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History and Development of Interprofessional Education

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Introduction

While Interprofessional education (IPE) has existed as a powerful construct for many years, the advent of the Patient Protection and Affordable Care Act (2010) in the United States (U.S.) has placed a new urgency on integration of an IPE model into the education of students in speech-language pathology and audiology. The American Speech-Language-Hearing Association (ASHA) has embraced the IPE concept [1], and the ASHA Ad Hoc Committee on Interprofessional Education has strongly recommended that ASHA support IPE within its academic curriculum for Audiologists and speech-language pathologists. As a result, it is very likely that ASHA will require that academic programs in its purview to train students, both academically and experientially, in IPE concepts and practices. As noted in the Ad Hoc report, "We need to immediately begin educating the academic arm of our professions so that they can begin educating and training other educators, practicing professionals, and future practitioners in IPE/IPP" (p. 4). At present, audiology and speech-language pathology lag behind other allied health professions (e.g., Nursing, Physical Therapy, and Occupational Therapy) in these efforts, and this review seeks to place the ASHA imperative within a historical perspective, as well as to provide two examples of Interprofessional education integrated into the academic and clinical education curriculum in one university setting.

Interprofessional Education

Education within the health professions, and most specifically Audiology and Speech-Language Pathology, is undergoing a radical transformation, arising from several converging environmental forces. The World Health Organization (WHO) envisioned an educational system that would promote interprofessional learning with those outside their discipline as a means of improving the quality and effectiveness of health care worldwide. In the WHO view, the aim of interprofessional education is to "prepare all health professions students for deliberately working together with the common goal of building a safer and better health care system" [2].

Notwithstanding its growing popularity, IPE is not a recent phenomenon. In 1969, a paper entitled "Interprofessional Education in the Health Sciences" reported:

It appears that health professionals employ their talents inappropriately, and, as a consequence, scarce human resources are wasted. Evidence also indicates fragmentation and compartmentalization and poor communication between those who provide different components of the health services Accordingly, a committee on IPE in the health sciences has been established to promote interprofessional education and to experiment with educational programs to arrive at recommendations concerning what the students should learn together and how they should learn it [3].

With roots in the 1960s and 1970s, mostly across the United Kingdom (U.K.) and United States [4,5], the IPE movement became energized in the late 1980s through two WHO reports, Continuing Education for Physicians [6] and Learning Together to Work Together for Health [7]. In the U.K., IPE originated in numerous discrete initiatives largely unknown to each other in various fields of professional practice [8]. Early IPE efforts were largely based on the premise that teamwork and collaboration not only help to better meet the needs of patients and clients, but also help resolve tensions between professions practicing in close proximity [5].

The Centre for the Advancement of Interprofessional Education (CAIPE) led IPE efforts in the U.K. following its creation in 1987 [9]. These efforts were complemented in 1992 through creation of the Journal of Interprofessional Care [5], which was committed to Interprofessional learning. The Journal helped to establish IPE as "a disciplined activity, grounded in scholarship and worthy of a place in academe" (Barr, p. 5).

Debating Differences and Finding Common Ground

As IPE became more widely discussed, differences in definitions, perceptions, purposes, and approaches became apparent among stakeholders, including healthcare providers, professional associations, regulatory bodies, universities, and the burgeoning IPE research community. To some, IPE was a mechanism to resolve misunderstanding and tensions between and among the professions [10]. To others, it was a means of improving teamwork or reforming professional education [2].

Views about the degree of IPE instruction varied as well. Some felt that an occasional presentation of IPE was sufficient to produce and sustain a collaborative workforce, and yet others argued that IPE could only be effective if it were pervasive, being thoroughly imbedded in the curriculum of all health professions [11-13]. Some held that IPE must be inculcated from the beginning of a student's pre-licensure studies, while others suggested a more delayed exposure [14-16]. Some IPE enthusiasts pressed for a single method of IPE teaching and learning; others cited the merits of a repertoire upon which teachers and facilitators, based on the situation, could employ the most appropriate method or approach to adult learning [17].

