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Capacity Building to Improve Interprofessional Collaboration through a Faculty Learning Community

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Capacity Building to Improve Interprofessional Collaboration through a Faculty Learning Community

Abstract
Though much has been written on Interprofessional Education (IPE) and Faculty Learning Communities (FLCs) independently, there is limited literature devoted to examining the use of

FLCs to enhance IPE for the health professions. A FLC dedicated to building capacity for IPE in a small, private midwestern university comprised of faculty representing occupational therapy, physical therapy, nursing, public health, gerontology, medical anthropology, psychology, social work, and exercise science was conducted over the course of one semester. This article details the implementation process for the IPE FLC; describes outcomes related to teaching, scholarship, and service of faculty from a qualitative evaluation conducted 18 months after the completion of the FLC; and concludes with a discussion based on lessons learned from the process and experience of conducting an IPE FLC.

Comments
The authors have nothing to disclose.

Keywords
Collaborative, Education, Faculty Development, Interprofessional, Learning Community

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According to the World Health Organization (WHO, 2010), interprofessional education (IPE) occurs when "students from two or more professions learn about, from and with each other to enable effective collaboration and improved health outcomes" (p. 7). IPE has gained widespread acceptance over the past decade and is now viewed as a vital component in training future health professionals to provide safe, high-quality, patient-centered care (Wise, Frost, Resnik, Davis, & Iglarsh, 2015). Increased focus on IPE has been partially driven by concerns about adverse health outcomes stemming from a lack of teamwork and communication skills among health professionals (Brashers, Owen, & Haizlip, 2015). In response to these concerns, the Institute of Medicine (2009) suggested that academic programs and health care organizations facilitate IPE to instill collaborative practice skills for students pre-licensure and emphasized the importance of interprofessional collaborative practice (IPCP) after licensure. The WHO (2010) defines IPCP as when "multiple health workers from different professional backgrounds provide comprehensive services by working with patients, their families, carers (caregivers) and communities to deliver the highest quality of care across settings" (p. 13).

In 2009, six national organizations in the United States representing professionals in medicine, nursing, public health, pharmacy, and dentistry formed the Interprofessional Education Collaborative (IPEC). In 2011, the IPEC published a report presenting a vision for IPCP in health care and defining the core IPCP competencies to guide the development of health professions curricula in preparing students to practice team-based care effectively. In 2016, the IPEC updated the report to reaffirm the value of the core competencies, to organize the competencies under a single domain of interprofessional collaboration, and to broaden the competencies to better achieve the Institute for Healthcare Improvement's Triple Aim (IPEC, 2016). The Triple Aim goals include improving the patient experience of care, improving the health of populations, and reducing the per capita cost of health care (IPEC, 2016). Also in 2016, the American Occupational Therapy Association (AOTA) joined the IPEC as one of nine additional professional organizations. In doing so, the AOTA strengthened the commitment to the overarching goals of preparing future health professionals to contribute to the team-based care of patients and collaboration to improve population outcomes.

Despite the recognition of IPE as an integral component of pre-licensure education by multiple health professions, several experts in IPE and IPCP have suggested that university administrators and faculty continue to face barriers to implementing and sustaining comprehensive IPE curricula (Brandt, 2015; Brashers et al., 2015; Curran, Sharpe, & Forristall, 2007; Hall & Zierler, 2014; Wise et al., 2015). The director of the National Center for Interprofessional Practice and Education has suggested that within colleges and universities structural barriers, such as different schedules and program lengths, expanding class sizes, accreditation requirements, and curricular demands, can impede the development and sustainability of IPE programs (Brandt, 2015). Another obstacle to implementing IPE curricula successfully is that

faculty may feel unprepared to teach IPE effectively (Brandt, 2015). Health professions faculty striving to design quality IPE experiences for students need knowledge, support, and training (IPEC, 2016).

Occupational therapy (OT) often plays an integral role on interprofessional teams. Academic programs in the health sciences, including OT programs, are striving to train their students in IPE (Schreiber & Goreczny, 2013). In 2012, the Accreditation Council for Occupational Therapy Education (ACOTE) incorporated interprofessional terminology in the accreditation preamble, standards, and definitions (ACOTE, 2012). The preamble specifies that students with an OT education should, "Be prepared to effectively communicate and work interprofessionally with those who provide care for individuals and/or populations to clarify each member's responsibility in executing components of an intervention plan" (ACOTE, 2012, p. 2). For students to achieve this, OT and other health professions faculty must be knowledgeable and equipped to prepare students for engaging in IPCP during both classroom and fieldwork experiences. Faculty Learning Communities centered on IPE offer one method for faculty to build knowledge and skills related to IPE.

