

Chapter 9

Interprofessional Education

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ABSTRACT

Interprofessional education (IPE) is recognized as an important component in the education of healthcare students. The goal of bringing students together to learn with, from, and about each other is to ultimately impact collaborative practice and improve patient care. Over the last 20 years there has been increased focus on the design and implementation of IPE experiences. Several IPE collaborative organizations and IPE centers have been formed to provide evidence-based recommendations and guidelines. Strategies have been created for designing and implementing high quality IPE activities, developing faculty in IPE, overcoming student stereotypes, determining assessment strategies, and identifying barriers to IPE. This chapter will focus on each of these elements and provide specific recommendations on how to create and implement IPE that improves student learning.

INTRODUCTION

In 2001, the Institute of Medicine (IOM) published the Quality Chasm report stating that “the health care delivery system has floundered in its ability to provide consistently high-quality care” (Institute of Medicine, 2001, p. 2). In a follow-up report, the IOM commented further on one component as a tool to address the problem. That report focused on health care education and recognized the need for a focus on interprofessional education (IPE). The report stated: “All health professionals should be educated to deliver patient-centered care as members of an interdisciplinary team” (Greiner & Knebel, 2003, p. 45).

IPE and the training of students to function as an interprofessional team is crucial to enhance the provision of quality health care (Remington, Foulk, & Williams, 2006). Students who participate in IPE are more likely to be collaborative practitioners (Bridges, Davidson, Odegard, Maki, & Tomkowiak, 2011). High-quality IPE experiences require strategic instructional design. In and of itself, interprofessional education has unique pedagogical principles and nuances. Faculty members and administrators must consider several specific components throughout the creation and implementation process. These relate to design methodology, faculty development, student preparation, barriers to IPE, and assessment techniques. Each of these important components will be discussed in detail in this chapter.

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Design Methodology

Designing IPE activities can be a daunting, yet exciting task. It can be thrilling to work with faculty across professions and create an opportunity that elevates the individual professional experience. In order to create an IPE student event or program, there are several things to consider including: how should students interact; which competencies and objectives to focus on; who should be involved; which topic to choose; and how to integrate with established curricula.

Setting and Environment

In designing IPE experiences, faculty members should consider the context of their academic setting. The academic environment of the school or college will influence the IPE opportunities available to a program (Buring, Bhushan, Brazeau, et al., 2009; Kahaleh, Danielson, Franson, Nuffer, & Umland, 2015). Institutions with a medical center will often have a wide variety of professions that may be interested in IPE curricula. Stand-alone schools may have to identify IPE partners in the community or at other academic institutions. One of the first steps to creating an IPE experience or program is identifying the interested or key partners. For that reason, it may prove least cumbersome to begin IPE work with the individual professions within an institution. Faculty members may already have established relationships with other professions at their own institutions from which to base IPE discussions and interest. Once identified, discussions regarding programmatic needs, opportunities, and interest in IPE should begin (Buring, Bhushan, Brazeau, et al., 2009; Kahaleh et al., 2015).

A variety of teaching methodologies have been used successfully in IPE. Examples of interactive learning methods include seminar-based discussions, visits to patients/clients, problem-based or team-based learning, simulation including role playing and simulated clinical learning environments, and interprofessional clinical placements (Oandasan & Reeves, 2005a; Reeves, Goldman, & Oandasan, 2007). Oandasan et al. recommend small group learning settings as effective IPE teaching environments. Most IPE programs report that they create groups of 5-10 students (Oandasan & Reeves, 2005a; Reeves et al., 2007). Anderson et al. found that students particularly enjoyed IPE experiential activities that incorporated direct patient care (Anderson, Smith, & Hammick, 2015). Langton describes five different ways to format IPE activities. IPE could be inserted into new or existing curricula as one or more modules. It could be incorporated into clinical practice or work. It could be done as an online component in conjunction with other courses. Or it could be part or all of a program of common curricula across all professions (Langton, 2009).

Some suggest that it is important to the learning environment that the number of professional students represented be balanced (Kahaleh et al., 2015; Oandasan & Reeves, 2005a; Reeves et al., 2007). If there is a larger number of any profession represented per group, it is possible that they will dominate the interaction. While it is not essential to have equal numbers, there should be some effort to balancing student numbers to ensure that one profession will not dominate the group or activity (Horsburgh, Lamdin, & Williamson, 2001; Reeves et al., 2007). If possible, maintaining group consistency across activities is also recommended. This has been suggested to enhance interactions but may be too logistically challenging for some institutions (Oandasan & Reeves, 2005a; Ruiz, Ezer, & Purden, 2013).

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