

SCAFFOLDING IN INTERPROFESSIONAL EDUCATION:  
IMPLICATIONS FOR SOCIAL WORK EDUCATION

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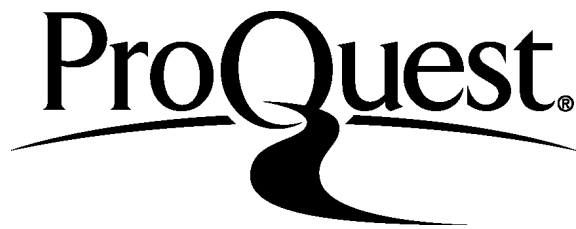
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Accepted by the Graduate Faculty, Indiana University, in partial fulfillment of the requirements for the degree of Doctor of Philosophy.

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## DEDICATION

This dissertation is lovingly dedicated to my family, who supported, encouraged, challenged, and inspired me to be able to finish my PhD program. Specifically, I want to dedicate this work to my wife, Adrienne, who has always been there for me. Without her support and sacrifice, I would not have been able to finish this program.

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Jennifer June Anderson

SCAFFOLDING IN INTERPROFESSIONAL EDUCATION:  
IMPLICATIONS FOR SOCIAL WORK EDUCATION

Medical errors due to failure to communicate and collaborate are one of the top causes of death in the United States. Interprofessional education (IPE) is an integrated instructional approach where various health care disciplines create opportunities for students to learn together in order to function as cohesive, effective, and collaborative interprofessional teams. Successful IPE program design is a multi-faceted challenge, especially for social work educators in light of the changes in EPAS 2015. Academic institutions are being encouraged to offer IPE programs; faculty members are then charged with developing IPE programs for their institutions. IPE program design could generate a multitude of advantages for students, faculty, academic programs, professions, university partners, and communities—provided the approach is systematic and inclusive. This prospectus will explore IPE program design in field settings for social work faculty as a scaffold design, which targets proactive understanding of resources and applications. The prospectus will explore three interrelated special considerations: 1) the connections between IPE and social work education; 2) the learning needs (learning styles and fear of negative evaluation) of students most likely to be invited to participate in an IPE program; and 3) the needs of field instructors and needs of social work students in relation to their field experience. Social work faculty as program developers new to IPE will gain insights from this work and be better able to concurrently layer educational outcomes with professional gains, while initiating opportunities for interprofessional collaborative practice skill-building in field settings—ultimately enhancing health outcomes.

Margaret E. Adamek, PhD, Chair



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## Chapter 1. Introduction

Profound rates of inadequate care, under-utilization, and rising costs of health care services have been linked to issues in quality of care and preventable mortality, morbidity, and medical errors across the American health care industry (Institute of Medicine 2000; 2001a; Nolte & McKee, 2008). A recent public health index reported that nearly 20 million persons seek out primary care services annually; 71% of those individuals are at or below 100% of the federal poverty base rate, more than half have multiple major medical needs, 38% are uninsured, 35% are Hispanic/Latino, and 27% were African American (National Association of Community Health Centers, 2011). These combined factors (disparities in coverage, income, and needs) make providing safe and effective health care services a challenge for providers (Lau, Lin, & Flores, 2012; Purden, 2005). No one profession can truly provide comprehensive health care (Lumague et al., 2006).

Various barriers in accessing health care services, whether due to social and/or economic determinants, have been linked to inadequate health care (Carillo et al., 2011; Kennedy, Paeratakul, Ryan & Bray, 2007). Inadequate health care translates into two interrelated concepts. First, the patient's benefits offered by insurance are inadequate. Being underinsured means someone has inadequate health insurance coverage to address the financial expenses associated with health care services, resulting in financial strain, medical debt, or postponing needed care due to costs (Rosell, Scarborough, & Lewis, 2010; U. S. Department of Health and Human Services, 2011). As such, the person may not ask for, seek, or respond to health care recommendations (Cunningham & Sammut, 2012; Toner, Ferguson, & Sokal, 2009). Second, inadequate health care also means that

service deliverables were not offered, were inappropriate to the patient's needs, were excessive, and/or unwarranted (Cardoso, Ribeiro, Aragão, Costa-Pereira, & Sarmiento, 2013). Either way inadequate health care is viewed, the ultimate outcome is that the patient fails to get the care he/she needs and deserves.

Further complicating the provision of safe and efficient health care is the struggle of health care providers to effectively communicate and collaborate. In 1999, the Institute of Medicine (IOM) revealed that 44,000 to 98,000 people die every year in US hospitals due to medical errors. Poor communication and collaboration are the leading root causes of sentinel events, serious unexpected occurrence that leads to grave injury or death as reported by the Joint Commission (IOM, 2000). To view the gravity of the situation from a larger perspective, the Joint Commission—formerly the Joint Commission on Accreditation of Health Care Organizations (JCHAO) has consistently ranked medical errors as being one of the top 10 causes of death in United States. In fact, medical errors are ranked ahead of accidents, gunshot wounds, diabetes, breast cancer, Alzheimer's disease, and AIDS (Joint Commission, 2015; O'Daniel & Rosenstein, 2008). New research estimates up to 440,000 Americans are dying annually from preventable hospital errors. This puts medical errors as the third leading cause of death in the United States (James, 2013).

In *To Err is Human: Building a Safer Health System*, the Institute of Medicine (2001b) suggested that interdisciplinary teams be implemented as a way to increase health care quality and safety. The Institute of Medicine (2004) affirmed the link between interdisciplinary teamwork and quality health care. Educators of health care professional students are urged to incorporate IPE into their curriculum and across



academic programs (Reeves, Reeves, Goldman, & Zwarenstein, 2009). Sullivan and colleagues (2011) discuss the myriad of concerns and challenges that providers experience when delivering health care services to complex patients in the absence of an interprofessional collaborative team such as, time constraints, language barriers, cultural misunderstandings, low health literacy, limited financial understanding, and difficulty in educating consumers about health insurance as well as accessing insurance on behalf of their consumers. The use of interprofessional collaborative practices is therefore viewed as a promising approach (Politi et al., 2011). To best understand the emergence of interprofessional collaborative practices, it becomes critical to explore the origins of IPE.

For more than a decade, multiple national associations called for a unified competency-based educational approach that creates sustainable change in health care delivery through instruction on interprofessional collaborative practices. This call for change fostered the emerging paradigm of interprofessional education (IPE).

Interprofessional education is charged with increasing the educational and training efforts of students from the primary, ancillary, and allied health professions (Pullon & Fry, 2005). Primary refers to those professionals that provide direct treatment—for example, medicine and nursing, ancillary is the typical designation for providers that target social care of a patient—for example, social workers, and allied health professionals provide supplemental health and social care—for example occupational and physical therapists (Fort-Cowles, 2003). The intent of IPE is to foster collaborative practices for the promotion of safer, more effective, and higher quality patient care (Browning, 2001; Cup et al., 2011; Gilbert, 2010). As the IPE movement grows, the language of primary, ancillary, and allied health care professions are being redefined to health and social care

professionals with an increasingly global view of health (Lennox & Anderson, 2012; Patel, Mingsheng, & Piscioneri, 2014; Reeves et al., 2009).

The thrust of these repeated demands for interprofessional collaborative teams is that better communication equates to improvements in patient care (Reeves et al., 2008). Greater communication has been linked to improved patient satisfaction, better treatment compliance, fiscally conservative approaches to care plans, and increased provider satisfaction (Advisory Committee on Interdisciplinary, Community-Based Linkages, 2005). The passage of the Recovery and Reinvestment Act of 2009 (Steinbrook, 2009) and the Patient Protection and Affordable Care Act (ACA) of 2010 (Kaiser Family Foundation, 2010) have created new health care delivery models in hopes of achieving better patient care outcomes. The delivery of safe and high quality health care will require health care providers-as-students to be educated differently, inclusively versus silo-based instruction, and be trained in interprofessional collaborative practices (Agency for Healthcare Research and Quality, 2005; Rouse, Delunas, Anderson & Anderson, 2010).

Collaboration in health care teams are synergistic efforts that foster effective communication and ethical decision-making where separate and shared knowledge is combined with various professional skill sets to influence patient care (McKay, & Crippen, 2008; Way, Jones, & Baskenville, 2001). IPE is a competency-based approach to education. Interprofessional collaborative practice becomes applied in various professional settings (D'Amour, Ferrada-Videla, Rodrigues, & Bealieu, 2005). This synergy creates what has become known as interprofessional collaborative practice (IPCP). ICPC occurs as “multiple health workers from different professional

backgrounds work together with patients, families, caregivers, and communities to deliver the highest quality of care” (World Health Organization, 2010, p. 33).

The purpose of IPE is the transformation of students into professionals through cognitive and behavioral changes that share the language of collaboration, a patient-centered philosophy, and scope of practice (Bell & Allain, 2011; Poulton, 2003). Furthermore, it is suggested that placing IPE programs in the field or work-based learning is the optimal choice for learning IPCP (Barr, 2009; Cameron, Rutherford, & Mountain, 2012). For the profession of social work, the practice setting is viewed as students’ participation in their field education program. Many health and social care professions contain a field education component within their academic sequence (Blue, Zoller, Stratton, Elam, & Gilbert, 2010). Field education is a longstanding term often encompassing internships, practicums, rotations, and/or clinicals, used to describe professionally-based experiential learning (Abramson & Fortune, 1990; Barr, Freeth, Hammick, Koppel, & Reeves, 2005; Blount & Bailly, 2014). Proponents of IPE have created a myriad of applications in academe and by extension, in the practice community (Allison, 2007; Numer, MacLeod, Sinclair, & Frank, 2008).

Through thoughtful paradigmatic integration, IPE could be readily integrated into the profession of social work within field education programs as well as other health and social care professions (Barr, 2012; Barr, Freeth, Hammick, Koppel, & Reeves, 2005; Barr & Ross, 2006). By doing such, it would foster compliance with the request by the Pew Health Professions Commission that encourages 25% or more of clinical education in the health professions to be in field settings that support interprofessional collaborative practice (Bellack & O’Neil, 2000; Handron, Diamond, & Zlotnick, 2001)—a request that

is habitually overlooked (Johnson, 2012). Graybeal and colleagues (2010) explored discipline-specific participation in IPE programs across academic institutions deemed leaders in the field of IPE and found social work is the 3<sup>rd</sup> most frequently invited discipline.

### **Scaffolding Paradigms**

To gain a full understanding of IPE, it becomes important to explore the terms paradigm and scaffolding. There are a number of historical debates concerning the emergence of the term paradigm and how paradigms fit the work of scientific and professional communities (Kuhn, 1974; Nickles, 2003). This writing views paradigms from the classical definition as a “characteristic set of beliefs “(Kuhn, 1972, p.17), while acknowledging an expanded definition that paradigm is a “conceptual-interpretive framework—an interlocking network of presuppositions, assumptions, attitudes, beliefs, premises, expectations, and values” (Rosen, 1988, p. 392).

The paradigms of interprofessional education and interprofessional collaborative practice provide synergy to the tenets and goals of field education programs. Scaffolding is a systematic approach to layering efforts to promote learning, which fits well with the intent of IPE to blend or integrate knowledge into practice skills. Education programs scaffold content and context as a means to promote engagement in the learning process (Smit, Van Eerde, & Bakker, 2013; Trevillion & Bedford, 2003; Van De Pol, Volman, & Beishuizen, 2010), which exists between student and instructor within an academic setting and extends to field settings (Anderson, 2005; Dempsey, Halton, & Murphy, 2001; Hodkinson, 2005; Stupans, Scutter, & Sawyer, 2011).

Scaffolding or systemic construction can happen from a bottoms-up perspective, which targets proactive understanding of resources and applications—capacity building, as well as the more traditional top-down approach, which supports administration consensus and institutional investment in IPE (Ngiap, Chirk, Wahid, & Lee Gan, 2014; Swisher, Woodard, Quillen, & Monroe, 2010; Wheeler & Dodd, 2011). The manner of scaffolding can impact the type of design used, disciplines selected, constructs or learning objectives, the flow of knowledge, and certainly extends into educational outcomes (Brashers, Owen, Erickson, & Peterson, 2012; Sibbald, Wathen, Kothari, & Day, 2013). Scaffolding to program design is akin to generating methods that align to the research question (Shields & Ranganajan, 2013).

Interprofessional education (IPE) is an integrated instructional approach, which seeks to blend multiple concepts-as-domains and behaviors-as-competencies into one effort—interprofessional collaborative practice (See Appendix). A multitude of paradigms can be used to foster and promote educational outcomes by discipline, by school of thought, by theoretical orientation, and by scope of professional practice (Payne, 2005). IPE programs typically develop in academic settings where various health care professions are being brought together with a hope that they will be able to function as a more cohesive and effective professional team. Academic institutions are readily constructing a multitude of IPE programs (Blue, Mitcham, Smith, Raymond, & Greenberg, 2010). Given that health care disciplines often require a field education component as part of its curriculum, developing IPE program designs in field settings is an excellent way to concurrently layer educational outcome with professional gains (Walsh, Gordon, Marshall, Wilson, & Hunt, 2005). As such, it becomes important to

explore field settings as special considerations in IPE program design consideration. Field education programs and field settings can provide a useful starting point for the construction of an IPE program.

This body of work will advocate that the ideal initial scaffold for IPE program design is in field education programs within field settings. An IPE program design in a field setting allows for a program to be built up by adding on relevant paradigms for greater educational gains and scaffolding the necessary domains and competencies for greater professional gains through skill building. There are numerous conjoining constructs involved in IPE program development. The next scaffold in designing an IPE program is to understand the intent of IPCP, its domains, and competencies. Scaffolding paradigms of where a program is anchored—field settings, with what IPE and IPCP frames--domains and competencies, allows the supports to be carefully considered—students and disciplines) creates greater application, relevance, and understanding for all involved in IPE program design. Scaffolding in IPE program design lends itself to a scaffolding of knowledge and competency for researchers as well. As such, the multiple manuscript option will be used within this writing.

### **Multiple Manuscript Dissertation**

Congress (2012) suggests that life-long learning is a critical component of the profession, while costs of education, advances in technology, and employment constraints challenge professions to remain current. A doctorate degree is an opportunity for a social worker to embrace professional learning while developing a new professional identity as an academic—teacher and/researcher (LaMendola, Ballantyne, & Daly, 2009). The multiple manuscript dissertation option seeks to advance the work of the doctoral

candidate through the use of a clear and easily understood format (Snowden, 2014), articulated (Ash & Clayton, 2004), reflective (McCoyd & Kerson, 2013), socially cohesive (Berkman, 2000), and highly applicable format (Edwards, 2014) aimed at the candidate emerging with an affirmed academic identity (Baretti, 2004; Dellgran, 2001; Jawitz, 2009; Tweddie, Clark, Johnson, & Kay, 2013). Furthermore, the multiple manuscript dissertation options embraces a different process and is viewed as promising in that it removes the hardships and outdated power dynamics typically associated with the dissertation drop-out (Cohen, 2011; Leichty, Liao, & Schull, 2009).

By being able to produce a dissertation with embedded ready-to-submit manuscripts, the emerging scholar can maximize their contributions (Horowitz & Christopher, 2013; Torres, Jones, & Renn, 2009)—to the knowledge base, to their doctoral program by matriculating (Burawoy, 2005), and to their future academic employer by imitating success or tenure-ability (Renaud, 2004). Another way to view the multiple manuscript dissertation option is that it affords the candidate with significant deliverables as evidence of the doctoral journey (Kamler, 2008; Segol, 2012), while supervising the candidate through the process as a relevant teaching practice (Augustsson & Jaldemark, 2014). It is the intent of this multiple manuscript dissertation prospectus to gain competence in IPE program design through a best practices inquiry where the current knowledge of the model (IPE) is concurrently viewed as an emerging research agenda for the researcher (Holosko, 2010; Petr & Walter, 2005), with an emphasis on its potential application in social work field education.

## Criteria for Multiple Manuscript Dissertations

As within most academic programs, there are criteria that an emerging scholar must meet in order to demonstrate competency. This holds true for earning the PhD in Social Work from Indiana University as well. This document serves as the dissertation prospectus and will include one theoretical piece and two data-driven research projects—each developed into potential manuscripts for publication. Table 6 highlights how the criteria for the multiple manuscript option for the dissertation recently approved by the PhD Curriculum Committee are met for each manuscript, thus, ensuring this prospectus meets all requirements.

*Table 1: Evidence of Criteria Met for Publishable Manuscripts*

Criteria	Manuscript 1	Manuscript 2	Manuscript 3
Topic	EPAS 2015	Learning Styles	Field Liaison Role
IRB Approval	Exempt	1312965383 Exempt	201028 Exempt
Full-length format	Yes	Yes	Yes
Publishable Form	Yes	Yes	Yes
Intended Journal	Advances	Journal of Research in Interprofessional Practice and Education	Field Educator
Informational Website	Yes	Yes	Yes
Peer-Reviewed Journal	Yes	Yes	Yes
Manuscript Prepared Under Supervision	Dr. Susan Rouse Dr. Ellen Szarleta	Dr. Susan Rouse Dr. Jill Chonody	Dr. Susan Rouse Dr. Ellen Szarleta
Focus of Manuscript	Theoretical	Data-based	Data-based
Status of Submission	*7/1/2015	*8/1/2015	*9/1/2015
Primary Authorship	Student	Student	Student
Note: * Identifies the planned date for submission of each manuscript.			

## Emerging Competency

Learning is incremental in much the same way as demonstrating competency—both are developed over time. Developing and achieving competence as a social work professional is a multi-faceted experience (Freddolino, et al., 2014)--akin to the multi-faceted nature of IPE and IPCP programming. For social work, researchers, teachers, students, professional communities, and emerging scholars--there is simply more work to



be done in developing competency in IPE program design. There is a plethora of research connected to the value of IPE and IPCP skill building, yet more attention needs to be paid to IPE program design (McCulloch, Rathbone, & Catchpole, 2011; Payler, Meyer, & Humphris, 2007; Smith & Anderson, 2008). Thus, IPE program design and program considerations—as evidence-based practices or even communities of practice, could become a welcome contribution to the existing body of knowledge. IPE can also be readily implemented within social work field education programs.

## **Chapter 2. Manuscript 1**

EPAS 2015: Implications for Interprofessional Education in Social Work

Indiana University School of Social Work

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## EPAS 2015: Implications for Interprofessional Education in Social Work

### **Abstract**

The ability to generate sustainable, mutually beneficial, interprofessional teams becomes a critical skill for today's emerging professionals. In academe, these relationships are often community-university partnerships, but they can also be across and within academic disciplines. Viewing relationships as collaboratives can bridge the intellectual resources of academe with the needs of its teachers, students, field settings, and communities. In social work education, relationships can also exist within paradigms. The language of the Educational Policy and Accreditation (EPAS) 2015 offers some challenges to social work education in that it requires educators to understand the relationships that exist between paradigms, processes, and programs. As EPAS 2015 uses IPE-related terms, it is important for social work educators to become actively involved in IPE programming efforts to support social work students' interprofessionalism as well as be prepared for potential future accreditation guidelines.

***Key Words:*** Interprofessional education, field education, and community engagement

## **EPAS 2015: Implications for Interprofessional Education in Social Work**

Relationships are multi-faceted interactive processes (Thigpen, 2013) and are important to academic institutions as well as academic disciplines (Gilbert, 2005; Inui, 1996; Rabow, Newman, & Remen, 2014; Suchman et al., 2004). Team work starts by forming solid relationships, which can also be viewed as collaboratives (Anderson, 2012; López-Bonilla & López-Bonilla, 2013). In academe, these relationships are often community-university partnerships, but they can exist within academic disciplines (Bloedon & Stokes, 1994). Viewing relationships as collaboratives can bridge the intellectual resources of academe with the needs of its teachers, students, field settings, and communities (Raskin, Wayne, & Bogo, 2008).

This paper examines the relationships that exist between the paradigms of interprofessional collaborative practice (IPCP), community engagement, and social work education, which when combined can positively impact communities as well as academic programs and institutions. The ability to develop and sustain relationships across academe, academic disciplines, and community-university partnerships are key components of social work education—especially in light of the Council on Social Work Education’s 2015 Education and Policy Accreditation Standards. Thus, the goal of this manuscript is to inform social work educators about the key aspects of interprofessional education (IPE) and interprofessional collaborative practice (IPCP) and to consider the shared perspectives of IPE and social work.

### **Social Work Education**

Social work educators attempt to engage students and offer viewpoints on the world of social work, its history, its values, its theories, and its practices. Educators then

encourage students to engage in the world through a newly developed social work mindset. For social work, professional development for students is referred to as the program of field education (Garthwait, 2008) and has long been a key element of social work education (Poulin, Silver, & Kauffman, 2006).