Faculty Learning Communities (FLCs)

According to Beach and Cox (2009), Miami University developed the FLC concept in 1979. Cox (2004), a leading scholar in the implementation and scholarship surrounding FLCs and founder of the original Lilly Conference on College Teaching at Miami University, defines an FLC as

> a cross-disciplinary faculty group of six to fifteen members . . . who engage in an active, collaborative, yearlong program with a curriculum about enhancing teaching and learning and with frequent seminars and activities that provide learning, development, the scholarship of teaching, and community building. (p. 8)

Since 2004, FLCs have gained traction in academia and have been used with a wide variety of faculty for faculty development across diverse institutions and spanning a wide range of topics (Furco & Moely, 2012; Garland & Kolkmeyer, 2011; Ward & Selvester, 2012). Evidence suggests that participation in FLCs can lead to a positive impact on faculty attitudes about teaching and advancements in learning for students (Beach & Cox, 2009).

FLCs can be cohort-based or topic-based. A cohort-based FLC centers on the learning and teaching needs of a specific cohort of faculty or staff, such as junior faculty, senior faculty, or department chairs (Beach & Cox, 2009; Cox, 2004). A topic-based FLC involves faculty and staff from a variety of ranks convening to focus on a specific teaching and learning issue, such as designing quality student assessments or engaging undergraduate students in research (Beach & Cox, 2009; Cox, 2004). The FLC described in this article is considered topic-based, since it involved faculty and staff from across ranks but had the specific focus of IPE.

To date, there is limited literature showing application of the FLC model to improve the teaching of IPE. Robinson-Dooley and Nichols (2016) conducted a pilot study to test the implementation of a clinic-based interprofessional

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model of care developed from an FLC but did not address the process or mechanics of the FLC. Other health science disciplines have embraced the use of FLCs, but not for the explicit purpose of exploring IPE. For example, Drummond-Young et al. (2010) praised the use of an FLC for new nursing faculty as a crucial underpinning for successful implementation of a BScN program. Another study involving a survey of clinical faculty members at five medical schools uncovered positive benefits for medical school faculty who participate regularly in learning communities as faculty mentors for medical students (Wagner et al., 2015).

In the context of these parallel but not yet intersecting bodies of evidence on IPE and FLCs, the authors designed an FLC dedicated to IPE at a small, private university in the Midwest. They successfully applied for internal funding and implemented the FLC on campus during the 2014-2015 academic year. The IPE FLC fit the needs of the university health professions division at that time, as several of the health professions were confronting new mandates to develop IPE programming in order to meet accreditation standards. Faculty had been charged with developing and participating in IPE initiatives, but no formal education or training had been offered to faculty interested in IPE. The purpose of this article is to describe the implementation and evaluation of an FLC and the lessons learned from the authors' experiences of leading a topic-based FLC dedicated to IPE.

Implementation and Evaluation of the FLC

An application requesting internal funding for an IPE FLC was submitted and accepted in 2014. The application included a description of the project, a case on the need to enhance IPE on campus, the intended outcomes, and a list of faculty on campus who expressed interested in participating. The following outcomes were designated on the submitted FLC application with specification that they would be completed at the conclusion of the FLC:

- Members will formulate specific next steps for interprofessional collaboration on campus.
- Members will formulate plans for building on intersecting areas of interest for future or current health-related research.
- Members will know enough about other disciplines represented among the members to be able to articulate and clarify the disciplines to the greater faculty community.
- Members will increase their comfort level and form collegial relationships.

The initial application listed 10 faculty participants who had expressed tentative commitment. Fifteen were recruited, and an average of 10, including the two leaders, regularly participated over the course of the semester. All 15 members who committed to the FLC attended at least two times over the course of the semester. Members of the IPE FLC included faculty and staff from nine different health-related fields: OT, physical therapy (PT), nursing, public health, gerontology, medical anthropology, psychology, social work, and exercise science. Approved FLC leaders received a small stipend.

The IPE FLC met seven times over the semester from January to April with an introductory meeting to get to know fellow group members, five

sharing sessions following a pre-determined agenda focused on introducing and discussing specific health professions, and a final session dedicated to closing the group. After the first session, leaders asked the FLC members to use a shared, electronic sign-up sheet to select one of the upcoming sessions to provide a detailed overview of their profession and answer peer questions. The leaders facilitated the five sharing sessions in the same way. At the beginning of each session, the leaders of the group facilitated an activity to stimulate conversation, increase knowledge, and dispel myths about the health professions being presented. The FLC members were given multiple sticky notes and asked to anonymously write down any preconceived ideas or stereotypes about the professions being presented and any questions they would like the speakers to address. The members were asked to post the comments for the speakers to read. This proved to be an effective tool to add humor, promote group bonding, initiate open discussions, and clarify misconceptions about various health professions programs offered at the institution.

