COMMENTARY

Intentional Interprofessional Experiential Education

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The experiential component of a doctor of pharmacy curricula is an ideal, yet underutilized vehicle to advance interprofessional education (IPE) initiatives. To date, most experiential-based IPE initiatives occur in a naturally occurring, non-deliberate fashion. The American Association of Colleges of Pharmacy (AACP) Experiential Education Section formed the Task Force on Intentional Interprofessional Education in Experiential Education in academic year 2015-2016 to explore the issue. This commentary describes the work of the task force, including the following elements: defining intentional interprofessional experiential education as “the explicit effort by preceptors and practice sites to create/foster educational opportunities or activities designed specifically to achieve interprofessional educational competencies;” conducting a systematic literature review to identify examples of intentional interprofessional experiential education in the published literature; surveying faculty with oversight of experiential education programs and preceptors within those programs; and generating recommendations to stakeholders including AACP, pharmacy schools, and experiential education administrators.

Keywords: interprofessional education, experiential education, preceptor development

Background

Pharmacy educators have embraced the interprofessional education (IPE) movement. Since the American Association of Colleges of Pharmacy (AACP) was one of the original member organizations of the Interprofessional Education Collaborative (IPEC), whose expert panel report has become the seminal competency framework for interprofessional collaborative practice, this is, perhaps, not surprising.1 Increasing IPE-specific mandates from the Accreditation Council for Pharmacy Education (ACPE) have served as further motivation to advance IPE.2 Standards 2016 features IPE prominently throughout, and relies heavily on the language used, and competency domains proposed by IPEC.1,2 In addition to a dedicated IPE standard (Standard 11), nine other standards describe IPE as an important component, with assessment of students’ readiness to participate in IPE a vital part of documentation of success for pharmacy schools. More recently, entrustable professional activities (EPAs) for pharmacy graduates have also been published in an AACP special report.3 A total of six core EPA domains have been identified; one of them includes collaboration as a member of an interprofessional team. Importantly, these new accreditation standards and finalized EPA statements justify the need for IPE throughout the continuum of the experiential curriculum, culminating with a demonstration of competence in Advanced Pharmacy Practice Experiences (APPEs).

A survey of 95 US pharmacy schools conducted in 2011 reported that IPE was consistently occurring in introductory pharmacy practice experiences (IPPEs) in 55% of schools.4 Of the programs that incorporated IPE in IPPEs, 90% indicated the IPE components were a required experience and most common activities included clinical experiences with the health care team (80%), interprofessional service learning (61%), shadowing other health care professionals (54%), and case-based learning in a classroom (34%). Twenty percent indicated using an exam or standardized assessment instrument to measure interprofessional

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team performance; 70% used informal observation, and 10% used no form of evaluation. While some is known about the quantity of IPE in IPPEs, little is known about their quality or intentionality and even less is known about APPEs. As a result, developing and delivering high quality interprofessional experiential education (IEE) is viewed as a major challenge.

Leadership within AACP’s Experiential Education Section convened the “Task Force on Intentional Interprofessional Education within Experiential Education” to address this challenge. The task force was charged with determining relevant needs within the Section, then identifying and generating resources that might be used by preceptors and/or practice sites to advance intentional IEE in IPPEs and APPEs. As a first step, the task force developed the following definition of intentional IEE to guide the work: “The explicit effort by preceptors and practice sites to create/foster educational opportunities or activities designed specifically to achieve interprofessional educational competencies.”

The IPEC and Canadian Interprofessional Health Collaborative (CIHC) competency frameworks were highlighted as examples of IPE competencies. The task force performed a literature review to examine available evidence, conducted a national survey of preceptors, and developed recommendations for the academy, preceptors and practice sites. The purpose of this commentary is to share an overview of this work and to generate discussion within the academy around the need to transform experiential IPE in IPPEs and APPEs into a deliberate process designed to achieve consensus IEE competencies.

Literature Review

A comprehensive literature search was conducted in 2016 in PubMed, ERIC, and CINAHL databases for examples of intentional IEE as defined by the task force. Details of the search strategy can be found in the task force’s full report posted within the library of the Experiential Education Section Community via AACP Connect. Thirty-seven potentially relevant articles were identified; however, none of them met all inclusion criteria. One article involved intentional IEE in health professional students, but did not report educational outcomes. Findings from the review demonstrated a lack of intentional IEE initiatives in the published literature. Several studies identified, however, contained relevant and valuable information. Cohen and Welch described the use of reflective practice as a valuable mechanism to advance intentional student learning. Walsh and colleagues identified themes that preceptors/sites might prospectively incorporate into intentional IEE activities, including role clarification, professional identity formation, and educational delivery. They also reported barriers that preceptors/sites might address during the planning phase such as a lack of adequate time for, and negative baseline attitudes toward, collaborative practice. Moreover, Gruppen highlighted humility and respect as core values and facilitators of IPE. Relevant lessons include the need for early orientation of students during the didactic curriculum to the roles of team members, including known barriers to IPE, so they can be mindful and reflective during the intentional IEE experience, as well as emphasizing the importance of humility and respect in all relationships at practice sites. Lastly, those charged with infrastructure development at the institutional level are encouraged to explore the Interprofessional Collaborative Organizational Map and Preparedness Assessment.