Yet, the field of social work practice is ever-changing; new trends and paradigms constantly emerge. It is within the field programs of social work education that change becomes the ever-constant (Curl & Cary, 2014) as field programs are in a unique position to inform the curriculum to match the needs of employers, while sensitively supporting field settings about competency-based education (Williamson, Callaghan, Whittlesea, Mutton, & Heath, 2011). Wayne and his colleagues (2006) state that “field education was designed in the societal, organizational, and academic environment of the early 20<sup>th</sup> century” (p. 168). As changes occur within the accreditation process, academe then responds, prescriptively or creatively, to each distinct accreditation standard (Colby, 2013). This process of response leads to changes to in the curriculum, field education programs, and the profession (Reeves, Goldman, & Zwarenstein, 2009).

The Council on Social Work Education (CSWE) believes in the inherent value and worth of field education when it was declared the signature pedagogy: it “is a central form of instruction and learning in which a profession socializes its students to perform the role of practitioner. Professionals have pedagogical norms with which they connect and integrate theory and practice” (CSWE, 2008, p. 8). Field education programs are reciprocal processes that are interconnected to curriculum, competency development, and professional growth with each aspect informing and enhancing the other as an educational enterprise (Lager & Robbins, 2004; Slaymaker, 2014; Wayne, Bogo, &

Raskin, 2010). Field education is an essential experience for students in professional preparatory programs as it fosters the emergence of a professional identity (Hoffmann & Berg, 2014). Furthermore, field education, through the student's participation in community agencies, serves as a pivotal point-in-time to evaluate student's performance of the pre-defined professional practice behaviors (Petracchi & Zastrow, 2010a, 2010b).

One of the most significant changes to social work education is that of interprofessional education, a competency-based approach. EPAS 2015 makes a significant contribution to IPE by embracing its language and its purpose, while challenging social work educators to become acclimated to changes in meanings and potential applications of instruction. Both social work education and social work practice must adapt their understanding of new terms and new processes as reflected in EPAS 2015. When addressing relationships across disciplines, the understanding of new terms becomes directly connected to changes in approaches (Suchman, 2006). Furthermore, these changes reflect that shared education and training experiences foster greater understanding and respect between different professionals (Barr & Lowe, 2012).

### **Understanding Changes in Terms**

The changes in terms and their applied meanings are important considerations for practice settings as well as academic social work programs. Gilbert (2012) states "as with all complex questions, however, terminology is of prime importance" (p. 283). The term "interprofessional" and its alternatives are inserted as new language in EPAS 2015 (see Table 2). Social workers need to understand the new terms and how they are anchored within the competencies and related practice behaviors (CSWE, 2015). Table 3 presents the various terms and their definitions. This becomes especially important given

that the vast majority of IPE initiatives include social work students (Graybeal, Long, Scalise-Smith, & Zeibig, 2010). As EPAS 2015 moves forward, it will become increasingly important to understand the changes in relation to how social work programs assess competencies that reflect interprofessionality.

*Table 2: Changes in EPAS 2015 Related to IPE and IPCP*

LOCATION	COMPETENCY	PRACTICE BEHAVIOR
Competency 1	Social Workers also understand the role of other professions when engaged in <b>interprofessional teams</b> .	
Competency 4	Social workers understand that evidence that informs practice derives from <b>multi-disciplinary</b> sources and multiple ways of knowing.	
Competency 6	Social Workers value principles of relationship-building and <b>interprofessional</b> collaboration to facilitate engagement with clients, constituencies, and others professions as appropriate.	
Competency 7		Apply knowledge of human behavior and the social environment, person-in-environment, and other <b>multi-disciplinary</b> theoretical frameworks in the analysis of assessment data from clients and constituencies.
Competency 8	Social workers value the importance of <b>interprofessional teamwork</b> and communication in interventions, recognizing that beneficial outcomes may require <b>interdisciplinary</b> , <b>interprofessional</b> , and <b>interorganizational</b> collaboration.	Apply knowledge of human behavior and the social environment, person-in-environment, and other <b>multi-disciplinary</b> theoretical frameworks in intervention, and <b>interorganizational</b> collaboration.  Use <b>inter-professional</b> collaboration as appropriate to achieve beneficial practice outcomes.
Competency 9		Apply knowledge of human behavior and the social environment, person-in, environment, and other <b>multi-disciplinary</b> theoretical frameworks in the evaluation of outcomes.

If the insertions of IPE-related terms in EPAS 2015 to be meaningfully applied in social work education, then an accurate understanding of IPE and IPCP are needed by social work educators. In addition, the placement of interprofessional language in the competencies, but its absence in corresponding practice behaviors, highlights a missed

opportunity for students to learn, experience, and apply interprofessional learning in a meaningful way. It also creates a missed opportunity for assessment among social work faculty and IPE program developers. Although the language of multi-disciplinary work is reflected in several practice behaviors, there is an implied assumption that this is an understood concept as it is omitted in the connected competency.

*Table 3: Terms and Definitions*

<b>TERM</b>	<b>DEFINITION</b>
Multi-disciplinary	Multi-disciplinary is “when two or more professions work side by side” (Grant & Alexander, 2014, p. 297)
Inter-disciplinary	Inter-disciplinary teams “are comprised of persons who share a common purpose, contribute their expertise to the work at hand, and collaborate to achieve some mutually agreed upon outcome” (Miley, O’Melia, & DuBous, 2007, p.377).
Interorganizational	Interorganizational “is an organized group of joined activities carried out by two or more organizations to achieve common objectives” (Koen & Maasdorp, 2012, p 33).
Interprofessional collaborative practice (IPCP)	When “multiple health workers from different professional backgrounds work together with patients, families, careers, and communities to deliver the highest quality of care” (WHO, 2010, p. 33).
Interprofessional education (IPE)	IPE occurs “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. 30).
Interprofessional Teams (IPT)	IPT are “the levels of cooperation, coordination and collaboration characterizing the relationships between professions in delivering patient-centered care” (Interprofessional Education Collaborative Expert Panel, 2011, p.17).

IPE and IPCP are constructs built from the historic terms of multi-disciplinary and inter-disciplinary. To further clarify, multi-professional learning is when two or more professions receive shared instruction, but do not participate in shared learning activities (Freeth, Hammick, Koppel, Reeves, & Barr, 2002). Multi-professional learning is not the same as interprofessional education as the goal of IPE is the exchange of knowledge about, from, and with students-as-learners (Grant & Alexander, 2014). The primary goal of IPE is instruction of health and social care students-as-professionals where content and competencies are at the forefront of relationship-centered learning experiences (Cooper,



Beach, Johnson, & Inui, 2006). Thus, the ultimate goal of IPE is the emergence of a practice culture of collaboration (Delunas & Rouse, 2014).

The changes in these related terms are two-fold. First, the language reflects a change in thinking about how students learn and how educators teach where the focus is not solely on content, but includes interactive processes (Rabow et al., 2014; Thigpen, 2013). Second, the change in meaning behind the terms reflects a deviation away from a task-centered approach to teaching professional skills as developmental (Abedin, Daneshgar, & D'Ambra, 2012). The common feature across all IPE and IPCP initiatives is that there is an “integrated application of knowledge where the student can adapt to change, develop new behaviors, and continue to improve performance” (Walsh, Gordon, Marshall, Wilson, & Hunt, 2005, p. 232). Thus, the changes reaffirm the interactive instructional process of competency-based curriculum (Gittell, Godfrey, & Thistlethwaite, 2013).

### **Developing the Relationship Trifecta**

The use of a metaphor can be helpful in understanding the meaning made from new applications—in data, in research, and in knowledge (Sandelowski, 1998). “Trifecta” is a term associated with gambling and refers to the ability to successfully wager the winning of three ranks: first, second, and third concurrently in one bet. Trifectas and their stories are poetic, artistic, and if not outright creative adaptations of hope for something better (the win) based on the strength of the obstacle (the wager). Academic institutions are looking for the trifecta in pedagogy, in research, and in funding. Students consider the trifecta from their studies, application, and potential for gainful employment. Faculty engages the trifecta of teaching, service, and scholarship.

Integrating the paradigms of IPE through the competencies for IPCP in social work field education programs as a mechanism for promoting community engagement by academic institutions becomes a trifecta. Thus, a trifecta can also exist within relationships and across disciplines.

Moreover, the synergy that emerges from interconnecting disciplines results in a trifecta of opportunity for academic institutions, students, and faculty through a platform of sustainable and reciprocal community engagement (Kearney, Wood, & Zuber-Skerritt, 2013; Kevany & MacMichael, 2014; Ostrander & Chapin-Hogue, 2011; Rosenman, 2007; Silver & Leslie, 2009; Steinert, 2005). Within a trifecta, the paradigms, practices, and participants work together to build upon one another's strengths and shared understandings (Glover & Silka, 2013; Klak & Mullaney, 2013; Mileski, Mohamed, & Hunter, 2014; Patel, Mingsheng, & Piscioneri, 2014).

### **Shared Understandings**

Community engagement emphasizes sustainable change, and change for the greater good. Interprofessional collaborative practice, which comes out of the pedagogy of interprofessional education, and social work education through its competency-based curriculum and "signature pedagogy" of field education have a great deal in common with the purpose and goals of community engagement. Exploration of these shared understandings as a mechanism for enhancing social work education programs is important given that these shared understandings represent an avenue to support strong sustainable community-university relationships as a form of community engagement.

## **Community Engagement**

Community engagement as a collaborative and effective partnership is shaped by several shared understandings (McNall, Sturdevant-Reed, Brown, & Allen, 2009). First, universities seek to influence students in civic matters and to develop the capacity of their students to respond competently—thus promoting quality of life (Aronson & Webster, 2007; Pardeck, 2005). Second, community engagement includes service learning, but incorporates a service function that a university must integrate into its pedagogy along with its teaching function (Langseth & Plater, 2004; Kellogg Commission on the Future of State Land Grant Universities, 1999). This integration is not a substitute for professional service, but exists as a particular style of teaching, research, and service *in and with* the community (Campbell, 2010; Thomson, Smith-Tolken, Naidoo, & Bringle, 2011). Third, through a platform of community engagement, universities become more responsive to the socio-economic issues of the larger community (Castle & Osman, 2003; Fourie, 2003). Lastly, community engagement creates a dynamic environment for students to engage in deeper critical thinking about the nature of reality, knowing, and doing (Whitaker & Albertson, 2011).

Community engagement involves activities that are undertaken within collaboratives that aim to achieve greater social responsibility and awareness of the needs of others (Dharamsi et al., 2010; Wolff, 2003). Interprofessional collaborative practice provides the domains and competencies that target educating or re-educating professionals to advance patient care. Students earn a degree, graduate, and obtain employment. Community organizations hire graduates and often are tasked with training their workforce in response to evidence-based practices. Academic institutions are then

intimately linked to the needs of students, professionals, and community partners.

Therefore, creating a collaborative that targets continuing education for social and health care professionals is one way to participate in community engagement.

Thus, community engagement is collaboration between institutions of higher education and their larger communities (local, regional/state, national, global) for the mutually beneficial exchange of knowledge and resources in a context of partnership and reciprocity (Hattis, 2002; Wright, et al., 2011). The purpose of community engagement is the partnership of college and university knowledge and resources with those of the public and private sectors to enrich scholarship, research, and creative activity; enhance curriculum, teaching and learning; prepare educated, engaged citizens; strengthen democratic values and civic responsibility; address critical societal issues; remediate health and social problems facing communities; and contribute to the public good (Ahmed & Palermo, 2010; Berezin, 2011; Bryan, 2009; Kruss, 2012; Nongxa, 2010). Student involvement in such engagements may include community service, internships, consultation, student teaching, student research, capstone courses, clinical courses, and art performances (Bringle & Hatcher, 2002; Klak & Gaalas-Mullaney, 2013).

The core assumptions within the paradigm of community engagement are four-fold: a) that academic institutions embrace the notion of engagement with its community; b) engagement permeates institutional policies and procedures; c) that universities view community partnerships as equivalent to research and teaching; and d) that executive leadership are invested in community engagement, encourage it, and provide the infrastructure for its support (Buys & Bursnall, 2007; Sandmann & Platter, 2009; Sargent & Waters, 2004). Central to the assumptions is the view of community-engagement as a

form of scholarship with a widened understanding of research as products (Commission on Community-Engaged Scholarship in the Health Professions, 2005; Hall, 2010).

By aligning educational objectives with community partners' needs, active and productive community-university partnerships can create reciprocal benefits. Thus, community engagement endeavors to support service as the third core function of universities (London, Migel-Zagofsky, Huang, & Saklar, 2011; Thomson et al., 2011). By actively engaging with the community, institutions of higher education can make many contributions within a social context (Du Pre, 2003; Karasik & Wallingford, 2007; Netshandama, 2010). The tenets of community-engagement mirror the origins of IPE as both embrace institution-wide curriculum efforts that are coordinated with the practice community (Cerra & Brandt, 2011). Furthermore, IPE and community engagement are anchored in interprofessional collaborative practices.

### **Interprofessional Collaborative Practice**

Interprofessional collaborative practices are interdependent concepts linked to interprofessional education as an educational effort for health and social care professional students (Masterson, Maslin-Prothero, & Ashby, 2013), while IPCP are the practices that enhance patient outcomes and emerge from IPE involvement (Gilbert, 2010; Oandasan & Reeves, 2005). It is these collaborative practices that form an emerging paradigm of thought and action. Wilson and colleagues (2010) share their observation that “health profession education as a means of assuring a more collaborative health care workforce, as a higher standard of health care delivery in the United States, has had an inconsistent history” (p. 210). Models used for IPE and initiatives used for IPCP programming are

varied, often targeted to a patient population or clinical setting, and have not been adequately validated and replicated (Payler, Meyer, & Humpris, 2008).

Attention and intention are key ingredients in IPE program development. IPCP can be viewed as creating a culture of interprofessionality. D'Amour and Oandasan (2005) define interprofessionality as a:

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... [I]t 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. (p. 9)

This definition becomes relevant to social work through the intent of EPAS 2015 and its language. EPAS 2015 states “an individual social worker’s competence is seen as developmental and dynamic, changing over time in relation to continuous learning” (CSWE, 2015, p.6). In fact, this is happening within the social profession as it responds to the inclusion of interprofessional terms and practices. In addition, EPAS 2015 asserts that “signature pedagogies are elements of instruction and of socialization that teach future practitioners the fundamental dimensions of professional work in their discipline—to think, to perform, and to act ethically and with integrity” (CSWE, 2015, p.12).

Competency-based approaches to interprofessional education have developed in parallel to competency-based approaches within the health professions. These have emerged in response to the limitations of learning outcomes (Barr, 1998). Within EPAS 2015, each competency “describes the knowledge, values, skills, and cognitive and affective processes that comprise the competency” (CSWE, 2015, p.7). Within the framework of IPCP, each competency domain identifies a set of more specific

competency statements. Thus, EPAS 2015 uses the term competency in the way that the language of ICPC uses the term domain. Practices behaviors in EPAS 2015 are viewed as competencies within the framework of IPCP. Furthermore, the competencies and practice behaviors of EPAS 2015 have a great deal in common with both the domains and competencies of IPCP. It is important to note that the commonalities between EPAS 2015 and IPCP are not exact in wording or number.

### **IPCP Domains**

The domains and specific competencies of IPCP serve as the primary organizing tenets or purpose of IPE. These were intentionally designed to be amenable, wide-ranging, and contextualized to the individual profession and/or the institutional setting in which they would be applied (Barr, Koppel, Reeves, Hammick, & Freeth, 2005; Bolesta & Chmil, 2014). They are written in interprofessional language and imply the active sharing of knowledge through experiential learning.

There are four domains of collaborative practice: a) *team/teamwork*—consisting of 11 competencies; b) *values/ethics*—consisting of 10 competencies; c) *communication*—which contain eight competencies; and d) *roles/responsibilities*—which contains nine competencies. Each of the four domains contains their own precepts that interconnect with the goals of IPE and provide the framework for IPCP. Thus, IPE provides the foundation through integrated instruction in these four areas, while promoting collaboration as a professional practice skill. In many ways, teamwork is a relationship-centered practice (Payne, 2000). It includes aspects of all the IPCP domains: 1) the ability to understand the roles and responsibilities of all parties (Garrett et al.,

2001), 2) the ability to communicate, and 3) the ability to discern the values/ethics of one's own discipline (Suter et al., 2009) as well as that of each member of the team.

*Teams/Teamwork.* In collaboration, it is not a matter of team work or solo-practices, but that the emphasis must be placed on what type of team, for what purpose, and under what set of conditions (Cooke, Dorman, & Rowe, 2009). Teamwork is behavior exhibited by health and social care professionals where consumer's goals are shared. Evidence of teamwork is seen in the patient-centered delivery of care; coordinating patient care with other health professionals so that gaps, redundancies, and errors are avoided; and sharing in the decision-making (Interprofessional Education Collaborative Expert Panel, 2011). To work effectively in teams, health and social care professionals must share their own expertise and share aspects of patient care with other professions to achieve better outcomes (Lyrtzopoulos et al., 2012). Effective teams have the ability to recognize the prevailing cultural norms of varied health and social care professions (Hall, 2005; Park, Hawkins, Hawkins, & Hamlin, 2013). The team domain and its 11 competencies are defined in Table 4.



*Table 4: Teams/Teamwork Domain and Competencies*

<b>Domain</b>	<b>Domain Definition</b>	<b>EPAS 2015 Competencies</b>
Team/ Teamwork	Apply relationship-building values and the principles of team dynamics to perform effectively in different team roles to plan and deliver patient-/population-centered care that is safe, timely, efficient, effective, and equitable.	<ul style="list-style-type: none"> <li>• <i>Competency 1: Demonstrate Ethical and Professional Behavior</i> Social workers understand the role of other professions when engaged in inter-professional teams (EPAS, 2105).</li> <li>• <i>Competency 4: Engage in Practice-Informed Research and Research-Informed Practice.</i> Social workers understand that evidence that informs practice derives from multi-disciplinary sources and multiple ways of knowing.</li> <li>• <i>Competency 6: Engage with Individuals, Families, Groups Organizations, and Communities.</i> Social workers value principles or relationship-building and interprofessional collaboration to facilitate engagement with clients, constituencies, and other professions as appropriate.</li> <li>• <i>Competency 8: Intervene with Individuals, Families, Groups, Organizations, and Communities.</i> Social workers value the importance of interprofessional teamwork and communication in interventions, recognizing that beneficial outcomes may require interdisciplinary, interprofessional, and interorganizational collaboration.</li> </ul>
<b>Competency</b>	<b>Competency Definition</b>	<b>EPAS 2015 Practice Behaviors</b>
TT1	Describe the process of team development and the roles and practices of effective teams.	
TT2	Develop consensus on the ethical principles to guide all aspects of patient care and team work.	<i>Competency 2—Practice Behavior: Make ethical decisions by applying the standards of the NASW Code of Ethics, relevant laws and regulations, models for ethical decision-making, ethical conduct of research, and additional codes of ethics as appropriate to context (EPAS,2015).</i>
TT3	Engage other health professionals—appropriate to the specific care situation—in shared patient-centered problem-solving.	
TT4	Integrate the knowledge and experience of other professions—appropriate to the specific care situation—to inform care decisions, while respecting patient and community values and priorities/preferences for care.	
TT5	Apply leadership practices that support collaborative practice and team effectiveness.	
TT6	Engage self and others to constructively manage disagreements about values, roles, goals, and actions that arise among healthcare professionals and with patients and families.	
TT7	Share accountability with other professions, patients, and communities for outcomes relevant to prevention and health care.	
TT8	Reflect on individual and team performance for individual, as well as team, performance improvement.	<i>Competency 1—Practice Behavior: Use reflection and self-regulation to manage personal values and maintain professionalism in practice situations (EPAS, 2015).</i>
TT9	Use process improvement strategies to increase the effectiveness of interprofessional teamwork and team-based care.	<i>Competency 1—Practice Behavior: Use supervision and consultation to guide professional judgement and behavior (EPAS, 2015).</i>
TT10	Use available evidence to inform effective teamwork and team-based practices.	
TT11	Perform effectively on teams and in different team roles in a variety of settings.	

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*Values/Ethics.* The domain of values and ethics are patient-centered with a community/population orientation, grounded in a sense of shared purpose to support the common good in health care. They reflect a shared commitment to creating safer, more efficient, and more effective systems of care (Jensen, Brasic-Royeen, & Purtilo, 2010). Values and ethics represent professionalism and can be anchored in discipline-specific knowledge (Landau & Osmo, 2013). They include constructs of humanism and morality (Baldwin, 2006) and are interconnected with decision-making (Osmo & Landau, 2006). Mutual respect and common trust are necessary for effective ICP across the health professions. A necessary connection between interprofessional values and effective care coordination is that “even timely, accurate information may not be heard or acted upon if the recipient does not respect the source” (Gittell, 2009, p. 16). Table 5 highlights the values/ethics domain definition and its competencies, showing the commonalities with EPAS 2015.

