Development of a Continuing Interprofessional Education Partnership: Learning from our Learners

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Background

Well-designed continuing interprofessional education (CIPE) contributes to the development of an interprofessional workforce and patient-centered, collaborative practice. The University of Wisconsin-Madison Schools of Nursing, Medicine and Public Health, and Pharmacy formed the Interprofessional Continuing Education Partnership (ICEP) to explore opportunities to support the growing need for CIPE across health professions.

Methods

In 2015, ICEP launched the Joint Accreditation application process. Two online surveys were conducted in Spring 2016, reaching the participants of 24 interprofessional live conferences and 22 interprofessional regularly scheduled series (RSS).

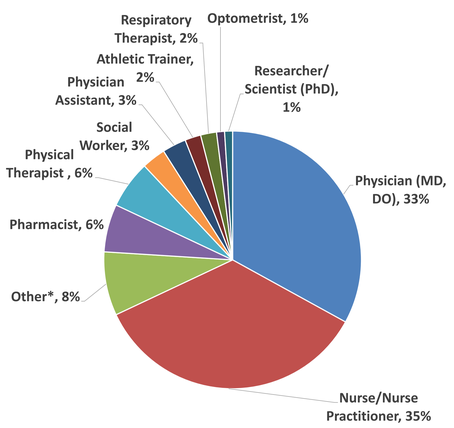
CIPE occurs when members from two or more health and/or social care professions learn with, from, and about each other to improve collaboration and the quality of care.[1] For survey purposes, a conference was considered to be interprofessional if it was planned by representatives from multiple professions reflecting the target audience, which included more than one health profession. An RSS was considered to be interprofessional if: (1) it was approved for the current two-year cycle as an interprofessional activity, (2) it already had or was in the process of establishing an interprofessional planning committee, and (3) it had an interprofessional target audience and exhibited other features of CIPE. Thus, the inclusion criteria were flexible to include mature interprofessional activities as well as those working toward CIPE.

Both surveys included similar questions focused on perceptions about the activity, educational outcomes, and barriers to collaborative practice. Survey respondents could choose only one activity to evaluate. We used descriptive statistics to summarize quantitative data and qualitative analysis to examine responses to open-ended questions. The latter included open coding to identify distinct concepts and categories in the data, and review of emerging categories to recognize core categories and related themes.

Respondents

The surveys were sent to 4,830 learners, and 698 (14.45%) responded. The respondents represented more than 20 professions, with nurses and physicians being the two largest groups: 241 (35%) and 227 (33%), respectively.

Respondents by Profession, Both Surveys (n=698, 14.45% response rate)



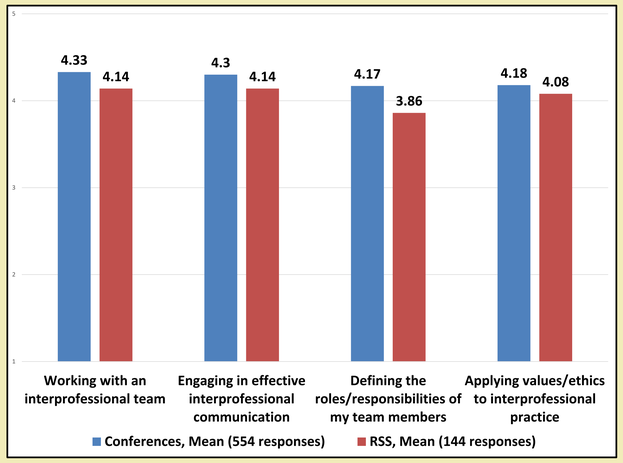
*Included other professionals such as study coordinators, veterinarians, occupational therapists, clinical psychologists, radiology technicians, and IT specialists.

Results

Perceptions About Activities Being Interprofessional

Analysis revealed high levels of agreement regarding activities being perceived as interprofessional. The respondents were given a definition of CIPE[1] and were 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.

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 provided negative feedback, such as comments about presenters not representing the interprofessional audience, and a particular activity not being a good venue for CIPE.

Educational Impact

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, thus extending learning and supporting 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, and others made statements about collective knowledge change at the level of their team or department.

Education Improved Abilities, Triggered Intentions to Change Practice, and Helped to Identify Strategies for Effective Team-Based Care. Respondents reported increased competence of individuals and health care teams. Some respondents stated intentions to change practice, and others described strategies and tools to improve practice that were considered or developed due to participation in the educational activity.

Participants Reported Improvements in Individual and Healthcare Team Performance. Collectively, respondents provided many examples of improvements in practice, including changes in individual professional behavior, enhancements in team-based care, and systems changes at the department, hospital, and/or practice level. Some respondents described enhanced team capacity and specific improvements in how teams work.

Examples of Evaluation Responses

Nurses

"We worked to change our nursing care plan into a multidisciplinary care plan, including PT/OT/Speech, Case Management, and Dietary."

"As the Director of Nursing Informatics, my team works collaboratively with physicians, pharmacy, nursing leaders and end users. This conference brought all the teams together, in addition to the ancillary departments, to work toward system improvement towards patient centered care."

Physicians

"We designed new care workflows and applied lessons learned to improving provider efficiency and reducing meaningless EHR processes."

"We had a pre-clinic huddle 2 days later and discussed how several of the resources or standards could be applied to our clinic activities."

Pharmacists

"We will use the new insulin dosing calculator from within the MAR. This will require significant collaboration with nurses, physicians and pharmacists."

Social Workers

"We continue to enhance the Deferred Prosecution Program Child Abuse Initiative as we receive new information, knowledge and skills on an ongoing basis. This conference particularly influences our efforts at reviewing and maintaining clear eligibility requirements and program standards."

Barriers to Collaborative Practice

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

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."*

Lack of Clinical Knowledge Creates a Barrier to Collaborative Practice

Several respondents commented on how *lack of clinical knowledge complicates effective health care team work.*

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 barriers by other respondents. Several respondents made statements about *differences in perspectives* and *organizational or within-the-profession cultures* that may negatively influence team-based care.

Time- and Resource-related Issues

These were commonly stated barriers. Notably, several respondents viewed *collaborative practice as something separate and in addition to their daily work.*

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."*

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.*

Complexity of Referrals, Administrative Issues and Other Systems Barriers

Respondents reported a variety of systems barriers to collaborative practice.

Resistance to Change

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

Discussion and Limitations

The overall feedback about the interprofessional educational experience was positive with some respondents commenting on the value of continuing education for their profession, and suggesting that interprofessional offerings should expand, but not entirely replace, all the continuing education activities accredited by ICEP. The results of these surveys will be used by ICEP to collaboratively increase the capacity for planning interprofessional education in our institution and provide to learners from multiple professions a diverse portfolio of meaningful interprofessional learning experiences.

Limitations

Survey respondents' ability to recall past educational activities limited accuracy of their feedback. Educational outcomes that were presented were self-reported.

Conclusions

1. The data demonstrated that participants of the evaluated interprofessional live conferences and RSS perceived that these activities met the definition of CIPE as described by Reeves.[1]
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 educational activities.
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 interprofessional team.

Reference

1. Reeves S. An overview of continuing interprofessional education. J Contin Educ Health Prof. 2009 Summer;29(3):142-6.

Acknowledgements

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