The Need for Consensus about IPS: Adopting Definitions

In the mid-1990s the CAIPE formally defined IPE as "occasions when two or more professions learn with, from and about each other to improve collaboration and the quality of care" [5]. To differentiate IPE from other healthcare professional interactions, the CAIPE further

defined multiprofessional education (MPE) as “occasions when two or more professions learn side by side for whatever reason” [5].

These definitions were further refined by the World Health Organization (2008) [18], which observed that in many settings, health care professionals already work in various types of teams and actively communicate to plan and deliver care. However, the WHO classified that level of teamwork and communication as cooperative and coordinated, but not collaborative [19]. Thus, the concept of IPE now includes collaboration: Interprofessional care involves teamwork with a higher level of engagement that revolves around respectful understanding of diverse and competing scopes of practice including a value of the unique contributions that each profession brings to the health care team [19,20]. It includes the capacity, competence, and confidence to negotiate the plan of care in a true shared-work environment. Way, Jones and Baskerville [21] defined collaboration as an Interprofessional process of communication and decision making that enables the separate and shared knowledge and skills of care providers to synergistically influence the client/patient care provided.

IPE in context: A Spectrum of Learning

Harden [22] introduced the notion that health professions students should be exposed to a "spectrum" of learning with others. Within this spectrum there are profession-specific competences that are best taught in a uniprofessional manner that employs the most appropriate, discipline-specific teaching and learning methodologies. This form of learning has been the traditional approach to teaching and training future health professionals [14]. Learning to become a collaborative practitioner, however, demands interprofessional education, defined by CAIPE as occasions when two or more professions learn with, from, and about each other to improve collaboration and the quality of care [5]. Thistlethwaite and Moran [23] suggested, however, there may be times when a multiprofessional approach (students brought together to learn in parallel) is most efficient and effective. Oandasan and Reeves [8] proposed that in choosing whether to engage a uni-, multi-, or Interprofessional learning strategy, educators must consider both the learning objectives of the curriculum and learning context, including phases or stages of education, the environment or setting, the participants, the learning approach, and the material to be presented or taught.

Increasing Attention to IPE in the United States

The focus on IPE in the U.S. sharpened following the Institute of Medicine's (IOM) publication of three seminal reports related to health care quality, patient safety, and the relationship of these to health professions education: To Err is Human: Building a Safer Health Care System [24], Crossing the Quality Chasm: A New Health System for the 21st Century [25], and Health Professions Education: A Bridge to Quality [26]. Blue, Brandt, and Schmitt [9] observed that this Institute of Medicine trilogy provided "significant impetus to a new approach and urgency to rethinking interprofessional relationships . . . and team-based care" (p. 205). Since the 1990s, the Institute for Healthcare Improvement has also initiated a national effort to stimulate new thinking about fundamental changes in health professions education as a way to improve safety and quality [11].

Internationalization and Integration

From the early 1970s, the world health organization (WHO) has been instrumental in advancing IPE internationally [8]. Other international organizations, including the Organization for Economic Co-operation Development (OECD) and the World Federation of Medical Education (WFME) have also been proactive in fostering the interests of IPE [8]. In more recent years, the IPE movement has been greatly energized by creation of the Canadian Interprofessional Health Collaborative (CIHC) [15], the American interprofessional health collaborative (AIHC) [9], and Collaborating across borders (CAB) [13], all of which were organized for the express purpose of advancing interprofessional education and collaborative practice locally and abroad.