*Table 5: Values/Ethics Domain and Competencies*

<b>Domain</b>	<b>Domain Definition</b>	<b>EPAS 2015 Competencies</b>
Values/Ethics	Work with individuals of other professions to maintain a climate of mutual respect and shared values.	<i>Competency 2: Engage Diversity and Difference in Practice. Social workers understand how diversity and difference characterize and shape the human experience and are critical to the formation of identity (EPAS, 2015).</i>
<b>Competency</b>	<b>Competency Definition</b>	<b>EPAS 2015 Practice Behaviors</b>
VE1	Place the interests of patients and populations at the center of interprofessional health care delivery	
VE2	Respect the dignity and privacy of patients while maintaining confidentiality in the delivery of team-based care.	
VE3	Embrace the cultural diversity and individual differences that characterize patients, populations, and the health care team.	<i>Competency 2—Practice Behavior: Apply and communicate understanding of the importance of diversity and difference in shaping life experiences in practice at the micro, macro, and mezzo levels (EPAS, 2015).</i>
VE4	Respect the unique cultures, values, roles/responsibilities, and expertise of other health professions.	<i>Competency 2—Practice Behavior: Apply self-awareness and self-regulation to manage the influence of personal biases and values in working with diverse clients and constituencies. (EPAS, 2015).</i>
VE5	Work in cooperation with those who receive care, those who provide care, and others who contribute to or support the delivery of prevention and health services.	
VE6	Develop a trusting relationship with patients, families, and other team members (CIHC, 2010).	
VE7	Demonstrate high standards of ethical conduct and quality of care in one’s contributions to team-based care.	<i>Competency 2—Practice Behavior: Make ethical decisions by applying the standards of the NASW Code of Ethics, relevant laws and regulations, models for ethical decision-making, ethical conduct of research, and additional codes of ethics as appropriate to context (EPAS, 2105).</i>
VE8	Manage ethical dilemmas specific to interprofessional patient/population centered care situations.	
VE9	Act with honesty and integrity in relationships with patients, families, and other team members.	<i>Competency 2—Practice Behavior: Present themselves as learners and engage clients and constituencies as experts of their own experiences (EPAS, 2015)</i>
VE10	Maintain competence in one’s own profession appropriate to scope of practice.	

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*Communication.* Communication prepares health and social care professionals for IPCP, and expressing a desire to work effectively is essential for IPCP. Additionally, effective communication is an interrelated skill when working in diverse settings, professions, teams, and direct practice (Lloyd & Hartel, 2010). Health literacy, understanding of health in order to make an informed decision, and practice

preparedness, the ability to develop a plan for care, are part of teamwork and patient-centered care (Boykins, 2014). Presenting information that other team members, patients, and caregivers can understand contributes to safe and effective interprofessional care (Messinger-Rapport, 2009). Table 6 highlights the communication domain definition and its competencies.

*Table 6: Communication Domain and Competencies*

<b>Domain</b>	<b>Domain Definition</b>	<b>EPAS 2015 Competencies</b>
Communication	Communicate with patients, families, communities, and other health professionals in a responsive and responsible manner that supports a team approach to the maintenance of health and the treatment of disease.	<i>Competency 9: Evaluate Practice with Individuals, Families, Groups, Organizations, and Communities. Social workers recognize the importance of evaluating processes and outcomes to advance practice, policy, and service delivery effectiveness.</i>
<b>Competency</b>	<b>Competency Definition</b>	<b>EPAS 2015 Practice Behaviors</b>
CC1	Choose effective communication tools and techniques, including information systems and communication technologies, to facilitate discussions and interactions that enhance team function.	<i>Competency 2—Practice Behavior: Demonstrate professional demeanor in behavior; appearance; oral and written, and electronic communication (EPAS, 2015).</i>
CC2	Organize and communicate information with patients, families, and healthcare team members in a form that is understandable, avoiding discipline-specific terminology when possible.	
CC3	Express one’s knowledge and opinions to team members involved in patient care with confidence, clarity, and respect, working to ensure common understanding of information and treatment and care decisions.	<i>Competency 9—Practice Behavior: Apply knowledge of human behavior and the social environment, person-in-environment, and other multi-disciplinary theoretical frameworks in the evaluation of outcomes.</i>
CC4	Listen actively, and encourage ideas and opinions of other team members.	
CC5	Give timely, sensitive, instructive feedback to others about their performance on the team, responding respectfully as a team member to feedback from others.	
CC6	Use respectful language appropriate for a given difficult situation, crucial conversation, or interprofessional conflict.	
CC7	Recognize how one’s own uniqueness, including experience level, expertise, culture, power, and hierarchy within the healthcare team, contributes to effective communication, conflict resolution, and positive interprofessional working relationships (University of Toronto, 2008).	<i>Competency 8—Practice Behavior. Apply knowledge of human behavior and the social environment, person-in-environment, and other multi-disciplinary theoretical frameworks in intervention, and interorganizational collaboration.</i>
CC8	Communicate consistently the importance of teamwork in patient-centered and community-focused care.	

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*Role/Responsibilities.* Learning to be interprofessional requires an understanding of how health and social care professional roles and responsibilities complement each other in patient-centered care (Garrett et al., 2001). Being able to describe one’s own professional roles and responsibilities to health care team members of other professions is important. Similarly, understanding other profession’s roles and responsibilities in relation to one’s own role are viewed as a core competency for IPCP (Evans, 1994; Suter et al., 2013). Table 7 highlights the roles/responsibilities domain definition and its competencies.

*Table 7: Roles/Responsibilities Domain and Competencies*

<b>Domain</b>	<b>Domain Definition</b>	<b>EPAS 2015 Competencies</b>
Roles/ Responsibilities	Use the knowledge of one’s own role and those of other professions to appropriately assess and address the healthcare needs of the patients and populations served.	<p><i>Competency 1: Demonstrate ethical and professional behavior. Social workers understand the profession’s history, its mission, and the roles and responsibilities of the profession. (EPAS, 2015).</i></p> <p><i>Competency 7: Assess Individuals, Families, Groups, Organizations, and Communities. Social workers recognize the implications of the larger practice context in the assessment process and value the importance of interprofessional collaboration in this process.</i></p>
<b>Competency</b>	<b>Competency Definition</b>	<b>EPAS 2015 Practice Behaviors</b>
RR1	Communicate one’s roles and responsibilities clearly to patients, families, and other professionals.	
RR2	Recognize one’s limitations in skills, knowledge, and abilities.	<i>Competency 2—Practice Behavior: Use supervision and consultation to guide professional judgement and behavior.</i>
RR3	Engage diverse healthcare professionals who complement one’s own professional expertise, as well as associated resources, to develop strategies to meet specific patient care needs.	<i>Competency 7—Practice Behavior. Apply knowledge of human behavior and the social environment, person-in-environment, and other multi-disciplinary theoretical frameworks in the analysis of assessment data from clients and constituencies.</i>
RR4	Explain the roles and responsibilities of other care providers and how the team works together to provide care.	
RR5	Use the full scope of knowledge, skills, and abilities of available health professionals and healthcare workers to provide care that is safe, timely, efficient, effective, and equitable.	<i>Competency 8—Practice Behavior: Critically choose and implement interventions to achieve practice goals and enhance capacities of clients and constituencies.</i>
RR6	Communicate with team members to clarify each member’s responsibility in executing components of a treatment plan or public health intervention.	<i>Competency 7—Practice Behavior: Develop mutually agreed-on intervention goals and objectives based on the critical assessment of strengths, needs, and challenges within clients and constituencies (EPAS, 2015).</i>
RR7	Forge interdependent relationships with other professions to improve care and advance learning.	<i>Competency 3—Practice Behavior: Apply their understanding of social, economic, and environmental justice to advocate for human rights at the individual and systems levels.</i>

<b>Competency</b>	<b>Competency Definition</b>	<b>EPAS 2015 Practice Behaviors</b>
RR8	Engage in continuous professional and interprofessional development to enhance team performance.	<i>Competency 6—Practice Behavior: Apply knowledge of human behavior and the social environment, person-in-environment, and other multi-disciplinary theoretical frameworks to engage with clients and constituencies.</i>
RR9	Use unique and complementary abilities of all members of the team to optimize patient care.	<i>Competency 8—Practice Behavior: Use interprofessional collaboration as appropriate to achieve beneficial practice outcomes.</i>

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## **Goals of IPCP**

The primary goal for IPCP is the matching of knowledge with application for students-as-learners and future-providers for a community of learners (Hostetter, Williamson, Byers, & Huggins, 2007; Morrison, Boohan, Jenkins, & Moutray, 2003). It is essential to conceptualize effective IPE programs when the domains become the thrust of design—from implementation into evaluation. In this manner, the design of IPE programs are informed and intimately linked to the desired outcomes of IPCP through the use of the domains and competencies as organizing principles.

For decades, health care professional organizations have called for changes in how their membership is educated and have requested that this instruction be applied across academic programs (Barnsteiner, Disch, Hall, Mayer, & Moore, 2007). The Cochrane Collaboration concluded that IPE as a vessel for IPCP should begin early in the curriculum for health profession students to promote role understanding, improve communication, and advance patient safety (Zwarenstein, Goldman, & Reeves, 2009). There has been increased focus on the re-education of the health care delivery system in order to promote the concepts of interprofessional teamwork and collaborative care, as well as improvement in institutional quality of care and patient safety (Agency for Healthcare Research and Quality, 2008; Baker, Gustafson, Beaubien, Salas, & Barach, 2005; Salas, King, Battles, Baker, Alon, Salassor, Tommey, Salisbury, & Webster, 2008).

## Discussion

Research has been conducted in social work education, practice, and field education with increasing attention on relationship-centered constructs (Briggs & Stephens, 1990; Ersing & Loeffler, 2008; Gelman, 2004; Hopkins, Holtz-Deal, & Dunleavy-Bloom, 2005). Hawkins and Maurer (2010, 2011) propose several goals for field education programs: a) transform students-as-learners into professionals; b) develop and sustain professional relationships; and c) demonstrate competence through accountability. These goals are best viewed as achieved incrementally over time and involving experiential learning that has both personal and professional meaning. The goals of field education for social work are markedly similar to the goals of IPE, and as such, the failure to recognize shared purpose across disciplines has been viewed as an omission in IPE programming (Clark, 2011).

The benefits of recognizing the shared purposes between EPAS 2015 and IPE are three-fold. First, participation in IPE programs—whether as a student or educator, affords an opportunity to enhance interprofessional collaborative practice skills (Zorek & Raehl, 2013). Developing and achieving competence as a social work educator and as a professional is a multi-faceted experience (Freddolino et al., 2014; Moriarty, Manthorpe, Stevens, & Hussein, 2011).

Second, getting involved in IPE supports community engagement. For the social work profession, its researchers, teachers, students, and professional communities, there are always relationships to initiate. From the numerous studies connected to IPE, IPCP, and community engagement, it is clear that more attention needs to be paid to developing and sustaining relationships as collaboratives (Schmidt et al., 2012). Scholarship is still

developing in this area (Herbert, 2005a; 2005b; McCulloch, Rathbone, & Catchpole, 2011; Payler, Meyer, & Humphris, 2007).

Third, IPE programming promotes service, teaching, and research opportunities. Greater focus on research, program, and curriculum design development has become increasingly evident (Reeves, Goldman, Burton, & Sawatzy-Girling, 2010; Selmer, Jonasson, & Luring, 2013), while the need for research targeting quality of training and orientation for IPE programs remains (Anderson et al., 2014). The emerging fields of translational research and organizational change are contributing to the interprofessional understanding of how interventions work by placing an emphasis on the common dimensions involved within practice (Ginsburg & Tregunno, 2005; Woods & Magyary, 2010) and working towards a greater good for the community (Bozic & Dunlap, 2013; Bryant-Rochbach, Hudson, & Tuchmayer, 2014; Stanistreet, 2013).

In conclusion, change is often driven by social needs and policy rather than by research (Thistlethwaite, 2008). This is true for IPE and IPCP as well as EPAS 2015. As EPAS 2015 uses IPE -related terms, it becomes important for social work educators to become actively involved in IPE programming efforts to support social work students' interprofessionalism as well as be prepared for potential future accreditation guidelines. Social work educators serve a unique role in IPE programming as faculty must not only serve as ambassadors of their professions across their own academic institutions, but they also serve to recruit participants. Through IPE involvement, social work educators have the opportunity to work, collaborate, and network interprofessionally in the classroom, across the institution, and into the greater community. This is not only advantageous for



the promotion of research agendas, but also for modeling interprofessionalism for colleagues, community partners, and students.

Furthermore, the entire premise of declaring “signature pedagogy” for social work rests on crafting our teaching aims to help students learn, think, and perform like a social worker and to develop both interprofessionally and professionally (Moriarty et al., 2011). The intent of our “signature pedagogy” might be understood to reflect all of social work education’s aims—the trifecta of theory, practice, and purpose which can be integrated with the trifecta of IPE, IPCP, and community engagement with, about, and from our field education programs (Braunsberger & Flamm, 2013; Calleson, Jordan, & Seifer, 2005; Earls-Larrison & Korr, 2013) in collaboration with our health and social care professions as partners (Charles, Barring, & Lake, 2011; Kruss, Visser, Aphane, & Haupt, 2011).

The amount of monies allocated at the federal and state level for IPE programming is an indication that the federal government recognizes the value and impact of IPE. For example, the Health and Human Service Administration (HRSA) recently opened a 2015 grant cycle designating \$12 million dollars to be used for IPE programming, the development of field/clinical settings, and IPE trainings through Area Health Education Centers (AHEC), application of IPE in rural health centers, and the support of community-university partnerships that deliver IPE programs (Health Resources and Services Administration, 2015).

Thus, social work faculty can better support field education programs through integrating of IPE and IPCP. By scaffolding paradigms for greater inclusion and impact, social work education and its field programs can make substantial contributions in the

communities we serve on behalf of our universities. Through the scaffolding of paradigms social work field education would meet the request of greater promotion of external collaboration as well (CSWE, 2014). IPE and IPCP initiatives abound. The diversity of IPE programming ensures social work students and social work educators have choice in how they participate. With the changes in language and meaning in EPAS2015, understanding IPE, getting involved in IPE initiatives, and embracing the assessment of interprofessional competency is critically important for social work educators.

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## **Chapter 3. Manuscript 2**

Student Learning Styles: Implications for Interprofessional Education Program Design

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## Student Learning Styles: Implications for Interprofessional Education Program Design

### **Abstract**

This cross-sectional descriptive study investigated differences in students' learning styles across multiple academic disciplines. Surveys were administered to 448 students registered in six professional preparatory programs at a Midwest regional commuter-based campus. Results support the need for interprofessional education initiatives to be developed from a student-centered perspective where the attributes of learners are interwoven—explicitly and implicitly, into the learning experience.

***Keywords:*** Learning styles, interprofessional education

## **Student Learning Styles: Implications for Interprofessional Education Program Design**

Interprofessional collaborative practice (IPCP) has been viewed as an important avenue to increase health care quality and safety (Institute of Medicine of the National Academies, 2001). In creating these types of collaborative health care teams, a plethora of academic attention is being paid to how health profession educators incorporate interprofessional education (IPE) into the curriculum (Barnsteiner, Disch, Hall, Mayer, & Moore, 2007; Institute of Medicine of the National Academies, 2004; Ten Cate & Schelle, 2007). The Cochrane Collaboration concluded that interprofessional education should begin early in the curriculum for health profession students as a way to promote role understanding, improve communication, and advance patient safety (Reeves, Zwarenstein, Goldman, & Sawatzky-Girling, 2008; Zwarenstein, Goldman, & Reeves, 2009). Emergent models of IPCP have been clarified through the passage of the Recovery and Reinvestment Act of 2009 (Steinbrook, 2009) and the Patient Protection and Affordable Care Act of 2010 (Kaiser Family Foundation, 2010) with the intent to improve the delivery of health care services. These new concepts in care will require health care providers to be trained in interprofessional collaborative care to promote high quality health care services (Agency for Healthcare Research and Quality, 2008, Baker, Gustafson, Beaubien, Salas, & Barach, 2005; King, Battles, Baker, Alonso, Salas, & Webster, 2008). Thus, it becomes important to design IPE programs that take learner characteristics into account.

## **Significance of Interprofessional Education**

IPE is concerned with training, teaching, and fostering competent health care professionals while they are students, so that their new found knowledge, skills, and attitudes align with collaborative interprofessional practice (Barr, 1998; Blue, Brandt, & Schmitt, 2011). IPE is a competency-based educational approach that contains specific content domains and related practice behaviors which were designed to be flexible, wide-ranging, and adaptable to the individual profession and to the clinical or institutional settings (Ten Cate & Schelle, 2007). The core premise of all IPE initiatives is the support of “integrated applications of knowledge where the student can adapt to change, develop new behaviors, and continue to improve performance” (Walsh, Gordon, Marshall, Wilson, & Hunt, 2005, p. 232). Interprofessional education is “when students from two or more professions learn about, from, and with each other to enable effective collaboration and improve health outcomes” (World Health Organization, 2010, p. 30). The delivery of IPE encompasses different pedagogies—didactic (class or online method of interactive instruction), case competitions (written plans of care), problem-based learning (experientially learning concepts through solution-focused review), simulations (real or online tasks), and clinical rotations (field education) (Pollard, 2009; Twill, Elpers, & Lay, 2011; Wilson et al., 2010). However, most IPE models take the form of didactic, simulation, or clinical approaches (Wilson, Rozensky, & Weiss, 2010).

To maximize learning, IPE program developers need to be aware of student’s internal learning dispositions (Heimberg, Mueller, Holt, & Hope, 1992). Students bring interpersonal dynamics into their participation in special programs, which can impact learning outcomes both negatively and positively (Novak, Shah, Wilson, Lawson, &

Salzman, 2006; Pollard, 2009). In many ways, these interpersonal dynamics can impact the very premise of IPE—that greater collaboration among students will create more effective and collaborative practices as professionals. For example, anxiety can certainly impact the learning process and impede the collaborative experience of student groups/teams (Litvack, Bogo, & Mishna, 2010).

Each individual learner that participates in an IPE initiative brings with him or her worries, fears, and/or attributes that can impact the enterprise, whether that be computer anxiety (Choi, Ligon, & Ward, 2002), general anxiety—both social and in the workplace (Eng, Coles, Heimberg, Safren, 2005; Haslam, Atkinson, Brown, & Haslam, 2005; Schneier, 2006), their need for social support (Halbesleben, 2006) and interpersonal decision-making skills (Ferris, Witt, & Hochwarter, 2001). Placing a group of students in a computer-simulated learning environment when they have high levels of anxiety with computers might not generate the types of desired outcomes of program developers or students-as-participants in IPE initiatives. Whereas, intentional design of an IPE collaborative clinical rotation with students that indicate a preference for high-levels of support and demonstrate high interpersonal decision-making could produce highly prized outcomes. There are a myriad of internal student characteristics that could be a focal point in designing a reflexive and “best fit” program for learners.

IPE has received increasing research attention, yet there is a lack of *intention* given to the variety of professional disciplines invited to participate in IPE programs—those typically referred to as ancillary or allied health professions (for example, social work and public health) versus the typical association of primary health professions (for example, medicine and nursing) (Graybeal, Long, Scalise-Smith, & Zeibig, 2011). This

lack of inclusivity is a major problem in two ways. First, it poses a major challenge to how IPE educational initiatives are designed and implemented. Second, with balanced inclusivity and attention to pre-design, a more thorough understanding of the learning needs and styles of students-as-participants from multiple academic disciplines could support improved educational outcomes.

A wide variety of health care disciplines play a vital role in the delivery of safe, effective, and high quality health care services. Equally missing in the literature is *attention* to program design that matches the types of IPE being developed (clinical, didactic, simulation, or service-learning) with the needs of the student learners-as-participants in mind. There are numerous considerations that emerge as potential focal points for designing a reflexive and “best fit” program for learners. Within IPE program design, it is important to consider the interactions of learning styles of students participating in collaborative IPE initiatives. IPE program designers could use these understandings to inform which academic health care disciplines (primary, ancillary or secondary, and allied as tertiary) might participate in future research efforts (Cioffi, Wilkes, Cummings, Warne, & Harrison, 2010; Cup, Pieterse, Hendricks, Van Engelen, Oostendorp, & Van Der Wilt, 2001; Sibbald, Wathen, Kothari, & Day, 2013).

