Faculty development in interprofessional education (IPE): Reflections from an IPE coordinator

Ruby E. Grymonpre, Pharm.D.

University of Manitoba, Winnipeg, Canada

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Abstract

Objectives: Faculty development in interprofessional education (IPE) and interprofessional collaboration (IPC) is an important component enabling the cultural shift towards this new mode of education and practice. Most published studies describing interprofessional faculty development focus on facilitating interprofessional groups of learners without consideration of the much larger role that faculty can play as interprofessional ambassadors. This paper aims to describe strategies that fostered interprofessional faculty development within the University of Manitoba IPE Initiative (the Initiative) between 2008 and 2015, highlight exemplars that were implemented and evaluated, and offer reflections from the IPE coordinator.

Methods: Three overarching strategies fostered interprofessional faculty development within the Initiative: developing interprofessional ambassadors through leadership training; using an adoption model framework that explicitly identified interprofessional faculty development as one key micro-component; and actualizing
partnerships within and between academia, practitioners and the government.

Results: Interprofessional faculty development opportunities for non-practice- and practice-based faculty are described, and evaluation results are presented. The strategies were aligned with most, if not all, of the seven previously published recommended approaches to interprofessional faculty development. Based on the number of participants and evaluation results, the interprofessional faculty development opportunities offered through the Initiative were effective in raising faculty awareness of IPE and IPC and improving perceived interprofessional facilitation skills.

Conclusion: Upon reflection, the Initiative’s interprofessional faculty development undertakings were reactive as opposed to strategic. Future recommendations include reaching consensus on a broad definition of faculty development, adopting a theoretical framework to guide the stated learning outcomes, and developing observation-based assessment strategies to measure the achievement of interprofessional learning outcomes.

Keywords: Academia; Faculty development; Interprofessional education; Learning outcome

Introduction

In Canada in 2003, the First Ministers’ Accord on Health Care Renewal concluded that the Canadian health care system was no longer affordable and sustainable. In 2005, as part of a Pan-Canadian Health Human Resources Strategy, Health Canada announced a large funding commitment to the Interprofessional Education for Collaborative Person-Centred Practice (IECPCP) initiative. The overarching goal of the IECPCP initiative was “changing the way we educate health providers so Canadians will have better and faster access to the health care they need when they need it, ultimately boosting the satisfaction of both patients and health care providers.” The acronym IECPCP is unique to Canada, stemming from a recognition that interprofessional education (IPE) is necessary to achieve interprofessional collaboration (IPC) and that the patient must be central to collaborative practice. IECPCP is the author’s preferred acronym, as it is the only acronym to her knowledge to describe IPE and IPC that includes a “P” for the patient.

Evidence in support of IECPCP continues to emerge globally. The desired outcome of IECPCP is to modify behaviours and ways of working together to foster effective collaboration between patients/families and their health and social care professionals, thereby improving health care outcomes, safety and quality, service efficiency, cost-effectiveness, and provider satisfaction. Academic institutions and health care delivery organizations have responded by exploring innovative strategies to move both pre-licensure health sciences students and front-line health and social care practitioners towards interprofessional collaboration.

Interprofessional education (IPE) is defined as a teaching strategy or educational approach where learners from two or more different health professions learn ‘about, with and from each other’ for the purposes of achieving collaborative care and improving the health and wellbeing of individuals, families and communities. By definition, IPE is grounded in educational theories, including adult learning theory, case-based learning, experiential learning, small-group learning, and cooperative learning. Consistent with these theories, attributes of IPE include small-group, interactive learning utilising case-based or simulation formats relevant to real practice or practice-based (experiential) approaches. Of note, facilitators trained in IPE are reportedly a critical element of interprofessional learning.

To date, most published reports relevant to IPE have focused on the development, implementation and evaluation of innovative interprofessional learning opportunities, with limited attention given to faculty development in IPE. A literature search of papers published between 1980 and 2003 did not produce any articles that specifically examined this topic. In a more recent (2005–2010) literature review of 83 studies involving IPE interventions, Abu-Rish et al. also noted that, despite its importance, few studies reported on efforts to prepare, recruit, and retain faculty to assume pivotal roles in IPE. The University of Manitoba IPE Initiative (the Initiative) was somewhat innovative in this regard. The University of Manitoba interprofessional ambassadors have identified interprofessional faculty development as a priority in the Initiative’s guiding principles and strategic plan since its inception in 2008.

