



Interprofessional Conferences and Regularly Scheduled Series: Participant Surveys

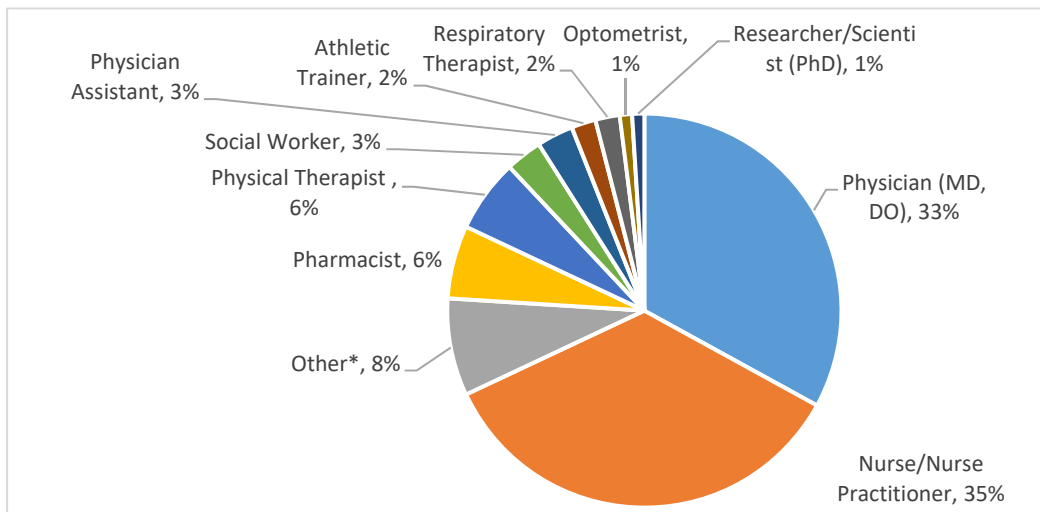
EXECUTIVE SUMMARY

The University of Wisconsin Schools of Medicine and Public Health, Nursing, and Pharmacy formed the Interprofessional Continuing Education Partnership (ICEP) to explore opportunities to support the growing need for continuing interprofessional education (CIPE) across health professions. In 2015, ICEP launched the Joint Accreditation application process, and in Spring 2016, conducted two online surveys reaching the participants of interprofessional live conferences (Conferences Survey) and interprofessional regularly scheduled series (RSS Survey). Both surveys included similar questions focused on perceptions about the activity, educational outcomes, and barriers to collaborative practice. The survey respondents could choose only one activity to evaluate. The key findings are presented below.

Survey Participants

The activity inclusion criteria were flexible to include mature interprofessional activities as well as those working toward CIPE. The Conferences Survey was administered to 3,901 participants of 24 interprofessional live conferences that occurred in 2014-2016, and the RSS Survey, to 929 participants of 22 interprofessional RSS, with sessions held between July 2015 and February 2016. The response rate was 14.2% for the Conferences Survey, and 15.5% for the RSS Survey. A total of 698 learners responded to the surveys. They represented more than 20 professions, with nurses and physicians being the two largest groups at 35% and 33%, respectively.

Respondents by Profession, Both Surveys (N=698)

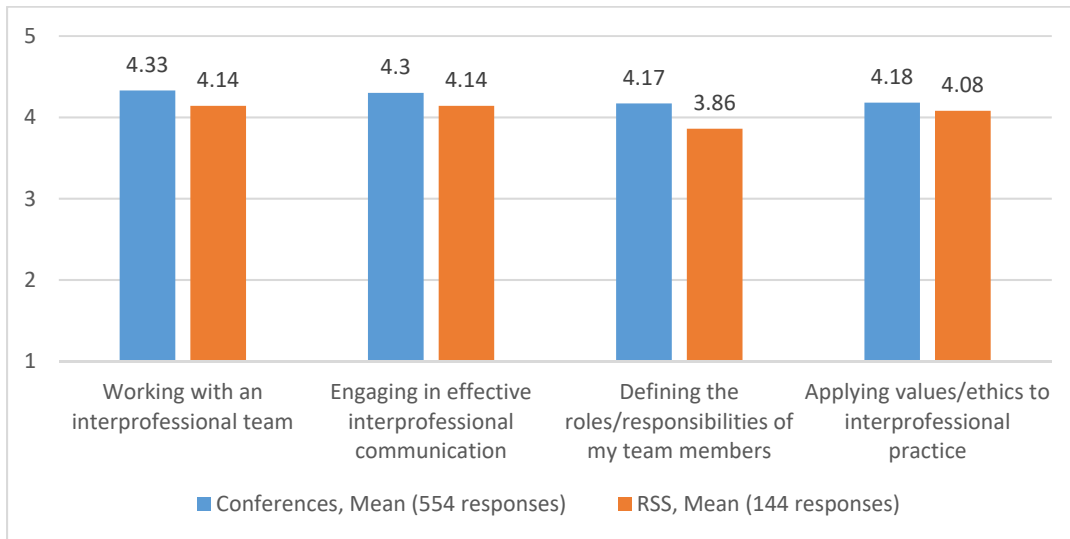


*Other included study coordinators, veterinarians, occupational therapists, clinical psychologists, radiology technicians, IT specialists, and others.

