Importance of Interprofessional Education in Occupational Therapy Curricula

The American Occupational Therapy Association (AOTA) asserts that entry-level occupational therapy curricula should include interprofessional education (IPE) in which students have opportunities to learn and apply the knowledge and skills necessary for interprofessional collaborative practice. To achieve the goals of improved health outcomes and client experiences, along with reduced health care costs, practitioners must be prepared to contribute to interprofessional care teams (Earnest & Brandt, 2014). In the 21st century, clients’ health and well-being will benefit when occupational therapy students are taught firsthand that interprofessional collaborations are essential in the health care arena and community-based systems of care. The purposes of this position paper are to describe the history of IPE, to provide evidence for the benefits of including IPE in professional curricula, to define key concepts and core competencies associated with IPE, to address implications of including IPE in entry-level occupational therapy curricula, and to provide resources for faculty.

Background

History of Interprofessional Education

IPE is not a new concept in health professions education. It has been attempted, reported on, and discussed since the 1970s. In a 1972 Institute of Medicine (IOM) report titled *Report of a Conference: Educating for the Health Team*, Pellegrino wrote,

> A major deterrent to fashion health care that is efficient, effective, comprehensive, and personalized is our lack of design for the *synergistic interrelationship* [emphasis added] of all who contribute to the patient’s well-being. . . . We face a national challenge . . . the development of educational programs aimed at preparing future professionals for interprofessional collaboration. (p. 4)

In the 1st decade of the 21st century, the IOM issued two significant reports that reexamined the U.S. health care system and health professions education. The first of these reports, *To Err Is Human: Building Safer Health Systems* (IOM, 2000), focused on improving patient safety. The second report, *Crossing the Quality Chasm: A New Health System for the 21st Century* (IOM, 2001), also focused on quality-related issues and recommendations for innovative redesign to improve care. Together, these reports added urgency in the development of interprofessional educational programs and interprofessional collaborative health care practice across the country.

One outcome of these reports was the establishment of the IOM’s Committee on the Health Professions Education Summit. The members of the committee met to discuss and develop strategies for better preparing health care professionals to practice in the 21st-century health system. Specifically, the committee addressed strategies for “restructuring clinical education to be consistent with the six national quality aims of . . . safety, effectiveness, patient-centeredness, timeliness, efficiency, and equity . . . across the continuum of education for the allied health, medical, nursing, and pharmacy professions” (IOM, 2003, p. 20). National efforts in many arenas of health care professions education and practice have progressed and culminated in the 2012 establishment of the National Center for Interprofessional Practice and Education (2015) at the University of Minnesota. The need for integration and coordination of health
care delivery in dealing with the rising incidence of chronic diseases, the complexity of the health care system, and the use of technology in health care are the driving forces behind the current IPE movement (Page et al., 2009).

**Interprofessional Education, Occupational Therapy, and Accreditation**

*Interprofessional education* is defined as “occasions when students from two or more professions learn about, from, and with each other to improve collaboration and the quality of care” (Centre for the Advancement of Interprofessional Education [CAIPE], 2002). The ultimate goal of IPE is improving patient-centered care, a goal resonant with the core values of occupational therapy (AOTA, 2015). Client-centered practice focuses on the occupational needs of individuals, families, and communities to improve their health and well-being through participation in meaningful occupations (AOTA, 2014; Townsend, Brintell, & Staisey, 1990). Similarly, IPE focuses on the needs of individuals, families, and communities to improve their quality of care, health outcomes, and well-being (Barr & Low, 2011). Collaborating with clients and factoring their input into the decision-making process, a hallmark of client-centered care, is based on parity and inclusion. Similarly, in IPE all professions collaborate regardless of status and power. Just as client-centered occupational therapy values clients’ individuality regardless of their differences, IPE respects individuality and diversity within and between the professions. The unique identity, expertise, and contributions of individual professions are recognized and valued in IPE (Barr & Low, 2011).