### **IPE as a Learning Process**

Way and colleagues (2007) illustrate that collaboration in health care teams are synergistic efforts that foster effective communication and ethical decision-making where separate and shared knowledge is combined with various professional skill sets to influence patient care. This synergy creates what has become known as interprofessional collaborative practice, which is when “multiple health workers from different

professional backgrounds work together with patients, families, care givers, and communities to deliver the highest quality of care” (WHO, 2010, p. 33). The aim of IPE is the transformation of students to professionals—cognitive and behavioral changes that share the language of collaboration, patient-centered philosophy, and scope of practice (D’Amour & Oandasan, 2005; King, Battles, Baker, Alonso, Salas, & Webster, 2008; Poulton, 2003).

### **Links to Theory**

Payler, Meyer, and Humphris (2008) concluded that no educational pedagogy was superior to another until a theoretical framework could be established for IPE that evaluated various interventions. Sargeant (2009) asserted that an “array of related theories can contribute to understanding and implementing IPE” (p. 179)—such as but not limited to social learning theories, while noting the value of reflective, experiential, and situational learning models in instruction (Brandt, Farmer, & Buckmaster, 1993; Cooke, Dorman, & Row, 2009). The literature supports the significance of students’ learning styles in areas of vocational training (Sahoo & Chandra, 2013), field education (Pollard, 2009), online learning environments (Moallem, 2007), distance education (Logan & Thomas, 2002), continuing professional development (Sadler-Smith, Allinson, & Hayes, 2000), and in relation to different instructional methods (Kumar, Kumar, & Smart, 2008). All of these areas traverse and directly connect to the variety of IPE program designs—for example, field education to clinicals and online learning to simulations. Assessing the needs of students-as-participants for improved IPE program implementation is a logical extension of numerous pedagogical practices (Park, Hawkins, Hawkins, & Hamlin, 2013).

## **Outcomes of IPE Participation**

The substantive literature on IPE programs and initiatives is vast, and systemic reviews and meta-analyses provide a wealth of information regarding the outcomes of IPE programs. One such systematic review found that participants' attitudinal changes towards collaboration created a positive culture of change in both the organizational cultures (responsiveness) and patient care (integration) (Barr, Hammick, Koppel, & Reeves, 2000). Barr et al. (2008) extended the tenet of culture change and found IPE programs increased the focus of the participants' learning through recognizing personal change in knowledge, skills, and in patient care. Hammick and colleagues (2007) reported a greater linkage between learning tasks and instructional processes and positive learning outcomes for participants. Reeves and colleagues (2008) discovered that IPE program evaluations employ rigorous research designs and small sample sizes and tend to report positive changes to professional practices and patient satisfaction, and that there is heterogeneity in IPE programming. The increased attention on IPE has created an increased focus on the various types of education initiatives (Reeves, Goldman, Burton, & Sawatzy-Girling, 2010).

Yet with all the details available on the successes of IPE programming, minimal attention on assessments of the learning needs of students-as-participants prior to participating in IPE programming is found in the literature (Vaughn & Baker, 2001). As malleable as the constructs of IPE and IPCP are, there remains a lack of attention to the learning styles and learning needs of students-as-participants and to the intention of IPE program developers to plan initiatives with those needs in mind (Grasha, 1996; Smith & Anderson, 2008). The purpose of this study was to examine the differences in students'

learning styles across multiple academic disciplines. The disciplines chosen (social work, criminal justice, medicine, nursing, dental, and radiology) were the most frequently invited to participate in IPE initiatives in a College of Health and Human Services (CHHS) at an urban commuter-based university in the Midwest. The differences in learning styles serve as special considerations for IPE program design.

### **Methods**

This study addressed the question: What are the unique differences in learning styles across students from various academic disciplines or programs of study? The design of this study is a cross-sectional descriptive survey of learning styles across multiple academic disciplines that may participate in collaborative-based IPE initiatives. College of Health and Human Services (CHHS) students at this Midwest university are often asked to work collaboratively on interprofessional education initiatives, service learning projects, and community programs. Yet, little is known about the unique learning styles from the disciplines participating in IPE and how these elements might be important considerations for program design. This research project was approved by the university's Institutional Review Board.

Respondents were recruited from six academic disciplines, which were selected given the high likelihood they would be invited to participate in the academic institution's interprofessional education initiatives in the near future. Any registered CHHS student attending graduate and/or undergraduate courses in the spring semester of 2014 from any of the previously mentioned disciplines were invited to participate.



## **Data Collection**

Eleven professors across 15 courses agreed to distribute the paper-pencil survey in their courses. Of those students invited to participate, 84% completed the survey (n=448). Respondents received a recruitment letter, a study information sheet that explained the purpose of the study, their rights as participants, and the voluntary nature of participation as well as contact information for researchers in case they had any questions. No personal identifying information was collected through the survey, and no follow-up contacts were sought.

## **Measures**

A paper-based self-administered survey was employed as it has a higher rate of return/completion than other survey methods (Teo, 2013). The survey contained two sections: learning styles (60 items) and demographics (8 items). The questionnaire took approximately 20 minutes to complete.

*Learning Styles.* The 60-item Grasha-Reichmann Student Learning Style Scales (GRSLSS) represents six learning styles: independent, avoidant, collaborative, dependent, competitive, and participant (10 items per learning style). Avoidant students tend to be at the lower end of the grade distribution and tend to exhibit absenteeism, poor organization of work, and little responsibility for their learning. Participative students are characterized as willing to accept responsibility for self-learning and relate well to their peers. Competitive students are described as suspicious of their peers leading to competition for rewards and recognition. Collaborative students enjoy working harmoniously with their peers. Dependent students typically become frustrated when facing new challenges not directly addressed in the classroom. Independent students

prefer to work alone and require little direction from the teacher (Reichmann & Grasha, 1974). The higher the aggregated score in a learning style, the more the respondent identified with that approach. The GRSLSS uses a 5-point Likert type scale (1= strongly disagree to 5= strongly agree). Cronbach's alpha for four sub-scales were satisfactory in this study (collaborative, competitive, avoidant, and participant), while two sub-scales were poor (dependent and independent) as represented in Table 8.

*Table 8: Reliability of Learning Styles Scale*

<b>Category</b>	<b>N</b>	<b>Excluded</b>	<b>%</b>	<b>Alpha</b>	<b>Mean</b>	<b>Variance</b>	<b>SD</b>
Collaborative	438	10	2.2	.784	36.15	39.69	6.30
Competitive	442	6	1.3	.769	25.28	41.56	6.45
Avoidant	432	16	3.6	.748	26.38	41.56	6.42
Participant	434	14	3.1	.717	38.53	30.60	5.53
Dependent	435	13	2.9	.543	38.13	18.72	4.32
Independent	432	16	3.6	.580	35.04	21.37	4.62

Demographic information included: gender (male or female), race/ethnicity (White/Caucasian Non-Hispanic, African American, Hispanic/Latino, Asian/Pacific Islander, Bi-racial, Multiracial, or other), grade point average, program of study, age, involvement in IPE programs (yes/no), and status in their program (graduate or undergraduate).

### **Study Participants**

Convenience sampling was used to recruit respondents from across the various disciplines of social work, nursing, medicine, radiography, dental, and criminal justice. The CHHS consists of many academic disciplines and views itself as a school consisting of professional-preparatory programs. Sampling inclusion criteria consisted of any registered CHHS student attending graduate and/or undergraduate courses in the spring semester 2014 from any of the previously mentioned disciplines.

The data recruitment strategy was equitable with an equal number of professors and courses solicited by discipline, differences in sample size by discipline exist (range=

34-93). The Dental and Medical Schools had the smallest sample size. The cohort model is used by the these two disciplines, and class sizes tend to be smaller as admission protocols limit admissions by cohort and level of academic programming.

### **Pre-Testing**

Two instructors (nursing and social work) recruited students for pre-testing of the survey, distributed it to one of their classes. The pre-test sample size was 56 students with 20 from social work and 36 from nursing. None of these students were surveyed as part of the project's implementation in the spring semester. The researcher was given the first 20 minutes of both class sessions to introduce the study, review the recruitment letter, and invite students to review the survey. Out of the 56 students, 52 completed the survey and 31 provided either written or verbal feedback.

The students shared that the layout of the instrument was visually appealing, readable, that the content made sense to their role as learners, and that the survey was easy to move through. Both groups completed the survey in 16 minutes. Students reported that the questions clearly linked to styles of learning. These responses endorsed the face and content validity of the instrument. Students made the following suggestions: shorten the survey where possible, correct the minor typos to promote greater clarity, and increase space for narrative remarks. The survey was modified in two succinct ways: 1) the instructions were clarified; and 2) the learning style scale wording was revised to support general course reflection versus specific course reflection (Reichmann & Grasha, 1974).

## **Analysis**

Descriptive statistics were used to summarize results for each scale and participants' demographics. Demographic information was compared across disciplines. The six learning styles were compared to determine existing relationships. Aggregated scores for each scale and both score sets were compared by program of study. An analysis of variance (ANOVA) was used to ascertain the differences between group means. Post-hoc analyses were used if ANOVAs were significant. Bonferroni analysis was used to adjust the significance rating to control for the risk of a type I error for multiple comparisons (Rubin & Babbie, 2011).

## **Results**

### **Descriptive Statistics**

The sample consisted primarily of White non-Hispanic (67%) females (76%), in the age range of 18-28 (72%), which was defined as traditional students given the nature of the academic programs being surveyed (see Table 9). Within this sample, 79% of CHHS students self-reported a 3.0 or above grade point average for the most recent semester. More undergraduate students (82%) were represented. Less than 5% of the sample reported prior participation in IPE programs or initiatives. Medical students earned performance ratings as grades. The GPA of medical students ranked as "high performance" was recoded into a 3.75 GPA.

Table 9: Sample Characteristics

Characteristic	Total (N=448)	Criminal Justice (n=91)	Dental (n=47)	Medicine (n=34)	Nursing (n=98)	Social Work (n=93)	Radiology (n=85)
<b>Age</b>							
Traditional	324 (72%)	80 (88%)	39 (83%)	28 (82%)	73 (74%)	48 (52%)	56 (66%)
Non-Traditional	112 (25%)	11 (12%)	7 (14%)	5 (14%)	24 (24%)	40 (43%)	25 (29%)
<b>Race/Ethnicity</b>							
White Non-His	304 (67%)	52 (57%)	36 (77%)	20 (58%)	69 (70%)	54 (58%)	73 (86%)
African-American	48 (11%)	14 (15%)	3 (6%)	3 (9%)	8 (8%)	20 (22%)	
Hispanic	48 (11%)	14 (15%)	6 (12%)	1 (3%)	13 (13%)	9 (10%)	5 (6%)
Asian	9 (2%)	0	0	8 (24%)	0	0	1 (1%)
Bi-racial	15 (4%)	9 (10%)	0	0	2 (3%)	3 (3%)	1 (1%)
Multiracial	4 (1%)	0	1 (2%)	0	0	2 (2%)	1 (1%)
<b>Gender</b>							
Female	340 (76%)	39 (43%)	46 (98%)	19 (56%)	85 (87%)	85 (91%)	66 (78%)
Male	108 (24%)	52 (57%)	1 (1%)	15 (44%)	13 (13%)	8 (8%)	19 (22%)
<b>GPA</b>							
2.0-2.99	64 (14%)	32 (35%)	1 (2%)	0	12 (12%)	14 (15%)	5 (6%)
3.0-3.50	219 (49%)	37 (40%)	35 (74%)	0	64 (65%)	31 (33%)	52 (61%)
3.51-4.0	136 (30%)	17 (18%)	9 (19%)	32 (94%)	18 (18%)	36 (39%)	24 (28%)
<b>Level</b>							
Undergraduate	369 (82%)	88 (97%)	47 (100%)	0	98 (100%)	50 (54%)	85 (100%)
Graduate	79 (18%)	3 (3%)	0	34 (100%)	0	43 (46%)	0
<b>IPE</b>							
Yes	18 (4%)	3 (3%)	0	2 (6%)	6 (6%)	5 (5%)	2 (2%)

*Demographic comparisons.* A series of chi-square analyses were used to examine differences among students by demographic variables and academic program. Given the multiple analyses, a Bonferroni-adjusted significance level was calculated to account for the increased possibility of type-I error. Accordingly, the Bonferroni correction to adjust the  $p$  value from  $p < .05$  for each analysis (9) to  $p < 0.008$  to neutralize this risk.

A statistically significant difference by race was found across programs,  $\chi^2 (1, N=441) = 146.85, p < .001$ . White Caucasian Non-Hispanic ethnicity accounted for nearly 70% of the sample size, while all minorities accounted for the remaining 30%. Three programs (criminal justice, medicine, and social work) had the most racially diverse students.

There was a significant difference by gender across academic programs,  $\chi^2 (1, N=448) = 92.794, p < .001$ . Males accounted for 24% of the overall sample, but 57% of the criminal justice sample were male. The five remaining disciplines had more female than male respondents.

Academic programs were significantly different by level of student (undergraduate or graduate),  $\chi^2 (1, N=448) = 249.159, p < .001$ . A vast majority of the sample, 80%, were undergraduate students. The highest percentages of graduate students per program were found in medicine and social work. Lastly, no statistically significant difference was noted by academic program and IPE involvement.

*Scale mean scores by program.* Collaborative learning style was high for the social work, nursing, and dental students; the criminal justice students had the lowest mean score for collaborative learning style. Regarding the competitive learning style, medical students had the highest mean score and social work had the lowest mean score. The avoidant learning style scores were highest for dental students and the lowest for nursing students. The highest mean score on the participant learning style was for nursing students and the lowest score was for medical students. The program with the highest mean scores for a dependent learning style was dental students, and the lowest mean scores were from medical students. The highest mean score for an independent learning style was from medicine and the lowest was from radiology.

Academic programs had distinct differences and similarities across the six categories of learning styles (see Table 10). The criminal justice, radiology, and dental students had the highest mean scores within the dependent learning style. Nursing students had the highest collaborative learning style mean scores. Medical students had the highest mean score in the independent learning style. The participant learning style had the highest mean scores for social work students. The competitive learning style held the lowest mean scores for the following programs: criminal justice, dental, social work,

and radiology. Nursing and medical students has the lowest mean scores for the avoidant learning styles.

*Table 10: Differences in Learning Style by Discipline*

	<b>Nursing M (SD)</b>	<b>Medical M (SD)</b>	<b>Criminal Justice M (SD)</b>	<b>Dental M (SD)</b>	<b>Social Work M (SD)</b>	<b>Radiologic M (SD)</b>
Independent	34.9(4.61)	37.5(4.75)	35.3(4.47)	35.2(4.06)	35.5(4.51)	33.4(4.69)
Avoidant	24.1(5.26)	27.6(7.34)	28(7.06)	29(6.45)	24.8(5.45)	27.1(6.44)
Collaborative	37.1(5.9)	34.9(5.56)	34.3(6.93)	36.3(5.82)	38.4(5.4)	34.9(6.69)
Dependent	38.3(3.93)	36.5(4.4)	38.1(4.79)	40.2(3.39)	37.3(4.53)	38.4(4.12)
Competitive	24.3(5.71)	27.6(5.35)	26.6(6.61)	25.5(5.97)	23.8(6.71)	25.5(7.04)
Participant	41.1(4.61)	34.4(5.27)	37.9(6.7)	37.9(4.32)	38.9(5.15)	37.7(4.99)

## **Correlation**

The six learning style distributions (independent, avoidant, collaborative, dependent, competitive, participant) were reviewed and each approximated normal distributions. The assumptions of normal distribution, sampling, and item independence were met. A range of negative and positive low level statistically significant correlations (10 out of 28 correlations) across the variables were found and moderate correlations near or above .5, +/-) were statistically significant in two out of 28 correlations (Creswell, 2011). Avoidant learning style demonstrated a negative moderate-level correlation to participant learning style,  $r^2$  (420) = -.59,  $p < .01$ , while there was a positive moderate-level correlation between participant and collaborative learning style,  $r^2$  (425) = .49,  $p < .01$ . Thus, a learner with an avoidant style would not readily participate or seek avenues to participant in learning as a group activity. Furthermore, a learner who actively participates in their own learning process is more likely to collaborate with others in learning activities.

## **Analysis of Variance**

*Learning style differences by discipline.* An analysis of variance was conducted to evaluate the relationship between learning styles and academic discipline. The

dependent variables were the aggregated scores of the six sub-scales on the learning styles instrument. The independent variable was academic discipline. These findings can be found in Table 11.

*Table 11: ANOVA Results*

		<b>Sum of Squares</b>	<b>df</b>	<b>Mean Square</b>	<b>F</b>	<b>Sig.</b>
<b>Independent</b>	Between Groups	451.168	5	90.234	4.388	.001*
	Within Groups	8759.609	426	20.562		
	Total	9210.777	431			
<b>Avoidant</b>	Between Groups	1333.414	5	266.683	6.925	.000*
	Within Groups	16404.327	426	38.508		
	Total	17737.741	431			
<b>Collaborative</b>	Between Groups	1019.023	5	203.805	5.394	.000*
	Within Groups	16321.126	432	37.780		
	Total	17340.148	437			
<b>Dependent</b>	Between Groups	347.829	5	69.566	3.838	.002*
	Within Groups	7776.082	429	18.126		
	Total	8123.911	434			
<b>Competitive</b>	Between Groups	612.597	5	122.519	3.016	.011
	Within Groups	17713.702	436	40.628		
	Total	18326.299	441			
<b>Participant</b>	Between Groups	1283.959	5	256.792	9.182	.000*
	Within Groups	11969.806	428	27.967		
	Total	13253.766	433			

Statistically significant findings were found for five of the learning styles by discipline: independent  $F(5, 426)=4.39, p<.001$ ; avoidant  $F(5, 426)=6.93, p<.001$ , collaborative  $F(5, 432)=5.39, p<.001$ , dependent  $F(5, 429)=3.83$ , and participant  $F(5, 428)=9.18, p<.001$ . In using the conservative approach to control for a Type 1 error, the Bonferroni-correction, the adjusted alpha value from  $p<.05$  to that of  $p<.08$ , one learning style did not show a significant difference by discipline relationship: i.e., competitive  $F(5, 428)=3.02, p=.011$ .

The Tukey HSD was used to best determine which groups differed from each other. Table 12 reviews the post-hoc findings. The mean score for the independent learning style for medicine was significantly different than radiology ( $M=4.12, SD=.95$ ). This suggests that the students within the medicine program identify with the independent learning style at a higher rate when compared with radiology students.



Table 12: Post-Hoc Analysis: Learning Styles by Program

Learning Style Mean Differences by Program							
Learning Style	(I) Program	(J) Program	Mean Difference (I-J)	Std. Error	Sig.	95% Confidence Interval	
						Lower Bound	Upper Bound
Independent	Medicine	Radio	4.12*	.95	.000*	1.41	6.83
	Social Work	Radio	2.17*	.69	.023*	.18	4.16
Avoidant	Criminal Justice	Nursing	3.86*	.92	.001*	1.22	6.51
	Criminal Justice	Social Work	3.14*	.94	.012*	.45	5.84
	Dental	Nursing	4.88*	1.11	.000*	1.70	8.06
	Dental	Social	4.16*	1.12	.003*	.94	7.38
	Nursing	Radio	2.99*	.93	.018*	.33	5.67
Collaborative	Nursing	Criminal Justice	2.83*	.91	.025*	.22	5.43
	Social Work	Criminal Justice	4.06*	.91	.000*	1.43	6.70
	Social Work	Radio	3.47*	.93	.003*	.80	6.13
Dependent	Dental	Medicine	3.66*	.97	.002*	.90	6.43
	Dental	Social Work	2.83*	.77	.003*	.63	5.02
Competitive	Medicine	Social Work	3.75*	1.28	.041*	.09	7.42
	Criminal Justice	Social Work	2.74*	.95	.047*	.02	5.46
Participant	Nursing	Medicine	6.61*	1.08	.000*	3.53	9.96
	Nursing	Criminal Justice	3.14*	.78	.001*	.91	5.38
	Nursing	Dental	3.12*	.96	.014*	.39	5.84
	Nursing	Radi	3.38*	.79	.000*	1.19	5.63
	Criminal Justice	Medicine	3.47*	1.10	.020*	.33	6.60
	Social Work	Medicine	4.50*	1.09	.001*	1.39	7.61
	Radiologic	Medicine	3.24*	1.10	.040*	.08	6.39

There were statistically significant differences in the avoidant learning style for criminal justice students compared to nursing ( $M=3.86$ ,  $SD=.924$ ) and to social work ( $M=3.14$ ,  $SD=.94$ ); dental by social work ( $M=4.16$ ,  $SD=1.11$ ) and nursing ( $M=4.88$ ,  $SD=1.12$ ); and nursing to radiology ( $M=2.9$ ,  $SD=.93$ ). Learners who rated themselves more avoidant in their approach were found in the criminal justice and dental programs rather than nursing and social work.