After the initial activities in the sharing sessions, one to three different members talked about their health professions and engaged peers in discussion. Each member was given a guiding outline to follow when he or she was presenting that included instructions to add or subtract content wherever deemed appropriate. For example, if the presenter's profession did not have accreditation policies related to IPE, then he or she would not address this portion of the guiding outline. The outline also requested that they share the following: What their discipline is/does, how their discipline approaches health, required curricular/accreditation guidelines related to IPE, existing curriculum components dedicated to IPE, future visions of the role of IPE in the profession, and ways they would like to collaborate with other disciplines on campus. The FLC members approached the way they discussed their professions differently. Some chose to put together handouts to share, some used brief, web-based materials, such as videos about their professions, and some gave short lectures. During the final, closing meeting, the leaders asked the members to reflect on the experience of participation in the FLC and to share both what they gained from participating and feedback for improving future FLCs.

Institutional evaluation to determine outcomes of the IPE FLC was conducted in September and October of 2016 to follow up with participants 1 academic year and nearly 18 months after participation in the FLC. The timing of the IPE FLC was particularly strategic in that it occurred in the spring semester of 2015, and thus preceded a major campus move involving nearly all of the professions represented in the FLC being reconfigured together in one building on campus. Therefore, the evaluation was also well-timed to gather feedback reflecting on 1 year of sharing space in what might be considered a more "IPE friendly" environment. In addition, it is worth noting that the participants' evaluation responses are situated in the context of major physical and cultural changes involving the health professions on the university campus as well as an unusually high level of transition of overall university structures, including multiple leadership and department

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structural changes.

IPE FLC Evaluation Outcomes

As part of the evaluation, 13 FLC participants provided detailed responses through email both to questions about the original goals of the FLC and to requests for suggestions for improvement of future FLCs. Twelve of the participants were tenure track or tenured faculty and one was a staff member. Two of the participants were men and 11 of the participants were women. The participants ranged in age from the mid-twenties to the mid-fifties, and there was diversity in years of experience at the university varying from faculty in their second year to faculty with over 20 years of service to the university. Table 1 shows which health professions were represented, the number of participants from each, and the participants' years of experience at the university.

Table 1

IPE FLC Evaluation Participants

Profession	Number of evaluation responses from each profession	Years at institution
Exercise Science/Wellness	1	10+
Medical Anthropology	1	0-5
Nursing	1	5-10
Occupational Therapy	2	0-5, 5-10
Physical Therapy	3	0-5, 0-5, 20+
Public Health and Public Health/Gerontology	3	0-5, 0-5, 5-10
Psychology	1	0-5
Social Work	1	0-5

Outcomes in Alignment with FLC Goals

The participants' evaluation responses were analyzed and categorized to provide examples illustrating outcomes aligned with the original FLC goals stated in the FLC application. The evaluation did not specifically ask the participants to mention the outcomes connected with specific parts of the FLC. The participants' responses emerged in a way that led Outcomes 3 and 4 to be linked together into one goal. Qualitative comments illustrating the IPE FLC outcomes are organized in this section per the goals:

1. Formulate specific, next steps for interprofessional collaboration on campus.
2. Formulate plans for building on intersecting areas of interest for future or current research related to health.
3. Know enough about other disciplines represented among members to be able to articulate and clarify the discipline to the greater faculty community, increase comfort level, and form collegial relationships.

Since the evaluation took place over 1 academic year after participation in the IPE FLC, several of the participants shared that they not only had formulated next steps, but many had executed research, teaching, service, and other activities related to IPE that they felt connected back to their

participation in the FLC.

Formulate specific next steps for IPE collaboration on campus (Outcome 1). Table 2 provides sample comments illustrating the ways the FLC members formulated or executed plans for collaboration, categorized by teaching, service, and other outcomes that did not explicitly fit in the traditional categories of teaching or service in the university context. By the date of the IPE FLC evaluation, at least eight FLC members had fully completed activities they considered as IPE collaboration, ranging from significantly revising and co-teaching IPE in one specific course to serving on faculty search committees for other health professions. In addition, at the time of the evaluation, at least five FLC members had formulated next steps for collaboration, including initiating more IPE collaboration at a new institution and plans to continue interprofessional discussions centered on specific health issues, such as quality health care for older adults.

