



# Interprofessional Education and Social Work

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*In this issue's Conversation, we turn our attention to interprofessional education and explore the implications of this framework for social work education. The goal of interprofessional education is to promote collaborative team-based practice with the aim of improving patient care and health outcomes, while also reducing health care costs. Betsy Voshel, Director of Field Education at the University of Michigan, interviews Shelley Cohen Konrad, Director of the University of New England's Center for Interprofessional Education in Biddeford Maine (<http://www.une.edu/ceipe/>). The center promotes educational programming and collaborative practice across health professions, including social work, nursing, and pharmacy. – Editor's Note*

**Betsy:** I'm very excited to have this opportunity to talk with you about your work in interprofessional practice and interprofessional education.

Probably the best way to start off would be to have you give us a definition of interprofessional practice. Also, I'm interested in how interprofessional practice differs from other approaches that have been around for a while. I throw that out, because I've been a practicing social worker for 36 years; in the old days, it was called "clinical case management," then we had "interdisciplinary practice" or "multidisciplinary practice" and then "inter-institutional practice." So, taking that all into consideration, what definition would you use now as it relates to social work practice today?



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**Shelley:** Well, it's funny you should ask that, because I just recently did a presentation at the Council on Social Work Education. I had an opportunity to look back and ask "how is interprofessional practice different than what we already do?" Social workers are by nature collaborators, team builders and community builders.

How is what we're doing now different? Laura Bronstein's<sup>[1]</sup> is one of the early social work scholars interested in the resurgence of this thing they're calling interprofessional education. Her definition is great. She states that "interdisciplinary collaboration is the achievement of goals that cannot be reached when individual professions act on their own."

**Betsy:** Wow, that's powerful.

**Shelley:** Nationally, the definition that many of the professions, including social work, are using is: interprofessional education is when two or more professions *learn* together for the goals of improving the quality of care.

"Interprofessional collaborative practice" is similar in that it's when two or more professions work together to improve the safety and quality of the *work* we do.

It's really thinking about the "how we work together" up front. The intentional educating of people in skills to work together effectively, to communicate effectively, to understand each other's values and ethics, to work as a team.

In the past, professionals were thrown into teams without the knowledge and skills they needed for building teams.

**Betsy:** That's a good segue to my next question related to skill sets: What skills and practice expertise do social workers need in order to be considered competent, interprofessional team members? Are there essential evidence-based skill sets? Would you recommend any particular academic courses or training? Also, are there particular field experiences that would help build these skill sets?

**Shelley:** The skills that social workers need to be excellent members of interprofessional teams are the same essential skills they need to be excellent social workers. Communication skills are very important. Social workers need to know how to listen actively, how to listen without bias or assumptions, how to engage and build relationships that are mutual and productive—having hardcore communication skills that include a willingness and openness to learn about other people and to be respectful of both shared goals and differences.

Another essential skill is the skill of developing strategies for dealing with difficult situations or complicated situations and being able to use your voice in a way that you can advocate for your position.

In the medical world, they teach a strategy called "CUS" as part of the [TeamSTEPPS](#) approach. "CUS" stands for "I am Concerned, I am Uncomfortable, or there is a Safety issue." It's there to

encourage anyone on a team to speak up when they feel there's a problem or there's something that can be done to avert or avoid a problem. Social workers also need to have the skills to stand up in a group to advocate.

Another skill is collaborative leadership: facilitating effective conversations with team members with the goal of person-centered care, helping others to express their views, managing team conflict, and bringing the client voice to the table.

Collaborative leadership is a skill social workers already value, but we need to be able to exert this type of leadership across professions—to be able to work collaboratively, no matter the composition of the group.

Also, the skills are translatable to any cross-professional group; they are not exclusive to healthcare settings. It's appropriate in schools or legal settings. It's appropriate in any kind of community-based organizing. I think all of these skills are very much transferable.

**Betsy:** Is there an evidence base for the particular skills you have identified?

**Shelley:** The evidence for these skills is a little trickier to pinpoint. There is evidence for the use of the [IPEC competencies](#)?

There's some effort to see whether these competencies can make a difference in how people practice their professions. The only research I'm aware of pertains to health care. What they're finding is that good communication across teams averts medical errors and helps patients better adhere to their medication protocols and to follow up on visits. There also seems to be a reduction in crisis-oriented health management, so they're seeing a decrease in emergency department visits. It cuts down on cost in that, when clients are seen by a team, they may have one visit with a couple of team members rather than six visits with six different team members.