The objectives of this paper are to describe the strategies that fostered interprofessional faculty development within the Initiative between 2008 and 2015 and to highlight exemplars that were implemented and evaluated. The paper concludes with the author’s reflections and recommendations regarding future interprofessional faculty development undertakings.

Materials and Methods

Three overarching strategies fostered interprofessional faculty development within the Initiative:

- Developing interprofessional ambassadors
- Using an adoption model framework to enable the sustainable implementation of IECPCP innovations, including interprofessional faculty development
- Actualizing partnerships

Developing interprofessional ambassadors

Within the IECPCP paradigm, faculty have an important role as interprofessional ambassadors or leaders who not only develop and facilitate interprofessional learning but also advocate for sustainable and scalable IECPCP innovations at the micro-, meso- and macro-levels within and between the educational, health and government
sectors. The Lancet Commission proposed instructional reforms to achieve transformative learning in the 21st century and graduate health professionals with the requisite leadership attributes to influence change. Effective leaders have the ability to create a shared vision within an organization, empower others, and foster organizational culture and values. Table 1 is an adaptation of the IPE coordinator job description (2008–2015), which outlines the roles and responsibilities of a (full-time) interprofessional ambassador. These responsibilities are closely aligned with the desired attributes of an effective leader, as determined by Negandhi et al. in their extensive literature review to identify interdisciplinary leadership competencies in health care (Table 2).

In 2008, fifteen University of Manitoba academics were invited to participate in the University of Toronto weeklong face-to-face course entitled Educating Health Professionals in Interprofessional Collaboration (EHPIC). The overall goal of the course was “to develop leaders in interprofessional education who have the knowledge, skills and attitudes to teach both learners and fellow colleagues the art and science of working collaboratively for patient-centred care”. As a consequence of their involvement in the course, the University of Manitoba had 15 interprofessional ambassadors who had developed the necessary knowledge, attitudes and skills to advance IECPCP within both the University of Manitoba and between relevant key stakeholders.

<table>
<thead>
<tr>
<th>Table 1: Proposed roles and responsibilities of an interprofessional ambassador.</th>
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<tr>
<td>1. With a focus on advancing IPE for IPC, actively network, collaborate and disseminate within and between:</td>
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<tr>
<td>• academic institutions and health authorities, including clinical practice environments</td>
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<tr>
<td>• provincial Ministries of Education and Health and professional regulatory authorities</td>
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<tr>
<td>• national professional regulatory and accrediting authorities and IPE networks (e.g., Canadian Interprofessional Health Collaborative (CIHC)) and international IPE networks (e.g., CAIPE, AIPPE, AHIC), possibly through the WCC.</td>
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<td>2. Ensure that the implementation of IPE at the home university is proactive rather than reactive and is strategic and coordinated, maintaining its relevance in achieving person- and family-centred health and wellness outcomes.</td>
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<td>• Contribute to the development of a strategic plan to include a mission, vision, guiding principles, values, timelines and milestones.</td>
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<tr>
<td>• Contribute to the planning, coordination, development, implementation, and evaluation of interprofessional learning opportunities to achieve specified interprofessional learning outcomes along the learning continuum.</td>
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<tr>
<td>• Serve as the liaison between the home and participating academic units to ensure that lines of communication are open, transparent, and proactive.</td>
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<td>3. Lead and co-lead the preparation of funding proposals to support IPE scholarly works when available.</td>
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<td>4. Lead and co-lead integrated knowledge translation strategies through the preparation of reports, publications, scholarly works, and other dissemination opportunities when available.</td>
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<td>5. Serve as a resource for IPE accreditation requirements for undergraduate and post-graduate curricula.</td>
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<td>6. Oversee day-to-day administrative activities associated with IPE programme development, implementation and dissemination.</td>
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<tr>
<td>7. Facilitate, assess and provide feedback to interprofessional groups of learners during non-practice, simulation and practice-based interprofessional learning opportunities.</td>
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<th>Table 2: Attributes of an effective leader.</th>
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<tr>
<td>• Self-awareness</td>
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<td>• Visionary with a sense of mission</td>
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<td>• Self-regulation</td>
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<tr>
<td>• Committed and motivated</td>
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<tr>
<td>• Decisive, courageous, and honest</td>
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<tr>
<td>• Good communication/interpersonal skills</td>
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<tr>
<td>• Ability to influence peers to innovate</td>
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<tr>
<td>• Strategic and tactical planner</td>
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<tr>
<td>• Networker, team collaborator</td>
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<tr>
<td>• Ability to encourage innovation and facilitate transformation</td>
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<tr>
<td>• Ability to set a direction</td>
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<tr>
<td>• An effective change agent and role model</td>
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Source: Negandhi et al.