The World health organization's 2010 Report: Framework for Action on Interprofessional Education and Collaborative Practice [20] further elevated IPE to the global health and education agenda when it recognized IPE as a necessary component to every health professional's education. A recent and first-ever environmental scan confirmed that IPE now occurs in several countries, including the U.S., Canada, England, Australia, Belgium, Denmark, Finland, Greece, Hungary, Iran, Ireland, Japan, Malaysia, New Zealand, Norway, Poland, and South Africa. It is clear that a number of health professions have engaged IPE, with the greatest representation coming from nursing, the allied health professions, physicians, and social workers [27]. This global review of IPE practices further revealed that IPE is utilized to varying degrees across developed and developing countries, and there is wide variance in the degree to which educational institutions across the globe implement many of the evidence-based practices associated with implementing and sustaining IPE [27]. Creation of the CIHC, AIHC, CAB, and other above noted associations have done much to effectively integrate what had previously been a fragmented community of IPE teachers and scholars.

The Business Case for Interprofessional Education

Several systematic reviews have indicated the benefits of IPE [28-31]. The case for interprofessional education and collaborative practice was perhaps best expressed by the World Health Organization [20].

After almost 50 years of inquiry, there is now sufficient evidence to indicate that interprofessional education enables effective collaborative practice which in turn optimizes health services, strengthens health systems and improves health outcomes. . . . Research evidence has shown a number of results:

Collaborative practice can improve:

- Access to and coordination of health-services
- Appropriate use of specialist clinical resources
- Health outcomes for people with chronic diseases
- Patient care and safety
- Collaborative practice can decrease:
- Total patient complications
- Length of hospital stay
- Tension and conflict among caregivers
- Staff turnover
- Hospital admissions
- Clinical error rates, and
- Mortality rates. (p.18-19)

Current Drivers of Interprofessional Education

Although early initiatives in IPE emerged in the 1960s, what actually developed was a recurring pattern of short-lived efforts to educate health and medical professions students together [4]. Change was slow and the drive to establish IPE clearly lacked sufficient positive drivers [32]. Baldwin contends greater success was never met because "there was never a compelling national mandate or any long-term supportive reimbursement mechanisms" (p. 194). Today, these and other barriers are being addressed and mitigated as never before [8,33]. The 2013 ASHA Ad Hoc Committee report is clear evidence of this move in the allied health professions. Increasingly, participants and observers of IPE are concluding that "IPE has become a mainstay of health professions education and is here to stay" [34]. Baldwin (2010) observed.

I personally have never before seen the national experts, media, and citizenry so interested and concerned about the need for better communication and collaborative teamwork among health professionals. Whereas previous concerns over communication and collaboration affected limited special conditions like diabetes and stroke . . . the current concern over patient safety is universal. (p. 195).

Current and projected shortages of needed health professionals at least partially arise from an aging population and increasing prevalence of long-term chronic disease. These issues further fuel the demand for team-based, collaborative care [35]. Other current-day drivers include the recent passage of the Patient Protection and Affordable Care Act (2010) [36] and the Health Care Education and Affordability Act (2010) [37]. These major legislative reforms call for wide spread changes not only in the way we organize and deliver care, but also in our methods and approaches to health professions education [4].

Farnsworth, et al. [39] found that both administrators and faculty within the allied health professions are strongly committed to development of IPE in training settings. While 63% of Deans and over 94% of surveyed faculty were either moderately or extremely interested in establishment of IPE in their university settings, just over 17% of Deans and 30% of faculty felt that they had made good or significant progress in that implementation. Thus, faculty and university administrators differ in their perceptions of both the urgency and successful implementation of IPE within the same institutions. Fifty-five years following the call to fully embrace IPE, we remain faced with the daunting challenge of implementing IPE in institutions dedicated to the highest level of instruction in best practices. There remains a critical opportunity for reform of education in the health professions [10,24-26].

Two Implemented Interprofessional Education Programs

With the support of the division of health sciences (DHS) within Idaho State University, the department of communication sciences and disorders has implemented two interprofessional education programs in an effort to inculcate IEP into the DHS curriculum. These two programs encompass both assessment and intervention from a broad interprofessional perspective.

