Journal of Interprofessional Care

http://informahealthcare.com/jic
ISSN: 1356-1820 (print), 1469-9567 (electronic)

J Interprof Care, 2013; 27(5): 353–355
© 2013 Informa UK Ltd. DOI: 10.3109/13561820.2013.806449

informa healthcare

EDITORIAL

The moving target: outcomes of interprofessional education

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Introduction

With the explosion of enthusiasm for interprofessional education as a means to increase collaborative practice and improve important healthcare outcomes, many institutions are devoting new resources to interprofessional educational programs. Although most interprofessional education programs described in the literature are discrete curricular events with relatively short assessment periods (Abu-Rish et al., 2012; Reeves, Perrier, Goldman, Freeth, & Zwarenstein, 2013), a few institutions have outlined larger institutional frameworks for their interprofessional education programs (Blue, Mitcham, Smith, Raymond, & Greenberg, 2010). In order to reach the overarching goal of interprofessional education that improves the health of patients, longitudinal curricula should include sequenced educational experiences that build toward proficiency in practice (Josiah Macy Jr. Foundation, 2013). As leaders of large interprofessional education programs at our respective institutions, we describe the challenges facing this goal and some possible approaches to being successful.

Two challenges facing interprofessional education

Although competency documents like the one recently published by Interprofessional Education Collaborative (Interprofessional Education Collaborative Expert Panel, 2011) provide overarching goals for health professions education, individual graduates from any professional program may have more narrowly defined needs. For example, a student planning to practice in a resource-poor, primary care setting needs specific skills in teamwork, leadership and followership that bolster collaboration by allowing all health professionals in a community to practice at the top of their licensed abilities. Health professionals in this setting are often not located in the same space and, thus, must connect and collaborate with other professions across different community settings. Continuing professional development for these individuals should be driven by the unmet needs of the community. In contrast, graduates who begin practice in higher acuity environments enter settings where team members work with less geographic separation. Care is usually more urgent and hierarchical (Retchin, 2008). These practitioners may need greater skills at navigating complex systems and recognizing when to go outside the established power structure. Continuing professional development should be guided by larger system efforts at improving performance (Institute of Medicine, 2010). Other practitioners, such as those in oral health or rehabilitation services, may work collaboratively with other professions regularly but require increased knowledge and skills regarding coordinating care with external health professionals to ensure optimal patient care. With minimal evidence to support how different contexts should shape interprofessional education (Mitchell et al., 2012), curricula currently seek to teach general teamwork skills and knowledge of other professions with the hope that learning outcomes would be transferable across settings.

In addition to the current challenges to educational planners stemming from the fledgling experience in, and developing evidence about, interprofessional education, practice is rapidly evolving. The increasing demands on the healthcare system from an aging (Institute of Medicine, 2008) and increasingly multicultural population (Lie, Carter-Porkas, Braun, & Coleman, 2012) are forcing care structures to be reconsidered. In USA, insurance coverage expansion will suddenly increase primary care shortages and likely spur innovations in care delivery (Bodenheimer & Phan, 2010). Educators, in response, are forced to anticipate these models and provide experiences for trainees targeting potential – perhaps aspirational – models of care. For example, while effective interprofessional practice was critical to successful care coordination projects recently funded by the Centers for Medicare and Medicaid Services, only 27 percent of all the funded projects were successful (Brown, Peikes, Peterson, Schore, & Razafindrakoto, 2012). As research defines the best clinical models, expanding these models will require a workforce ready to participate in those care processes. Educators must be attuned to these changes so that they can adjust training accordingly.

Three paths forward

We suggest three ways forward to help overcome the tensions identified above. The easiest path forward for educational planners is to maintain the current dominant focus of learning generalized interprofessional competency within the context of acute care teams. As members of a developing field, interprofessional educators could not be faulted for trying to meet the basic educational needs of their graduates within current training

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settings and relying on continuing professional development and later training in the workplace setting. However, this approach shifts the educational burden for interprofessional education from institutions of higher learning to individuals and entities that may lack the expertise, resources and patience to transform the healthcare delivery into a more collaborative system (Institute of Medicine, 2012). In addition, this strategy does not graduate practice-ready professionals and may lead to graduates who are less competitive for desirable positions.

A second path forward is to embrace healthcare's position as a complex, adaptive system defined by the unpredictable emergence of dominating structures (Patton, 2011). Each factor or event, depending on interactions with other constituents of the system, may have a large impact. Healthcare, with surging demand, changing practice patterns and societal and financial pressures for reform, is a system ripe for innovation in care delivery. To prepare health professional students to thrive in a complex, adaptive system, educators could provide deeper training about the theoretical basis of interprofessional practice. While team training for a specific scenario, such as emergent resuscitation, may benefit a future patient in that specific situation, more important for the breadth of many students' future practice is the ability to develop transferable behaviors grounded in an understanding of how to engage the expertise of other health professions across settings. Similarly, clinical experiences in existing practice models such as the outpatient clinic or inpatient ward introduce collaborative patterns to students, but, to prepare for the future healthcare system, students need a richer understand of how the underlying concepts of collaboration apply across settings, populations and individual patients. To adapt to changing practice, health professionals need a more profound view of collaboration where they understand how health professionals work together to provide patient-centered care to individuals and their families through evolving networks of individual connections. Educating students in the theoretical basis for interprofessional practice and asking them to demonstrate application of these concepts across educational settings may develop more transferable abilities in interprofessional care.

A final path forward is to increase the link between future employers and current educational institutions. Large healthcare employers will drive much of the upcoming evolution toward interprofessional practice. By partnering with educational institutions, employers could define the desired collaborative competencies in graduates. Moreover, employers could provide clinical training opportunities for students to begin to indoctrinate future employees into the preferred patterns of practice. Pilot projects between educational institutions and healthcare employers offer potent opportunities for both entities to learn from one another with a common goal of developing transferable practice behaviors. Working together to devise curriculum and measure outcomes has the secondary gain of relieving tensions that are often present between academic faculty and healthcare practitioners charged with implementing clinical education. In addition, it has been our experience that students learning from and with each other often stimulate greater interprofessional practice in their preceptors. This approach faces some challenges. Developing partnerships requires time and other resources. In addition, new graduates can have high rates of job turnover (Institute of Medicine, 2011) which may make training investments seem futile for health care delivery organizations. However, bridging education and practice seems to have the most promise for graduating practitioners ready to practice and thrive in a new clinical environment.

Concluding comments

As the leaders of interprofessional education at an institutional level, we are challenged to define the desired interprofessional outcomes for individual students. Each learner will have a unique career that will be shaped by the settings in which they choose to practice, the divergent needs of interprofessional practice across clinical settings and an evolving healthcare system. While maintaining a focus on generalized interprofessional competency is a feasible short-term strategy, that approach may not prepare graduates optimally for future practice. Providing students with a deeper understanding of the underpinnings of interprofessional practice is one direction that may improve the ability of graduates to provide care effectively across settings. Another prospect is to partner with health care delivery organizations to shape curricular experiences and develop the competencies desired by the employer. From our perspective as campus leaders of interprofessional education, we strive to think broadly but never lose sight of the goal of graduating individuals with the foundation to be successful at delivering collaborative, patient-centered care.

Declaration of interest

The authors declare no conflicting interests. Alan Dow is supported by the Josiah H. Macy Jr. Foundation as part of their Macy Faculty Scholars Program. The authors alone are responsible for the writing and content of this paper.

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