ORIGINAL ARTICLE

Interprofessional Education and Practice Guide No. 1; Developing faculty to effectively facilitate interprofessional education

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Abstract

With the growth of interprofessional education (IPE) and practice in health professional schools, faculty members are being asked to assume new roles in leading or delivering interprofessional curriculum. Many existing faculty members feel ill-prepared to face the challenges of this curricular innovation. From 2012–2013, University of Missouri – Columbia and University of Washington partnered with six additional academic health centers to pilot a faculty development course to prepare faculty leaders for IPE. Using a variety of techniques, including didactic teaching, small group exercises, immersion participation in interprofessional education, local implementation of new IPE projects, and peer learning, the program positioned each site to successfully introduce an interprofessional innovation. Participating faculty confirmed the value of the program, and suggested that more widespread similar efforts were worthwhile. This guide briefly describes this faculty development program and identifies key lessons learned from the initiative. Peer learning arising from a faculty development community, adaptation of curricula to fit local context, experiential learning, and ongoing coaching/mentoring, especially as it related to actual participation in IPE activities, were among the key elements of this successful faculty development activity.

Introduction

This first guide focuses on strategies for developing faculty to effectively facilitate interprofessional education (IPE). Increasing collaborative activities in a variety of health professions schools have raised faculty awareness of IPE; however, many institutional and personal barriers may prevent faculty members from being fully engaged as leaders of interprofessional learning (Barnsteiner, Disch, Hall, Mayer, & Moore, 2007; Curran, Sharpe, & Forristall, 2007). Simply bringing faculty from differing health care professions into the same learning space should not be assumed to result in beneficial IPE experiences (Buring et al., 2009). Many health professionals had little or no exposure to IPE activities during their own training, and many clinical sites in which faculty oversee training lack robust or explicit examples of interprofessional team-based care. Development of faculty members has been identified as key factor supporting success of IPE initiatives (Ho et al., 2008), with a focus on developing interprofessional facilitations skills a particularly critical need for faculty (Ruiz, Ezer, & Purden, 2013). Recently identified competencies for IP collaborative practice may assist faculty in identifying topics for IPE activities (Interprofessional Education Collaborative Expert Panel, 2011; Schmitt, Blue, Aschenbrener, & Viggiano, 2011). However, the planning and implementation of new IPE curricular offerings can be challenging, requiring leadership to overcome resistance to change, the complex coordination of schedules, flexibility in course content, and use of new evaluation tools to assess efficacy (Gilbert, 2005; Jensen, Harvan, & Royeen, 2009; Clark, 2011). IPE leaders must understand and respect professional differences and be able to manage discussions in which those differences are explored. The sheer scope of IPE initiatives can also be daunting, in some cases involving hundreds of students, and often accompanied by the need for dozens of faculty members to facilitate large numbers of small interprofessional groups.

Beginning in early 2012 in the US, under the leadership of University of Missouri – Columbia and the University of Washington, eight academic health centers undertook a year-long pilot faculty development program to train a cadre of faculty leaders in IPE at each of the institutions. In addition to the sponsoring institutions, the participants included: Columbia University, Medical University of South Carolina, University of Indiana, University of Kentucky, University of North Dakota, and University of Virginia. The program utilized a combination of didactic presentations, small group activities, and immersion experiences with direct involvement in IPE facilitation to build interprofessional leadership skills. Coaching and peer learning helped to stimulate the translation of these skills to local interprofessional work. Participating leaders in turn equipped faculty at their home institutions to participate in the introduction of new IPE activities. This guide describes the processes used to prepare the faculty for this work and summarizes the lessons learned through this project.

Key lessons learned

Several key lessons regarding the development of faculty to participate in IPE have emerged from the feedback provided by

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participating faculty members and the evaluation of the program outcomes.

Secure the commitment of top institutional leaders

Growing a successful IPE program requires ''top-down administrative support and leadership'' as well as ''investment of resources in personnel, time and money'' (Brazeau, 2013). All institutions participating in this project enjoyed support of the top leaders in their participating health professions schools. Given the complexity of scheduling IPE events, without leadership declaring IPE as a priority, progress often will not occur. Most of the institutions described a process of building this vision and commitment through initially smaller IPE projects that expanded in scope and complexity over time.