Using an adoption model framework

Although this paper focuses on faculty development in IPE, one cannot overemphasize the importance of using a multi-dimensional and multi-level approach to advancing IECPCP within and between relevant organizations as opposed to focussing on any single intervention. An important deliverable of the Health Canada-funded IECPCP initiative was the D’Amour Oandasan IECPCP Evolving Framework (Figure 1). This framework was conceptualized through a comprehensive review of relevant literature, definitions, theoretical models, determinants, and policy levers and nicely illustrates the interdependency between interprofessional education for collaborative patient-centred practice. It illustrates how the sustainable diffusion of IECPCP requires change both within and between the educational and practice domains at the micro- (individual/team), meso- (organizational), and macro- (system/policy) levels, with efforts aimed at simultaneous engagement and parallel initiatives. The framework underscores the importance of achieving ‘harmonization of motivations’ within and between all stakeholders to achieve scalable and sustainable programme implementation. In a separate publication, a group of University of Manitoba interprofessional ambassadors described in greater detail how they used the D’Amour framework to guide the sustainable implementation of their IPE innovations. Relevant to this paper, faculty development in IPE is identified as one key micro-component of the D’Amour framework. As IECPCP innovations are developed, implemented, and evaluated, faculty who are responsible for teaching and mentoring health professional learners in the classroom and practice environments must acquire a new set of knowledge, attitudes, beliefs, skills and behaviours to advance IPE.
Actualizing partnerships

The D’Amour framework also reminds us that achieving the desired educational outcomes of an interprofessional faculty development undertaking requires partnerships within and between academia, health care delivery organizations, regulators, accrediting bodies, and the government. Within the Initiative, the Interprofessional Faculty Development Working Group was established to develop and implement interprofessional faculty development opportunities for non-practice interprofessional learning. Paradoxically, planning interprofessional faculty development required ‘interprofessional collaboration for interprofessional education’. The Interprofessional Faculty Development Working Group engaged thirteen academics from seven different academic units and a librarian, all of whom dedicated their time and expertise. The names and affiliations of all members of the Interprofessional Faculty Development Working Group who contributed to these activities between 2008 and 2014 are listed in the acknowledgements section.

Not surprisingly, faculty development for practice-based interprofessional learning proved to be more complex than expected, requiring additional partnerships between the University of Manitoba and Manitoba’s largest regional health authority, the Winnipeg Regional Health Authority. This partnership was fostered through cross-representation on key leadership and planning committees within both organizations, shared responsibility and co-authorship on collaborative care innovations, demonstration and research projects, and joint presentations at senior management committee meetings. The Initiative’s Interprofessional Clinical Placement Working Group was established involving twenty academics from 13 different academic units, four representatives from the Winnipeg Regional Health Authority, and one student. The names and affiliations of all members of the Interprofessional Clinical Placement Working Group who dedicated their time and expertise between 2008 and 2014 are also listed in the acknowledgements section. The mandate of this working group was to develop sustainable interprofessional clinical placement opportunities for senior pre-licensure learners (as part of their required clinical placement/fieldwork/practicum/rotation) within environments where practitioners effectively model interprofessional collaboration.