Developing and incorporating standards for IPE and interprofessional care into accreditation and certification criteria is one way to ensure integration into curricula (Allison, 2007, p. 567). In actuality, the impetus for curriculum redesign to include IPE has in many fields been the accrediting bodies for the various professions and the insurance industry (Zorek & Raehl, 2013). Occupational therapy accreditation standards appear to align with this trend. The Preamble of the 2011 Accreditation Council for Occupational Therapy Education (ACOTE®) Educational Standards states that a graduate from an ACOTE-accredited doctoral-, master’s-, or associate-degree-level occupational therapy program must “be prepared to effectively communicate and work interprofessionally with those who provide care for individuals and/or populations in order to clarify each member’s responsibility in executing components of an intervention plan” (ACOTE, 2012, pp. S6–S8). This is the first time an educational standard specific to IPE and interprofessional practice has appeared in this document. In addition, ACOTE Standard B.5.21 states that students will be able to “effectively communicate, coordinate, and work interprofessionally with those who provide services to individuals, organizations, and/or populations in order to clarify each member’s responsibility in executing components of an intervention plan” (ACOTE, 2012, p. S48). Although ACOTE standards have only recently addressed IPE specifically, collaboration and communication with other professional team members and consumers in all phases of occupational therapy processes have been integral to the educational standards and the profession’s ethics standards (AOTA, 2015) for decades. Principle 6 of the *Occupational Therapy Code of Ethics* (2015) (AOTA, 2015) speaks to fidelity as it relates to interprofessional relationships. Occupational therapy personnel are specifically called to promote collaborative actions and communication as a member of interprofessional teams to facilitate quality care and safety for clients [as well as] respect the practices, competencies, roles, and responsibilities of their own and other professionals to promote a collaborative environment reflective of interprofessional teams.

**Key Concepts and Core Competencies**

The definition of IPE has been expanded by the Institute of Medicine (2003), CAIPE (2002), and the World Health Organization (WHO) to “when students from two or more professions learn about, from, and with each other to enable effective collaboration and improve health outcomes” (WHO, 2010, p. 13). On the basis of this definition, students are required to interact with one another in learning activities.
that are authentic and that require the complex problem solving that involves the knowledge and skills of multiple professions. Reflection on the experiences is a critical component to improve on the collaborative process. The overall goal is to develop interprofessionality, defined as the process by which professionals reflect on and develop ways of practicing that provides an integrated and cohesive answer to the needs of the client/family/population. . . . [It] involves continuous interaction and knowledge sharing between professionals, organized to solve or explore a variety of education and care issues all while seeking to optimize the patient’s participation. . . . Interprofessionality requires a paradigm shift, since interprofessional practice has unique characteristics in terms of values, codes of conduct, and ways of working. (D’Amour & Oandasan, 2005, p. 9)

IPE is paramount to promoting effective interprofessional practice and collaboration. Multidisciplinary becomes interprofessional when team members transcend their separate disciplinary perspective and weave together their unique perspectives, methods, and practice to overcome problems and perform their work collaboratively (Klein, 1990). Pellegrino (1972) stated,

Each member of the team, while providing the group with the knowledge and skills of his or her disciplinary perspective, also strives to incorporate that perspective with those of others to create solutions to healthcare problems that transcend conventional discipline specific methods, procedures, and techniques. (p. 4)

Others who have written on the distinction between multidisciplinary and interprofessional practice have commented on the quality of communication and degree of collaboration between professional team members (Hirokawa, 1990) and the cohesive, collaborative decision making in team-oriented health care delivery (D’Amour & Oandasan, 2005).

The Interprofessional Education Collaborative (IPEC) published a report from an expert panel (IPEC Expert Panel, 2011) that is the landmark document for the delineation of core competencies for interprofessional practice and that guides a competency-based approach to IPE. This document describes four core competency areas for practice, the ultimate goal of which is to guide the development of interprofessional learning activities and “prepare all health professions students for deliberatively working together” (p. 3):

- Competency Domain 1: Values/Ethics for Interprofessional Practice
- Competency Domain 2: Roles/Responsibilities
- Competency Domain 3: Interprofessional Communication
- Competency Domain 4: Teams and Teamwork.

