Spring 5-2-2018

Academic Preparedness of Social Workers for Interprofessional Education/Collaborative Practice (IPECP)

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Academic Preparedness of Social Workers for Interprofessional Education/Collaborative Practice (IPECP)

A Dissertation Presented to

The Faculty of the Doctor of Social Work Program of

Kutztown University / Millersville University

In Partial Fulfillment

of the Requirements for the Degree Doctor of Social Work

By Amy C. Sagen

April 2018

This Dissertation for the Doctor of Social Work Degree

by Amy Corwin Sagen

has been approved on behalf of

Kutztown University|Millersville University

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ABSTRACT OF THE DISSERTATION

ACADEMIC PREPAREDNESS OF SOCIAL WORKERS FOR INTERPROFESSIONAL EDUCATION/COLLABORATIVE PRACTICE (IPECP)

By

Amy C. Sagen

Kutztown University / Millersville University, 2018

Kutztown, Pennsylvania

Directed by Dr. Edward Hanna

Are social workers emerging as competent collaborative practitioners? The cost of education is rising, employer training budgets are shrinking, and the World Health Organization (WHO) is forecasting a shortage of personnel trained effectively in interprofessional practice. The Interprofessional Education Collaborative (IPEC) developed four core competencies for interprofessional practice. Interprofessional awareness was added to the latest Council on Social Work Education's (CSWE) educational policy and accreditation standards (EPAS) for 2015. Using a socio-cultural learning framework, social workers will be questioned as to their perceived educational preparedness to enter into interprofessional education/collaborative practice.

NASW-PA membership comprised the 304 completed surveys. Respondent findings indicate 73% do not perceive they are educationally prepared to practice in interprofessional settings and 84% inaccurately defined interprofessional education. Furthermore, 75% of respondents believe they are engaged in an interprofessional practice setting. Future research is needed to determine if social workers are engaged in interprofessional practice and if interprofessional education, the precursor to interprofessional practice would benefit the next generation of social workers.

Keywords: Interprofessional Education, IPEC core competencies, CSWE EPAS, social work, educational competence

Signature of Investigator _____ Date _____

Dedication & Acknowledgements

Kevin, my husband… We did this!
I could not have completed this without you. All of the sacrifices, late nights, and mixed up schedules with the girls. You were always there, you were always supportive, and you only ever asked me one question "Is this what you want?" Thank you for letting my follow my dream. I am proud to be with you. I am excited that we will have time to focus on us, again. With much love and gratitude.

Samantha and Alexandra, my girls…
We started this journey when you entered Kindergarten and Pre-K. You are amazing girls and I could not ask for more than you gave me these last three years. You showed me grace when I had to "go to work" to study, write papers, and teach. Your smiles, giggles, and hugs meant the world to me, as there were some hard times of mommy being away or busy. Sami, "I love you to pieces, sweetcakes" and Alex you are my "sweet pea, monkey," always and forever!

Mom & Dad
Thank you for believing in me, instilling in me the value of hard work, and always challenging me to reach higher and further than I was comfortable. Congratulations to you, as your third (and final) child achieves the title of Dr. "Corwin." Here it is dad, "To thine own self be TRUE."

Jenna
This journey started with you… your "gentle" push to move me out of my comfort zone, into a new arena to use and share my knowledge, experience, and skills. I accomplished this… let's go climb Katahdin!

Phyllis
Thank you, your support and guidance are immeasurable… and learning that I enjoy all aspects of research! You are right, I believe interprofessional education / practice to be an expansive area of research and an important competency area for social work students, more so the profession.

Friends
This journey was not easy, but worth it! Your unconditional love and support was and continues to be appreciated. It is time to celebrate, relax, and reconnect… now there is TIME! Alicia, thanks for holding down the "fort." Jill…I am changing our weekly 10:30 pm call, to earlier in the day!

Kutztown University Faculty
Dr. Hanna, my chair…
Thank you for believing in me, "counseling" me, and guiding me through this adventurous experience. Your stories, cartoons, and encouragement helped me to stay the course and arrive here, with the prefix of Dr.

Dr. Conahan and Dr. Sharma, committee members…
You were (and remain) an integral part of my educational and professional journey. Thank you.

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Problem Statement and Reasoning

Do social workers perceive educational preparedness for interprofessional collaborative practice?

Scope of Problem

Attainment of higher education is almost a rule rather than an exception in today's society. College graduates generally receive higher compensation and enjoy lower unemployment rates, yet the New York Times reports that only 55% of students graduate within six years (Bui, 2016). Thus, both students and parents take on debt for the advancement of knowledge and pursuit of employability (Appendix A). Students and paying family members charge academic institutions to produce strong discipline-specific practitioners, as well as members and leaders of interprofessional teams (Pardue, 2013). The purpose of this paper was to analyze whether social workers perceive they are educated to practice in interprofessional collaborative practice (CP).

This research was important for several reasons: one justification was to determine if the curriculum set forth by the Council on Social Work Education (CSWE) was educating social workers adequately for current practice. As a result, this research was to provide a voice to students, faculty, and professionals as to the strength of CSWE Educational Policy and Accreditation Standards (EPAS) integration of interprofessional language. The importance of understanding or uncovering the impact the EPAS have on social workers is vital to the future of the profession. CSWE would benefit by being responsive to receiving insights from the social workers and students who participated in the study.