Table 2

IPE FLC Outcome 1 Sample Faculty Comments: Formulating and Executing Specific IPE Collaborations

Teaching	Service	Other Outcomes
I significantly revised and combined IPE teaching with OT and PT.	I co-led a 2nd IPE FLC in 2015-2016.	I initiated a multi-department discussion . . . related to providing quality health care for older adults.
I/we created an IPE simulation experience for students from multiple health professions of AT, OT, PT, SW, and Nursing.	I joined the simulation group.	I worked with kinesiology and public health to develop a university IPE project . . . and write a grant around older adults and fall prevention.
I [guest lectured] for Nursing students [more than once].	I/we expanded the nursing simulation group to other professions.	Asked by an OT faculty to contribute to an external program with youth.
We were able to integrate courses from other programs into our curriculum as electives, increasing the opportunity for interdisciplinary [interaction] for students.	I have been asked to serve on search committees in other departments that I may not have been [asked for] since I didn't know those individuals [prior to the FLC].	
I guest lectured in an OT class.		
I have since moved to another institution, but have already started conversations about IPE collaboration, such as working with OT on a poverty simulation activity.		

Formulate plans for building on intersecting areas of interest for future or current research related to health (Outcome 2). The original research-related goal for the FLC was for members to formulate plans for building on intersecting areas of interest for future or current health-related research. The participants shared not only that plans for research had been formulated, but also that several interprofessional research endeavors had been completed or were in progress. This was a notable aspect of the evaluation because the institution has been viewed historically as a teaching institution with limited research output.

Some of the participants expressed

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excitement about the research collaborations that emerged from the FLC, and others described multiple points of dissemination spanning local presentations, national presentations, and publications. Several evaluation participants shared more details about the research they perceived was related to the FLC. For example, two participants noted an ongoing project involving collaboration between nursing and PT faculty that developed directly from contact made during the IPE FLC. This research involves studying the teaching and learning aspects of a simulated acute care patient experience where nursing and PT students work together in a mock hospital setting. After an initial pilot simulation activity, it has been repeated multiple times over 2 years with the goal of full curricular integration into the senior undergraduate nursing and PT programs. Two research studies examining student experiences with the nursing and PT simulation have been conducted leading to regional dissemination at an on-campus interdisciplinary conference and national dissemination at the Professional Nurse Educators Group 2016 Annual Conference.

Additional research activities were mentioned by faculty as having linkages back to the IPE FLC and involved a diverse range of interprofessional teams. For example, another simulation activity was developed with representation of students and faculty from nursing, OT, and athletic training as well as faculty from psychology and social work. The faculty team is currently in the process of writing a paper on the experience that will be submitted for publication. Other examples of research collaboration teams that the IPE FLC participants perceived were linked to their participation in the FLC include PT and OT; PT and public health; exercise science and psychology; exercise science and PT; and OT, public health, and PT.

Know enough about other disciplines represented among members to be able to articulate and clarify the discipline to the greater faculty community, increase comfort level, and form collegial relationships (Outcomes 3 and 4). Evaluation comments linking to these goals illustrated that faculty members felt they had evolved in terms of knowledge, comfort, and relationship building connected with participation in the FLC. One faculty member shared that the experience expanded his/her knowledge base: "I found the IPE FLC extremely helpful in learning about other professions, scope, overlap and the individuals at [our university] in each [d]epartment." Another faculty member reported increased knowledge of and an evolution of comfort with other professions: "It helped me to move outside of my comfort zone and opened my eyes to what many other programs were doing that worked in tandem with something that happens with my own program."

Several faculty members highlighted how important the IPE FLC was for directly connecting them with partners for interprofessional teaching and research, using words and phrases such as "platform," "springboard," and "great opportunity to connect." The positive spirit and environment of the meetings was also addressed in the evaluation, with one faculty member saying, "There was a strong feeling of collegiality in the group and a

willingness to collaborate on projects that would facilitate student learning." Another faculty member, who despite feeling that he/she had not benefited much in the way of collaborative activities, mentioned, "I definitely have been more open to IPE as a result of the group." This type of outcome is important to note for people who might not have moved on to participate in any interprofessional collaboration. Such attitudinal changes may be precursors of behavior change (Azjen, 1991), which in this case might mean behavior change resulting in more IPE collaboration in the future.

In addition to gathering outcome-related feedback, the participants shared limitations and suggestions for improvement of future IPE FLCs at the university. A few of the participants mentioned timing, both as a positive and a negative related to the IPE FLC. One faculty member commented, "I think the FLC was really well timed in that it happened just before the transition into this new building, where I suddenly had new colleagues everywhere." In contrast, regarding the perception of limited action after the FLC, another faculty member said, "Of course, departments moved to the [new building] and the university (as always) was looking at new directives, which I believe side-tracked some of the support and energy [for IPE]."

