

INTERPROFESSIONAL AND TEAM-BASED CONTINUING EDUCATION FOR HEALTH PROFESSIONALS

BILJANA GJORGJESKA

University "Goce Delcev", Stip, Macedonia

ABSTRACT

The benefits of implementing interprofessional and team-based programs are well recognized. However, for interprofessional education to be effective and broadly implemented, the health professions, policymakers, insurers, academic institutions, health care providers, and regulatory bodies should embrace and adopt a new, interprofessional education framework. These stakeholders should create a shared value and vision for interprofessional health professions' education, research, and practice. This vision should be patient-oriented and contain a measurable component across the entire educational continuum, from admission into a health professional program through retirement. Such a framework would maximize and value the strengths of individual professions in the integrated delivery of high quality care. Finally, in creating a successful model, a series of questions should be considered: how best can team competence be measured, how should individual behavioral changes be documented when we think of individual rather than team-level changes, how do we create and measure performance criteria based on shared understanding and experience in the practice setting?

Within academic settings, there are more specific barriers including a lack of administrative support, financial and human resources for interprofessional education, conflicts in schedules and health professions' curricula, and limitations to the time required to plan and implement faculty development for interprofessional learning. Finally, despite progress, there remain regulatory and professional barriers to achieving full and meaningful implementation of effective models. Recommendations which are given emphasize that investing in research to evaluate the efficacy of continuing education and its impact on patient outcomes and the healthcare delivery system is inherent in this process.

UDC CLASSIFICATION & KEYWORDS

■ 001.18 ■ Continuing education ■ Health professionals ■

INTRODUCTION

Interprofessional approaches to care are not new. In the U.S., three decades ago, Halstead published the first review of the outcomes of interprofessional team approaches in the area of chronic illness and rehabilitation (Halstead LS, 1976). This approach was later used in many other areas of care such as primary care, mental health, geriatrics, critical care, chronic illness, and hospice care. However, the interprofessional approach has been used mostly in responding to critical issues in health care delivery. In rehabilitation, in geriatrics, and more recently, in chronic illness care, an underlying issue has been the need for complex, comprehensive care. Starting in the 1960's have driven the development of interprofessional care models in primary care, access to care for underserved populations, as well as family-oriented and preventive care needs, including the creation and growth of the nurse practitioner role (Charney E, Kitzman H, 1971).

Objective

Interprofessional education (IPE) is defined as "any type of education, training, teaching, or learning session, in which two or more health and social care professions are learning interactively". The definition includes both instruction in formal training programs and continuing education efforts, including workplace learning. However it is defined, interprofessional education remains relatively underdeveloped and undervalued in health professions education and formal continuing education (Baldwin DC, Baldwin MA, 2007). The aim of this study was to find out what can be done for developing IPE from the point of all participants engaged in this process.

Discussion

In light of growing concern over patient safety and quality, it is recommended the integration of five competencies as core to all health professions' education. One of these is these is competence to work in interprofessional teams.

Other recommendations emphasized establishment of national goals for improvement in the core competencies, and the need for engagement and coordination of those in charge of oversight processes, such as those providing accreditation of educational programs, professional licensure, and certification bodies, to ensure that the core competencies were integrated into health professions education programs. Supportive training environments were advocated, along with the development of a stronger base of evidence in professional and interprofessional educational approaches, whose outcomes could be linked to improved patient care. Better measurement of core competencies, such as the ability to work in interprofessional teams was viewed as an important part of strengthening the evidence base.

More explicit attention has been paid to improving communication, teamwork behaviors, and care coordination in the workplace as the result of standard setting by the professional bodies. The gaps, errors, redundancies, and other problems associated with limitations of the structure and processes of interprofessional care (and implicated in poor care coordination) have become the target of team-building literature and programs in institutional contexts.

They range from changing individual professional attitudes, skills (including communication skills and behaviors) to team-based interventions (such as interprofessional unit rounds) to large institutional culture change interventions, as well as the creation of checklists and technological “fixes” that can support improvements in interprofessional care processes (Salas E, DiazGranados MS, Weaver S J, King H, 2008. King HB, Battles J, Baker DP, Alonso A, Salas, E, Webster J, Toomey L, Salisbury M, 2009. Lingard L, Regehr G, Orser B, Reznick R, Baker GR, Doran D, Espin S, Bohnen J, Whyte S, 2008). However, the progress is noted, particularly in high-risk institutional settings, in refining our understanding of critical interprofessional care processes, such as communication processes and strategies for improving them (Apker J, Propp KM, Zabava Ford WS, Hofmeister N, 2006).