National Survey

The task force developed and administered an Experiential Education Section-wide, two-step survey regarding intentional IEE practices in March 2016. The purpose of this survey was to quantify the amount and characterize the types and assessments of intentional IEE activities taking place within pharmacy schools nationally. In step one, faculty members with oversight responsibilities for experiential education listed in the Section registry received an email request to complete a brief demographic survey about their program and institution related to IPE. In step two, faculty members who agreed to participate were asked to forward a link with a suggested prompt to an additional survey about intentional IEE to their network of preceptors. Preceptors who completed the survey shared a variety of details about intentional IEE activities ranging from type of experiential offering and time commitment to types of collaborating health professions and assessment strategies employed. The majority of activities described by preceptors did not meet the definition of intentional IEE. Preceptors whose descriptions met the definition most commonly reported IPPE and APPE activities in the hospital/health system setting and in collaboration with the nursing profession; examples of these activities included rounds/team huddles, answering drug information questions, and giving presentations to other health care professions. The survey results confirmed that intentional IEE is time consuming and labor intensive, usually involving more than 9-10 hours to complete. Structured assessment of learning outcomes was uncommon. Finally, a significant barrier to intentional IEE was a lack of other health care professional learners at the site. More detailed information from the survey can be found in the task force’s full report.

Recommendations

ACPE has clearly outlined expectations for IPE, yet our literature review provided minimal guidance on how
to intentionally develop and assess IPE activities in experiential education settings. Additionally, there is a clear disconnect, as highlighted in the survey results, between how preceptors and academics responsible for student learning outcomes define IPE and intentional IEE. While the majority of learning activities reported described rounding, the lack of intentionality and assessment of IPE competencies achieved following these activities was noteworthy, especially since the definition of intentional IEE was provided as a reference for survey items. Finally, the central barrier of a lack of access to other health care professionals remains a major issue for many pharmacy programs with the greatest need existing in the community pharmacy setting to create meaningful and intentional IEE activities. Findings from the literature review and survey highlight a gap in pharmacy education in need of attention to ensure learners are exposed to, learning from, and achieving IPE competencies through intentional IEE activities. The following section outlines our recommendations to AACP, pharmacy schools, and experiential education administrators.

The lack of published literature describing intentional IEE activities, including assessment of such activities, is a key problem that emerged from the work of this task force. The significant variation among institutions and preceptors reported in the Section-wide survey, including the most basic step of working from a common definition, highlight this problem and draw attention to the difficulties inherent in attempts to quantify and characterize intentional IEE across the academy. AACP has been a leader in IPE working with other health professions educational organizations and their work should be commended and encouraged to continue. Regarding the creation, delivery, and assessment of IEE and the intentionality with which it is done, we recommend that AACP can enhance its efforts by: 1) endorsing and promoting the definition of intentional IEE developed by this task force at the organizational and membership levels; 2) charging appropriate groups within AACP to collaborate and identify appropriate instruments to assess IEE; 3) promoting publication of high quality intentional IEE research and reports of experimental intentional IEE pilot programs; 4) augmenting the AACP website to include evidence-based tools to aid pharmacy schools in their intentional IEE efforts; 5) advocating for the expansion of faculty and preceptor development programs targeting an evidence-based approach to the design, implementation, and assessment of intentional IEE; 6) establishing a grant program for development and delivery of IEE programs demonstrating both educational and patient care outcomes; 7) establishing an award that recognizes institutions that have successfully designed, implemented, and contributed to innovative and intentional IEE; 8) designating an individual staff member to oversee IPE initiatives and serve as a direct resource to pharmacy schools; 9) supporting the continued growth of the AACP IPE Community of Practice that launched in 2016, and encouraging this group to focus on intentional IEE; 10) partnering with IPEC, the American Interprofessional Health Collaborative, the National Academies of Practice, and/or the National Center for Interprofessional Practice and Education to create an academic/administrative fellowship program to advance intentional IEE nationally; and 11) leveraging resources and connections with other health professional organizations to request enhanced collaboration for this initiative.

