



Research

Practice Site Readiness for Interprofessional Education (PRIPE): Instrument development and pilot study

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Abstract

Objective: To describe the development and pilot study of the Practice Site Readiness for Interprofessional Education (PRIPE) instrument.

Methods: The 30-item PRIPE instrument was developed to assess the structural and procedural readiness of experiential pharmacy practice sites for interprofessional education (IPE) using the Interprofessional Education Collaborative (IPEC) core competencies for interprofessional collaborative practice (IPCP) as a main source of inspiration. A pilot study of PRIPE was conducted via investigator-led, structured interviews of geriatric and pediatric experiential preceptors. Descriptive statistics were used to characterize the results.

Results: Twenty interviews were completed, yielding a response rate of 51.3%. There was an equal distribution of geriatric and pediatric preceptors; 55% were faculty and 45% were adjunct. All practice sites were found to train other health care professional students (nursing 95%; medical 55%; social work 35%; physical therapy 25%; occupational therapy, physician assistant, and psychology 20%; dentistry 15%; and public health 0%). Journal clubs and topic discussions emerged as opportunities to expand IPE. Over 50% of preceptors reported frequently meeting the IPEC core competencies related to communication (listen, exchange ideas, and use respectful language), teamwork (use complimentary abilities, build relationships, and share accountability and patient-centered problem-solving), and roles/responsibilities (clarify responsibilities). Of the preceptors, 80% of them reported that their practice met the definition of interprofessionality.

Conclusions: PRIPE is a useful instrument to identify potential IPE collaborators and collaboration-friendly IPE activities at experiential practice sites as well as to assess the frequency with which critical IPEC core competencies are being met. The authors envision academic and practice site administrators utilizing PRIPE as a quality control measure.

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Introduction

The interprofessional education (IPE) and interprofessional collaborative practice (IPCP) movements continue to gain momentum in the United States (US). After decades of IPE and IPCP promotion by the Institute of Medicine (IOM), provisions for both were codified into law in 2010 with the passage of the Patient Protection and Affordable Care Act (ACA).^{1–4} The previous year, the professional associations representing all US colleges and schools of dentistry,

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medicine, nursing, pharmacy, and public health formed the Interprofessional Education Collaborative (IPEC). The IPEC published an expert panel report outlining core competencies for IPCP in May 2011, which is intended to aid incorporation of IPE initiatives into health professional curricula.⁵

Sequential review articles published since 2001 highlight the nascent, yet growing state of this field.^{6–8} The most recent review identified only 15 studies of sufficient rigor and quality for inclusion. These studies evaluated a wide array of IPE interventions and measured a variety of different outcomes. As a result, the authors concluded that it remains impossible to make evidence-based inferences about the effectiveness of IPE. The evolution of IPE has continued despite the lack of a compelling body of evidence. Consensus definitions for IPE and IPCP have emerged alongside theoretical frameworks for understanding the field and evaluating IPE initiatives.^{9–15} These definitions, proposed by the World Health Organization (WHO) and endorsed by the IPEC, are provided below:

Interprofessional Education: When students from two or more professions learn about, from and with each other to enable effective collaboration and improve health outcomes.

Interprofessional Collaborative Practice: When multiple health workers from different professional backgrounds work together with patients, families, carers [sic], and communities to deliver the highest quality of care.

In addition to the above developments, accrediting bodies in nursing [Commission on Collegiate Nursing Education (CCNE)] and pharmacy [Accreditation Council for Pharmacy Education (ACPE)] have incorporated robust IPE-/IPCP-related language into their standards.¹⁶ The Liaison Committee for Medical Education (LCME), the group responsible for assuring the quality of allopathic medical education in the US, held a recent vote to finalize a proposed interprofessional education standard (ED-19-A).¹⁷ This new LCME standard took effect on July 1, 2013. Furthermore, prominent US institutions have begun linking institution-wide IPE development to their regional re-accreditation.^{18,19} This is an especially important development as it demonstrates that individual health professional colleges and schools are beginning to be held accountable for this change.

The Readiness for Interprofessional Learning Scale (RIPLS) has emerged as a dominant tool for evaluating individuals and tracking their development in this arena.^{20–22} However, little work has been done in assessing institutional capacity for IPE. To our knowledge, there is no readily available tool for an academic administrator to determine, for example, if the clinical training sites under their purview are conducive to IPE. In other words, the success of an IPE initiative is unlikely if the structures and processes needed for IPE are absent. We created the Practice Site Readiness for Interprofessional Education (PRIPE) instrument to address this deficiency and then pilot tested it with geriatric and pediatric preceptors at the Texas Tech University Health Sciences Center (TTUHSC) School of Pharmacy (SOP). We chose these populations for two

reasons. The first was to dovetail with a unique curricular feature at TTUHSC SOP; specifically, that advanced clinical training in both geriatrics and pediatrics is required for Doctor of Pharmacy graduation. Secondly, these fields, especially geriatrics, have a strong history of embracing IPCP and promoting IPE.^{23–30}

Methods

Survey development

Overview

The PRIPE survey was developed with four sections. The first two sections aim to take an accounting of structural elements related to IPE. The third section utilizes IPEC competencies to assess the frequency with which IPCP activities take place. The final section asks preceptors to make a global judgment of the nature of IPE/IPCP at their practice site. The clinical practice site is the unit of analysis for the first section. The preceptor's service is the unit of analysis for the remaining sections. Specific descriptions for each of the four sections are provided below.

Section I

This section documents the types of other health professional students who also train at the practice site (e.g., medical, nursing, and occupational therapy), as well as their academic institutions (Table; "Section I: Your Practice Site"). The intent was to capture all health professional students, even if the preceptor does not interact with them in the scope of their current practice. From an administrative perspective, the identification of these students and their academic institutions would be useful to facilitate future collaborative efforts.

Section II

The aim of this section was to identify collaboration-friendly activities that take place at the practice site in addition to interprofessional daily rounding, which we suspected would be the most prevalent form of collaboration (Table; "Section II: Your Service"). Preceptors were presented with a number of potential collaboration-friendly activities and asked to rate the frequency with which they occur. Preceptors were given an opportunity to provide other collaboration-friendly activities not specified in the survey as well. The frequency scale includes the following options: "never," "rarely (one to two times per month)," "occasionally (three to four times per month)," and "frequently (greater than or equal to five times per month)." If structural elements of IPE were present at the practice site, we reasoned, then the site would lend itself well to IPE initiatives. Likewise, identified structural deficiencies would provide the preceptor evidence to work with their colleagues at the practice site to build the capacity for IPE.

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