In academic institutions, there are a number of challenges to the planning, implementation, and evaluation of IPE models in practice and education. Challenges include differences in: history and culture, in language and jargon, in schedules and professional routines, and in accountability, payment, and rewards; professional and interprofessional professional identity, and clinical responsibility; levels of preparation, qualifications, and status; and in requirements, regulations, and norms of professional education. (Headrick LA, 2000. Ho K, Jarvis-Selinger S, Borduas F, Frank B, Hall P, Handfield-Jones R et al., 2008).

Within academic settings, there are more specific barriers including a lack of administrative support, financial and human resources for interprofessional education, conflicts in schedules and health professions’ curricula, and limitations to the time required to plan and implement IPE faculty development for interprofessional learning. (Steinert Y, Cruess S, Cruess R, Snell L, 2005).

There remain regulatory and professional barriers to achieving full and meaningful implementation of effective IPE models.

Conclusion

As the conclusion the recommendations which are given emphasize that investing in research to evaluate the efficacy of continuing education and its impact on patient outcomes and the healthcare delivery system is inherent in this process.

4.1 Educators, curriculum planner and others should consider and incorporate meaningful, formal and experiential, interprofessional education in entry-level and advanced training of all health professionals. This should include, but not be limited to, curricular redesign, creation of experiential learning opportunities, evaluation of IPE activities, and design/implementation of IPE continuing education programs specific to work settings. (Barr H, Freeth D, Hammick M, Koppel I, Reeves S, 2006).

This culture shift would create a framework for health professions’ education that incorporates and builds upon common values and goals related to patient-centered care, mutual respect, effective communication, knowledge regarding health professional roles and responsibilities, and behaviors that express cooperation, coordination, and collaboration. IPE curriculum planning should incorporate a determination of the types of interprofessional experiences appropriate for different learning levels, how these experiences can best be integrated into health professions’ curricula and identification of core IPE competencies for all health professionals. IPE experiences should be dynamic and incorporate interactive activities.

To support the integration of IPE curricula and core competencies into health professions’ education, several elements are necessary:

- Faculty and staff development that focuses on the development and implementation of interprofessional content and learning strategies needs to occur early in the development of an IPE curriculum;
- health professional education accrediting bodies’ have to identify a clear and meaningful standards for IPE that establish expectations, drive curricular change, and require performance measurement and translation into practice;
- collective actions by interprofessional education, research, and clinical practice leaders should foster the testing of innovations and the subsequent modification of health professions curricula to foster IPE; and
- partnerships among health professional schools should facilitate exchange of resources and best practices, to promote IPE innovation and curricular development and to support the development of a common value base.

4.2 Organizations concerned with the assessment of competence, including licensing and certifying bodies, should develop and assess interprofessional team competencies in conjunction with health professional organizations. Based on nationally agreed-upon core competencies, the development of a standardized assessment process would help determine health professionals’ abilities to work effectively together and translate these knowledge and skills into practice. Further, a standardized assessment would create measurement and performance tools focused on effective team functioning.

4.3 Continuing education providers, faculty members, and certification and accreditation bodies should support and create strategies for meaningful, outcomes oriented IPE. These strategies should include streamlined curricula and program design and the development of certification processes to encourage IPE complementing the individual professional accreditation components and systems.

The development of IPE would articulate the individual, organizational, and system factors that need to be addressed to enhance quality care to patients.

To achieve this goal, health professionals should create IPE experiences using effective learning methods that encourage knowledge-sharing among healthcare professionals. IPE should engage healthcare professionals, at both the individual and organizational levels, to deliver and demonstrate knowledge and understanding of the issues or problems that concern practitioners and consumers.

Through the adoption of these methods and policies, clinical educators, faculty, and administrators, as well as academic and health care institutions can affect IPE that is evidence-based and improves care outcomes.

Finally, accrediting bodies should attend to the development and implementation of meaningful accreditation and certification criteria that support outcomes-oriented, team based care.

4.4 Healthcare institutions should create or collaborate to ensure multiple opportunities for meaningful, interactive health professional learning experiences that provide feedback on the health professional's performance. In addition, healthcare institutions' accrediting and regulatory bodies should incorporate requirements for IPE experiences into standards and policies.

This recommendation requires organizations that set professional standards for healthcare institutions, professional specialties, and academic institutions to support the creation and implementation of performance measures that reflect intra and inter professional behaviors leading to improved patient outcomes.

Integrating IPE into health professionals' education and into their daily practices and schedules is critical. Investing in research to evaluate the efficacy of IPE and its impact on patient outcomes and the healthcare delivery system is inherent in this process.

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