These core competencies for practice as applied to education can be effectively planned in education through a learning continuum of exposure → immersion → competency (as entry to practice), using tools of reflective learning and formative assessment (CAIPE, 2002).

Ultimately, IPE aims to create more effective systems of interprofessional practice, defined as a higher form of practice wherein health care professionals from different disciplines make up a team, unique to the individual client–patient, that works with the client to develop a unified decision (National Academies of Practice, 2012). IPP results in safer and more efficient delivery of health care (Guitard, Dubouloz, Savard, Metthé, & Brasset-Latulippe, 2010) as well as greater patient satisfaction (Howell, Wittman, & Bundy, 2012; Kent & Keating, 2013; Shiyanbola, Lammers, Randall, & Richards, 2012; Solomon & Risdon, 2011), thus validating the need to embed IPE into entry-level preparation for occupational therapy practitioners.

Assessing the Outcomes of Interprofessional Education

Positive outcomes associated with IPE have been documented at several levels from students to patient, client, and consumer. Assessments used in these studies have focused on measuring changes in attitudes, perceptions, behaviors, knowledge, skills, and abilities, although changes in student attitudes and percep-
tions are by far the most commonly assessed variables. In addition to positive changes in students’ perception of health care teams and IPE, recent studies have noted that students who participate in IPE increase knowledge of their own professional roles, improve communication skills with people outside of their own profession, and develop critical skills necessary for working on interprofessional teams (Buff et al., 2014; Howell et al., 2012; Olson & Bialocerkowski, 2014; Solomon & Risdon, 2011). Some studies have noted that engagement in interprofessional learning may lead to health care providers who demonstrate higher levels of safety and more efficient delivery of medical care. Unfortunately, the literature that connects student participation in IPE and potential benefit to health service delivery or patient outcomes is limited (Knier, Stichler, Ferber, & Catterall, 2014; Shadrer, Kern, Zoller, & Blue, 2013).

The Canadian Interprofessional Health Collaborative (CIHC) has published several interprofessional resources over the past few years, including an inventory of 128 IPE measurement tools (Lindqvist, Duncan, Shepstone, Watts, & Pearce, 2005). The majority of these assessments measure student attitudes (64 tools) versus knowledge, behavior, or patient or provider satisfaction. Of note, no psychometric information was found in 33% of the report’s entries. Nevertheless, the IPE field’s overall high regard for quantitative measurement is impressive and remains a focus for future studies.

The National Center for Interprofessional Practice and Education offers online access to a collection of assessments used for IPE and collaborative practice (IPECP) research (National Center for Interprofessional Practice and Education, 2013; available at https://nexusipe.org/measurement-instruments). The collection started with a review of the CIHC inventory but narrowed the assessments to those that focused on IPECP and variables specifically related to attitudes, behavior, knowledge, skills, abilities, organizational practice, patient satisfaction, and provider satisfaction. Table 1 outlines commonly used assessments organized using the National Center’s outcome levels, all with adequate psychometrics for educational research.

Table 1. Commonly Used Outcome Measures in Interprofessional Education and Collaborative Practice

