
Why We Chose It:
Interprofessional education (IPE) has been a topic of discussion in ACCME for many years. This year, a focus on IPE is included in the criteria for Accreditation With Commendation. This article attempts to look at attitudes towards and effectiveness of IPE.

Main Learning Points:
1. IPE is generally well received
2. IPE is most successful when there is organizational/leadership support
3. Facilitator development is key
4. Outcome data beyond level 2 (satisfaction of the learner) is limited but seems to be emerging

How Can These Principles Be Applied to CME and AAP:
Patient care over the past few decades has involved many more professionals than just the physician. A whole team of professionals is often needed to care for a patient with chronic or complex disease. Education in certain circumstances, around certain conditions, or to address quality initiatives may involve the entire team of caregivers. For example, simulating a rapid response or code blue is best done utilizing the actual professionals who will be at the bedside to assume the roles they normally play. Addressing social determinants of health in the medical home often requires a team of professionals and learning how best to care for these patients may be able to be done together. The AAP will need to decide how to lead these efforts and in what areas to continue to provide the best education to care for pediatric patients in the best ways.

The AAP might also lead the way in focusing on different modalities of education based on different outcome goals. For example, management of the diabetic patient might be interprofessional to deal with the complex aspects of managing this disease process (nutritionist, endocrinologist, social worker, psychologist, etc). Other disease processes or desired outcomes, like diagnostic testing in the child presenting with abdominal pain or management of constipation, might only involve the primary physician. Thinking about the ideal way to structure care given a certain disease process or outcome goal might direct the educational efforts; this might also start to redefine processes of care and new modalities of approaches to patients as opposed to traditional fee for service models.
Continuation from previous review in 2007
   Added 25 articles to the 21 previously reviewed
   Utilized the 3 P model (presage-process-product) and the Kirkpatrick

Learners respond well to IPE
   Attitudes and perceptions improved
   Increased collaborative knowledge and skill

Presage:
   Context: policy and clinical drivers (THE AAP CALLS FOR MORE COLLABORATIVE WORKING LINKED TO ADDRESSING PATIENTS’ COMPLEX NEEDS, REDUCING CLINICAL ERROR, AND IMPROVING SAFETY)
      Organizational support/leadership support (funding time etc)—central to success
      Desire to improved patient care or delivery/service
      Carving out time for this specifically

   Learner characteristics:
      Attitudes, previous exposure, willingness, hierarchies and stereotypes…

   Teacher characteristics:
      Need for faculty development to facilitate
      Need for quality facilitation

Process:
   Time for reflection by the facilitators helped, informal learning
   Coaching and mentoring was important
   Learner choice - customization
   Facilitator debriefing

Product:
   Mostly positive outcomes were reported (levels below)
      Reaction – positive learner feedback
      Perceptions and attitudes – attitudes toward collaborative working
      Knowledge and skills
      Behavioral change
      Organizational practice
      Patient care