There is a national movement to do more research on interprofessional care, and I think we need more research to prove that there is validity and benefit, not only around cost, but to the benefit of people's health and well-being.

**Betsy:** Your comments remind me of my previous work in the Veteran's Administration (VA). We called interprofessional collaboration "clinical case management." Our team practiced these competencies in the ways you have described, so it's really exciting to hear that this is being researched now.

**Shelley:** Well, it's funny that you should say about your former work at the VA. I was watching a

webinar from the VA today about interprofessional education using [the PACT model](#). I was talking to some of the folks that were there. I was trying to explain that all the principles are there and have been there for a long time.

The real difference in what we're trying to do now is we're trying to teach these skills at the Universities before students move to the workplace. We're trying to get students to practice not only within their own professional groups, but across their professional groups; we are preparing them to work as members of collaborative teams.

So you're right. Some of this stuff has been around for a very, very long time. It's just that now we're saying these competencies need to be taught early. Here, at UNE [University of New England], where I teach and direct the program [the Center for Excellence in Interprofessional Education], we start with students in their freshman year teaching them in classrooms together across their professional disciplines.

They sometimes don't get it. They don't know why we're doing it. But several years later, when they start doing their field and clinical placements, they say, "Oh! Oh, I see why we were doing that."

**Betsy:** As a Field Director, I love the emphasis on exposing students to other professions and exposing them to skills *before* they head into the work environment! This helps to shift some of the burden for teaching skills to the classroom and alleviates the pressure on the field setting. Given this, do you see any present-day challenges for social work educators in terms of responding to teaching interprofessional practice?

**Shelley:** Yes. It's hard for faculty when we say, "Oh, and by the way, you're not only teaching your own students, but we really want you to facilitate some critical and analytical and meaningful discussion across professional groups."

**Betsy:** Right.

**Shelley:** I think that's a lot to ask people. Our position—or I should say, here at UNE but also my personal philosophy and position—is that in order to do a good job teaching interprofessional practice to our students, we need to train our faculty as well.

Providing training, providing opportunities for our faculty to work collaboratively with each other, to do collaborative research, to do collaborative classrooms to really learn these principles that we want them to model for our students—it's an essential feature of what we're hoping to do.

Other barriers are scheduling, getting classrooms together, and differing accreditation standards.

I would say to you the two biggest barriers in the teaching arena are scheduling classes together and really supporting and mentoring faculty in this new way of doing education.

**Betsy:** That really hits home, because I think of the efforts we have in my program to work across disciplines. Sometimes I call it, “the tail wagging the dog.” The professors are willing, the material is there, the students are eager, and we can’t find a room, or the scheduling is a nightmare.

**Shelley:** You’re so right!

**Shelley:** What we started to do is work around the scheduling problems by offering extracurricular and co-curricular and service learning opportunities that bring our students together to interact, to learn with and from each other outside of their traditional classroom. We found that worked really well. Suddenly, what began to happen is that faculty started saying, “How can we integrate some of this into our classroom?”

This made us think about our common learning objectives across the professions. Cultural competency quickly emerged. Health literacy emerged – also difficult conversations and end-of-life issues. These were topics that students needed to learn. So we began to develop programming where faculty could assign students projects that were tied in to some of these interprofessional common learning activities.

**Betsy:** What would you say about applying this approach to field-based learning?

**Shelley:** The bigger challenge, honestly, Betsy, is bringing it to the field in designing field opportunities for our students that are shared. That’s in part because a lot of our community placements are not ready to be collaborative learning environments for students. They’re just getting on board with the IPE competencies and with service delivery changes coming down from the Affordable Care Act.

We try to work with individual placements by saying: “Is there a sweet spot here where we might place a social work student and a pharmacy student and find opportunities for them to share maybe some clients, and to share some didactics and do some reflective journaling?”

We’ve got a couple of sites that have been piloting these shared field placements. We’re keeping on top of the evaluation of these projects and the themes in the students’ journals, and getting a sense of how we can build on what we’re learning from that. The feedback we’re getting from students is very, very exciting and very positive.

**Betsy:** That sounds absolutely intriguing. In terms of the Affordable Care Act, I think students are

rightly concerned about not being prepared to be in the workforce under the new ACA guidelines. Can you talk more about the role that interprofessional education plays with these shifts in our health care policy?

**Shelley:** At UNE this year, our annual symposium will focus on the Affordable Care Act and its impact on service delivery and payment. We'll bring together students from all the professional programs. Students will learn about the ACA from experts, and then they will apply what they've learned to a case study. Each student will be assigned to an interprofessional team where they will address issues of collaboration, health insurance resources, and how to address gaps in health insurance coverage. They'll also be asked to view themselves as change agents.

