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Interprofessional Continuing Education in the Ambulatory Care Setting

abstract

Ambulatory care is a rapidly growing specialty practice area. This article describes how interprofessional continuing education can serve as a platform to support this growth and how the nursing professional development practitioner can use their skills to lead the way.
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Interprofessional education (IPE) occurs when "two or more professions learn about, from, and with each other to enable effective collaboration and improve health outcomes" (World Health Organization, 2010, p. 13). Aligning with continuing nursing education, the Association for Nursing Professional Development (ANPD) *Scope and Standards of Practice* (Harper & Maloney, 2016) states that interprofessional continuing education (IPCE) "requires that members of the interprofessional team work deliberately together in the planning and evaluation of continuing education activities" (p. 18). Both IPE and IPCE rely on team building, communication, trust, and transformative change to reach its goals. The ANPD (Harper & Maloney, 2016) Standard 13 addresses IPCE under the topic of collaboration. They note that the ANPD generalist "collaborates with others in the planning and implementation of lifelong learning activities for individuals and groups of leaders" (p. 52). The focus of IPCE is often the professional development of the RN to improve patient outcomes, as is the focus of most continuing education.

IPCE AND AMBULATORY CARE

Perhaps the need for IPCE is nowhere more evident than in the ambulatory care setting, where the practice model is rapidly changing (Vanderboom, Thackeray, & Rhudy, 2015). What was once a physician driven, often private business is transforming into a team-based system where partnerships and standardized work allow for a greater focus on proactive, patient-centered health care within populations. As this new care model evolves, many professions are trying to understand how to prepare, or, in some cases, catch up, while they also learn the intricacies of navigating collaborative communication that is vital to success. Moving to a new model in ambulatory care is a culture change for health care teams, as well as for patients and their families. IPCE may be a key strategy to bridging the gaps that exist for these groups.

In ambulatory care, as in other specialty areas of practice where RNs play a primary role in managing the care of the patient, the nurse is often the instigator for change. According to the American Academy of Ambulatory Care Nursing (2017) position statement:

> RNs are the team members best prepared to facilitate the functioning of interprofessional teams across the care continuum, coordinate care with patients and their caregivers, and mitigate the growing complexity of transitions in care. (p. 1)

For illustration, consider that ambulatory care teams include physicians, nurse practitioners, physician assistants, RNs, licensed practical nurses, medical assistants, clerical staff, and health care leaders, among others. These teams may have a current state of deeply embedded practice behaviors whereby clinical staff provide care at the direction of the physician. This leads to increased work burden on physicians, while not allowing staff to work to the full extent of their license. To move to the future state of proactive team-based

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care, a major shift in culture is needed. Novice groups need to explore and recognize the basic knowledge gap of understanding and appreciating the value of team-based care, in which each member of the team is accountable for specific roles for the delivery of patient care. Physicians and advanced practice providers can focus on the medical care of the patient, while clinical staff review charts for gaps in preventative care and prepare those findings for previsit team huddles. Other clinical team members can work with patients to devise individualized plans to meet health goals, while others follow up with patients after hospital visits to ensure smooth transitions.

Like all high-quality education, the IPCE development process in the ambulatory care setting begins with an identified gap in knowledge, skill, or practice. Then, the interprofessional planning team verifies the educational need. Discussion is facilitated by an identified subject matter expert who uses collaborative approaches for all members of the planning team to share their thoughts. The discussion includes how the topic affects each role, as well as the entire team. Planning discussions encourage team building as the group begins to understand each other's perspective. For example, in one ambulatory care setting, the author noted that many patients with diabetes were not getting the recommended preventative care including various laboratory testing and eye examinations. The nursing professional development (NPD) practitioner was engaged to determine the need for education of clinical staff as to the importance of this preventative care. Upon validation, a planning team made up of individuals from multiple professions gathered to design an educational program. For this scenario, the planning team consisted of nurses, a physician, quality leaders, administrative support, and diabetic educators. Assignments were made for the group to identify salient points, which were then presented to their peers with a coordinated, collaborative, professional perspective. The group shared current practices, protocols, and perceived challenges. Learning strategies were selected that would engage all members of the health care team without a bias toward any one profession. These strategies included live presentations with interprofessional application case studies lasting no more than 15 minutes, question-and-answer sessions to ensure understanding or gaps in knowledge of the team, and a pilot run of a new protocol with education as the main outcome. The pilot run specifically allowed all team members to learn the information by using it in practice. This method also provided rich feedback to the planning team on how well the outcomes were met.

Evaluation of the learning strategies found that most members of the team understood the basic concepts of a team-based approach to diabetes care. Using the teaching method of a pilot run, providers, clinical staff, educators, and even patients were able to raise questions that pointed to areas where educational gaps still existed. This allowed the planning team to regroup and plan phase two of the education with the newly identified data. This cycle of understanding individual learning outcomes, as well as methods of collaborative learning, has promoted interprofessional growth that translates to practice where preventative care for patients with diabetes is highly understood and valued.

CONCLUSION

Research has shown us that although there may be limited influence between continuing professional education and practice change, notable advantages exist when using an inclusive education design process to create a collaborative practice environment (Mast, Rahman, Schatzman, Bridges, & Horsley, 2015). This collaboration results in a work environment change that is more conducive to the delivery of safe patient care, if not by practice then by the interprofessional team being willing to change the crucial conversations that support team-based care.

Although this change in culture takes time, it may not have to be a long time. When health care teams come together with a shared future vision, change can naturally evolve. Putting action to the vision can be accomplished through the structure of IPCE. After all, learning about, with, and from each other is not just how we change our culture, it is the essence of what created our culture to begin with.

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