Results

Faculty development for non-practice-based interprofessional learning

The efforts of the Interprofessional Faculty Development Working Group led to the development and delivery of three different faculty development opportunities in IPE.
Introduction to IPE

This was a three-hour session recommended for all faculty within all thirteen academic units participating in the Initiative. The sentiment was that even faculty who had no intention of facilitating interprofessional learning opportunities still required a broad understanding of and appreciation for IPE as possible members of curriculum or tenure and promotion committees and as individuals who might at some time be asked to ‘trade’ a lecture time slot to accommodate an interprofessional learning opportunity. The session was offered twice per year in January and June.

The learning objectives of this session included:

- To increase knowledge of, driving forces of, and resources surrounding IPE
- To learn about the University of Manitoba IPE Initiative
- To generate ideas for IPE activities using the Points for Interprofessional Education Score (PIPES) instrument
- To increase knowledge of student-initiated IPE activities
- To provide opportunities for faculty from various academic units to network

Evaluations of this session were favourable. The teamwork and collaboration subscale of the revised Readiness for Interprofessional Learning Scale (RIPLS) was administered to 24 participants from eight academic units who attended the June 2011 workshop. The teamwork and collaboration subscale includes 9 items rated on a 5-point Likert scale, including statements such as “patients would ultimately benefit if health care students worked together to solve patient problems” and “learning with other students will help students become more effective members of a health care team”. There was a significant increase in the mean score pre- versus post-session, suggesting improved attitudes towards IPE by faculty participants. Qualitative feedback was also favourable, with participants noting that they learned new information about IPE, appreciated interacting with other professionals, and found the interprofessional small-group activity involving the use of the PIPES to be beneficial in helping them to plan future IPE activities.

How to facilitate IPE

This was a more advanced three-hour workshop designed to prepare faculty to facilitate a specific interprofessional learning opportunity entitled ‘Learning Health Promotion Interprofessionally’. The session included a general overview of the Initiative, a didactic session on the attributes and skills of an effective interprofessional facilitator, and the use of a student assessment rubric. A detailed facilitator guide tailored specifically to the health promotion session was also prepared. In particular, participants enjoyed the final component of the workshop, which used fish bowl and role play strategies that allowed faculty to enact the interprofessional health promotion session as either the facilitator or a student, with observer feedback and opportunities for role exchange.

Similar to the introductory session, evaluations of the March and October 2012 offerings of the How To Facilitate IPE workshop were favourable. In this study, 94% of the 33 facilitator respondents rated the workshop as either good or excellent. After the session, facilitators were asked to complete an adapted version of the Interprofessional Facilitation Scale (IPFS). The adapted IPFS is a 20-item 4-point Likert scale survey designed to obtain self-assessments of interprofessional facilitation skills. Over 70% of the 29 facilitator respondents rated 16 of the 19 items as ‘good’ to ‘excellent’, reflecting their perceived comfort in the stated facilitation skills. Nevertheless, the remaining three items were rated as ‘good’ to ‘excellent’ by only 55–69% of the facilitator respondents. Perceived weaknesses included explaining how IPC can enhance patient-centred practice; asking questions to encourage participants to consider how they might use each other’s professional skills, knowledge and experiences; and discussing issues related to hidden power structures, hierarchies and stereotypes that may exist among different health professionals. Only 66%, 69%, and 55% of responding facilitators, respectively, rated their skills in these areas as good to excellent.

IP facilitator brown bag session

This one-hour session was offered to academics who had previously facilitated an interprofessional learning opportunity and wanted a ‘refresher’ and an opportunity to share interprofessional facilitation strategies and challenges with other academics.

