwork result in medical error and poor patient outcomes [2,3]. There is substantial interest and support in having intentional opportunities for health professional students to learn together. IPE is defined as, "Two or more professions who learn with, from and about each other to improve collaboration and quality of care" [4]. This paper describes an effort by nursing, medical, and radiological technology education to infuse IPE activities into their curricula.

According to the World Health Organization [5] Interprofessional Care (IPC) is linked with improved outcomes in family health infectious disease humanitarian efforts, responses to epidemics and non-communicable disease. Others improvements with IPC are noted in access to care and coordination of services, appropriate use of specialty care, chronic disease outcomes and safety. Safety indicators include complications and error rates, lengths of stay, conflict among care givers, staff turnover and mortality rates which are improved in collaborative care environments.

Green and Johnson relate that Interprofessional Education (IPE) and IPC are related [6]. Advocates argue that IPE must be a part of the professional training of health care workers in order to successfully implement IPE. Within this scenario, future health care workers are existing in a local context and are there to meet the needs of the local health care population. Therefore health care workers should be trained to work together as members of a collaborative practice-ready workforce. This workforce trained for IPC emerges from the IPE training experiences. The goal is to deliver better health care outcomes to the population. Receiving formal training in IPE is beneficial. It can be argued that some people without training in collaborative practice might be able to ascertain how to function in IPC. Models of IPE have shown that training people in IPE leads to members who show respect and positive attitudes towards each other. Therefore IPE and IPC are linked to what society needs which is a workforce trained to work better as a team to deliver better outcomes to the community it serves [7].

Guerin notes that the relatively recent effort of IPE to ensure that health systems provide comprehensive and efficient care through

increased collaboration across the professions [8]. The once siloed approach to health care services is evolving into a professional practice model covering both preventative and reactive health care services. In recent years schools of medicine public health, nursing and other health care providers have defined the competencies necessary for success in the interprofessional care arena. This effort has led to the development of soft skills which focus on the relationships between oneself and others. These include social virtues which are necessary for successful interaction such as "empathy, vulnerability, mindfulness sensitivity, tolerance and detachment among others" (pg.38). Learning about relationships in social emotional contexts individuals may learn to work more successfully in diverse team environments.

Pfeifle and Earnest argue that IPE will evolve to eventually have an impact on global health outcomes [9]. As the concept of IPE evolves so does the understanding of what is needed to support successful collaborations across the professions. The overarching aim of IPE in the global health arena is to equip our future health providers with the skill set that will develop and effective collaborative to improve global outcomes. The opportunities to collaborate across the professions and participate in innovation can lead to transformative change with the promise of improving health and health care outcomes and opportunities to advance professional goals of all those who become involved.

Moving from Idea to Actualization

Developing IPE opportunities for students across various health professions can be a daunting and challenging endeavor. Student and faculty scheduling, credit allocation or credit sharing, and academic policies are just a few of the barriers that can impede the development and success of integrating IPE into program curricula. The development of faculty knowledge of and expertise in the IPEC competencies is a fundamental requirement when first entering the planning stages of IPE curriculum development, but knowledge alone is not sufficient. Faculty, and especially those charged to lead IPE opportunities, must embrace and integrate the IPEC competencies into their professional views, language and attitudes.

Faculty Development

Health professions who are educated in silos tend to view their profession from an egocentric view point. This perspective can be

carried through, whether consciously or subconsciously, in the health profession academicians, who are then given the task to develop or include IPE content into their courses. During the planning and development of an IPE program between nursing, radiologic sciences, and medicine, it became very clear that before we could become the teachers of IPE, we first had to be the learners. There was an expectation that our students would learn “with, from, and about each other”, but we, as faculty, knew very little about our counterparts in the various health profession faculty roles. We used different language for our courses, different terms for academic progression, different plans of study, and different pedagogies. Faculty from varying health professions had a lack of knowledge about the academic preparation of the students; who took what courses and when. Knowledge that was assumed to be tacit, was not. The faculty quickly learned that before we could come together to teach our students, we had to come together and learn with, from and about each other, first.

Four representatives attended the Fall 2014 IPEC Conference Interprofessional Education Institute: Building a Framework for Collaboration held in Herndon, Virginia. The intent of the conference was to provide health professions faculty and their IPE colleagues both quality time and dedicated space for guided learning, team-based planning activities, and consultation with experts and peers in order to emerge with a programmatic action plan for IPE. Presentations were provided by health care leaders advocating for the importance of IPE to promote interprofessional collaboration in the healthcare environment and faculty who successfully implemented IPE activities and curricula at their academic institutions. A workbook that outlined a step by step approach to developing IPE activities was provided to the participants and completed section by section during the conference.

The format of the IPEC Institute created a template from which to develop our IPE sessions and navigate the numerous barriers, both logistics and perceptions that inhibited our progress. Many stereotypes, restrictive language, and incorrect perceptions were broken down and common paths in our educational programs and views were identified. We worked to resist falling into the easy trap of emphasizing students’ clinical skills and knowledge, there was a focus on the IPEC competencies and activities that would nurture the development of communication skills, value and respect for the roles and responsibilities of other health care professionals, teamwork and reflection.

Implementing the IPE Plan

The first of four IPE sessions was planned and implemented in early September 2015. There, 72 students (26 medical students, 13 graduate nursing students, 24 undergraduate nursing students and 9 baccalaureate radiologic science students) engaged in a 3-hour IPE session involving 4 separate activities. The students were chosen primarily on their schedules. This was the first group of medical school students. So the entire cohort of 26 who were three months into a three year program participated. Nurse practitioner students were midway through the program, nursing students were halfway through a 15 month accelerated program, and radiology technology students were seniors in a four year program. Most were close to or had the equivalent of a bachelor’s degree.