Use interprofessional leadership

For faculty development efforts to be successful, they must model the interprofessional principles we are trying to teach our students (Silver & Leslie, 2009). Leadership of IPE efforts should be collaborative, reflecting shared decision-making and respect for the unique contributions of each profession. In our project, the national leadership team and the local leadership at each site were purposefully interprofessional, with appropriate time and effort devoted to building our leadership teams. Achieving this collaboration was facilitated by identification of shared values, joint planning, and investing the time and effort needed to build trust and accountability into the interprofessional leadership team.

Be clear about the objectives for your faculty development program

Use of an outcomes-based design has been recommended in the building of successful faculty development programs aimed at promoting interprofessional collaboration (Silver & Leslie, 2009). We identified goals of the IPE faculty development efforts early in our initiative, helping to guide both programmatic development and assessment of efficacy. Primary objectives of our program were to pilot a faculty development program in team-based care with a small group of committed academic health centers, successfully implement at least one new IPE activity at each participating institution, assess the impact of the IPE faculty development activities, and propose successful models for faculty development utilizing new knowledge acquired from evaluating this program. Declaring these objectives initially and periodically revisiting them with the leadership team helped to prevent the project goals from migrating off target.

Review the faculty development literature that relates to your focus area

Project leaders reviewed published accounts of previous successful faculty development programs (Steinert et al., 2006; Frankel, Eddins-Folensbee, & Inui, 2011) and IPE initiatives (Thistlethwaite, 2012), and incorporated lessons learned into the design of this program. Inclusion of faculty members with linkages to the practice community facilitated translation of interprofessional collaboration into practice. Emphasizing experiential learning throughout the faculty development conferences and subsequent projects fostered engagement. Peer relationships and learning for participating faculty members were stimulated through joint development conferences, periodic group calls, establishment of a secure joint website for sharing of best practices and barriers in the IPE initiatives, and presentation of IPE innovations followed by peer feedback.

Create a faculty development structure that fits the context

Creating enduring change in healthcare requires a deep awareness of the context in which the change is being implemented (Batalden & Davidoff, 2007). With over thirty faculty IPE leaders from eight institutions participating in this program, we understood that the most important benefits from this project would occur when faculty successfully introduced changes into the local settings of the participating institutions. We used an initial 3.5-day faculty development conference to ensure common grounding in key IPE knowledge. By hosting the conference at one of the participating institutions, faculty members participated in simulation exercises and served as faculty for an interprofessional error disclosure curriculum as part of the training. This shared experience proved to be an important foundation upon which faculty could build innovation in IPE with local teams at their home institution. Participants at each site developed and deployed a strategy for preparing faculty to participate in their curriculum, often using techniques modeled during the initial training. Four of the institutions chose to replicate the patient safety error disclosure program; sharing of processes and outcomes among these sites increased the learning between centers. Other institutions chose to introduce IPE elements fitting strategic needs within their interprofessional curriculum landscape.

Teach faculty to develop interprofessional initiatives that are competency-driven

All sites were introduced to the IPEC competencies in IP team-based care (Interprofessional Education Collaborative Expert Panel, 2011). In this report, the expert panel noted that core interprofessional competencies can guide professional and institutional curricular development, providing the foundation for creating a lifelong learning trajectory. Development of competency-based IPE curricula also ensures that efforts are aligned with current accreditation standards. Buring et al. (2009) also noted that competencies needed by faculty facilitating IPE mirror the competencies needed by health professions learners to engage in successful interprofessional collaboration: optimizing team performance, intrateam communication, conflict resolution, and setting common goals. Review of current curricular offerings at institutions helped to identify gaps in competencies that were not yet being addressed with interprofessional curricula, and assisted in shaping new IPE efforts. The IPEC sub-competency statements often suggested appropriate outcomes measurements to help determine if new interventions were successful.

Focus on experiential learning

Steinert (2011) notes the importance of ''self-directed learning, peer mentoring, and work-based learning'' in faculty development activities. Even as IPE students report that small interprofessional group learning provides more value than large group lecture format (Rosenfeld, Oandasan, & Reeves, 2011), the participants in our program found that the most valuable training involved ''hands-on'' learning. Recognizing that faculty members need some fundamental background knowledge in order to be effective IPE facilitators, we provided several brief didactic presentations. However, these were interspersed with small group classroom activities, moving frequently from passive to interactive learning. Participation in actual IPE activities provided many opportunities for learning practical application of their collaborative knowledge and skills. By clearly defining their roles, preparing them for that role with an appropriate pre-brief, pairing them with a ''local'' faculty member as part of a faculty dyad, and debriefing the IPE experience immediately following the training, faculty members

experienced deep and enduring learning, allowing many of them to replicate the curriculum at their home institution in the following months.