<table>
<thead>
<tr>
<th>Name of Tool</th>
<th>Tool Description</th>
<th>Setting and Sample</th>
<th>Citation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attitudes Toward Health Professionals Questionnaire (AHPQ)</td>
<td>20 items (1 for each profession) 2 components, caring and subservice, with visual analog scales</td>
<td>University in UK 160 students from 6 professional programs</td>
<td>Lindqvist et al. (2005)</td>
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<tr>
<td>Attitudes Toward Health Care Teams</td>
<td>3 subscales: Quality of Care/Process, Physician Centrality, and Cost of Care 20 items with 4-point Likert scales</td>
<td>Community and hospital settings in US 1,018 interdisciplinary geriatric health care teams</td>
<td>Heineman, Schmitt, Farrell, &amp; Brallier (1999)</td>
</tr>
<tr>
<td>Attitudes Toward IP Learning in the Academic Setting</td>
<td>4 areas: campus resources and support, faculty, students, and curriculum/outcomes supporting IP learning 13 items with 5-point Likert scales</td>
<td>University in Canada 194 faculties from 4 health disciplines</td>
<td>Curran, Sharpe, &amp; Forristall (2007)</td>
</tr>
<tr>
<td>Attitudes Toward Teamwork questionnaire (also applies to Outcome Levels 2 and 3)</td>
<td>Subscales: Orientation Toward Team Problem Solving, Problem-Solving Confidence, Team Preparedness, Attitude Toward Interdisciplinary Team, and Self-Efficacy 10 items each with 5- or 6-point Likert scales</td>
<td>University in US 410 alumni from 8 allied health disciplines</td>
<td>Lindqvist et al. (2005)</td>
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Table 1. Commonly Used Outcome Measures in Interprofessional Education and Collaborative Practice (cont.)

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<tbody>
<tr>
<td><strong>Index of Interprofessional Team Collaboration for Expanded School Mental Health (IITC–ESMH)</strong> (also applies to Outcome Level 4)</td>
<td>4 subscales: Reflection on Process, Professional Flexibility, Newly Created Professional Activities, and Role Interdependence</td>
<td>Schools in US 436 members of IP health care teams</td>
<td>Mellin et al. (2010)</td>
</tr>
<tr>
<td><strong>Professional Identity Scale</strong></td>
<td>Strength of students’ professional identity regarding readiness for IP learning</td>
<td>University in UK 933 students from various health disciplines</td>
<td>Hind et al. (2003)</td>
</tr>
<tr>
<td><strong>Readiness for Interprofessional Learning Scale (RIPLS)</strong></td>
<td>3 subscales: Teamwork and Collaboration, Negative and Positive Professional Identity, Roles and Responsibilities</td>
<td>University in UK 120 students from 8 health disciplines</td>
<td>Parsell &amp; Bligh (1999)</td>
</tr>
<tr>
<td><strong>Interprofessional Delirium Knowledge Test (IDKT)</strong></td>
<td>Delirium case study tool 4 areas: identification, causes, and management of delirium in terminally ill patients; psychosocial care of patient and family; roles of team members and contribution to patient care; and communication 5 open-ended questions scored with rubric</td>
<td>Palliative care unit in Canada 10 team members, volunteers, and students from 6 professions</td>
<td>Brajtman et al. (2008)</td>
</tr>
<tr>
<td><strong>Attitudes Toward Teamwork questionnaire (also applies to Outcome Levels 1 and 3)</strong></td>
<td>Subscales: Orientation Toward Team Problem Solving, Problem-Solving Confidence, Team Preparedness, Attitude Toward Interdisciplinary Team, and Self-Efficacy 10 items each with 5- or 6-point Likert scales</td>
<td>University in US 410 alumni from 8 allied health disciplines</td>
<td>Lindqvist et al. (2005)</td>
</tr>
<tr>
<td><strong>Team Skills Scale (TSS)</strong></td>
<td>17 items with 5-point Likert scales. Modified from original: 17 of the 20 items related interdisciplinary team skills were used. Remaining 3 attitudinal items examined individually.</td>
<td>Hospital in US 25 students from 4 disciplines</td>
<td>Robben et al. (2012)</td>
</tr>
<tr>
<td><strong>Collaborative Practice Assessment Tool (CPAT)</strong></td>
<td>8 domains: mission, meaningful purpose, goals; general relationships; team leadership; general role responsibilities and autonomy; communication and information exchange; community linkages and coordination of care; decision making and conflict management; and patient involvement. 57 items with 7-point Likert scales 3 open-ended questions on team’s strengths, challenges, and help needed to improve collaborative practice</td>
<td>111 practice teams in Canada</td>
<td>Schroder et al. (2011)</td>
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Table 1. Commonly Used Outcome Measures in Interprofessional Education and Collaborative Practice (cont.)