Statistically significant differences were also found in collaborative learning style between social work with criminal justice ( $M=4.06$ ,  $SD=.93$ ) and with radiology ( $M=3.47$ ,  $SD=.93$ ). Thus, learners from social work programs scored higher in collaboration (more collaborative) than learners from the criminal justice and radiology programs.

Within the dependent learning style, there were statistically significant mean differences between the dental students and two other programs: medicine ( $M=3.66$ ,  $SD=.97$ ) and social work ( $M=2.86$ ,  $SD=.77$ ). Dental students scored higher as a group on

having a dependent learning style than their peers from the medical school and social work program. There were several statistically significant mean differences across the participant learning style; between nursing and medical students ( $M=6.61$ ,  $SD=1.1$ ); nursing and criminal justice students ( $M=3.14$ ,  $SD=.78$ ); nursing and radiology students ( $M=3.38$ ,  $SD=.79$ ); and social work and medical students ( $M=4.5$ ,  $SD=1.1$ ).

### **Discussion**

Distinct differences in learning styles by academic discipline were found in this study. In summary, the sample scored highest in three learning styles: participant, dependent, and independent. The collaborative learning style also earned high scores from five of the disciplines (nursing, medical, dental, social work, and radiologic sciences). The collaborative learning style was not the first learning style identified for these groups, but was in the top three for each discipline. Students from medicine identified with the independent learning style, while the students from the criminal justice, dental, and radiologic sciences programs identified with the dependent learning style. Students from social work and nursing shared high scores in the participant learning styles. This is a particularly interesting finding given students from the nursing program had means scores that approximated those of the social work program, while both disciplines rated themselves higher in participant learning style than students from all the remaining programs. This suggests that the students from the social work and nursing programs self-identify with the learning style of participant more so than medical, criminal justice, and radiology programs.

Determining the “best fit” for an IPE program can be balanced against the attributes associated with each learning style. For example, students with an independent

learning style may perform well autonomously and feel confident in their own abilities/knowledge, but may fail to collaborate when needed. Results from this study indicate that medical students would fit well in an IPE program that was competitive in nature and allowed for independent efforts. A team-based clinical rotation may prove to be a challenge for an independent learner, but a case-based learning activity might work out well.

Students with a collaborative learning style enjoy the exchange of ideas and efforts, but may not be well-versed in handling competition. Collaborative learners develop effective group skills and might enjoy engaging in a collaborative IPE program such as a service-learning project, a clinical experience, or a didactic initiative. Students with a participant learning style enjoy taking part in the action, discussion, and activities of learning. This group is good stewards of the learning process, but can struggle to maintain boundaries in group tasks—they tend to take on more than their fair share. Participating and collaborating in learning activities are action-oriented behaviors. IPE initiatives would do well to include features from both of these learning styles into any of the following design types: clinical rotations, multi-focal service learning projects, didactic events, and team-based simulations.

Students with an avoidant learning style are not actively involved in the process or tasks of learning, can be poor collaborators, and struggle to perform. IPE may generate a challenge for these students. Both the dependent and the avoidant learning style exhibit a passive approach to the learning process. The dependent learning style does not actively engage in learning processes or tasks, views instruction as the source of learning, and struggles with autonomous performance. These two groups would struggle

to perform in a problem-based or case-based learning environment or in a simulation that relied on collaborative skills.

It becomes clear that placing a group of students that are avoidant or dependent into a competitive IPE program, which relies on a team approach will not bode well for the learning process for participants or the feedback from participants on the program's tenets. A competitive learning style would lend itself well to problem-based learning, case-based learning, and case competitions as this group tends to prefer autonomous work and places value on recognition and praise. Instructors should be aware that the competitive learner might struggle to work collaboratively. A more proactive understanding of the learning styles of students and their disciplines would allow IPE programmers an opportunity to target desired outcomes with organizational tenets (Kumar et al., 2004; Park et al., 2013; Sadler-Smith et al., 2000) or what might better be known as a parallel process (Shulman, 2014). Assessing for learning styles becomes an avenue for more effective and responsive IPE program design, while also promoting students' self-awareness (Negi, Bender, Furman, Fowler, & Prickett, 2010).

### **Limitations and Considerations**

There are several limitations to this study. First, the ability to generalize findings is limited in a few very distinct ways: 1) the study was a one-point in time survey of available and amenable professions; 2) the recruitment site is a non-typical university setting in that it is a commuter-based campus in an urban area versus a residential campus with a broader array of health care professions; and 3) there was a significant amount of student respondents who have yet to participate in an IPE initiative. Students from a larger campus with a larger array of health care professions and IPE initiatives to choose

from and the frequency of those opportunities might generate very different results. Second, the survey itself consisted of multiple sections and took several minutes to complete. This could have been viewed as lengthy by respondents. And lastly, the data collection plan relied on pen and paper administration of the survey. This strategy produced a high level of respondents.

### **Implications and Future Research**

The findings from the project suggest that matching learning styles with program design is an important consideration in order to maximize educational gains (Bahar, 2009; Merriam & Caffarella, 1991). Yet, the approach to learning is often dependent on the constructs and designs of the IPE programs (Wilson, Rozensky, & Weiss, 2010). The development and assessment of IPE programs is an inter-dependent process encompassing both reflective and reflexive properties (Bell & Allain, 2011). Looking at the type of IPE program being considered, the type of students that are being invited to participate, and the unique characteristics of the learners-as-participants becomes critical to the evaluation of the process (Park et al., 2013; Sadler-Smith et al., 2000).

The learning styles of students-as-participants are an active learning process. This active learning process is the central tenant of IPE and serves as an important consideration for instructional methods (Grasha, 1972; 1990; Grasha & Kirschenbaum, 1986; Hruska-Riechmann & Grasha, 1982). IPE initiatives can be designed in a wide variety of ways. Thus, IPE program design can be tailored to meet the learning needs of students. This project compared students from different disciplines in terms of their dominant learning style and offers several points for program consideration.

The findings have a number of direct applications to IPE program design. First,

program developers have direct knowledge about the number of students that have participated in IPE programs previously and the types of disciplines that have yet to be asked. Second, the scales were selected because it focused on the students' interaction with the learning group, with the facilitator, and across the learning process (Reichmann & Grasha, 1974)—these being essential ingredients in IPE program initiatives at the collegiate level. Third, the GRLSS is a scale that measures learning styles in relation to social interaction and allows for social and affective dimensions in relation to learning/teaching environments.

IPE program designs are naturally social in that they are trying to build a culture of interprofessionalism and collaborative practice. Thus, knowing the learning styles of respondents prior to implementing an IPE program design informs the nature of instruction and the selection of learning activities. Fourth, the anchored definitions of each learning style relate to the purpose of IPE and the operationalization of the IPCP domains. There are a wide variety of uses for knowing the learning styles of students-as-participants in IPE programs. For example, certain learning styles could be used as criteria for placement in an IPE program. Targeting the instructional approach might better accommodate diverse learning styles as well.

There are several implications for academe, which functions as the central developer in IPE programming (Logan & Thomas, 2002; Sahoo & Chandra, 2013). IPE programs should be developed with both diversity and inclusivity in mind. This approach would extend to types of academic programs invited to participate in an initiative and into the programming aspect that diverse and well-structured learning activities may support the needs of a larger array of students-as-learners. Designers should consider the learning

style of the students being invited. Does the nature of the academic program lend itself to a competency-based educational approach? If not, then the IPE initiative should be constructed with that in mind. Orientation to IPE programming is the essential ingredient to an IPE initiative given the differences and similarities across disciplines. Orientation could be a great bridge to the exploration and assessment of student learning styles as well as how the program is developed (Ten Cate & Schelle, 2007).

The implications for future research in the scholarship of teaching and learning applied to IPE programming are vast. Studies in concurrent design of IPE initiatives with a lens towards teaching and learning styles could make substantial contributions. What learning styles work best in what type of IPE initiatives? What types of academic programs work best with what types of IPE program? Best practices of IPE programs and potential fidelity studies within IPE types are additional avenues for research.

The goal of IPE and IPCP is to create a personal to professional change in participants that lead to better practices through collaboration (Campbell, 2012; Sims, 2011). Thus, targeting university-community partnerships where employers are hiring and evaluating students that participated in IPE initiatives versus those that did not will be essential. Furthermore, ensuring that IPE programs are informed by the domains of IPCP will be crucial to creating systemic change in the interprofessional delivery of health care services.

### **Conclusions**

As IPE efforts and initiatives begin to emerge as pedagogy, it will become increasingly important to balance the needs of students-as-learners with instructional methods and program aims (D'Amour & Oandasan, 2005). Increasing the attention and

intention of program developers in a systematic fashion can better produce the true goals of IPE—for all health care profession students to understand disciplinary roles, improve communication, and advance patient safety through collaborative practice.



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## **Chapter 4. Manuscript 3**

Field Liaisons as “Bridge Builders” in Social Work Field Education: The Role of Social  
Capital

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Field Liaisons as “Bridge Builders” in Social Work Field Education: The Role of Social  
Capital

**Abstract**

With the promotion of social work field education as the profession’s signature pedagogy, it has become crucial to evaluate and reflexively review the needs of those involved in field education programming—including students, faculty field liaisons, and field instructors. Descriptive qualitative analysis was used to examine the narrative comments of graduate-level social work students (N=243) and their field instructors (N=163) at the conclusion of their field experience over a five-year period. The emergent themes, anchored in the constructs of social capital, highlight the role of faculty field liaisons as “bridge builders.” The key component to whether students and field instructors value their participation in field was the perceived value of their relationship with the faculty field liaison. It is these relationship-centered requests that become fruitful considerations for staffing and training in field education programs.

**Key Word:** Social work, field education, social capital, linking, bridging, bonding



## Field Liaisons as “Bridge Builders” in Social Work Field Education: The Role of Social Capital

Social work students are required to fulfill a number of field practicum hours as part of their degree, and this field education is considered an essential learning experience for students.

The Council on Social Work Education (CSWE) declared field education as a signature pedagogy and asserted that classroom-based learning and learning in the field are equitable partners in the instruction of social work students (CSWE, 2008; Shulman, 2005a, 2005b). This shift in thinking was supported by both social work educators and social work practitioners as it supports the belief that field education serves as a pivotal point-in-time to evaluate student’s performance of the pre-defined professional practice behaviors (CSWE, 2008; Petracchi & Zastrow, 2010a, 2010b). Field education allows for classroom knowledge and skills to be applied in practice settings, and is overseen by a field liaison, which is frequently a faculty member who serves as a link between the school and the field education site. Copious literature supports the value and the process of field instruction based on the relationship between the student as a learner and the professional social worker as a trainer and educator (Bennett & Coe, 1998; Miller, Kovacs, Wright, Corcoran, & Rosenblum, 2005; Power & Bogo, 2002).

Despite the importance of the field liaison role and the recognition of social capitals a relevant organizing concept for social work (Fenge, Fannin, & Hicks, 2012; Gibbs & Garrett, 2007; Paat, 2015; Sugawara, 2009), these two concepts have not been examined together. The literature is sparse regarding the role of the field liaison, typically an academic position, which supports the totality of the field experience for the student

and field instructor (Bennett & Coe, 1998; Bogo, 1981; Hopkins, Deal, & Bloom, 2005; Rosenblum & Raphael, 1983; Tully, 2015). This paper begins with a review of the literature on social capital, its role within social work field education, and how the results of the descriptive qualitative analysis can serve as considerations for training professionals in the roles of faculty field liaison.

### **Social Capital in Social Work**

Social capital represents interconnected concepts (human, physical) that are highly relevant to social work practice and can be usefully applied to the educational process within field experiences (Ersing & Loeffler, 2008). Social workers use social capital in their work with the various populations they serve and in the situations that they encounter during their work. They can use and identify linking, bridging, and bonding opportunities for their clients (Hawkins & Maurer, 2011; Mathbor, 2007). In practice, an individual's social network is considered as an aspect of intervention planning (Scandrett, Joyce, & Emanuel, 2014). Social capital is a practice tool that links individuals with needed resources (Hawkins & Maurer, 2011) and can be used to match the needs of various populations with community resources (Peeters, 2012). Social workers can use network analyses to understand how individuals connect with others (Gaddis, 2012). Social capital has been researched in relation to social work practice (Fairtlough, Bernard, Fletcher, & Ahmet, 2014; Laser & Leibowitz, 2009; Miller, McAuliffe, Riaz, & Deuchar, 2015), but more research needs to be conducted with social capital in relation to social work field education.

Faculty new to the role of the faculty field liaison can struggle to understand the role's complexities. This struggle can exist because of myriad ways in which the role of

the field faculty liaison position is staffed: adjunct, contractual, doctoral students, new PhDs, and non-tenure track social work faculty. The literature is especially sparse when it comes to empirical studies on the effectiveness of social work faculty (part-time, tenure track, adjunct, consultant, or tenured) in the role of faculty field liaison (Bennett & Coe, 1998; Lager & Robbins, 2004; Miller et al., 2005; Power & Bogo, 2002; Rosenblum & Raphael, 1983). And the literature remains minimal on how faculty members feel about field education given workload issues (McMurty & McClellan, 1995; 1997; Raskin, Wayne, & Bogo, 2008). Thus, building an effective and integrative team of social work educators becomes a complex issue.

Social capital research has been conducted in social work education, practice, and field education (Ersing & Loeffler, 2008; Hawkins & Maurer, 2010, 2011), yet the literature on social capital in relation to social work field experiences is minimal. More research is needed on the relationship-centered practices in field education given that field settings often promote interprofessional learning, while the roles of the field team members (student, field instructor, faculty field liaison) foster the processes of interprofessional learning. It is important to understand the nature of field education programs, which build on relationship-centered practices as being connected to the process of interprofessional learning (Karim et al., 2014).

### **Field Education**

The field experience is meant to be a developmental process with incremental progressive steps from classroom learner-to-professional (Davys & Beddoe, 2000, 2009) and is in many ways task-centered (Caspi & Reed, 1998). Often, the success of the field experience is based on the relationship between the student and the field instructor

(Fortune, Lee, & Cavazos, 2005; Fortune, McCarthy, & Abramson, 2001; Knight, 1996; 2001). However, key to the success of knowledge transmission is the role of the faculty field liaison (Strom, 1991). Ideally, the faculty field liaison supports the field instructor's personal (Bogo, 1992) and professional development (Peleg-Oren, MacGowan, & Even-Zahav, 2007). Tantamount to the role of faculty field liaison is the ability to synthesize the multifaceted role of supervisor and educator of a student (Bennett & Coe, 1998), while supporting the learning process of the student (Chiu, 2010; Hannae & Koeske, 2010).

### **Social Capital as the Development of Human and Physical Capital**

Given that social capital is discussed in multiple disciplines (Adler & Kwon, 2002; Beugelsdijk & Smulders, 2003), it does not have one recognized definition. Social capital is about the relationships that individuals have, and “the quality and quantity of social relations” of an individual or group (Harpham, Grant, & Thomas, 2002, p. 106). Social capital is a connection among individuals, and it is based upon trust, common norms, and reciprocity. Networks form out of these interactions among individuals, and they could be conceived as resources (Adler & Kwon, 2002; Dakhli & De Clercq, 2004; Ersing & Loeffler, 2008; Luthans, Luthans, & Luthans, 2004; Peeters, 2012; Rothstein & Stolle, 2008; Rojas, Shah, Friedland, 2011; Torche & Valenzuela, 2011). Social capital is not only about whom you know, but it is also about the collaboration among individuals to produce goods, services, skills, knowledge, and ideas that benefit individuals and groups (Luthans et al., 2004; Putnam, 2000). Social capital connects individuals together through honesty, trust, and reciprocity; essentially, it becomes a model for relationship-centered engagement.

## **Physical Capital**

Social capital is the merging of physical capital with human capital. Physical capital is the physical items that a person has, for example, a computer, assets, resources, tools, and/or instructions (Woolcock, 1998). Physical capital allows for an individual to grow and adapt throughout their lifetime (Coleman, 1988). Physical and human capital can be cultivated through the experiences the individual has in life. For example, social workers may work with a consumer to develop resources to enhance their activities of daily living when faced with a medical situation that limits their mobility in the home.

## **Human Capital**

Human capital is the intangible tools that cultivate a person's experience in life, for example education, training, knowledge, and abilities (Dakhli & De Clercq, 2004, Luthans et al., 2004; Mathur, 1999; Woolcock, 1998). Human capital is multidimensional and has three facets. First, individuals need to have "early ability" that can be cultivated (Blundell, Dearden, Menghir, & Sianesi, 1999, p. 2.) Second, individuals will gain information and abilities through various life experiences. Third, individuals will learn new information from job training (Blundell et al., 1999). Human capital impacts an individual's physical capital, and human capital can increase an individual's physical capital (Mathur, 1999).

### *Strong and Weak Ties*

Strong ties and weak ties among network members are a way for social capital to form. Strong ties are connections to individuals that are in a person's life on a daily basis, and these individuals usually include family and friends. Weak ties are connections that are acquaintances that are made through various means. Weak ties often

provide individuals with the most opportunities in life, and these opportunities could benefit individuals professionally, academically, or through social networking (Putnam, 2000). Social ties allow for information to be distributed among individuals (Rojas et al., 2011), promote different types of interactions known as linking, bridging, and bonding.

### *Linking*

Linking as its own concept in social capital has only recently been viewed as independent as historically it has been used as a means to apply social capital theory (Hess, 2015; Szreter & Woolcock, 2004). As such, linking is viewed as norms of both respect and interactions across multiple systems (Eriksson, 2011; Poortinga, 2012). Thus, linking is as much a manner of approach as well as the style of engagement (Allan & Catts, 2014; Putland, Baum, Ziersch, Arthurson, & Pomagalska, 2013). Linking is then an interconnected process that supports bridging and bonding (Enfield & Nathaniel, 2013; Moody & Paxton, 2009).

### *Bridging and Bonding*

Bridging and bonding are necessary for social capital and networks to form among individuals. Bridging and bonding among individuals allows for trust and reciprocity to form among individuals and for information to be shared. Bonding allows reciprocity and trust to form among members of the organization, and it allows for a support network to form among members (Beugelsijk & Smukders, 2003; Harpham et al., 2002; Larson et al., 2004; Peeters, 2012; Putnam, 2000). Bonding is necessary throughout an individual's life. Bonding allows an individual's network to help in daily situations through trust and reciprocity (Coffé & Geys, 2006). Bonding also allows for bridging to occur. Bridging social capital allows for information and assets to be

distributed (Beugelsijk & Smukders, 2003; Putnam, 2000). Bridging connects one group with another. Information, trust, and assistance can be exchanged between groups (Larson et al., 2004). Bridging allows individuals to gain better opportunities in life (Coffé & Geys, 2006). Bridging and bonding allow for information to be distributed among individuals, and individuals are able to form networks with others.

### **Methods of Current Study**

Given the unknown processes connected to the view of faculty field liaisons by students and field instructors as informed consumers, this study lent itself to descriptive methods (Bryant & Charmaz, 2007; Sandelowski, 2000, 2006; Strauss, 1987). A descriptive qualitative study was conducted using comparative content analysis (Bleicher, 1980; Denzin & Lincoln, 2011; Grondin, 1995; Hekman, 1986; Mason, 1996; Willis, 2001). This methodological approach was chosen to facilitate an understanding of the experiences that shape the meaning of the role of the faculty field liaison for participants (Denzin, 1989). The intent of this study was to remain steeped in the original data and the substantive area, while using the framework of social capital as a result of data immersion as a useful approach to conceptualizing the role and value of faculty field liaisons (Bryant & Charmaz, 2007; Corbin & Strauss, 2008; Glaser & Strauss, 1967; Oktay, 2012; Strauss & Corbin, 1990, 1998).

The aims of this qualitative research study were to explore the needs of those involved in a graduate-level social work field education program and how the role of the faculty field liaison is perceived by graduate-level social work students and their designated professional social work supervisors—more commonly known as their field instructors. The primary research question guiding this study was, “How is the role of

the faculty field liaison perceived by its consumers—social work students and social work professionals?” These findings can be used to inform the staffing and training of field education programs. In that, faculty with expertise and aptitude in the role may be employed more regularly versus a forced requirement of service in the role. A better understanding of these critical learning relationships may pave the way for introducing interprofessional principles as called for by EPAS 15 through the use of role of the faculty field liaison and the expertise of the assigned faculty.