Activity 1 included a brief lecture about IPE; definitions, reasons, benefits and barriers were presented with representation from all professions. Student were then divided into groups of 8 with at least 1 member from each professional. Activity 2 had the students participate in an ice breaker activity that would allow them to have fun together, devoid of healthcare or medical situations. One at time, a member of the group viewed a Lego® model for 5-10 seconds and then reported back to their group to communicate to the group how to build the model with the Lego® pieces they were provided. Activity 3 was an exercise where each person in the group was to identify a stereotype that has been linked to their profession, describe the negative impact this stereotype can have on interprofessional collaboration, and strategies to breakdown these stereotypes to promote better teamwork

in the healthcare setting. Activity 4 involved having the students work through 2 different case studies, focusing on collaborative care and their profession’s perceptive of prior needs of the patients.

After the IPE experience, we gave the 72 participants a chance to rate their experiences. We ask three open ended questions: 1) What do you feel went well; 2) What do you feel could be improved; and 3) Comments. Overwhelmingly the Lego icebreaker activity was mentioned most as the favorite activity of the day. Comments such as, “Working together as a team, brainstorming between team, encouraging each other through problem solving.” were often repeated. They also mentioned the communication and getting to know the group made the activity positive and engaging. They felt that the stereotype exercise helped them to get to know the other professions and begin a dialogue about roles. Comments included that it was helpful to get to know one another and be comfortable working together. We did not query a comparison group of those who did not attend the IPE experience.

Evaluating and Moving Forward

Themes for improvement included having more time to get to know one another and introduce themselves. They also indicated a need for more group to group interaction so they could get to know more people than just the ones they were introduced to in their groups omit add. A number of the students requested that we provide opportunities for them to get to know other members of the group since we had kept them in their original groups for two activities. They recommended mixing the groups for future encounters so they could get to know more people. General comments included that the concept was good and that they were happy to meet their fellow professionals. Timing was difficult for some because of the business of all schedules.

Going forward, it can be easy to slip back into old habits, use restrictive rather than inclusive language, focus clinical competencies rather than interprofessional competencies, and become frustrated with the logistics of planning an IPE session, but with a team who are dedicated to the premise of IPE and who are willing to live the IPEC competencies, success can be had. IPE day 2 was another success and plans for 2 sessions in spring 2016 are underway. Whether at a large institution with many dedicated resources to IPE or a small college with only a handful of willing faculty, IPE opportunities can be integrated into programs.

Recommendations

Key advice from the IPEC Institute was, “just try something, then go from there”. From our experience, our recommendations are:

1. Identify a key leadership team that is inclusive of the health professions.
2. Have the leadership team engage in IPE training.
3. Make a plan for faculty development and involve faculty in the planning and implementation phases.
4. Include time for social interaction.
5. Focus on the IPEC competencies and not clinical competency.
6. Just try sometime; an IPE activity does not have to be grandiose to be successful; if logistics are limiting, plan an online activity, convene a smaller group of students, or plan an activity outside of regular academic hours.

Conclusion

The movement towards team-based care and interprofessional collaboration in the health care setting has been fueled by the numerous articles advocating its value and benefits as well as the recommendation from the Institute of Medicine to have all healthcare professionals work in teams (IOM, 2010) [10]. In order to support this charge for collaboration in the healthcare environment, many health profession academic accreditation agencies have begun to include

wording regarding need to include IPE within curriculum. Nursing and pharmacy, in particular, have accreditation standards that speak specifically to the requirement of IPE in the academic preparation of students [11]. As a result, integrating IPE activities and curricula into the academic setting has become a topic of interest across many health professions.

Many barriers to IPE can exist in the academic setting from fundamental logistics (scheduling, credits, time commitment, etc.) to an overall lack of faculty knowledge of IPE. In our experience, the latter is most influential factor in determining if IPE will be successfully integrated into the curriculum. Acknowledging the value of IPE and adopting the tenets of IPE and the IPEC competencies are two different concepts. Faculty development is the vital first step in any IPE endeavor. With a dedicated faculty and the focus on the IPEC competencies, IPE can be a rewarding and successful addition to the academic setting for both faculty and students.

References

1. Pardue KT (2015) A framework for the design, implementation, and evaluation of interprofessional education. *Nurse Educ* 40: 10-15.
2. Institute of Medicine (1972) *Educating for the Health Care Team*, Washington, DC: National Academy of Sciences.
3. Institute of Medicine (2003) *Health Profession Education: A Bridge to Quality*. Washington, DC: National Academies Press.
4. Centre for the Advancement of Interprofessional Education (2002) *Defining IPE*.
5. WHO (2010) *Framework for Action on Interprofessional Education and Collaborative Practice*. Geneva, Switzerland: World Health Organization.
6. Green BN, Johnson CD (2015) Interprofessional collaboration in research, education, and clinical practice: working together for a better future. *J Chiropr Educ* 29: 1-10.
7. Bridges DR, Davidson RA, Odegard PS, Maki IV, Tomkowiak J (2011) Interprofessional collaboration: three best practice models of interprofessional education. *Med Educ Online* 8: 16.
8. Guerin TT (2014) Relationships matter: the role for social-emotional learning in an interprofessional global health education. *J Law Med Ethics* 2: 38-44.
9. Pfeifle A, Earnest M (2014) The creation of an institutional commons: Institutional and individual benefits and risks in global health interprofessional education. *The Journal of Law, Medicine & Ethics* 42: 45-49.
10. Institute of Medicine (2010) *The future of nursing: Leading change, advancing health*. Washington, DC: National Academy of Sciences.
11. Zorek J, Raehl C (2013) Interprofessional education accreditation standards in the USA: a comparative analysis. *J Interprof Care* 27: 123-130.