When planning interprofessional innovations, use vectors as the explicit curriculum and teamwork as the implicit curriculum

When asked to reflect on IPE learning, recently-graduated students have reflected that students valued most the activities that offered meaningful opportunities for engagement with other professional students around a relevant clinical problem (Gilligan, Outram, & Levett-Jones, 2014). Interprofessionalism can often be taught through focus upon another vector, such as quality improvement, patient safety, or error disclosure (Josiah Macy Jr. Foundation, 2012). In our program, each participating institution found that interprofessional teamwork was often best taught by making it the implicit, rather than the explicit focus of interprofessional education. When vectors such as health-care simulation or improving patient safety are offered as the explicit topic, collaborative teamwork becomes a means to accomplish the desired end. With appropriately prepared IPE facilitators, learners can be taught the importance of teamwork in ways that resonate with existing learner professional goals, such as the desire to provide high quality, safe care to their patients.

Build in time for reflection

Successful faculty development efforts include the combining of experiential learning with appropriate reflective practice (Steinert, Naismith, & Mann, 2012). Building in time for group reflection following classroom activities or real life IPE teaching assignments helps to move faculty from ''head knowledge'' to ''practical wisdom'' regarding the facilitation of IPE. Skilled debriefing sessions help faculty members consolidate and continue to use successful principles for interprofessional learning. We found that peer reflection/mentoring, during the two conferences and throughout the project by means of phone calls and website interactions, was one of the most valuable rewards of this project.

Use IPE barriers and/or failures to advance faculty expertise

Establishing or improving interprofessional curricular offerings is complex, messy work. We realized that some IPE innovations tried during our program might not be successful, at least in the first iteration. To mitigate possible faculty discouragement and promote learning, periodic group conference calls were held throughout our one year program. When needed, project leaders scheduled individual coaching sessions with site teams to ensure that interprofessional faculty teams were constructively analyzing the failures and those strategies were modified as needed for future initiatives.

Measure outcomes to promote ongoing improvement

Monitoring outcomes of IPE initiatives is not only important to enhance scholarly productivity, but is essential to assess the effectiveness of the interventions. IPE leaders must ''define learning outcomes and match these with learning activities to ensure that IPE demonstrates added value over uniprofessional learning'' (Thistletwhaite, 2012). Many published studies regarding IPE initiatives lack in reporting of meaningful outcomes beyond measurement of student satisfaction and student learning about professional roles and interprofessional communication (Abu-Rish et al., 2012). Without meaningful information available to IPE leaders regarding the impact of their initiatives on learners, faculty, patients, and care systems, ongoing targeted

innovation can become random. The Plan-Do-Study-Act cycle (Langley, Nolan, Nolan, Norman, & Provost, 2009) forms a great framework for addressing ongoing improvement. In this project, IPE leaders focused process and outcomes measurements on those that were most likely to reflect the objectives of the interprofessional faculty development training, i.e. the preparation of faculty teams to successfully implement new IPE curricular elements in their home institutions.

Enhance the spread of IPE by exporting curricular elements from one institution to another

Despite obvious differences in context at the institutions participating in our pilot project, four academic health centers were able to successfully implement the patient safety error disclosure training at their institutions. Some modifications of the curriculum were made at each institution, i.e. changing the disciplines represented in the patient scenario to reflect the health professions schools at that institution, or adding in a personal story from a presenter or facilitator to make a point. However, the fundamental curriculum, supported by key elements such as video clips, was successfully utilized at numerous sites. This was accomplished with much less effort than would have been required to launch a new IPE curriculum *de novo*.

Use information resource centers to support interprofessional work and accelerate the pace of change

The Lancet report on transforming health professions education (Frenk et al., 2010) noted that strengthening of educational resources, to include syllabuses and didactic material, was needed to equip educators to teach interprofessional care. In this project, by creating a central repository for interprofessional resources, all participating sites had access to curricular resources and standardized evaluation tools. This provided a consistency of approach in many areas, promoting efficiency and allowing for multi-site learning. Participants indicated that creating even larger resource libraries in the future would be helpful as they expanded their portfolio of interprofessional projects. Emerging resources for IPE curricula include the National Center for Interprofessional Practice and Education and the iCollaborative within MedEdPortal (see key resources section for further information).