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<th>Name of Tool</th>
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<th>Citation</th>
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<tbody>
<tr>
<td>Interprofessional Collaboration Scale</td>
<td>Collaboration among multiple health professional groups 3 subscales: Communication, Accommodation, and Isolation (Nurse-Physician Relations Subscale of the Nursing Work Index and the subscales of the Attitudes Toward Health Care Teams Scale were used to measure the concurrent, convergent, and discriminant validity.)</td>
<td>Hospitals in Canada; number of sample not provided</td>
<td>Kenaschuk, Reeves, Nicholas, &amp; Zwarenstein (2010)</td>
</tr>
<tr>
<td>Index of Interprofessional Team Collaboration for Expanded School Mental Health (IITC-ESMH) (also applies to Outcome Level 1)</td>
<td>4 subscales: Reflection on Process, Professional Flexibility, Newly Created Professional Activities, and Role Interdependence 26 items with 5-point Likert scales</td>
<td>Schools in US 436 members of IP health care teams</td>
<td>Mellin et al. (2010)</td>
</tr>
<tr>
<td>Satisfaction With Treatment Team Planning Rating Scale (also applies to Outcome Level 6)</td>
<td>Patient satisfaction with treatment team planning 10 items with 4-point Likert scales</td>
<td>Inpatient psychiatric hospital in US 18 health professionals from 6 disciplines</td>
<td>Singh, Singh, Sabaawi, Myers, &amp; Wahler (2006)</td>
</tr>
<tr>
<td>Satisfaction With Treatment Team Planning Rating Scale (also applies to Outcome Level 5)</td>
<td>Staff satisfaction with treatment team planning 10 items with 4-point Likert scales</td>
<td>Inpatient psychiatric hospital in US 18 health professionals from 6 disciplines</td>
<td>Singh et al. (2006)</td>
</tr>
<tr>
<td>Satisfaction Survey</td>
<td>Attitudes toward teamwork and teamwork abilities 12 items with 5-point Likert scales</td>
<td>University in Canada 137 professionals</td>
<td>Curran, Heath, Kearney, &amp; Button (2010)</td>
</tr>
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Note. IP = interprofessional. Source: Arthur et al., 2012.

Designing, Implementing, and Sustaining Interprofessional Education

It is of the highest importance that occupational therapy educators teach students to build their interprofessional toolkit during their educational journey. This toolkit includes building trust, open communication, mutual respect, and professionalism, as well as the skills required for effective teamwork: conflict resolution, negotiation, and empathy. Creating an atmosphere and culture within occupational therapy curricula that emphasize being a team player and being client focused is well supported through IPE. When students demonstrate effective collaborative reciprocity within the educational environment, best practices of interprofessionalism in occupational therapy will follow.

As Greer and Clay (2010) asserted, “Developing and sustaining IPE requires a mammoth effort that incorporates institutional support, leadership, and shared vision and which transverses multiple divisions, units, schools, or colleges within and among educational systems” (p. 224). Once the goal of IPE is established, best methods for implementing the experience must be identified. It is important to assess the level of understanding of faculty, staff, and administration who are interested in collaborating in the IPE effort. Occupational therapy faculty initiating or supporting IPE activities may need to provide educational programming to ensure that everyone understands the importance of and reasons to engage in this educational component. This may be accomplished through campus workshops, webinars, reading groups, and attendance at a national conference on IPE.
The next step is to assess the strengths and opportunities both within and external to the institution that are in place to support one’s efforts. These can range from students and alumni in the community or settings in which interprofessional collaboration and practice exist to resources within the division or the university at large. Perhaps the institution has an office or advisory board that can assist in community outreach. Figure 1 displays important factors to consider at all levels of the institution when planning to implement IPE as well as suggested resources.