We're immersing them in a day of thinking about health care from multiple perspectives. The social work students are learning about this in their classes, so we have asked our social work students to be both teachers and learners in these groups.

Also, I don't know if you're aware of the [Clarion Competition](#), a national case-based competition focused on interprofessional care hosted by the University of Minnesota. We had students participate for the first time last year. Participation is voluntary. It's another way we're trying to get them to think about the implications, the practice applicability and also their job as advocates and as change agents who ensure that clients and families are getting what they need.

**Betsy:** Your case-based teaching approach is very dynamic, and in my experience this is the best way that students learn. I also think that your Spring Symposium provides students an incredible opportunity to learn and apply critical-thinking skills.

**Shelley:** Next fall, we are changing the focus of the Center a bit from larger activities to smaller, more frequent interactive projects, with less emphasis on didactic presentations and more use of simulation, case-based learning, and panel discussions. We want students to get more hands-on experience early on in their education.

**Betsy:** How does interprofessional education as you have described it fit with the competency-based standards approach required by the Council on Social Work Education? We're all under the gun, so to speak, to show that we've measured student proficiency with the stated competencies. What kind of measures are you using now to evaluate your outcomes in your training model?

**Shelley:** That's a great question, and I think we're all struggling with it. We certainly are measuring attitudes *towards* interprofessional education and working in teams with our students using some of the standardized instruments, such as Katherine Pollard's scale<sup>21</sup> and the [RIPLS Scale](#), and [Vernon Curran's work](#). We definitely gauge changes in attitudes about working with other professions and

working in teams, but that's not a proficiency. It's just, "I like it, or I don't like it."

We are hoping in the fall to have interprofessional scenarios in our sim lab and include a checklist of various skills, such as clear communication, use of plain language, and facilitated dialogue across professions. This will help to measure some of the behavioral components that you hope to see as students learn.

Also, in the College of Health Professions, which houses the School of Social Work, all of our syllabi have the four IPEC domains as part of their learning objectives. Faculty are measuring those in a variety of different ways, but it isn't systematic yet across the college. We've also asked each discipline to include learning objectives on interprofessional practice as part of their field competencies.

Those are being assessed and observed in our pilot placements by preceptors, and their final assignment is a team-based case presentation that focuses on how they have integrated interprofessional thinking and collaborative practice skills. I am not an assessment evaluation expert, but what I'm hearing from others nationally is that, at this stage of interprofessional education, evaluation focuses on using qualitative measures to assess process, to get a sense from students about how they're getting from point A to point B.

**Betsy:** Readers of the *Field Educator* will be interested in knowing how to create an interprofessional education focus at their schools. What's a first step? Is there advice you can share with us about how to identify a collaborative field learning site? I can think of several in my program now. What best advice would you give someone about how to start this process in their school or field program?

**Shelley:** The first thing I would say is something I said earlier: Train your faculty. Train your field instructors and your field advisers. Make sure that everyone's on the same page, that people are using the terms in the same ways and that they feel comfortable and confident in what they're doing. That's phase one.

I think that you're not going to get everyone on board, but you find your champions. You find people who are excited about this process to begin with. I think starting small with a cohort of people who really believe in what you're doing achieves a better end result.

The second thing would be to also think about a cohort that is not overwhelming. Some of our early projects tried to get everybody in all the professions engaged: physical therapists, occupational therapists, social workers—everyone who's being educated at the school! Of course, things did not work well, because we don't naturally work together all the time.

Try to find sites where you can have two or three professions working together. Sites where it has

worked for us are homeless health programs, community clinics, family medicine clinics where students go on home visits together.

Start small, and think about what works best for your students; have your successes, and then refine. I think getting your community site folks trained is really important too in getting them on board.

It took us two-and-a-half years to get our first site engaged. It was worth the planning, and we're now in our second year of that site. I wouldn't say it's flawless, but it's a finely-tuned machine where students are sharing groups of clients, where they're engaged in a weekly didactic session together, where they're doing shared case presentations and reflective journaling.

The student feedback, as I said before, is really terrific.

**Betsy:** It sounds like it took a lot of hard work from the very beginning with a measured level of patience.

**Shelley:** You have to have leaders in this. I think patience is a critical skill to have—flexibility, being able to tolerate uncertainty—and not everybody is comfortable with that. It's important to have people who can go with the proverbial flow. Also, I think it's important for people to feel appreciated for the efforts that they make, because this is hard.