Ten of the 13 faculty members who participated felt that participation in the IPE FLC led them to direct involvement in IPE activities related to the major areas of responsibility for faculty of research, teaching, and service. Two of the three faculty members who did not feel the IPE FLC benefited them directly shared examples of tangential activities they felt were indirectly linked to the IPE FLC, such as participation in an interdisciplinary qualitative research group and moving forward confidently with the assignment of teaching a new course for doctoral students on interprofessionalism in health care.

Multiple members of the IPE FLC offered valuable suggestions for improvement. One member felt that the interactions were "fairly surface level" and suggested holding a second, consecutive FLC for this same group of members to promote deeper discussion. Another member commented that expectations had not been met in terms of "activities focused on really connecting us into existing IPE activities." In a similar vein, one of the co-facilitators/members suggested that future IPE FLCs

> provide a more intentional step in the FLC curriculum for people to interact and make concrete plans for after the FLC . . . some people took initiative to connect after the FLC, but it would be ideal to build time for pairs or teams to connect based on their mutual interests.

Discussion

The participants in the IPE FLC indicated that the opportunity to meet with other faculty helped break down several perceived barriers to implementing IPE experiences. Bringing the faculty together in an intentional manner provided the impetus for several IPE initiatives linked to teaching, scholarship, and service that have continued after the IPE FLC concluded. Sustainability has been reported as a key factor in building successful faculty development programs

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for IPE (Hall & Zierler, 2015; Thistlethwaite & Nesbet, 2007). Hall and Zierler (2015) suggested that creating a community among the participants that provides an environment for peer learning and professional collaboration that can extend beyond the time frame of the initial project is an integral component of programmatic success.

Sustainability was evident in the outcomes of this IPE FLC based on the reports of the participants regarding several ongoing collaborative projects related to IPE and IPCP. These projects involved teaching, scholarship, service, and other related academic pursuits. The initial IPE FLC spawned a second FLC, led by the participants in the initial learning community, that allowed for ongoing faculty engagement and development around IPE in the health professions schools. With an increased campus-wide focus on IPE, a new interprofessional committee was recently developed related to IPE and IPCP in the health professions. This committee was created in partnership with a local health care network and includes faculty from across the health professions and professionals in the health care network. A central goal of the committee is to further facilitate IPE and IPCP opportunities for students, faculty, and practicing clinicians related to teaching and scholarship. As the emphasis on IPE continues to grow, faculty will need to be trained to teach, mentor, and assess students effectively across the health professions. An IPE FLC focused on faculty development related to interprofessional teaching, scholarship, and service is a potential next step for building the capacity of health professions faculty to effectively lead IPE initiatives.

Limitations and Future Research

One limitation worth noting about this IPE FLC and the subsequent evaluation is that the authors did not account for the participants' initial or prior interest in IPE. Therefore, it is possible that since the participants were already interested enough in IPE to join the FLC, they may have implemented IPE activities at some point without ever having participated in an FLC. Faculty members intending to design a formal research study to test the effectiveness of an IPE FLC in the future might benefit from a pre-assessment of potential FLC members' interests and current activities related to IPE in order to determine inclusion/external criteria or analyze the relationships between prior interest in IPE and the outcomes of an IPE FLC.

Of note, two of the three faculty members who did not feel that they benefited directly from the IPE FLC or who felt they made limited connections represented the more population-based health professions of medical anthropology and public health or psychology. At this institution, where the FLC and evaluation took place, population health oriented disciplines tend to be harder to integrate and link into IPE activities, in part because of historical investment and the reputation for clinical, rehabilitation professions. This may be one reason that two faculty members felt they did not benefit directly from the FLC. Future IPE FLC leaders might approach a group with diverse representation of health professions with this information in mind and undertake strategies to intentionally integrate non-clinical health professions.

Based on the work of Hall and Zierler (2015) related to faculty development programs in IPE, future IPE FLCs related to building capacity for faculty to grow IPE in the health professions should be developed with well-defined objectives, clear expectations among the leaders and members, an action plan once the FLC has concluded, and departmental and university support for both IPE and FLCs. Overall, the authors' experience and the evaluation results for this topic-based FLC suggest that FLCs may be a promising practice for enhancing the knowledge and skills of OT faculty, as well as other health professions faculty, for teaching IPE and IPCP. The authors recommend future research to formally test the impact of FLCs for enhancing IPE.

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