Figure 1. Institutional considerations and resources.

Note. IPE = interprofessional education.

A typical hierarchy of ease in implementation is to begin at the classroom level, then in-service learning and Level I fieldwork, and then campuswide experiences; however, depending on the balance of support available and the goals of the initiative, faculty may find a Level I fieldwork experience easier to carry out than a classroom experience. Level II fieldwork is certainly a place where students can put their interprofessional skills to the test, and it is recommended that all Level II fieldwork experiences have at least one assignment related to IPE and practice. Table 2 provides examples of IPE activities at all levels from classroom to community.
### Table 2. Models of Interprofessional Education

<table>
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<tr>
<th>Activity</th>
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<tr>
<td>Universitywide faculty IPE institute training</td>
<td>IP faculty training about campuswide IP initiatives; engagement of faculty on IP teams to develop universitywide IP activities and new programs.</td>
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</table>
| IPE Day                                                                  | Planned by representative group of faculty from several disciplines (e.g., medicine, nursing, OT, pharmacy, physician assistant, physical therapy, social work). Each member has a coordinating responsibility: space, food, handouts, scheduling faculty facilitators, and so forth. Students from several disciplines are assigned to IP groups that meet in several classrooms across the campus and engage in activities addressing IP core competencies at the appropriate level. Faculty facilitators meet over lunch to receive instructions, and 2 or more (from different disciplines) are assigned to each room. Social activity with refreshments follows.  
  **Examples:** Introduction to each discipline’s educational curricula and scope of practice; case-study discussion emphasizing each profession’s contributions and role. |
| Classroom                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                  |
| OT faculty coteach with faculty from other professions; faculty jointly create and foster a collaborative learning environment or activity for students from 2 or more professions | OT students engage with students from other professions to conduct interviews with family and caregivers of people who have chronic conditions. The team of students considers the role of caregivers and how various professions can work collaboratively to assist patients and their caregivers with long-term and ongoing health care issues.                                                                                                               |
| Sharing Knowledge and Skills: OTAs and PTAs: Adaptive Equipment and Gait Training | OTA students and PTA students teach each other. OTA students share, and provide simulations for, various pieces of adaptive equipment and explain their purpose(s) in daily activities. PTA students present case scenarios and rationale for gait training to increase problem solving and clinical reasoning behind the gait training process.                                                                                     |
| Community                                                                |                                                                                                                                                                                                                                                                                                                                                                                                  |
| Service learning with 2 or more professions working together to engage in community-based programming | OT students work with students from dental medicine to develop school-based oral health programs for children with multiple disabilities.                                                                                                                                                                                                                                                                    |
| Student-run free medical therapy clinics for uninsured patients          | OT students participate in student-run free clinics with other health professions including medicine, pharmacy, nursing, and physical therapy. These clinics provide free medical care and therapy services to uninsured and underserved patients while offering students an opportunity to translate their classroom learning directly to patient care in the form of experiential learning. As of 2014, 146 student-run free clinics are in existence, as tracked by the Society of Student-Run Free Clinics. |
| Cultivating Partnerships in the Garden: An IP Service Learning Experience: Quincy Gardening Club and OTA Students | Collaborative experiences between OTA and PTA, English, and forestry students, including  
  - Modifications to gardening tools and garden terrain  
  - Accessibility with raised garden beds  
  - Restructuring of gardening tasks  
  - Exploration of current market for adapted garden tools  
  - Documentary of collaborative experience.                                                                 |
Table 2. Models of Interprofessional Education (cont.)