### **Recruitment and Data Collection**

The data was collected from participants in a graduate-level field program of a small regional urban commuter-based campus in the Midwest. A selective sampling strategy (Padgett, 2008) was employed whereby data were collected annually over a five-year period. The data consisted of narrative comments to several open-ended questions: 1) what could the school have done better in relation to the field program? 2) what could the faculty field liaison have done better? What were the most helpful attributes of the faculty field liaison? and 3) what were the least helpful attributes of the faculty field liaison? The data were collected as part of a larger evaluation project. For purposes of this study, only the narrative data was reviewed. No demographic information was collected at the initial point of evaluation.

Each student was assigned to a social work professional as a field instructor. The data collected at the termination of each field experience from both the social work students ( $N=243$ ) and their assigned field instructors ( $N=163$ ). This study was approved by the university’s Institutional Review Board (IRB). Narrative responses as data are acceptable within a qualitative study (Charmaz, 2014).



## **Study Design**

This work is a descriptive qualitative study for the purposes of utilization-focused evaluation (Sandelowski, 2000, 2006; Mark, 1996). Utilization-focused evaluation targets specific intended users and for specific intended uses. Utilization-focused evaluation is a responsive approach to research that promotes the interactive process between the evaluator, users, and uses of the material (Denzin & Lincoln, 2011; Guba & Lincoln, 1989; Patton, 2008), while encouraging practical methodological choices (Charmaz, 2014; Creswell & Clark, 2011). This methodological approach was chosen to facilitate an understanding of the socially complex experiences, an inductive process, of graduate-level social work students and their field instructors (Padgett, 2008).

Survey responses were reviewed using an iterative process identified by Barritt, Beekman, Bleeker, and Mulderij (1984) where narrative remarks were read, important elements were identified, tentative themes emerged, themes were tested, and narrative statements were compared against themes to ensure credibility. The literature was explored in relation to the emergent themes. Documentation of the process included memo writing, notations, and iterative reviews of previous notes, which ensured the analysis and interpretations remained cyclical (Bryant & Charmaz, 2007).

Categorization and interpretation of the narrative data was informed from an ontological perspective in that it was assumed that the answers given were reflective of the real life experiences of the students/field instructors as expressed in their words with contextualized meaning. In addition, researchers viewed themselves as participants in the dialogic aspect of this project based on their own personal and professional experiences within field education programming (Strauss, 1987). Their informed perspective

contributed to a richer and deeper understanding of the emergent themes and overall theory (Walsham, 1995). An additional analysis was conducted using the framework of social capital to conceptualize the role and value of faculty field liaisons. The answers to these questions offer insight into the needs of the consumers of the field experience.

## **Results**

This descriptive study highlights what is needed or valued by field instructors and students to ensure a successful social work field program, focusing on the role of the faculty field liaison. This section reviews the themes by question and offers explanations of the emergent themes. These themes were defined by the researchers, but are anchored from the respondent's statements. Further, the three types of social capital (linking, bonding, and bridging) were used as a framework for categorizing participants' responses.

### **Helpful Attributes of the Faculty Field Liaison**

Three initial themes developed in relation to helpful attributes of faculty field liaisons: investment, communication, and knowledge. Investment is defined as the style of engagement and interpersonal approach. Investment in the students and their learning processes demonstrates relationship-centered instruction. Communication is defined as words and actions that send messages. Communication between the student and field instructor facilitates shared vision. Knowledge is defined as expertise in content, practice, and field expectations. Knowledge transference allows for the professional development and mutual understanding of the learning process. Table 13 highlights the helpful attributes of field liaisons within a social capital framework.

*Table 13: Helpful Attributes of the Faculty Field Liaisons*

	<b>Linking</b>	<b>Bonding</b>	<b>Bridging</b>
<b>Investment</b>	<ul style="list-style-type: none"> <li>• “professional, prepared, and personable”</li> <li>• “well prepared and available”</li> </ul>	<ul style="list-style-type: none"> <li>• “very good at processing experiences”</li> <li>• “genuine concern; very supportive”</li> <li>• “very positive and healthy relationship with the student”</li> <li>• “dedication to the program; felt she was in my corner”</li> </ul>	<ul style="list-style-type: none"> <li>• “genuine interest in both of our needs, encouraging, and supportive”</li> <li>• “good sensitivity to the needs of student and myself across the semester”</li> </ul>
<b>Communication</b>	<ul style="list-style-type: none"> <li>• “prompt and efficient”</li> <li>• “explained what she needed from us; held discussion about expectations”</li> <li>• “informative”</li> <li>• “responsive”</li> </ul>	<ul style="list-style-type: none"> <li>• “willingness to listen”</li> <li>• “let students discuss their concerns”</li> <li>• “willing to listen to questions and concerns; shared strategies for success”</li> </ul>	<ul style="list-style-type: none"> <li>• “available to talk”</li> <li>• “ran interference with challenging student”</li> <li>• “readily available to discuss ideas and issues, needs, and concerns”</li> </ul>
<b>Knowledge</b>	<ul style="list-style-type: none"> <li>• “experienced social worker”</li> <li>• “good mediation techniques”</li> <li>• “informative; had relevant clinical experience”</li> <li>• “resourceful with materials”</li> </ul>	<ul style="list-style-type: none"> <li>• “was experienced social worker and field instructor; helped me see my strengths and weaknesses”</li> <li>• “allowed members of cohort to share experiences and facilitated brainstorming”</li> </ul>	<ul style="list-style-type: none"> <li>• “facilitated my education”</li> <li>• “offered problem solving”</li> <li>• “resourceful to maximize our experience”</li> </ul>

### **Least Helpful Attributes of the Faculty Field Liaison**

Two themes emerged the responses from responses by students and field instructors in relation to the least helpful attributes of faculty field liaisons: unexpected change and interpersonal style. Table 14 provides an overview of the least helpful attributes of faculty field liaisons. These findings suggested missed opportunities for linking, bonding, and bridging. Unexpected change is best defined by participants as things that are not done and that needed to be done. Interpersonal style is defined as the style of engagement, temperament, and associated dynamics. The interpersonal style of the faculty field liaison is an essential component in the field process-as-education.

*Table 14: Least Helpful Attributes of Faculty Field Liaisons*

	<b>Linking</b>	<b>Bonding</b>	<b>Bridging</b>
<b>Unexpected Changes</b>	<ul style="list-style-type: none"> <li>• “not much advanced preparation”</li> <li>• “cancelled class without notice”</li> <li>• “very structured presentation style”</li> </ul>	<ul style="list-style-type: none"> <li>• “book assignments not important; not held to readings”</li> <li>• “too formal for setting”</li> <li>• “limited number of check-ups on student; no communication”</li> </ul>	<ul style="list-style-type: none"> <li>• “changes to forms were confusing”</li> <li>• “never rescheduled cancelled visits; played excessive phone tag”</li> </ul>
<b>Interpersonal Style</b>	<ul style="list-style-type: none"> <li>• “no feedback on learning plan, homework, or evaluations”</li> <li>• “poor facilitation of seminar—often dragged on”</li> <li>• “very neutral when talking”</li> </ul>	<ul style="list-style-type: none"> <li>• “off the wall statements”</li> <li>• “laughed inappropriately”</li> <li>• “too controlling; not in touch with student’s needs”</li> <li>• “negative toward schedule”</li> <li>• “wasn’t sure if she understood where I was coming from”</li> <li>• “no one ever reached out”</li> </ul>	<ul style="list-style-type: none"> <li>• “site visits focused on liaison”</li> <li>• “not in touch with student’s needs”</li> <li>• “no evidence of a liaison relationship in support of this placement”</li> </ul>

**Faculty Field Liaison “Could Have Been Done Better”**

The four themes that were identified from the students and field instructors in relation to what could have been done better were: course preparation, seminar facilitation, follow-up, and site visits. These themes were categorized in the following ways: 1) course preparation includes design and materials; 2) seminar facilitation is class style, attention, and process; 3) follow-up is the level of engagement across the field experience; and 4) site visits as opportunities to check-on both social work students and field instructors. Table 15 provides participants’ suggestions of what the faculty field liaison could have done better.

Course preparation exists as a launching opportunity where the entire field experience can be anchored in the expectations of the experience. Seminar facilitation supports expression, discussion, and learning from, with, and between the students and the faculty field liaison. Follow-up between students, field instructors, and faculty field

liaisons creates a climate of mutual reciprocity and sets the tone for the professional learning experience. Visits to the field site allow for an exchange of information, support rapport building, and reciprocal exchange of key information across all parties.

*Table 15: Faculty Field Liaison Could Have Done Better*

	<b>Linking</b>	<b>Bonding</b>	<b>Bridging</b>
<b>Course preparation</b>	<ul style="list-style-type: none"> <li>• “an introduction as beginning; orientation at start of the semester would have been helpful”</li> <li>• “improve communication on learning plans and tools”</li> <li>• “make all forms match with due dates and instructions; make everything available via internet”</li> </ul>	<ul style="list-style-type: none"> <li>• “demonstrate you are available, be positive, and encouraging, and act as if you support us”</li> <li>• “expectations were unclear at times”</li> <li>• “called early and introduce yourself”</li> </ul>	<ul style="list-style-type: none"> <li>• “should have asked about me, had much to tell but struggled with feeling like a rat”</li> <li>• “expectations were unclear at times”</li> </ul>
<b>Seminar facilitation</b>	<ul style="list-style-type: none"> <li>• “facilitate discussion versus dictate homework”</li> <li>• “be punctual”</li> <li>• “set guidelines”</li> <li>• “offer updates across the semester on our overall progress”</li> </ul>	<ul style="list-style-type: none"> <li>• “allows groups to establish rapport within seminar”</li> <li>• “brainstorm with us”</li> <li>• “treat students as adults deserving of respect”</li> </ul>	<ul style="list-style-type: none"> <li>• “discuss how we meet objectives within the practicum”</li> <li>• “speak to all parties together; send universal messages”</li> </ul>
<b>Follow-up</b>	<ul style="list-style-type: none"> <li>• “phone call at end semester to wrap things up:”</li> <li>• “meet independently with FI”</li> <li>• “take more initiative to communicate”</li> </ul>	<ul style="list-style-type: none"> <li>• “contact me more often about my progress”</li> <li>• “occasional phone call to remind me of what I could be doing to make best experience for student”</li> <li>• “communicate with me directly versus using students as messengers”</li> </ul>	<ul style="list-style-type: none"> <li>• “more face-to-face contact”</li> <li>• “more contact, early contact, and be consistent with follow-up on follow-through”</li> </ul>
<b>Site visits</b>	<ul style="list-style-type: none"> <li>• “needed an initial and final visit”</li> <li>• “needed additional visits”</li> <li>• “prepare yourself for the setting and environment”</li> </ul>	<ul style="list-style-type: none"> <li>• “offer guidance, ask questions, show interest, and stay more than five minutes”</li> <li>• “prepare yourself for the setting and environment”</li> </ul>	<ul style="list-style-type: none"> <li>• “get informed about agency before you come for the site visit”</li> </ul>

### **School “Could Have Done Better”**

One of the most interesting questions centered on what the school of social work could have done better to prepare social work students for their field experiences. The three themes that were identified from the students and field instructors include:

knowledge, curriculum, and development. Knowledge is gained from theory and practice and was seen by participants as practice skills. Curriculum is viewed as the content taught in the program. Development allows for students to become better prepared for the field. Table 16 presents the participants' suggestions.

Field instructors impact the knowledge that students receive to prepare them for the field of social work. Requests by field instructors become suggestions for field education programs as they encapsulate opportunities for teaching and learning to be implemented in advance of the student entering their field experience. Field instructors can influence the curriculum that students are required to take in the program by making suggestions to the faculty and through service on a program's advisory board. These statements provide suggestions for course content as well as suggestions for field seminar discussions. Field instructors can also influence the professional development of the students. Social work faculty need to incorporate these suggestions into the role of the faculty field liaisons.

*Table 16: Faculty Field Liaison Could Have Done Better*

<b>Linking as Development</b>	<b>Bonding as Knowledge</b>	<b>Bridging as Curriculum</b>
<ul style="list-style-type: none"> <li>• “students need to be professionally prepared with time and stress management”</li> <li>• “accept constructive criticism”</li> <li>• “students need to know how to develop professional relationships, communicate assertively, to problem-solve, and to mediate”</li> <li>• “develop understanding of responsibility, accountability, and self-reflection for self-correction”</li> <li>• “students need to read books on topic and setting they are interested in beforehand”</li> <li>• “understand work ethic; assess dedication to learning process”</li> <li>• “need to have high degree of awareness”</li> </ul>	<ul style="list-style-type: none"> <li>• “more active and engaged conversation between school and agencies”</li> <li>• “stress real life experiences”</li> <li>• “create opportunities to develop professional skill set earlier than practicum”</li> <li>• “educate students on the nature and culture of social service agencies”</li> <li>• “excess attention to detail is the norm”</li> <li>• “educate on the important of documentation”</li> <li>• “closer scrutiny of students and their history to determine suitability for this field”</li> </ul>	<ul style="list-style-type: none"> <li>• “more opportunities for counseling skills practice”</li> <li>• “more and earlier clinical classes”</li> <li>• “more exposure with DSM and assessment”</li> <li>• “increase group work, skills, and content knowledge”</li> <li>• “strengthen clinical component of program”</li> <li>• “need knowledge of juvenile justice and child welfare systems and practices”</li> <li>• “increase addictions classes, not just substance but behaviors”</li> <li>• “add group skills earlier in program not last class”</li> </ul>

## Suggestions for the Field Education Program

In response to asking for suggestions to improve the field education program, three themes that were identified from the students and field instructors include: training, tools, and professional development. Training is seen as pre- and post-preparatory efforts or orientations. Training facilitates an understanding of the process and tasks connected to the education and supervision process of learners. Tools are a part of field education programs and generate physical capital for field instructors. Multiple tools (i.e., learning plans, evaluations) are required for field instructors to facilitate field experiences, and they need to be able to navigate the various tools with ease throughout the field experience. Professional development is seen as engagement across the field experience, contact, trainings and supports. Professional development occurs for field instructors. Table 17 showcases the suggestions by participants for improving the field education program.

*Table 17: Results from the Perspective of the FI*

<b>Linking as Tools</b>	<b>Bonding as Professional Development</b>	<b>Bridging as Training</b>
<ul style="list-style-type: none"> <li>• “need a tool that is easy and simple to complete”</li> <li>• “all forms available electronically; allow for forms to be done online”</li> <li>• “make forms shorter, concise, and less repetitive”</li> <li>• “streamline what you need from us”</li> <li>• “provide samples of tools”</li> <li>• “offer more information on students and place in program”</li> </ul>	<ul style="list-style-type: none"> <li>• “offer me feedback; help me be a better supervisor”</li> <li>• “have more and ongoing interaction with the agency and staff”</li> <li>• “suggest literature; create support group for field instructors”</li> <li>• “make the time and opportunity for us to get to know each other”</li> <li>• “offer suggestions for handling different types of situations”</li> <li>• “meet with both me and the student; model team building”</li> <li>• “need better understanding of theory and curriculum covered in program; what theory we need to be teaching as well”</li> </ul>	<ul style="list-style-type: none"> <li>• “explain the student’s handbook to field people; offer trainings on paperwork”</li> <li>• “hold trainings across the semester, vary topics, and have make-up sessions”</li> <li>• “do a training on what is expected in field instruction”</li> <li>• “more articles, create networking opportunities for field instructors”</li> <li>• “summarize student learning in orientation; consider break-out sessions in orientation”</li> </ul>

## **Discussion**

The results of the narrative analysis highlight the importance of relationship-centered practices facilitated by the faculty of social work field education programs. As supported by past literature, these findings provide an opportunity for field education programs to reflect on the training and staffing of field courses. The tenets of social capital theory can be applied to field education programs. Findings suggest that additional relationship-building between the faculty field liaison, students, and field instructors is needed. Findings also suggest that faculty field liaisons need to be selected for the role based on their potential to meet the pragmatic nature of field (grading, evaluations and instructions), while also addressing the interpersonal professional development of all field parties.

An overarching theme emerged in the data with regard to the role that faculty field liaisons play; that is, they act as “bridge builders” from the academic instruction and classroom learning activities to the experiential learning process that occurs for further professional development. Faculty field liaisons have a unique opportunity to support the learning needs of students in terms of socialization to the profession, facilitation of academic learning to real-world practice environments, and acculturation to the nature of effective supervision. In addition, faculty field liaisons support the learning needs of field instructors by providing information and assistance in developing competency as an instructor and as a supervisor. Furthermore, faculty field liaisons bridge the discussion of field experiences of field instructors when they were students, with the aspirations for the field experiences they are now able to create for their own students.



The use of a metaphor can be helpful in understanding the meaning made from the data (Sandelowski, 1998). A famous poem, *The Bridge Builder*, written by Will Allen Dromgoole in the late 1900s, best explains the generative intent behind the role of the faculty field liaison:

An old man, going a lone highway, came at the evening cold and gray  
to a chasm vast and deep and wide, through which was flowing a swollen  
tide. The old man crossed in the twilight dim; the rapids held no fears for  
him. But he turned when safe on the other side. And built a bridge to span  
the tide.

‘Old man,’ cried a fellow pilgrim near, ‘You’re wasting your time in  
building here. Your journey will end with the closing day; you never  
again will pass this way. You have crossed the chasm deep and wide; why  
build you this bridge at even-tide?’

The builder lifted his old gray head. ‘Good friend, in the path I have  
come,’ he said, ‘There follows after me today. A youth whose feet must  
pass this way. This stream, which has been as naught to me, to that fair  
youth may a pitfall, be. He too must cross in the twilight dim —Good  
friend, I am building this bridge for him.’ (Doud, 1900, p. 86)

In reflection on the themes, an overarching ideal emerged as faculty field liaisons being “bridge builders” of the field experience. Thus, it affords field education programs an opportunity to reflect on the *attention* given to faculty members in role of faculty field liaisons as well as an opportunity to assess the *intention* of the field program within the goals of field education.

As such, it becomes important for faculty field liaisons to realize they build reciprocal connections from the student in the classroom to the practitioner in the field, but also extend back from the practitioner to the social work program itself. The bridge allows both locations to become accessible and travel is possible to and from—the classroom to the field and the field back to the classroom. In many ways, the bridge itself can serve as a support (a safe, well-constructed foundation that facilitates an undertaking)

for the educational journey of both students and field instructors. The researchers discerned from the analysis that both students and field instructors were seeking support and direction within their new roles and in their professional travels as learning. The bridge being built in field education also supports the transmission of knowledge. Bridges create connections; in an academic setting these can be connections between schools of thought and application of information.

As a more in depth understanding of the role of the faculty field liaison emerged, the researchers returned to the literature. The theory of social capital as a useful paradigm for reflexive field program evaluation emerged. This work illustrated the characteristics of liaisons that are beneficial to a student's success in their field experiences, and how these characteristics allow the opportunity for physical, human, and social capital to develop. Field liaisons not only construct the bridge between the social work program, the student, the agency personnel, and placement itself. They also serve as the bridge. Training opportunities need to be in place for the faculty field liaison in order to develop each theoretical component: physical, human, and social capital for the betterment of all parties involved in field programs.

### **Limitations**

There were several limitations to this research project. First, basic demographic information about the students, their field instructors, and their respective sites were not available for this analysis. Demographic information was not necessary with this qualitative design. In future studies, viewing the responses from through different demographic classifications might have generated additional meaning. For example, comparing the narrative statements by the type of site, concentration of the student,

and/or the length of experience of the field instructor in hosting social work students might yield additional considerations for field education programs, their design, and their continuing education requirements for field instructors. Second, the information was gathered over a five-year period, and the actual year was not indicated in the student or field instructor responses per survey. The year could have given context to what was occurring at that point in time, for the academic program, in the context of the field program, within the dynamics of a field site, and the participation of field instructors. Third, the number of responses from each open-ended question varied from each question. Some questions provided the researchers with an ample amount of responses to determine commonalities and differences, while other questions provided limited responses and proved more challenging. Fourth, the research project was limited by the nature of the survey distribution given that follow-up questions could not be posed to seek additional information. However, using interviews or focus groups would have meant being able to only interact with a limited number of participants due to the time involved. More research needs to be conducted to see if the themes remain over time. This analysis may provide a useful foundation for future research on the vital role of faculty field liaisons to their field programs, as a resource for community-university engagement, for students, and for social work professionals.

Nonetheless, the amount of data collected was ample and rich in terms of sample size and the depth of the narrative comments. Second, the researchers spent ample time in discussion of the findings, review of the literature, reflection on emerging themes, and further debate of the theoretical connections emerging from the analysis—the constructs of social capital. Third, the literature review supported the analysis, results, and

discussion of the project. The findings were congruent with the literature in that the premise of the field education programs is to prepare and develop social work students for a professional identity through bridging classroom-based knowledge with real-world application and through creating a mutually reciprocal professional relationship with a professional social worker in their area of interest. And lastly, this research project suggests investment in the role of the faculty field liaison as a crucial piece in the “signature pedagogy,” which is highly relevant for academic institutions, professionals, and/or academic faculty interested in the role, the practicum sites which partner with schools of social work, and the students as consumers.