Pharmacy schools can enhance intentional IEE during pre-APPEs and APPEs. Pre-APPE intentional IEE, especially within IPPEs, should introduce learners to foundational IPE concepts and allow them to develop key skills necessary to succeed in IPE during their APPE years. One solution proposed by Jones and colleagues was for each college or school of pharmacy to identify an IPE champion whose primary teaching and scholarship responsibilities would include identifying the development, delivery, and comprehensive assessment of IPE throughout IPPEs and into APPEs in collaboration with associated experiential faculty and partner institutions.

APPE intentional IEE activities should emphasize the core concepts of IPE taught in the pre-APPE years, providing additional exposure and opportunities to build upon their skills to improve patient outcomes. An important concept in developing and tracking IPE is that of curricular threading and including the IPE competencies into syllabi of the IPPE and APPE courses. An APPE in a health system with a rounding medical team, for example, is not necessarily intentional IEE by itself. The intentionality comes with specifically targeting IPE competencies in the design/developmental phases of the IEE activity. This might include reflection and assessment to determine whether the IPE competencies were achieved with the specific activities designed. It is particularly helpful if other professions work collaboratively with pharmacy schools to build these same competencies into their experiential syllabi and practice similar documentation methods.

Finally, pharmacy schools are encouraged to use a scholarly approach for intentional IEE so that other programs can benefit from successful models and lessons learned. Our task force identified educators well-published and respected in the area of IPE and asked them for examples of early innovations of intentional IEE activities or ideal experiential settings for IEE that should be utilized. The five suggestions were well supported as potential
Methods. Interprofessional Experiential Courses. Interprofessional Patient Care Rounds, Interprofessional Nursing Home Visits, Interprofessional Clinic Visits, Interprofessional Specialty Practice Experiences, and Mixed Methods Interprofessional Experiential Courses. While many of these are ideally performed at large academic health centers with a variety of health care professions onsite, the concepts are flexible and could potentially be adapted according to institution-specific constraints. Detailed descriptions of each can be found in the task force’s full report.

In these or other types of IEE activities, intentionality can be achieved if the stated goals for the experience also include IPE competencies, reflection on these competencies is required, and assessment of the outcomes of how well the students worked together to achieve the competencies are documented. A meaningful discussion with the learners should summarize what went well interprofessionally and what could be improved. Finally, careful attention should be paid to whether experiences are designed longitudinally or episodically and that the objectives chosen for each experience aptly match the assessment created or used.

For experiential education administrators, preceptor development is paramount. It is critical to convey to preceptors the importance of post-licensure professional development in collaborative practice and teamwork skills. Ultimately, the quality of IPE learning is dependent upon the practice models preceptors create. Helping preceptors transform their IPPEs and/or APPEs into successful intentional IEE will require robust training and collaborative building of these experiences between experiential administrators and partner institutions. The experiences students have are meant to prepare them to continue to work interprofessionally as practitioners. In the non-academic world, preceptors are encouraged to involve themselves and students in intentional IEE work at their respective practice sites whenever possible.

Interprofessional collaboration is based on positive relationships with colleagues making it critical that practitioners who precept students take time to develop a strong team dynamic before hosting students at their site. Modeling this type of practice reinforces that interprofessional collaboration is an essential element to effective practice and not simply an academic add-on. All IPE competencies should be modeled and taught with a special focus on communication given that “diagnostic accuracy, clinical decision-making, adherence to regimens, satisfaction with care, and malpractice risk are all influenced by the quality of the communication between the clinicians and the patient and family” as outlined by the National Academy of Medicine.

Results from one question in the national survey warrant special attention as it relates to experiential administrators. Preceptors were asked to describe intentional IEE activities occurring at their site, and the majority of responses provided did not meet the definition of intentional IEE. This highlights a key challenge and opportunity for preceptor and practice site development; namely, the need for professional development targeting the basics of IEE and how, if possible, preceptors might make IEE activities intentional by specifically targeting IPE competencies. Depending on the environment, practitioners may find the development and implementation of high-quality intentional IEE challenging and would benefit from tools to use with students on practice experiences. Several of the resources curated by the task force and posted on the Experiential Education Section website are designed specifically for preceptors in practice. Additionally, any intentional IEE work currently being performed should be evaluated for potential publication and dissemination, especially work measuring the impact of IPE on collaborative practice and patient outcomes.

CONCLUSION
Findings from a literature review and national survey confirm there is a critical need to build intentional interprofessional experiential education throughout the continuum of the curriculum. To do so, we believe the first step is agreeing on consensus terminology. The IPEC and CIHC competency frameworks, and more recently EPA statements, have provided a common target in terms of competencies. To ensure our graduates are collectively prepared not only for APPEs, but most importantly to practice competently within high-functioning health care teams upon licensure, we believe experiential learning activities must explicitly and prospectively target IPEC and/or CIHC competencies. Little progress in this area is expected until colleges and schools of pharmacy collaborate with health care systems toward practice transformation.

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