Teaching Interprofessional Education and Family-Centered Care: Preliminary Results of Standardized Outcomes in a National Network

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BACKGROUND

- Family-centered care (FCC) and Interprofessional team care (IPC) are essential educational outcomes
- Different training methods may result in differential improvement in these skills
- Lack of standardization leaves programs to rely on idiosyncratic measures to determine competency
- We developed and tested a faculty observation tool based on key dimensions of competency (milestones)
- As a first step in creating a national quality improvement database, we implemented the new tool, as well as a previously developed trainee self-report measure, in 4 training programs

OBJECTIVE

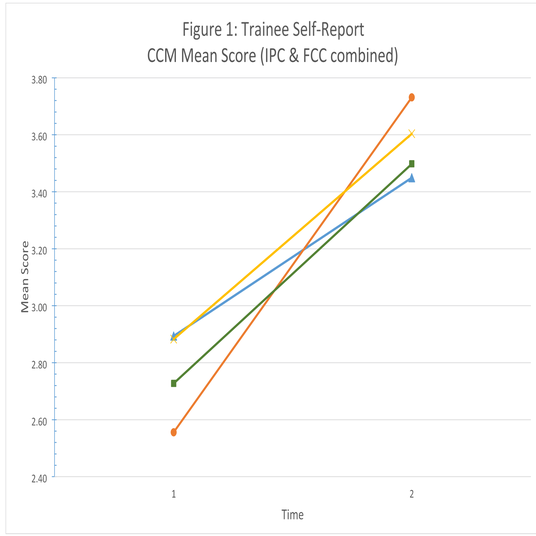
- To test the feasibility of implementing standardized measures of IPC and FCC in a national network of training programs

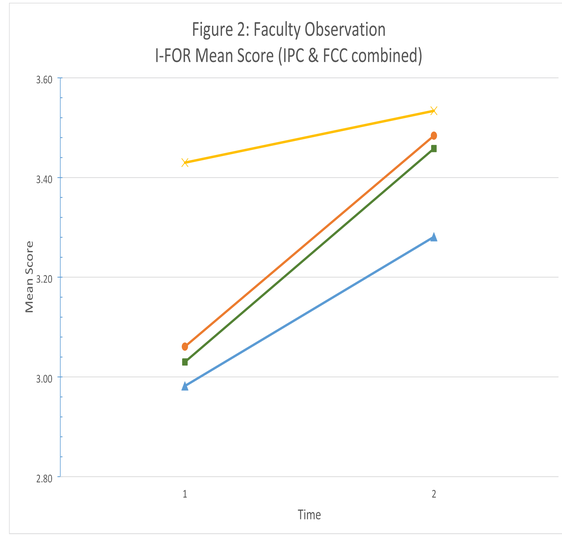
DESIGN/METHODS

- Trainees and faculty at 4 Leadership Education in Neurodevelopmental Disabilities (LEND) training programs participated
- FCC and IPC are core LEND values
- LEND programs provide graduate-level training in interprofessional settings
- In addition to pediatrics, 18 other disciplines were represented (e.g. psychology, audiology, education, PT, OT, speech-language pathology)
- Trainees completed a validated self-report measure, the LEND Core Competency Measure (CCM), at the beginning and end of training
- Faculty supervisors rated trainees using the new tool, the Interprofessional-Family-centered care Observation Rubric (I-FOR), near the beginning and at the end of training
- Faculty and trainees were asked open-ended questions regarding their experience

RESULTS

Both trainees (n = 86) and faculty (n = 78) reported satisfaction with completing the measures. The I-FOR demonstrated good internal consistency at both data points (Cronbach's alpha coefficients > 0.930) and test-retest reliability (IPC r = 0.862, FCC r = 0.823, p < 0.001). Nearly all participants reported that I-FOR questions accurately addressed the skills/behaviors faculty consider when assessing IPC and FCC skills. The I-FOR was not associated with the CCM on either sub-scale at T1 or T2. The CCM for each program demonstrated significant improvement from T1 to T2 (Figure 1). For the I-FOR, smaller improvements were seen in 3 of 4 programs. (Figure 2).