Change is hard, period, and most people, as you know, don't love change. Having this be a collaborative process from the get-go, having a team create what it's going to look like and what the learning objectives are going to be—I think those things are really important, but it does take time, and it can be frustrating at times.

Once the process gets working, it flows on its own. I used to have to oversee the pilot placements every week, and now they simply send me the student reflections, and I read them and I'm happy and they're happy. One cohort of students recently presented a paper on shared clinical education at a national conference. My job is to be obsolete.

**Betsy:** I think some of our readers would also be interested in some of the basic details. For example, in the site you just described, how is supervision handled across interprofessional practice domains?

**Shelley:** Each discipline needs to have their regular supervision with their discipline-specific supervisor. I would not want a social worker doing exclusive supervision with a pharmacist, let's say, because our fields are different. We need to hone our skills.

Then anybody can be a field adviser or preceptor from an interprofessional vantage point. We want

shared advisement; we want students to be learning from advisers from the other professions as a model of “we can really learn a lot from each other.” The advisement is on issues like communication—how do you work with a client or patient who’s really struggling to get to their appointments—the social context of what goes on for so many of the people that we work with.

I remember that the medical preceptor was agonizing over student supervision. She had a revelation one day. She said, “Oh, well, this is really about talking about good practice from a communication perspective and a position of respect and a position of thinking about the context of people’s lives. It’s not about how do you administer a shot or how do you draw blood or how do you manage bronchitis. It’s about how you manage human relationships.”

That’s a lot of what it’s about. It’s sitting and talking with people about why Mr. Jones, who lives in a third-floor walk-up and has neuropathy in his legs and high glucose levels, eats peanut butter every day. To sit down and explain that even though you, as a medical student, feel that he’s being irresponsible, for me, as a social work field adviser, it’s my role to explain that he has no transportation. He has a third-floor walk-up. It’s really hard for him to walk up and down those stairs. He’s living on an incredibly fixed budget, which is below the poverty level. From his perspective, peanut butter was a great choice.

**Betsy:** Peanut butter can go a long way on a tight budget. That is for sure!

**Shelley:** Right. Why are you being judgmental about this when you should be congratulating Mr. Jones for making that choice and then working with the social worker to help him with transportation, with looking at ways he can get more financial support. He lives in a neighborhood that doesn’t have a grocery store. Those are the lessons that are really powerful that we can do cross-professionally.

**Betsy:** That’s an excellent example that showcases the expertise of social work and focuses on the important role context plays when completing an assessment. It’s almost as if I felt the social worker was reminding the other discipline to look at the client as a human being living in an environment with identified barriers as opposed to viewing the client as a set of symptoms and/or a medical problem/diagnosis. The role that a social worker plays is certainly a powerful one.

**Shelley:** It’s not only powerful, it’s foundational. On the opposite end, for a social work student to understand what neuropathy is and some of the medical implications and to look for some physical signs of why Mr. Jones isn’t going down the stairs—maybe you should ask him if his feet hurt and is he taking his insulin, rather than just seeing it either as a social issue or an emotional issue.

To understand that knowing a little bit about medical information and knowing what questions to

ask his PCP or the community health nurse or the pharmacist – it really goes both ways, and that’s the beauty of it. I think social workers don’t always think about the biological or medical implications in some of these patients’ behaviors.

It’s a beautiful symmetry that can go on when people communicate well, respect each other’s knowledge, know they don’t have to carry everything themselves, and work together. It’s a perfect logic model.

**Betsy:** Can you give us another example of a complex case that has underlying ethical issues? Each discipline comes into professional practice with a diverse value base and varying Codes of Ethics. How have you been able to negotiate these?

**Shelley:** From a social work standpoint, we privilege confidentiality and the confidentiality within our relationship with our clients. Not all professions privilege that, in part because conveying information about a patient is about saving his or her life rather than protecting the patient’s privacy.

Also, one of the dilemmas is: when does a social worker advocate for a client and that client’s right to self-determination and autonomy, and when does the social worker think in terms of being a team member. I think about a case we created, the case of “Pat.” Pat is a young woman who has to have ankle surgery and, in preparing for it, discovers she has diabetes. We selected diabetes because it is in the forefront of the chronic healthcare conversation. Pat is young, 31, and newly diagnosed with diabetes.