Figure 2 illustrates the high number of academics who have participated in the three interprofessional faculty development sessions since 2010. These data suggest that a significant number of University of Manitoba academics had at least some awareness of and capabilities in IPE. The 2007 number reflected the fifteen academics who participated in the EHPIC™ training prior to the establishment of the Initiative. The two-year timespan with no faculty development activities reflected the time required by the Initiative developers to lay the groundwork. Between 2010 and 2015, 300 academics participated in the Introduction to IPE session, 151 participated in the How To Facilitate IPE session, and 48 participated in the Lunch ’N Share. The drop in attendance in the Introduction to IPE sessions noted in 2012 was because for many of the smaller University of Manitoba academic units (for example, the Faculty of Pharmacy and the Schools of Occupational Therapy and Physical Therapy), a point of saturation had been reached, as the vast majority of academics had already participated in the sessions. To maintain the interprofessional diversity of the participants, the Interprofessional Faculty Development Working Group extended invitations to mostly Winnipeg Regional Health Authority front-line health and social care practitioners and site managers to participate as a form of interprofessional continuing professional development for credit as required. In addition to increasing our participant numbers, this strategy provided opportunities for teams of front-line staff to attend the workshop and, guided by the PIPES, brainstorm how they might offer practice-based interprofessional learning to students who were completing their placements at their site. Also of note, the lower numbers in 2015 were due to the transition of the Initiative to a new organizational structure in March of that year.

Facility development for practice-based interprofessional learning

Interprofessional faculty development for front-line clinical staff was more implicit, ad hoc and site-specific
and involved those mentoring teams who participated in a series of interprofessional clinical placement projects between 2008 and 2014. Strategies may have included presentations by the IPE coordinator and a Winnipeg Regional Health Authority representative, EHPIC™ training, attendance at the Introduction to IPE session offered by the Initiative, and the use of a tool called the Interprofessional Collaborative Organization Map and Preparedness Assessment (IP-COMPASS). Teams were also provided with a detailed interprofessional clinical placement module entitled Interprofessional Practice Education in Clinical Settings Toolkit, which included an introduction (definitions and descriptions of collaborative practice, person-centred care, interprofessional education) and a detailed guide on organizing and facilitating interprofessional practice-based learning sessions at the exposure and immersion levels.

Table 3 shows the number of students and clinical environments involved in interprofessional clinical placements between 2008 and 2014. Cumulatively, 311 learners from seven different health professions participated in interprofessional clinical placements hosted by 16 different clinical environments situated within seven different Winnipeg Regional Health Authority health care facilities. Evaluation reports were prepared for the 2011 to 2013 academic years. Based on evaluations from participating site leads that were relevant to faculty development in IPE (putting aside feedback regarding logistical challenges), respondents noted that key success factors included support and cooperation within the team as well as from leadership at all levels (site leads, unit managers and discipline-specific leads). When asked how either the University of Manitoba or Winnipeg Regional Health Authority could help to improve future interprofessional clinical placements, team members requested more training in interprofessional collaboration and interprofessional facilitation and additional efforts directed at institutionalizing interprofessional collaboration such as including it in new staff orientations, job descriptions, and performance reviews. Although the number of students and clinical teams participating in interprofessional clinical placements over the six-year timeframe were relatively low, the series of interprofessional clinical placement offerings enhanced senior management and institutional awareness of
interprofessional clinical placements within seven of the Winnipeg Regional Health Authority’s nine institutions (2 acute care hospitals, 5 community hospitals and 2 long-term care centres).

Two evaluations of the interprofessional clinical placements were conducted and published.22,23 Using a controlled before-and-after study design, the projects examined a similar research question: Do clinician team facilitation and mentorship of pre-licensure learners participating in IP clinical placements improve team members’ attitudes, knowledge, skills and perceived behaviours in collaborative person-centred practice?22,23 For the first study, although formal educational interventions were not offered, teams were provided with a library of IECPCP resources, a handbook containing background reading on collaborative competencies, a detailed manual on how to facilitate student sessions, and optional facilitator training and observation of teaming behaviours with feedback using the Team Observation Scale.22 For the second study, intervention teams received formal team training in interprofessional collaboration involving facilitated team discussions and reflection guided by their item-by-item scores on the Assessment of Interprofessional Team Collaboration Scale.23

Results of both studies found either no significant changes22 or only a modest impact23 of team training and participation in interprofessional clinical placements on mentoring teams’ interprofessional collaborative practice from pre- to post-intervention. For both studies, the qualitative data conflicted with these quantitative results, with participants reporting perceived value and benefits of interprofessional clinical placements for both learners and mentoring teams. Feedback related to increased awareness of interprofessional collaboration, recognition that health care providers can do better as well as improvements in their collaborative practice and mentorship of students. More specifically, team members reported using reflection to a greater extent, valuing opportunities to share skills and engage in collaborative goal attainment, and focussing more on patients and families.