Analysis Revealed High Levels of Agreement Regarding Activities Being Perceived as Interprofessional

The respondents were given a definition of CIPE and asked to state their agreement, on a scale from 1=Strongly Disagree to 5=Strongly Agree, with the statement, “This conference met the definition of CIPE”. The mean responses were: 4.54 for the Conferences Survey (n=554) and 4.45 for the RSS Survey (n=144). The respondents also rated how the activity contributed to their professional effectiveness in respect to the four interprofessional competency domains (see next page).

Mean Agreement to the statement “This conference contributed to my professional effectiveness” by Interprofessional Competency Domain (On a Scale from 1=Strongly Disagree to 5=Strongly Agree)



Many reflected on the interprofessional focus of the activity and strategies consistent with best practices in continuing education. Some made specific suggestions for activity improvement. Several respondents left negative feedback, such as comments about presenters not representing the interprofessional audience, and a particular activity not being a good venue for CIPE.

Outcomes

When asked how their interprofessional team utilized the information provided during the activity, 74% described a positive impact on their team’s knowledge, competence and/or practice. Notably, many acknowledged sharing information with their team members and peers, which extended learning and supported practice change.

Education Resulted in Changes in Knowledge and Attitude. Many responses indicated that learning took place as the result of participation in the activity. Some respondents described what they learned relative to cognitive and/or affective domains of learning, and others made statements about collective knowledge change at the level of team or department. For example: “Our departments now know how to better assist each other due [to] understanding the roles of other team members.”

Education Improved Abilities, Triggered Intentions to Change Practice, and Helped to Identify Strategies for Effective Team-Based Care. Participant statements provided evidence for increased competence of individuals and health care teams. Some participants stated intentions to change practice, such as: “I brought back an electronic solution that we immediately started plans to implement to solve a long term problem that we had been experiencing.” “Strongly considering information presented to utilize an interdisciplinary team to monitor pre-admission medications.” Other

participants mentioned strategies and tools to improve practice that were considered or developed due to participation in education.

Participants Reported Improvements in Individual and Healthcare Team Performance.

Collectively, respondents provided many examples of improvements in practice resulting from attending the conference or the RSS. These improvements included changes in individual professional behavior, enhancements in team-based care, and systems changes at the level of department, hospital, or practice. Some respondents described specific improvements in how teams work, enhanced team capacity, and changes in clinical practice at the respondent workplace. For example: “We have been able to collaborate better with OR and other services to better support the patient but also acknowledge the family.” “We have used the information from this meeting to refine our protocols and incorporate them into our evidence driven order sets. There is better acceptance when staff see these as team developed.”

Barriers to Collaborative Practice

Reported barriers to collaborative practice were coded and categorized into eight themes.

Different Perspectives, Workplace Culture and Professional Bias Influence Collaborative Practice. Some respondents described how some members of their team *do not understand or appreciate the roles of other team members/professionals*. *Professional bias* and *lack of collegiality* were indicated as the barriers by other respondents. For example: “Competitiveness; lack of collegiality; intolerance to people from different backgrounds; disrespectful comments and jokes.” Several respondents made statements about *differences in perspectives* and *organizational or within-the-profession culture* that may negatively influence team-based care.

Working in Silos is a Barrier. Many reflected on geographic isolation, lack of opportunities for face-to-face contact with other professionals, or carrying out the workload that limits interaction with others.

Communication Barriers. Many responses emphasized poor communication or miscommunication as the major barrier to collaborative practice. For example: “Using the same words but different meanings. So much overlap in terminology that the context is often misunderstood.”

Time- and Resource-related Issues. These were commonly stated barriers. Notably, several respondents viewed collaborative practice as something separate and additional to their daily work.

Complexity of Referrals, Administrative Issues and Other Systems Barriers. Respondents reported a variety of the systems barriers to collaborative practice.

Lack of Clinical Knowledge Creates a Barrier to Collaborative Practice. Several respondents commented on how lack of clinical knowledge complicates effective work of health care teams.

Some Professionals Are Not Prepared by Previous Education to Collaborate. The quotation below provides a good summary of this category of barriers: “Schedules of various interprofessional students and accreditation requirements block the ability to get these students together to learn from one another. Students are educated in silos, lacking any interaction on an educational level pre-licensure. Then, once in practice, they do not know how to work collaboratively and do not learn from each other.”

Resistance to Change. Resistance of individuals, health care teams and organizations to change was also acknowledged.

Conclusions

1. The data demonstrated that participants of the evaluated interprofessional live conferences and RSS perceived that these activities met a definition of CIPE.
2. The surveys documented positive educational impact, with multiple examples of individual or health care team changes in knowledge, competence and/or practice resulting from participation in education.

3. A few negative responses and suggestions for improvement demonstrated that gaps exist in how the education was delivered.
4. Future directions for improving CIPE should include faculty development, linkage to quality improvement, and refining practices in activity planning by, for, and with the team.

Next steps

- Review and discuss the survey results with ICEP and CIPE planning committees to identify faculty development opportunities and key learner-focused educational strategies for improvement of future interprofessional educational activities
- Revise ICEP program-wide evaluation plan to enhance ongoing outcome data collection from multiple sources, to enable aggregate data analysis across multiple educational activities, and to increase utilization of objectively-measured and quantifiable data documenting educational impact