Create more robust linkages between education and practice

At most sites, the majority of IPE offerings were directed at learners who were either in pre-clinical phases of their education or were early in the clinical phase of learning. Clinical IPE experiences are lagging behind the pre-clinical work at most of the centers who participated in our project. Headrick et al. (2012) identified the lack of a critical mass of clinical faculty who are ready to teach about improvement as a rate-limiting step in building collaborative interprofessional quality improvement programs. In order to advance IPE in the clinical domain, additional faculty champions are needed, along with a larger number of highly performing interprofessional teams that can serve as exemplars. Partnerships with health systems, where goals of creating rich interprofessional clinical learning sites are shared between educational and clinical leaders, will be essential to advancing the clinical IPE work.

Identify new faculty development strategies to expand training to the many faculty in numerous professions that are needed to support IPE

Tens of thousands of faculty members representing all health professions can potentially benefit from faculty development

training focusing on IPE theory and practice. At the least, all health professions faculty need to understand the importance of interprofessional team-based care and refrain from actively discouraging inappropriate professional silos. Each professional training site needs faculty champions who can co-design, implement, and continuously improve meaningful interprofessional experiences for learners. The faculty participating in our project felt that ongoing support of faculty development in IP team-based care is essential to help equip the national health professions workforce to embrace collaborative practice. Building upon existing programs such as the IPEC Institute, recruiting allies from professional organizations who share these goals, advocating for faculty development funding from government agencies, payers, and foundations who share this goal, and finding more cost-effective ways of promoting spread are among the strategies that can be explored going forward.

Discussion

Throughout this project, we learned that just as authenticity and customization are important characteristics of successful IPE (Hammick, Freeth, Koppel, Reeves, & Barr, 2007), these are also important characteristics of IPE faculty development. Interprofessional faculty members value learning opportunities that are relevant and applicable to their educational work and context, findings also borne out by the work of Steinert et al. (2012). Being deliberate about developing faculty by imbedding such programs within the structures of academic health centers has been identified as a necessary driver of success in health professions teaching (Engbers, de Caluew, Stuyt, Fluit, & Bolhuis, 2013), and may be a particularly important factor in clinical team-based interprofessional faculty development. A contributing factor to our project's success was the community created among the participants in the faculty development program, providing the substrate for peer learning and ongoing professional collaboration, extending beyond the time frame of the project. O'Sullivan and Irby (2011) note that such communities are important products of faculty development efforts and are a reflection of the participants, programs, content, facilitators and the context of the activities. Future challenges remain to expand such initiatives to include larger numbers of faculty and to better link IPE faculty development efforts with practicing interprofessional care teams.

Declaration of interest

Key resources

Academy for Healthcare Improvement has a number of interprofessional curricula available on their website related to the teaching of quality and patient safety, which may be of use to faculty members developing offerings in these areas. These resources can be accessed at: http://www.a4hi.org/education/eduResources.cfm

American Interprofessional Health Collaborative has links to numerous IPE resources on their website, many of which could be useful in faculty development activities: http://www.aihc-us.org/

Canadian Interprofesional Health Collaborative (CIHC) is a not-for-profit organization working to advance interprofessional education in Canada. Their website, which includes an IPE toolkit with numerous resources, can be accessed at: http://www.cihc.ca/

Centre for the Advancement of Interprofessional Education (CAIPE) is a UK-based centre that promotes and develops interprofessional education and collaborative practice in universities and the workplace. A variety of interprofession education resources can be accessed the CAIPE website: http://caIPE.org.uk/

Interprofessional Education Collaborative – A collaborative of six national education associations of schools of health professions, formed in 2009. They offer the IPEC Institute for faculty development, and have a variety of IPE resources on their website: https://IPEcollaborative.org/About_IPEC.html

MedEdPortal is a well-established compendium of medical curricula, has developed a new repository for interprofessional curricula entitled: iCollaborative. This can be accessed at: https://www.mededportal.org/icollaborative/browse/

National Center for Interprofessional Education and Practice has posted numerous resources related to IPE on their website. The center's site may be accessed at: http://www.ahceducation.umn.edu/national-center-for-interprofessional-practice-and-education/

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