The findings from these studies led the authors to speculate that to impact a team’s interprofessional collaboration, multi-dimensional approaches are required. Guided by Donabedian’s quality framework, it is likely that in addition to interventions addressing a team’s knowledge, attitudes and behaviours relating to interprofessional collaboration, interprofessional faculty development initiatives in practice environments need to examine and address the team’s structures and processes of care.23,24 Two exemplar strategies were proposed to serve this purpose:

- The ‘Advancing Collaborative Care Teams’ protocol proposed eight indicators to support a team’s transition to IPC.25 They include setting aside time, sharing space and defining team goals and role statements. Processes include focussing on the patient, measuring and monitoring team performance, and implementing strategies for interprofessional care planning.
- The ‘IP COMPASS’ was developed to support teams that want to improve their IPC prior to hosting interprofessional clinical placements.18 The ‘compass’ includes four constructs: Commitment to IPC, Structures and Supports for IPC, Commitment to IPE, and Structures and Supports for IPE.

Both tools require the team to set aside time to undertake the transition, which involves self-study, action planning, and follow-up, and both strongly encourage the involvement of an external facilitator.

Discussion

The Initiative’s interprofessional faculty development strategies described in this paper were aligned with most, if not all, seven interprofessional faculty development approaches recommended by Steinert et al., as outlined in Table 4.7 Positive evaluation results provided further evidence that our strategies were effective. Nevertheless, the sessions were most commonly developed in reaction to immediate needs as opposed to being generated from a more planned and strategic approach guided by a theoretical framework. Upon reflection and building upon the approaches discussed above, three recommendations are proposed.

Decide on a definition of IP faculty development

At the outset of an interprofessional faculty development undertaking, programme planners should come to consensus on what they are hoping to achieve. As noted by Abu-Rish et al., of the few published reports on IP faculty development, most focused on the facilitation of interprofessional groups of learners, without consideration of the much larger role that faculty can play in enabling and sustaining the IECPCP cultural shift.23 Rubeck and Witzke defined faculty development as “the enhancement of faculty members’ educational knowledge and skill so that they can make educational contributions that advance the education programme rather than only teaching within it” (p. 32).26 Steinert adopted a similarly broad definition of faculty development initiatives should:

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<th>Faculty development initiatives should:</th>
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<td>1. Aim to create change at the individual and the organizational levels.</td>
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<td>2. Target diverse stakeholders.</td>
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<tr>
<td>3. Address three main content areas:</td>
</tr>
<tr>
<td>- Interprofessional Education and Collaborative Patient-Centred Practice</td>
</tr>
<tr>
<td>- Teaching and Learning</td>
</tr>
<tr>
<td>- Leadership and Organizational Change</td>
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<tr>
<td>4. Take place in a variety of settings, using diverse formats and strategies.</td>
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<tr>
<td>5. Model the principles and premises of interprofessional education and collaborative practice.</td>
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<tr>
<td>6. Incorporate the principles of effective educational design.</td>
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<td>7. Consider the adoption of a dissemination model to promote implementation.</td>
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Source: Steinert.7
development as “those activities designed to help educators in all settings (e.g., hospital, community, university) teach IPE and collaborative patient-centred practice in a more effective and satisfactory manner and promote organizational change and development” (p. 61)."  