### **Implications for Field Programs**

Faculty field liaisons function as the bridge between academe and its requirements with the practicum sites, field instructors, and the students in their field experience. In essence, their role bridges and fosters bonds as relationships, expectations, and the shared vision—the education of new social work professionals. As a result, faculty field liaisons need training, support, and assistance to ensure the bridge built is strong, sturdy, and ready to be crossed by the next generation of social workers. In addition, how faculty members perceive the role of a faculty field liaison becomes a highly relevant staffing issue. Faculty field liaisons must ensure that schools of social work graduate ready-to-practice professionals. In addition, faculty field liaisons must provide students the availability, support, and assistance they need to be successful in their field experience. Lastly, faculty field liaisons must develop and sustain opportunities for social work students to process their learning.

Faculty field liaisons need to understand the inherent value of their role in terms of bridging in the following ways: 1) the curriculum from the academic program into the practice community as a method of critical thinking and reflection (Razack, 2001; Wayne, Bogo, & Raskin, 2010); 2) the professional process of supervision as that of field instruction (Gelman, 2004; Gillis & Lewis, 2004; Peleg-Oren et al., 2007; Wilks, 2008); 3) the nature of professional development through mindful gatekeeping of the profession (Miller & Loerin, 2001); 4) the impact of field/academics on students (Kiser, 2008; Seipp, 1991; Ting, Morris, McFeaters, & Eustic, 2006), and 5) how to talk about the varied types of field experiences professionally (Loerin & Miller, 1995; Regehr, Stalker, Jacobs, & Pelch, 2001; Sherer & Peleg-Oren, 2005) as equally as within a seminar course as “accountable talk” (Garthwait, 2008; Shulman, 2005a, 2005b). Thus, the implications from this study, the findings, and the literature on field education support one another in directing future research concerning the role of the faculty field liaison.

### **Conclusions**

These findings support informed decisions about how field programs are managed and staffed. It is suggested that the faculty-as-professionals who take on the role and responsibilities of the faculty field liaison need: 1) a willingness to foster ongoing community-university engagement with practicum sites and their designated field instructors (bridging); 2) the ability to develop a working alliance with the students engaged in their field experience with mindful attention to the rigors of the practicum process as equally as the student’s professional development (bridging and bonding), and 3) the depth and breadth of their training for this unique role (bridging).

Schools of social work need to reflect on their own degree of preparation, orientation, and training of their faculty for this role—are the faculty field liaisons interpersonally amenable to all that the role requires? The knowledge of the various field education protocols can be helpful for a faculty field liaison as equally as well as having an understanding of the relationship-centered expectations of all the participants. Lastly, there is an increased focus on the mastery of core competencies and practice behaviors by social work students. As EPAS 2015 is implemented (CSWE, 2015), faculty field liaisons will have an increasingly more active role in the assessment and evaluation processes of field education. The key component to whether students and field instructors value their participation in field was the perceived value of their relationship with the faculty field liaison. It is these relationship-centered requests that become fruitful considerations for staffing and training in field education programs.

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## **Chapter 5. Conclusions**

In review, the introduction explored IPE as an emerging pedagogy, the purpose and goals of IPE were discussed, and the premise of scaffolding paradigms for IPE program design was introduced. Several inter-related paradigms were explored: IPE, IPCP, community engagement, and social work field education. Three chapters of the dissertation were presented as manuscripts.

Each manuscript highlights key considerations of IPE program design as implications for social work education. Thus, the intent of the completed dissertation is to create an organized body of knowledge, which showcases special considerations for social work faculty as program developers new to IPE: EPAS 2015, the importance of the role of faculty field liaisons, and the learning styles of students.

In addition, this writing offered an additional approach to viewing IPE program design--the trifecta. The trifecta in IPE program design is a critical concept for understanding the model for scaffolding paradigms. This next section will explore the scaffold model of IPE program design. Ultimately, the intent of the dissertation is to foster understanding about the value of scaffolding educational outcomes with professional gains in IPE program design.

### **Advantages of Scaffolding Paradigms**

There are a number of advantages for using a model for scaffolding IPE program design. First, there is a gap in IPE program design that matches the type of program with the domains and competencies for IPCP. To reframe the issue, the research on IPE program design has not answered the big questions: what type of IPE program design works best for what students' learning styles, with which health and social care

disciplines, in what type of setting, with what domains as organizing constructs, and with what competencies as outcomes to be assessed. A scaffolding paradigms model answers these questions and supports IPE program design decisions.

Second, there is a gap in IPE program design that targets inclusivity amongst all available health and social care disciplines. As such, there are several disciplines that are frequently invited to participate in IPE programs (Graybeal, Long, Scalise-Smith, & Zeibig, 2010), but those are not the same as those that crafted the competencies and domains of IPE. IPE research could expand to include a review of how various health and social care disciplines fit the movement of IPE. Thus, a framework for scaffolding paradigms would be useful for IPE program designers as a means to determine participation. Although social work students are frequently invited to participate in IPE programs, there has been little mention in the literature of how our discipline fits the emerging pedagogy of IPE and how the competencies of ICPC fit EPAS 15. Table 18 compares those disciplines invited to create the domains and competencies with those disciplines most frequently invited to participate in IPE programs.

*Table 18: Disparity in Disciplines by Invitation and Participation in IPE Programs*

<b>Invitation –by alphabetical order</b>	<b>Participation—by frequency</b>
Dental	Nursing
Medicine	Pharmacy
Nursing	Social Work
Osteopathic Medicine	Medicine
Pharmacy	Physical, Occupational, and Speech Therapy
Public Health	Public Health
	Dental

Third, there are myriad of IPE program designs employed in a wide variety of settings under a plethora of constructs. IPE program designers that employ a model for scaffolding paradigms would be able to select, explain, and assess their constructs as equally as determine the setting most in need of the type of supports an interprofessional



service learning and/or internship program can offer. Given that IPE is frequently placed in field settings, further attention must be paid to the needs of professionals within potential field settings as equally as to the learning needs of students-as-participants. In addition, the Council on Social Work Education (CSWE) states “Social workers value the importance of interprofessional teamwork and communication in interventions, recognizing that beneficial outcomes may require interdisciplinary, interprofessional, and interorganizational collaboration” (CSWE, 2015, p.8).

The design of an IPE program can scaffold a great many concepts and paradigms. Scaffolding, or systemic construction, can happen from a wide variety of perspectives—bottom-up or top down. The manner of scaffolding can impact the type of design used, disciplines selected, constructs or learning objectives, and certainly extends into educational outcomes (Brashers, Owen, Erickson, & Peterson, 2012). As such, this body of work seeks to advocate for a model for scaffolding paradigms in IPE program design that is pragmatic in approach, applicable for social work, and aids scholarship.

### **Scaffold Model of IPE Program Design**

Scaffolding paradigms present a framework for educating students-as-emerging professionals (McClam, Dianbra, Burton, Fuss, & Fudge, 2008)—the central tenet for social work education programs. This scaffolding design to IPE programming supports a more integrative, inclusive, and proactive approach where a multitude of advantages become layered for students, faculty, academic programs, health and social care professions, university partners, and communities.

## **The Model**

The trifecta exists in the relationship between service, teaching, and research as depicted in the outer layer of the model (see Figure 1). Typically, academic institutions are the leaders in IPE program designs. As such, faculty need to ensure that their efforts in IPE program design reflect the aims of the institution. Building a model anchored in these concepts ensures faculty are able to connect their IPE program work to the requirements for promotion and tenure.

A second trifecta exists within the paradigms of community engagement, IPCP, and IPE (see Figure 1). Recognizing the relationship between these paradigms fosters explicit and implicit construct selection in IPE program design. As the next layer in the scaffold model, it is built from the academic institutions' requirements of service, teaching, and researching. Yet, it allows for a myriad of opportunities for creativity, scholarship, and investment in faculty members' area of interest.

A third trifecta exists across the next level of the scaffold model. IPE programs add value through engagement and participation for students, for the university, and for communities in need (see Figure 1). Although this work previously explored the benefits of IPE programs for students and for universities, it is important to explore the benefits of developing IPE programs that provide services to vulnerable populations or communities in need.

The third level of the scaffold introduces a key concept for consideration in IPE program design—communities in need. Thus, it becomes important to explore how communities in need can be defined as well as how adding communities in need as an

essential consideration in IPE program design supports social work education, field education programs, and EPAS 2015.

### *Communities in Need*

The need for a broad and culturally relevant conceptualization of vulnerability is highlighted in the work of Ibrahim and colleagues (2003), who suggest that vulnerability to health and social care disparities is best viewed through an appreciation of the complexities of race, gender, age, income, geographic inequalities, and ethnicity (Marshall, Ruth, Sisco, Bethke, & Piper, 2011; Messinger-Rapport, 2009). Race and ethnicity frequently refer to skin color, but can also mean cultural heritage (Shi & Stevens, 2010). A need for a re-conceptualization of research on public health is advocated by Walters and Simoni (2009) with the strong additional caveat of “indigenizing the academy” (p. 71) with culturally competent and responsive researchers (Kruss, Visser, Aphane, & Haupt, 2011) and health care providers (Lyrtzopoulos et al., 2012).

IPE initiatives create a unique opportunity for knowledge to be socially constructed by its developers and participants and by extension engage those viewed as vulnerable with a strengths-based, empowering, and patient-centered practice style (Black, 2003; Davis, Gavazzi, Scheer, & Uppal, 2011). This engagement often provides a reframe of the term vulnerable populations to mean marginalized communities or communities in need. The synergistic overlap of disparities in health and social care for a given group of people is a combination of the following: a) individual or cultural experiences of disease; b) the characteristics of health care professionals, and c) the systemic nature of health care delivery to address and by extension eliminate health

disparities requires a targeted effort across all three (Hodge, Limb, & Cross, 2009; Krogstad, Hofoss, & Hjortdahl, 2002; Pullon & Fry, 2005). There is a vast amount of literature that highlights the multi-faceted and interconnected complexities of the health and social status of groups viewed as at-risk (Blankenau, Comer, Nitzke, & Stabler, 2010; Zuckerman, Haley, Roubideaux, & Lillie-Blanton, 2004).

The term “at-risk” has a typical association as meaning persons that have deficits within themselves and/or their circumstance (Sampson & Themelis, 2009). Numerous studies have been devoted to the exploration of connections between education, income, gender, and ethnicity in connection to acute illness, chronic illnesses, infant mortality, addictions, mental health, and death (Grycznski & Johnson, 2011; Lau, Lin & Flores, 2012; West, 2009). Yet, minimal attention is given to the policies and practices associated with the social determinants of health. The social determinants of health are global factors, often amenable, which impact the health of at-risk communities (Brotman, et al., 2011; Rosell, Scarborough, & Lewis, 2010; Youngstrom, Weist, & Albus, 2003).

This minimal attention can easily stem from the fact that marginalized populations are often small racial or ethnic minority groups (U. S. Commission on Civil Rights, 2004) and may be exacerbated by pervasive mistrust of program developers and researchers (Lewis & Leung, 1975). It is best asserted that

...to provide unequal care is untenable in a democratic society. For these and many other reasons, not the least of which is the economic cost to society, the elimination of disparities in health status and access to health care is now a national priority. (Ibrahim, Thomas, & Fine, 2003, p. 1619)

Encouraging enrollment of eligible individuals is one tactic to resolve disparities in health by ensuring persons have the means to pay for needed health care services (Johnson, 2012).

Yet, resources and access in and of itself will not foster compliance. The political underpinnings of colonization are often associated with marginalized communities obtaining care (Blankenau, Comer, Nitzke, & Stabler, 2010). Using health care services not delivered by known or trusted providers and by not providing health care services connected to the cultural nuances of communities and indigenous models (culturally representative) of care mistrust leads to under-utilization (Brave Heart, 2003; Jones, 2000; LeGrange, 2002; Reifel, Bayhllle, Harada, & Villa, 2009). Mistrust can be seen in a myriad of ways.

*Trust in the System.* The systematic issue of health care disparities for an entire group of people becomes entangled in bureaucratic and political processes (Chino & DeBruyn, 2006). The levels of vulnerability for populations far exceed social determinants for health, risk factors, and protective factors as contributing to an individual's health and as a public health issue (Lau, Lin, & Flores, 2012; Ogunwole, 2006). Thus, the health of an individual and of a community is affected by the nature of the system providing care.

Connections to land or geography are often equated as connections to people and to a community (Bridges, 2002; Lejano & Stokols, 2010) and frequently seen in rural health and social care practice (Toner, Ferguson, & Sokal, 2009). Loss of land enables an ecological risk factor to develop (Shi & Stevens, 2010). Often communities in need have an entrenched and conflictual history in relation to land often viewed as a place for living (Brave Heart, 2003). This struggle with land and environment then becomes a determinant of health as it is a stressor or a micro-aggression for those involved, impacts the community, and impacts the cultural identity of the community (Weaver, 2002).

Within IPE programs as well as social work field education programs, an opportunity exists to look at and engage with communities most in need of equitable, culturally competent, and patient-centered health care (George, Silver, & Preston, 2014). Health care institutions may be aware of the problems within marginalized communities, but may not be equitably trained to intervene in a style of interprofessional collaboration—across all disciplines connected to the care of the patient and with a shared model of decision making with the patient (McCubbin, McCubbin, Zhang, Kehl, & Strom, 2013; Thomas, Rosa, Forcehimes, & Donovan, 2011). Empirically-based approaches to science are often not endorsed or readily acceptable by indigenous people and/or marginalized populations (Chino & DeBruyn, 2006; Hodge, Limb, & Cross, 2009).

Systemic collaborative involvement is needed across all parties from the federal, state, and local governance to academic institutions that are training health care students-as-professionals. A vested interest must be imparted by all of the professional associations of health and social care professions to increase the health of marginalized communities as a multi-faceted public health promotion (Barker, Bosco, & Oandasan, 2005; Fiscella, et al., 2011). By using an interprofessional and interpersonal collaborative approach to health and social care practice, new protocols can be defined for gaining access to collaborative, patient-centered, health care delivery systems. Access to excellent health care means the ability for individuals as members of communities in need to have services that are readily available, affordable, conveniently located and that health and social care services must be rendered with the highest degree of cultural responsiveness (Ward, Meyer, Verity, Gill, & Luong, 2011). Interprofessional

collaborative health care practices would support cultural autonomy, while seeking to partner with indigenous communities not only in the perceptions of what health means, but in the most beneficial ways to build the capacity for health and health literacy (Leichty, 2011; Wheeler & Dodd, 2011).

*Figure 1: Model for Scaffolding Paradigms in IPE Program Design*



Ultimately, this proposed model for scaffolding paradigms in IPE design advocates for the placement of IPE programs within social work field education programs. This can be seen in Figure 1. Social work field education programs have unique advantages to IPE program developers. First, social work field education sites are

often multi-disciplinary, interdisciplinary, and interprofessional. Second, social work field education sites represent a wide range of health and social care settings. Third, field education programs are intricately connected to the evaluation of competency through the demonstration of practice behaviors. Fourth, the demonstration of practice behaviors as evidence of competency can be further developed to include the domains and competencies of IPE. Lastly, as EPAS 2015 moves towards an inclusive definition of diversity “as the intersectionality of multiple factors” and expands the parameters of advocacy to “advance human rights and social, economic, and environmental justice” the scaffolding model for IPE program design serves as a multi-faceted framework for social work educators that can support a competency-based educational approach to collaborative practice as well as social work practice (CSWE, 2015, p. 7).

### **Summary**

Thus, developing and achieving competence as a social work professional is a multi-faceted experience (Freddolino et al., 2014)—akin to the multi-faceted nature of IPE and IPCP programming. For the social work profession, its researchers, teachers, students, and professional communities, there is simply more work to be done—more collaboration to be initiated. From the numerous studies connected to IPE and IPCP, we know that more attention needs to be paid to ensuring the premise of the movement is continually addressed—safe, effective, and quality patient care (Smith & Anderson, 2008).

It stands to reason that scholarship is still developing in this area (McCulloch, Rathbone, & Catchpole, 2011; Payler, Meyer, & Humphris, 2007). Yet, it should not be assumed that minimal evidence of benefit means minimal benefit is evident (Herbert,



2005). Greater focus on research, program, and curriculum design development has become increasingly evident (Reeves, Goldman, Burton, & Sawatzy-Girling, 2010; Selmer, Jonasson, & Luring, 2013), while the need for research targeting quality of training and orientation for IPE programs remains (Anderson, et al., 2014) as well as exploring the common interprofessional dimensions involved within health and social care practice.

## Appendix: Interprofessional Collaborative Practice Competencies

### **Competency Domain 1: Values/Ethics for Interprofessional Practice**

*Work with individuals of other professions to maintain a climate of mutual respect and shared values. **Specific Values/Ethics Competencies:***

- VE1. Place the interests of patients and populations at the center of interprofessional health care delivery.
- VE2. Respect the dignity and privacy of patients while maintaining confidentiality in the delivery of team-based care.
- VE3. Embrace the cultural diversity and individual differences that characterize patients, populations, and the health care team.
- VE4. Respect the unique cultures, values, roles/responsibilities, and expertise of other health professions.
- VE5. Work in cooperation with those who receive care, those who provide care, and others who contribute to or support the delivery of prevention and health services.
- VE6. Develop a trusting relationship with patients, families, and other team members (CIHC, 2010).
- VE7. Demonstrate high standards of ethical conduct and quality of care in one's contributions to team-based care.
- VE8. Manage ethical dilemmas specific to interprofessional patient/population centered care situations.
- VE9. Act with honesty and integrity in relationships with patients, families, and other team members.
- VE10. Maintain competence in one's own profession appropriate to scope of practice.

### **Competency Domain 2: Roles/Responsibilities**

*Use the knowledge of one's own role and those of other professions to appropriately assess and address the healthcare needs of the patients and populations served. **Specific Roles/Responsibilities Competencies:***

- RR1. Communicate one's roles and responsibilities clearly to patients, families, and other professionals.
- RR2. Recognize one's limitations in skills, knowledge, and abilities.
- RR3. Engage diverse healthcare professionals who complement one's own professional expertise, as well as associated resources, to develop strategies to meet specific patient care needs.
- RR4. Explain the roles and responsibilities of other care providers and how the team works together to provide care.
- RR5. Use the full scope of knowledge, skills, and abilities of available health professionals and healthcare workers to provide care that is safe, timely, efficient, effective, and equitable.
- RR6. Communicate with team members to clarify each member's responsibility in executing components of a treatment plan or public health intervention.
- RR7. Forge interdependent relationships with other professions to improve care and advance learning.
- RR8. Engage in continuous professional and interprofessional development to enhance team performance.
- RR9. Use unique and complementary abilities of all members of the team to optimize patient care.

### **Competency Domain 3: Interprofessional Communication**

*Communicate with patients, families, communities, and other health professionals in a responsive and responsible manner that supports a team approach to the maintenance of health and the treatment of disease. **Specific Interprofessional Communication Competencies:***

- CC1. Choose effective communication tools and techniques, including information systems and communication technologies, to facilitate discussions and interactions that enhance team function.
- CC2. Organize and communicate information with patients, families, and healthcare team members in a form that is understandable, avoiding discipline-specific terminology when possible.
- CC3. Express one's knowledge and opinions to team members involved in patient care with confidence, clarity, and respect, working to ensure common understanding of information and treatment and care decisions.
- CC4. Listen actively, and encourage ideas and opinions of other team members.
- CC5. Give timely, sensitive, instructive feedback to others about their performance on the team, responding respectfully as a team member to feedback from others.
- CC6. Use respectful language appropriate for a given difficult situation, crucial conversation, or interprofessional conflict.
- CC7. Recognize how one's own uniqueness, including experience level, expertise, culture, power, and hierarchy within the healthcare team, contributes to effective communication, conflict resolution, and positive interprofessional working relationships (University of Toronto, 2008).
- CC8. Communicate consistently the importance of teamwork in patient-centered and community-focused care.

### **Competency Domain 4: Teams and Teamwork**

*Apply relationship-building values and the principles of team dynamics to perform effectively in different team roles to plan and deliver patient-/population-centered care that is safe, timely, efficient, effective, and equitable. **Specific Team and Teamwork Competencies:***

- TT1. Describe the process of team development and the roles and practices of effective teams.
- TT2. Develop consensus on the ethical principles to guide all aspects of patient care and team work.
  - TT3. Engage other health professionals—appropriate to the specific care situation—in shared patient-centered problem-solving.
  - TT4. Integrate the knowledge and experience of other professions—appropriate to the specific care situation—to inform care decisions, while respecting patient and community values and priorities/preferences for care.
  - TT5. Apply leadership practices that support collaborative practice and team effectiveness.
  - TT6. Engage self and others to constructively manage disagreements about values, roles, goals, and actions that arise among healthcare professionals and with patients and families.
  - TT7. Share accountability with other professions, patients, and communities for outcomes relevant to prevention and health care.
  - TT8. Reflect on individual and team performance for individual, as well as team, performance improvement.
  - TT9. Use process improvement strategies to increase the effectiveness of interprofessional teamwork and team-based care.
  - TT10. Use available evidence to inform effective teamwork and team-based practices.
  - TT11. Perform effectively on teams and in different team roles in a variety of settings.