She has a team of providers, including a visiting nurse, nurse practitioner, a physical therapist, a pharmacist, and a social worker. Pat confides to the social worker that she’s not really complying with anything that anybody is telling her to do, but she doesn’t want the social worker to tell anybody. In the meantime, the nurse practitioner is wondering why this woman isn’t losing weight. She’s supposed to be on a new diet because of the diabetes, and the pharmacist is concerned because the only medications he’s renewing are her pain meds.

There’s a rub there when the client says I’m telling you this stuff. I don’t really like the nurse and I’m not comfortable with him, and I just want to do what I want, and I don’t want you telling anyone. What do you do with that? It’s a real dilemma. Do you adhere to the social work code of ethics where confidentiality is at the forefront? Do you work with her to say, “How can I help you as part of this team?”

Do you say to her, “You know what? I’m really concerned about your health.” What do you do? Dilemmas, by their very nature, there’s no right or wrong answer. Social workers are thrust into that role as a team member to balance confidentiality, self-determination, and advocacy with the values

and ethics of other professions.

**Betsy:** You've shared a very good example of how important it is to be able to communicate across professions with the goal of understanding and respecting the differences that each practitioner brings to the table. It's not only the context of their practice, but differences found in their ethics, their individual value base, and their discipline specific knowledge and skills.

It occurred to me as I listened to you talk that using an interprofessional education approach could improve the overall image and reputation of social work. I don't know if you've sensed that or if you've experienced that. I think a lot of social workers struggle with social work's image and reputation.

What are your thoughts about how the interprofessional education training model might improve that image and reputation.

**Shelley:** As I said at the very beginning, social workers are natural collaborators. We also understand the social determinants of health, the implications of poverty, and the implications of mental illness. This is what we do. Also, we always advocate for the best interests of the clients, families, and populations that we serve.

As such, we are poised to be part of every team, if we can see ourselves in those roles. Part of the educational process is informing our colleagues about the scope of our practice. It's always so funny to me when I am talking to a large group, and I say, "I'm a social worker. Can someone in the audience, other than a social worker, tell me what I do?"

**Betsy:** That's a great question.

**Shelley:** They say, "You do discharge planning." Yes. "You work with kids who are abused." Yes. In those conversations, I try to get people to talk first about what they think social workers do and then about their biases and attitudes about social work. Of course, facilitating conversations about other professions is important too. If you ask a social worker what an occupational therapist does, for example, most can't answer.

We need to help people get out of the space of "I'm angry because people don't know what I do" to "Wow, wouldn't it be great if we all had a sense of what each other does? We can work more efficiently and effectively."

That's a really important, energizing element, I think, for social work and social work education, and we have a pivotal role. Truly, the bottom line for me, Betsy, is that it's all about the people we love.

It's about our mothers and fathers and children and partners and grandmothers, who we don't want to see harmed.

Whether it's the health care system or the social service system or the school system or the legal system (we have a big project in the local jail), if we do a better job communicating, it's less likely that we will see harm. It's really about the bottom line, which is caring for our families and our clients and our belief in health as a human right.

It's all about that, to do a better job. I think that if we do it together, and we think together, we're ultimately going to have a better end result.

**Betsy:** I can't think of a better note on which to end our interview. You are certainly a strong champion for the interprofessional education movement! Learning more about your efforts will help our readers feel very positive about their role as social workers, whether they're currently involved in interprofessional practice or any other type of collaborative work, or if they have a vision to do so in the future.

I think that your vote of confidence for social work's professional expertise, our wisdom, and our grounding that comes with our education and training is really where it starts. With the focus on the client and being in the moment with that client, you've nailed the common purpose.

To have all clients treated using an interprofessional practice perspective is an important goal for all of us. I have learned so much from our conversation and could spend the next two days talking about this!

**Shelley:** Well, we'll just have to get together.

**Betsy:** I want to get in the car and drive out to New England and meet you, see your Center, and visit your field training sites. Your Spring Symposium sounds wonderful and I'm thinking it certainly could be an exemplar for other schools of social work.

I also think that this is only the beginning of what is still to come related to your work, Shelley, so thank you for your contributions thus far and for your time today.

**Shelley:** You're so kind. Thank you so much. I feel very honored to be interviewed. It's been fun, and hopefully our paths will cross at some point.

**Betsy:** I hope so too. That would be great!

- [1] Bronstein, L. R., (2003). A model for interdisciplinary collaboration. *Social Work, 48*(3), 297-306. Doi: 10.1093/sw/48.3.297
- [2] Pollard, K., Thomas, J., & Miers, M. (2009). *Understanding interprofessional working in health and social care*. London, England. Palgrave Macmillian.