Articulate a theoretical framework and learning outcomes of the IP faculty development undertaking  
When accepting a broader definition of faculty development, consideration then needs to be given to a theoretical framework to guide the desired learning outcomes of an interprofessional faculty development undertaking. Figure 3 illustrates the four levels within Kirkpatrick’s educational outcomes framework and proposes desired educational outcomes of an interprofessional faculty development programme along an iterative continuum, from the affective (reaction) level to cognitive (learning) development and behavioural change, ultimately leading to measurable results.27

- At the affective level, the goal of interprofessional faculty development should be to ensure that faculty believe in IPE and value this educational approach. They must be genuine in their support for interprofessional learning and reinforce to students that IPE is necessary to achieve interprofessional collaboration and that interprofessional collaboration leads to improved health and wellbeing in individuals, their families and communities.
- Cognitively, faculty should possess knowledge of theoretically grounded interprofessional teaching and collaborative practice approaches. In the Canadian context, this means that they should be able to articulate the six Canadian Interprofessional Health Collaborative (CIHC) collaborative competency domains.28 Faculty should also be able to describe teaching strategies that foster the development of collaborative knowledge, skills, attitudes, and behaviours in learners such as explicitly stated IP learning objectives and content and the use of ‘teachable moments’, reflection and debrief.6,15
- Behaviourally, faculty trained in IPE should be able to demonstrate the unique set of skills required to facilitate and assess interprofessional groups of health professional learners.
  - Faculty trained in IPE should ‘walk the talk’ by role modelling appropriate collaborative behaviours in the classroom, simulation and practice settings and recognize when their own personal biases and lack of respect and trust of other professions could lead to role conflict and an inability to remain neutral.
  - Consistent with the definition of IPE (learning ‘about, with and from’), faculty should exhibit interprofessional facilitation skills that foster knowledge exchange and the sharing of professional perspectives among learners; support learners through disagreement, team decision making and the assumption of shared responsibility for outcomes; and include the use of strategies such as setting aside time for explicit reflection around one or more interprofessional collaborative competency domains.
  - Ongoing learner assessment and the provision of summative and formative feedback are integral to interprofessional learning and the promotion of learner achievement in the stated competence and capability.29 Faculty should have the necessary skills and tools to appropriately assess learners and offer feedback to promote further behavioural change in learners.
- Ultimately, the time, effort and resources spent on interprofessional faculty development should lead to observable results.
  - Faculty trained in IPE should be able to work collaboratively with faculty from other health and social care programmes to plan and develop interprofessional learning opportunities in the classroom, simulation and practice settings and contribute to collaborative and strategic planning of an IP curriculum along the learning continuum.
  - To support the diffusion of the IECPCP innovation, faculty must also develop the skills to serve as positive change agents and interprofessional ambassadors.

Assess faculty achievement on stated learning outcomes  
For assessment to have perceived value and a true impact on learning (in this case, of faculty), it is important that interprofessional faculty development offerings have explicitly stated learning objectives that are aligned with the program’s desired learning outcomes (capabilities) and, further, that the educational content and teaching strategies support learners in achieving the stated learning outcomes.

Figure 3: Desired educational outcomes of an IPE faculty development undertaking.
In response to a growing interest in competency-based learning and assessment, there has been an emergence of team-based and individual observational tools to assess interprofessional collaborative behaviours. To date, however, there has not yet been a parallel development of strategies and instruments to assess the desired outcomes of interprofessional faculty development undertakings. Currently, the assessment of faculty participants in interprofessional faculty development programmes has primarily involved the use of self-assessment instruments measuring interprofessional knowledge, skills and attitudes such as the RIPLS, IPFS, Interprofessional Team Self-Concept (IPTSC) scale, or feedback and reflection. There is a need to develop and use observation-based assessment strategies that measure the desired outcomes of interprofessional faculty development undertakings.

Conclusion

The diffusion of an innovation such as IECPCP is complex. Academics play a pivotal role in enabling the cultural shift towards IECPCP. Based on the number of participants and evaluation results, the interprofessional faculty development opportunities offered through the University of Manitoba IPE Initiative have been effective in raising awareness and improving perceived interprofessional facilitation skills. However, the interprofessional faculty development undertakings have been reactive as opposed to strategic. Recommendations include reaching consensus on a broader definition of faculty development, adopting a theoretical framework to guide explicitly stated educational outcomes, and developing and using assessment strategies to measure the desired outcomes of the interprofessional faculty development undertakings.

Conflict of interest

The author has no conflict of interest to declare.

Author’s contribution

RG conceptualized the intellectual perspectives presented in this scholarly work. She is responsible for the content and similarity index of the manuscript.

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References


R.E. Grymonpre 519


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