The Idaho state university interdisciplinary evaluation team (IET) was conceptualized and instituted in 1987 with the full support of the dean of the Kasiska College of Health Professions. The team gained visibility and IET was officially added to the curriculum as a course in 1991. (Use of the term “interdisciplinary” reflects on the date of implementation rather than the underlying structure, which has fully embraced interprofessional philosophies.) The team is designed to introduce students to the various models of the team assessment and collaboration, to provide an overview of the assessment goals and procedures associated with each discipline, to develop an appreciation of the various disciplines and their overlapping roles, to integrate the information from the disciplines into student’s own profession, and to offer clinical training opportunities for advanced students. To accomplish these tasks, students attend formal lectures from the individual discipline, which allows the student to gain a deeper understanding of the professions involved. Additionally, IET is charged with providing students in speech-language pathology, audiology, psychology, social work, nursing, occupational therapy, physical therapy, dietetics, dental hygiene and special education with the direct experience of assessment and diagnosis of individuals with varying complex comorbidities. Throughout the semester clients are referred to the team for a comprehensive assessment that includes all the disciplines. The students have a unique opportunity to participate and/or observe the entire process from the initial evaluation to the collective meeting after the assessments are complete. Furthermore, the students interact and learn from the professionals and other students within each discipline. In this model, all disciplines are full participants in assessment and post-assessment collaborative discussion to summarize the evaluation process, to integrate the evaluation findings, and to prioritize the recommendations for intervention and to identify sources of service delivery.

A more recent development has been the creation of the Northwest Centre for Fluency Disorders Interprofessional Intensive Stuttering Clinic [39], which provides IPE through a fully integrated interprofessional practicum experience to graduate students in both Speech Language Pathology and counselling during the treatment of individuals who stutter. Prior to interactions with clients, student clinicians complete online modules, and subsequently attend a three-day didactic IPE course. The IPE for this clinic primarily presents information about professional roles and responsibilities, communication in team settings, facilitation of teamwork environments, stuttering, and mental health through lecture and experiential learning activities. During the clinic, students and clients learn about the multidimensional aspects of stuttering, styles of communication, cognitive, emotional, and social mental health needs, and building support networks. Each client is assigned one graduate Speech-Language Pathology student and one counselling student to work with him or her throughout the clinic. Both clinicians attend and are involved in each therapy session and work to facilitate transference of progress to generalized settings. Speech-Language Pathology and counsellors provide appropriate supervision to the student clinicians throughout the clinic. Additionally, as a full group the clinicians and supervisors debrief about clients’ needs and progress for one and half hours each day. Following the clinic, student clinicians attend a one-day follow-up meeting, as is common practice in IPE. In this model, faculty supervisors and student clinicians work in teams to assess and treat the complex issues surrounding individuals who stutter. While outcomes of this program will be presented in future reports, on-going research indicates that clients and students in both professions gained meaningful and significant benefit from the experience.

Conclusion

For many institutions, IPE is still in its nascent stages. Accordingly, there remain clear and compelling opportunities for improvement. Expanding opportunities for bridging IPE between academic settings and practice environments will be supported through partnerships that embrace interactive methods of teaching that interfaces IPE principles and practices into existing policy, plans, and evaluation of outcomes in the clinical setting [40].

Programs in Speech-Language Pathology and Audiology that are within rich health professions environments (e.g., college of health professions; school of rehabilitation sciences) are well-situated to alter their curricula to embrace IPE, while those within colleges of liberal arts or education may well have to be more creative in their approaches. As noted by Farnsworth et al., [38] it is critical to actively nurture administrative interest in IPE, emphasizing the direction that ASHA and other allied health profession accrediting bodies are taking. Interprofessional Education requires creative scheduling coordination, but most importantly, requires buy-in from faculty. IPE will be developed most successfully by a program whose leadership embrace and embodies the change that is desired.

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