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<tr>
<th>Activity</th>
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| Adaptive Equipment Project: An IP Learning Experience | Collaborative experience between OTA and engineering students, including:  
• Creation of a piece of adaptive equipment intended for individuals with disabilities  
• Communication between students with different backgrounds and goals  
• Education of faculty, staff, and student body as well as the community. |
| Fieldwork—Level I | Students ask fieldwork educator to assist in seeking out a non–OT professional at the fieldwork site. Student shadows the professional for 30 minutes and conducts a 15-minute interview based on the following:  
• Describe what you do during a typical day.  
• What is the best part of being a _______?  
• How do you see yourself working in tandem with OT practitioners?  
• How important is it to be a team player for the health and well-being of your clients?  
Student writes a reflection on  
• Whether, during the observation of the professional, he or she saw the professional use therapeutic use of self while communicating with clients. Explain.  
• What he or she learned about the professional’s role in the care of clients and as a team member. |
| Synthesis and Application of IP Collaborative Education and Practice | Students read the IPEC Expert Panel's (2011) Core Competencies for IP Collaborative Practice before fieldwork. Students write a descriptive narrative about client care in relation to the following IP competencies:  
• Values/Ethics for IP Practice: Develop a trusting relationship with other team members  
• Roles/Responsibilities: Communicate one’s roles and responsibilities  
• IP Communication: Listen actively, and encourage ideas and opinions of other team members  
• Teams and Teamwork: Share accountability with other professions. |

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**Table 2. Models of Interprofessional Education (cont.)**

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<th>Activity</th>
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<tbody>
<tr>
<td><strong>Fieldwork—Level II</strong></td>
<td><strong>IP Collaborative Practice based on Educational Experiences</strong></td>
</tr>
<tr>
<td><strong>Learning outcomes:</strong></td>
<td><strong>On the basis of Level II fieldwork experiences, students write descriptive narratives of the following:</strong></td>
</tr>
<tr>
<td>• Effectively communicate and work IPly with those who provide services to individuals and groups to clarify each member’s responsibility in executing an intervention plan.</td>
<td>• Identify non–OT professionals encountered on a frequent basis.</td>
</tr>
<tr>
<td></td>
<td>• Discuss the level of collaboration between the above-named professionals and the OT staff during coordination of client care.</td>
</tr>
<tr>
<td></td>
<td>• Discuss the format and frequency of communication between the OT staff and non–OT professionals as it relates to coordination of client care.</td>
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<tr>
<td></td>
<td>• Discuss your level of confidence in effectively communicating with non–OT professionals as it relates to coordination of client care and explaining the basic tenets of OT.</td>
</tr>
<tr>
<td></td>
<td>• Discuss a specific incident in which you directly collaborated or communicated with a non–OT professional in regard to client care or explanation of OT services.</td>
</tr>
<tr>
<td></td>
<td>• List a specific component of a client’s intervention plan that requires team collaboration.</td>
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</table>

*Note. IP = interprofessional; IPE = interprofessional education; IPEC = Interprofessional Education Collaborative; OT = occupational therapy; OTA = occupational therapy assistant; PTA = physical therapy assistant.*

Ways to ensure that IPE initiatives are sustainable include meeting with administration to discuss the stakes for IPE, which may include enhanced professional skills for graduates, improved standards of education, and opportunities for emergent practice and scholarship for faculty across the campus and within the community. One of the most productive means of ensuring the sustainability of IPE is to build a goal into the program’s strategic plan in which each component of the educational experience has a measurable goal, identified strengths, and key stakeholders. Greer and Clay (2010) described a useful peer-reviewed instrument for assessing IPE in health care institutions that provides detailed insight into requirements for successfully implementing and sustaining IPE.

**Ethical Considerations for Occupational Therapy Education and Practice**

It is the professional and ethical responsibility of occupational therapy educators to provide students with opportunities to work and learn collaboratively during their professional education. Without opportunities to learn collaboratively as students, it is unlikely that occupational therapy practitioners will effectively work collaboratively in practice settings. Practice that is truly collaborative is aligned with health care reform efforts to benefit consumers with improved care and client experiences at reduced costs (IOM, 2003).

**References**


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