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## **CURRICULUM VITAE**

Jennifer June Anderson

### **EDUCATION**

1. Bachelor of Arts (BA) in Psychology/Spanish  
1994 St. Joseph's College
2. Master of Social Work (MSW)  
1997 Southern Illinois University-Carbondale
3. Doctor of Philosophy in Social Work (PhD)  
2016 Indiana University—Purdue University Indianapolis

### **LICENSURE**

- 2015 Wisconsin Department of Safety and Professional Service  
Licensed Clinical Social Worker (LCSW)
- 1999 Indiana State Professional Licensing Agency  
Licensed Clinical Social Worker (LCSW)

### **ACADEMIC APPOINTMENTS**

*Assistant Professor* (August 2015 to present)  
University of Wisconsin at Whitewater, Whitewater, Wisconsin

*Clinical Associate Professor* (Promoted in Excellence in Service; July 1, 2014 to July 1, 2015)

*Clinical Assistant Professor* (August 1, 2007 to June 30, 2014)  
Indiana University Northwest, Gary, Indiana

### **HONORS & AWARDS**

- Nominated, GADE Student Award for Leadership and Service. (2014).
- Nominated, Region 1, Social Worker of the Year, NASW Indiana (2014).
- Nominated, Founder's Day Teaching Award. (2013).
- Region 1, Social Worker of the Year, NASW Indiana, 2010.
- Award, Team Player, Edgewater Systems for Balanced Living, (2003)
- Award, Field Instructor of the Year, Indiana University Northwest, (2003)
- Edward Panozzo Award, Student Commitment to Social Services, Saint Joseph's College, (1993)

## **PROFESSIONAL EXPERIENCE**

2007 to 2014

Anderson & Associates

Clinical Social Worker

Provided a wide array of clinical and counseling services for adults in an outpatient setting; services included employee assistant programming.

2006 to 2007

CRS Rehabilitation Specialists, Munster, IN

Medical Social Worker

Provide adjustment-related counseling, social care, and supportive services to patients and their family system during the course of their outpatient rehabilitation and recovery.

2004 to 2006

Methodist Hospitals Northlake Campus, Gary, IN

Medical Social Worker

Provided the following clinical services: crisis intervention, supportive services, and discharge planning to a myriad of health care service delivery units: ER, ICU, Progressive Care Unit, Rehabilitation Unit, Hospice, and Home Health.

2000 to 2004

Edgewater Systems for Balanced Living, Gary, IN

Family & Youth Manager

Audited medical records, monitored program related budgets, and evaluated, enforced, and created policies and procedures relative to scope of practice across four social service programs. Provided clinical supervision of program staff and supervised IV-B cases as referred by Department of Child Services.

1999 to 2000

Porter-Starke Services, Valparaiso, IN

Outpatient Therapist

Served in the capacity of outpatient therapist within a community mental health center for children, adolescents, adults, and their attached family systems.

1998 to 1999

Cornerstone Program at Christian Haven, Wheatfield, IN

Therapist

Served in the capacity of therapist within a residential treatment center for children/adolescents referred by the Department of Child Services and Juvenile Probation.

1997 to 1998

Cedar's Academy Program, Valparaiso, IN

Therapist

Served in the capacity of therapist within a residential treatment center for children/adolescents referred by the Department of Child Services and Juvenile Probation.

1994 to 1997

Southern Illinois University, Carbondale, IL

Graduate Assistant

Served in the capacity of counselor/educator for university students within SIU-C's Wellness Center, which offered psycho-educational services, counseling, and educational workshops.

## **PROFESSIONAL ORGANIZATIONS**

- Council for Social Work Education, CSWE
- Society for Social Work Leadership in Health Care
- National Association of Alcohol and Drug Addiction Counselors, NAADAC
- Indiana Association for Addictions Professionals, IAAP
- National Association for Social Workers, NASW
- Lupus Foundation of America, LFA
- American Legion-Women's Auxiliary

## **ACADEMIC COURSEWORK**

### **2015**

- S312 Human Behavior and the Social Environment II, Fall  
Enrollment 13
- S372 Practice I, Fall  
Enrollment 17

### **2014**

- S696 Social Work Practice with Death, Dying, and Bereavement, Summer I  
Online/Enrollment 10

### **2013**

- S696 Social Work Practice with Death, Dying, and Bereavement, Summer II  
Online/Enrollment 8
- S693 Health Care Practice II, Spring  
\*Co-taught, Hybrid/Enrollment 7

### **2012**

- S692 Health Care Practice I, Fall  
\*Co-taught, Hybrid/Enrollment 8
- S693 Health Care Practice II, Spring  
Hybrid/Enrollment 7

### **2011**

- S692 Health Care Practice I, Summer II  
Hybrid/Enrollment 7
- S600 Social Work Practice with Death, Dying, and Bereavement, Summer I  
Hybrid/Enrollment 22
- S693 Health Care Practice II, Spring  
Hybrid/Enrollment 8
- S652 Concentration-Level Practicum, Health, Spring  
Seminar/Enrollment 5

## **2010**

- S651 Concentration-Level Practicum, Health, Fall  
Hybrid/Enrollment 5
- S618 Social Policy and Services, Summer II  
Hybrid/Enrollment 1
- S692 Health Care Practice I, Summer II, 2010  
Hybrid/Enrollment 8
- S694 Social Work Practice with Older Adults, Summer I  
Hybrid/Enrollment 16
- S693 Health Care Practice II, Spring  
Hybrid/Enrollment 5

## **2009**

- S692 Health Care Practice I, Summer II  
Enrollment 5
- S600 Social Work Practice with Death, Dying, and Bereavement, Summer I  
Enrollment 17
- S693 Health Care Practice II, Spring  
Enrollment 8

## **2008**

- S692 Health Care Practice I, Summer II  
Enrollment 8
- S632 Child Welfare Practice, Spring  
Enrollment 16

## **2006**

- S683 Community-Based Practice in Mental Health & Addictions, Summer II  
Enrollment 3
- S555 Foundation-Level Practicum, Spring  
Enrollment 15

## **2005**

- S683 Community-Based Practice in Mental Health & Addictions, Spring  
Enrollment 24

All academic courses taught have three (3) credit hours; field courses are nine (9) credit hours total.

## **PROFESSIONAL SERVICE**

- Mentor, Research Apprenticeship Program (RAP), UW-Whitewater, (2015-1016).
- Council Member, Appointed, CSWE (2015-2018)
- Planning Committee Member, NASW Region 1, (2013 to present).
- Board Member and Volunteer, Camp New Happenings, (2013-2015).
- Master Trainer, TeamSTEPPS educational programming in partnership with

Agency for Healthcare Research and Quality, AHRQ, TRICARE, and Department of Defense, (2009-2013).

- Peer Reviewer, *Journal of Social Services Research*, (2008-present).
- Committee Member, Indiana Health Care Disparities Initiatives, (2007-present).
- Faculty Advisor, Interprofessional Education Health Care Team Projects, College of Health and Human Services at Indiana University Northwest, (2007-2012).

## **COMMITTEE SERVICE**

### **University**

- LEAP Ambassador, New Applicant (2015)

### **College of Letters & Sciences**

- Public Health Minor, Member (2015-2017)

### **Social Work Department**

- Advisory Board, Member (2015-Present)
- Grade Appeals Committee, Member (2015-2017)
- Reaffirmation Organizational Committee (ROC), Member (2015-2017)

## **PREVIOUS COMMITTEE SERVICE**

- IUNW, CHHS Clinical Assistant Re-Appointment Committee (2015)
- IUSSW, Scholarship Committee (2014)
- IUSSW Search & Screen Committee—Senior Lecturer (2014)
- IUNW, Carnegie Foundation Task Force, (2013-present)
- IUSSW Search & Screen Committee—Field Coordinator, (2013)
- IUNW Student Appeals Committee, (2012-2013)
- CHHS Curriculum Committee, (2011-present)
- IUSSW, Health Curriculum Committee, (2009-present)
- CHHS Honor Code Committee, (2009)
- IUSSW Student Performance Review and Appeals Committee, SPRAC, (2008-2013)
- CHHS Clinical Rank and Promotion Guideline Development Committee, (2010)
- IUNW, Diversity Program Committee, (2010-2013)
- IUSB School of Social Work, Search & Screen Committee—Field Coordinator, (2008)
- IUNW Division of Social Work, Search & Committee—Director, (2008)
- IUNW, Wellness Committee, (2007-2010)
- IUSSW System-Wide Field Committee, (2007-present)

## **OTHER PROFESSIONAL ACTIVITIES**

### **REFEREED CONFERENCE PRESENTATIONS**

Anderson, J., Wightman, R., Donahue, R., & Zielinski, J. (2014, November). *Community Engagement: It is all about Relationships!* Presented at the 2014 Civic and Community Engagement Conference to be held at Indiana University Northwest, Gary, Indiana.

- Anderson, J. (2014, October). *Matching IPE Program Design Needs with the Learning Needs of Students*. Presented at the Annual Indiana Academy of Social Sciences conference in Anderson, Indiana.
- Anderson, J., & Clark, J. (2103, October). *Recognizing the Value of Social Capital within Social Work Field Experiences*. Presented at the Annual Indiana Academy of Social Sciences Conference held in Indianapolis, Indiana.
- Anderson, J. (2012, November). *The Future is Theirs, The Responsibility is ours: A Collaborative Model for Interprofessional Learning in Primary Care*. Paper presentation at the National Society for Social Work Leadership in Health Care conference held in Denver, Colorado.
- Anderson, J. (2011, November). *Utilization of an interprofessional education collaborative (IPEC): Partnering intraprofessional field education requirements for health care professional students with interprofessional education (IPE)*. Paper presented at the Interprofessional Educational Conference, Collaborating across Borders held in Tucson, Arizona.
- Anderson, J. (2011, June). *Linking Field Education Requirements for Health Care Professionals into a Community-Based Interprofessional Education Collaborative*. Paper presented at Interprofessional Education Faculty Development: Advancing the Future of Healthcare through Learning, University of Toronto, Ontario.
- Anderson, J., & Lynch, D. (2011, February). *Teaching field students to really work effectively across disciplines*. Paper presented at The 28<sup>th</sup> National Annual BPD Conference held in Cincinnati, Ohio.
- Rouse, S., Anderson, W. M., & Anderson, J. (2010). *Development of an interprofessional education healthcare team (HCT)*. Paper presented at Interprofessional Education: The New Foundation for Healthcare Delivery conference through the Indiana University School of Medicine, Indianapolis.
- Anderson, J. (2010, June). *Creation to construction of an interprofessional education practicum site for students in the health professions*. Paper presented at Interprofessional Education Faculty Development: Advancing the Future of Healthcare through Learning, University of Toronto, Ontario.

Anderson, W. M., Delunas, L., Rouse, S., & Anderson J. (2010, July). *Interprofessional student healthcare teams: Improving healthcare quality from the ground up*. Paper presented at Central Group of Medical Education (CGEA), Chicago.

Delunas, L., Rouse, S., Anderson, J., & Anderson, W. M. (2009, September). *Breaking down silos: Interprofessional education*. Paper presented at National League for Nurses Education Summit, Philadelphia.

Anderson, W. M., Bankston, P., Rouse, S., & Anderson, J. (2009, October). *An interprofessional student health care team*. Paper presented at International Association of Medical Science Educators: Leiden, Netherlands.

### **INVITED PRESENTATIONS**

Anderson, J. (2016, March). *Teaching About Trauma*. Workshop to be presented at the Annual NASW Region 1 Social Work Conference, which will be held in Merrillville, Indiana.

Anderson, J. (2013, October). *Reflexive Program Evaluation of Camp New Happenings*. Workshop presented at the Annual Indiana Episcopal Diocese Convention, Donaldson, Indiana.

Anderson, J. (2013, March). *Self-Care for Professionals*. Workshop presented at the 2013 Lunch-N-Learn series of NASW Region 1 in Merrillville, Indiana.

Anderson, J. (2012, May). *Interprofessional Education (IPE): The evolution of interprofessional collaborative practice (ICPC) into academe across the health care disciplines. What does this mean for social work?* Workshop presented at Annual Indiana Society for Social Work Leadership in Health Care (SSWLHC) in Indianapolis, Indiana.

Anderson, J., Behrens, S., & Olzsewski, L. (2012, April). *Fostering Interprofessional Education in the Clinical Setting*. Workshop presented at the Annual Area Health Education Center (AHEC) Program Meeting in Indianapolis, Indiana.

Anderson, J. (2011, August). *Utilization of an interprofessional education collaborative (IPEC) for interprofessional education (IPE)*. Workshop presented to Board of Directors of Northwest Indiana Area Health Educators Center (AHEC) in Crown Point, Indiana.

Anderson, J. (2011, March). *Is Our Community Safe and Healthy? An overview of the regional health of the Social Service Agencies in Northwest Indiana*. Workshop presented at Leadership Northwest Indiana (LNI), Hammond, Indiana.



Anderson, J. (2010, April). *Creating Personal Practices for Healing and Recovery*. Workshop presented at Peace in the Storm event held by the Lupus Foundation of America, Indiana Chapter, in Merrillville, Indiana.

Anderson, J., & Rouse, S. (2009, October). *Building Effective Social Service Delivery Teams*. Workshop presented at Northwest Indiana Symposium held in Merrillville, Indiana.

## **COMMUNITY AND/OR UNIVERSITY PRESENTATIONS**

Anderson, J., & Clark, J. (2013, April). *Recognizing the Value of Social Capital within Social Work Field Experiences*. Paper presentation at Public Affairs Month Symposium within the School of Public and Environmental Affairs (SPEA), Indiana University Northwest, Gary, Indiana.

Anderson, J., Crespos, L., Rogers, T., & Tamburro, A. (2012, October). *THE FEEDBACK PROJECT: Recognizing Student Contributions to University-Community Partnerships That Promote Regional Change and Sustainability in Social Service Agencies*, workshop presented as part of CSWE requirements for field instructor trainings and field program, at College of Health and Human Services, Indiana University Northwest, Gary, Indiana.

Anderson, J. Crespos, L., Rogers, T., & Tamburro, A. (2012, April). *THE FEEDBACK PROJECT: Recognizing Student Contributions to University-Community Partnerships That Promote Regional Change and Sustainability in Social Service Agencies*, presentation as part of Indiana University Northwest Undergraduate Research Conference for the College of Arts and Sciences, Gary, Indiana.

Anderson, J. (2012, April). *Essentials Training*. Workshop presented as part of the orientation for the Interprofessional Education Health Care Team for the College of Health and Human Services, Indiana University Northwest held in Gary, Indiana.

Anderson, J., & Rouse, S. (2011, August). *Essentials Training*. Workshop presented as part of the orientation for the Interprofessional Education Health Care Team for the College of Health and Human Services, Indiana University Northwest held in Gary, Indiana.

Anderson, J. (2011, January). *Essentials Training*. Workshop presented as part of the orientation for the Interprofessional Education Health Care Team for the College of Health and Human Services, Indiana University Northwest held in Gary, Indiana.

Anderson, J., & Rouse, S. (2010, January). *Essentials Training*. Workshop presented as part of the orientation for the Interprofessional Education Health Care Team for

the College of Health and Human Services, Indiana University Northwest held in Gary, Indiana.

Anderson, J., & Rouse, S. (2009, January) *Essentials Training*. Workshop presented as part of the orientation for the Interprofessional Education Health Care Team for the College of Health and Human Services, Indiana University Northwest in Gary, Indiana.

Anderson, J. (2007). *Creating a re-design while providing community outreach*. Workshop presented as part of strategic planning session for PFLAG Board meeting, Hammond, Indiana.

Anderson, J. (2005). *Inter-professional effective communication*. Workshop presented as part of program activities for Methodist Hospitals Professional Training, Gary, Indiana.

Anderson, J. (2004). *Maximizing the use of community resources*. Workshop presented as part of program activities for Methodist Hospitals Professional Training, Gary, Indiana.

Anderson, J. (2003). *Creating effective teams*. Workshop presented as part of program activities for ESBL Professional Training Series, Gary, Indiana.

## GRANTS

- Northwest Indiana Area Health Education Center, Mini-grant for Community Engagement, \$1000.00 requested and funded for 2015-2016. Proposal submitted; entitled: *Interprofessional Education as a platform for community engagement and continuing education*. Project will consist of developing a continuing education program facilitated in an interprofessional approach, delivered across the NWI region.
- Diversity Fellow, Center for Urban and Regional Excellence, Principal Investigator, 2013-2014. \$1000.00 capacity-building grant to develop an IPE infused service learning project within a community-university partnership.
- Master Online Course Development Grant Awardee, IUNW, 2013  
Recipient of \$4000.00 grant for the development of online master version of IUSSW S696 course, Social Work Practice with Death, Dying. Successful completion of Online Teaching 1: Introduction to Online Teaching and Design certificate course by CISTL.
- Faculty Research Fellow, Center for Urban and Regional Excellence, Co-Principal Investigator, 2011-2012 extended 2013-2014.  
Recipient of \$5,000.00 grant for a mixed methods research project for students-as-researchers/ This “Feedback Project” is a multi-layered research project that analyzes Social Work field practicum student Exit Interviews.

- Byron Root Foundation Grant, \$4000.00, Principal Investigator (2008, 2009). Recipient of \$4000.00 capacity building grant for the development and facilitation of an interprofessional education (IPE) service learning project that paired the learning needs of multiple health care disciplines with the needs of a university-community partner, while providing direct care to consumers in need.
- Wal-Mart Corporation Community Grant, \$1000.00, Program Coordinator (2001, 2002, 2003, 2004, 2005, 2006, 2007, 2010, and 2013) Recipient of \$1000.00 community outreach and program development grants received for a wide variety of social service events (2007), psycho-educational programs for youth (2010), and interprofessional education initiatives across IUNW (2013).
- Massage Therapy Foundation Community Service Grant, \$5000.00, Principal Investigator (2003-2004) Recipient of \$5000.00 grant to fund a service learning project in connection with a local addictions treatment program-Women's Recovery Home and Kaplan College regarding the relationship between massage therapy and recovery efforts for women struggling with addiction.
- Anderson Foundation Grant (2001, 2002, 2003) Recipient of \$2500.00 community outreach and program development grants for community-based service events and psycho-educational programs for at-risk youth through Edgewater Systems for Balanced Living.

## **REFEREED PUBLICATIONS**

- Anderson, J. (2016). Community engagement: It's all about relationships. *Journal of Community Engagement in Higher Education*. (Accepted; Spring).
- Anderson, J., & Adamek, M. (2015). EPAS 2015: Implications for interprofessional education in social work. Submitted and under review, *Advances in Social Work*. (In Review).
- Rouse, S., Delunas, L., Anderson, M., & Anderson, J. (2010). Interprofessional education: Development of an interdisciplinary health care team project at a Midwestern U. S. university. *Journal of the International Association of Medical Science Educators*, 20(2), 76-78.

## **NON-REFEREED PUBLICATIONS**

- Anderson, J. (2014). Community Engagement: It is all about Relationships! *EPHIC, University of Toronto Center for Interprofessional Education Newsletter*, 4.
- Anderson, J. (2013). New Acronyms=Greater Opportunities for Social Workers in Health Care Settings. *The New Social Worker*, 20, 1, 20-22.

Anderson, J. (2013). Applying the principles of IPE and IPCP into a summer camp experience. *EPHIC, University of Toronto Center for Interprofessional Education Newsletter*, 2.

Anderson, J. (2013). Embracing the potential of IPE: Creating a community of practice for the university and the region. *EPHIC, University of Toronto Center for Interprofessional Education Newsletter*, 1.

Anderson, J. (2012). The Future is theirs, The responsibility is ours: A collaborative model for interprofessional learning in primary care. *EPHIC, University of Toronto Center for Interprofessional Education Newsletter*, 4.

### **PUBLICATIONS IN PROCESS**

Anderson, J., & Adamek, M. (2015). Field liaisons as “bridge builders” in social work field education. Submitted and in review, *The Field Educator*.

Anderson, J., & Adamek, M. (2015). Student learning styles: Implications for interprofessional program design. Submitted and in review, *Evaluation and Program Planning*.