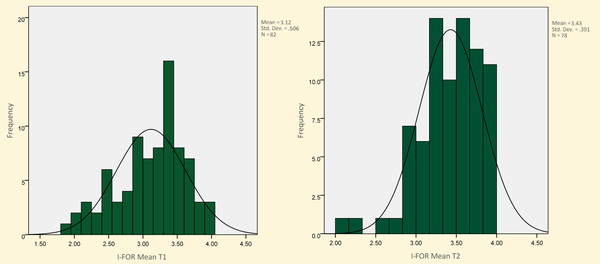
I - FOR: Interprofessional Care

1	1.5	2	2.5	3	3.5	4	
Lacks understanding of other professions and their significance		Defines general roles/ functions of other professions		Describes unique knowledge, skills, and training of other professions		Knows how to assemble interprofessional teams to address clinical, research, policy questions	N/A
☐	☐	☐	☐	☐	☐	☐	☐
Rarely attends/does not value interprofessional meetings		Attends interprofessional meetings		Participates actively in interprofessional meetings; excellent team player		Serves as a role model for others in interprofessional work; excellent team leader	N/A
☐	☐	☐	☐	☐	☐	☐	☐
Does not recognize need to use terminology accessible to other professions		Understands value of and sometimes employs terminology accessible to other professionals		Adjusts terminology to meet needs of team members		Understands other professions well enough to "translate" among those professions	N/A
☐	☐	☐	☐	☐	☐	☐	☐
Limited ability to recognize team dynamics and resolve conflicts		Beginning to recognize team dynamics; listens well; needs others to resolve conflicts		Recognizes team dynamics, gives and receives feedback; actively resolves conflicts		Recognizes team dynamics and manages conflicts; helps others to improve giving and receiving feedback	N/A
☐	☐	☐	☐	☐	☐	☐	☐
Tends to dismiss input from other professionals aside from own profession		Sometimes (< 50%) uses the input of other professions, but is unlikely to seek out those individuals when confronted with ambiguous situations		Usually (> 50%) seeks input of other professions; develops prioritized, coordinated plans that focus on the task at hand (not just intraprofessional needs)		Adopts tools, techniques and methods of other professions in their work; submerges professional identity to address task at hand/organizational needs	N/A
☐	☐	☐	☐	☐	☐	☐	☐
Does not recognize that professions differ in approach		Seeks answers only from intraprofessional colleagues, even when there are disputes		Recognizes different professional paradigms; appeals to scientific evidence to resolve disputes		Reconciles philosophical differences among professions; contributes to research to resolve disputes	N/A
☐	☐	☐	☐	☐	☐	☐	☐

I - FOR: Family-Centered Care

1	1.5	2	2.5	3	3.5	4	
Authoritarian decision maker; does not seek input from individual/family		Sometimes (< 50%) explores individual/family perspective; sometimes (< 50%) involves individual/family in plan		Usually (> 50%) explores individual/family perspective; usually (> 50%) involves individual/family in plan		Shared decision maker; always (> 90%) involves individual/family in plan	N/A
☐	☐	☐	☐	☐	☐	☐	☐
Informs individual/family of decision; plan is not provided		Acknowledges family priorities; plan is sometimes (< 50%) provided in accessible format		Addresses family priorities; plan is usually (> 50%) provided in accessible format		Substantially addresses family priorities; plan is always (> 90%) provided in accessible format	N/A
☐	☐	☐	☐	☐	☐	☐	☐
Does not assist family in accessing services		Sometimes (< 50%) assists family in accessing services; provides basic information		Usually (> 50%) assists family in accessing services; provides specific information		Always (> 90%) assists family by actively connecting them to needed	N/A
☐	☐	☐	☐	☐	☐	☐	☐
Rarely (< 10%) recognizes social, educational, or cultural issues affecting the family		Sometimes (< 50%) assesses social, educational, or cultural issues affecting family; attempts to apply this in interactions		Usually (> 50%) assesses social, educational, or cultural issues affecting family; applies this in interactions appropriately		Always (> 90%) assesssses and tailors recommendations to social, educational, cultural issues affecting the family	N/A
☐	☐	☐	☐	☐	☐	☐	☐
Sees the world through own eyes; trouble understanding and accepting other cultures		Acknowledges other backgrounds and views but at times seems insensitive		Accepts range of backgrounds and culture; includes these concepts in care plans; shows cultural humility		Celebrates individual/family diversity; provides open and accepting environment	N/A
☐	☐	☐	☐	☐	☐	☐	☐
Rarely (< 10%) recognizes the impact of a child with special needs on a family throughout the life cycle		Sometimes (< 50%) recognizes the impact of a child with special needs on a family throughout the life cycle		Usually (> 50%) recognizes and addresses the specific impact of a child with special needs on a family		Recognizes and addresses (at a systems level) the impact of a child with special needs on families	N/A
☐	☐	☐	☐	☐	☐	☐	☐
Rarely (< 10%) recognizes impact of service delivery systems on families from diverse backgrounds		Sometimes (< 50%) recognizes impact of service delivery systems on families from diverse backgrounds		Usually (> 50%) recognizes and addresses the impact of service delivery systems on a specific family from a diverse background		Recognizes and address (at a systems level) the impact of service delivery systems on families from diverse backgrounds	N/A
☐	☐	☐	☐	☐	☐	☐	☐

Figure 3. Distribution of I-FOR Total Score Means at T1 and T3



CONCLUSION

- Faculty and trainees can use standardized measures of FCC/IPC
- The I-FOR demonstrated good internal consistency and test-retest reliability, and had reasonable face validity
- Self-report and faculty-observation measures were not correlated
- Both measures may have value in program quality improvement

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