Furthermore, the research project was important with respect to social advocacy issues on behalf of the clients / patients to receive proper care and attention. Clients are the heart of social work practice, and the Code of Ethics ensures the profession does right by the client and

consequently is a strong incentive for many social workers to enter the profession. Given the current complex systems of care, advocating on behalf of clients is one of a social worker's main role. Complex systems of care include, but are not limited to, medical, child & youth, school, and community-based organizations. Within these complex, multidisciplinary systems, the social worker usually ensures that clients have an understanding of what is happening (informed consent), a voice (right to self-determination), and awareness of resources for support. Social workers, therefore, benefit from interprofessional education for honing communication skills, understanding ethical considerations, and interacting as an equal with other professionals, thus enhancing social advocacy skills for the benefit of their clients.

This research is important to prevent "value loss" of the social work profession, which loses value or credibility when social workers are not properly prepared for collaborative practice. In 1998, the World Health Organization (WHO) outlined the importance of interprofessional education (IPE) and again in the 2010 Framework for Action. WHO foresees interprofessional practice as being the backbone of change within the healthcare arena, globally (WHO, 2010). Preparation of social workers is imperative, as not only do social workers work on interprofessional teams in the healthcare field, but in almost every field social workers find themselves -such as parole and probation, schools, academics, and the aging fields to name a few.

Goldkind and Pardasani found a leadership disconnect between the "significant expansion of the nonprofit sector…(and) the field of social work administration has not followed suit" (2013, 573). As a result, numerous non-profit social service agencies are being run by non-social workers, paralleling the reduction of social workers prepared for leadership positions in organizations. The change in social work education landscape is less student exposure to

administration and leadership classes, as these classes are offered at half of the schools compared to clinical tracks (Goldkind & Pardasani, 2013). Knee and Folsom (2012) recognized the change in social work education away from leadership and identified five skills that could be more explicitly connected to management. These five skills are taught to each foundation year social work student of communication, supervision, facilitation, teaming, and interpersonal skills. Furthermore, moving away from educating social workers as leaders is source of value loss in the profession and is especially related to perceptions of social workers' lack of preparation for the current job market. Historically, the profession has been encroached upon by nurses providing Care Management services in healthcare settings, Home and School Visitors (HSV) providing social work services within K-12 school settings, and licensed marriage and family therapists or licensed professional counselors taking positions in community agencies which were formerly held by social workers. These jobs of leadership within social service agencies are vital to continuation of the social work profession.

The collaborative nature of the profession puts social workers in a unique position to both interact and influence other professionals with the theoretical underpinnings of the "Person-in-Environment" perspective (Bolin, 2015) and the "Strengths" perspective to serve clients (Jones & Phillips, 2016; Weiss-Gal, 2008). Collaborative practice occurs when multiple disciplines maintain interprofessional working relationships for the betterment of individuals, families, and communities (Careau, Bainbridge, Steinberg, & Lovato, 2016).

Social workers are employed in numerous collaborative settings. In 2015, The Council on Social Work Education (CSWE) identified 23 categories of field placement, most of which involve collaboration with other disciplines, such as medical (doctors, nurses, pharmacists, nutritionists, physical therapists, occupational therapists, speech language therapists, surgeons,

hospital administrators or nursing home administrators), child welfare (teachers, law enforcement, healthcare professionals), school social work (teachers, administrators, families, guidance counselors), corrections (judges, law enforcement, parole officers, healthcare professionals, clergy), and addictions to provide a sampling of interdisciplinary social work employment opportunities. Field placements mirror professional placements of collaborative practice in the healthcare arena, mental health, parole & probation, legal offices dealing with child welfare or conservatorships, education, and community organizations. Thus, the importance of educating social workers to interact, collaborate, and work interdependently with other professions cannot be ignored. Ensuring social workers have these fundamental skills is vital to the social work profession and individual employment opportunities available to social work professionals.

Interprofessional education (IPE) is a "critical pedagogy" (Jones & Phillips, 2016, p. 19) from which healthcare professionals are trained to practice in interdisciplinary or collaborative settings. The World Health Organization (WHO) defines healthcare teams as "two or more people working together towards a common goal" (1988, p. 6), and describes interprofessional education as 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. 7). This is the most commonly accepted definition has been adopted by the majority of interprofessional associations (NEXUSIPE, 2017). Thus, IPE is more than a guest speaker providing knowledge or insight into a topic. It is the interaction of team members learning how to communicate effectively, understanding roles, appreciating ethical frameworks, and having respect for team members' contributions to the common goal which is the basis of contact theory (Youngewerth & Twaddle, 2011).

Common misconceptions surround the terminology employed within IPE pedagogy. Choi and Pak (2006) documented the differences between the terms multidisciplinary, interdisciplinary, and transdisciplinary. Multidisciplinary is discipline oriented; members are responsible only for activities and roles related to their own discipline, rarely impacting another team member's performance. Interdisciplinary represents collaboration between professionals who bring unique skills and expertise to a team yet work as a team toward a common goal of bettering the patient or community. The transdisciplinary model blurs boundaries of disciplines with immense sharing of knowledge for the betterment of the client system. Thus, interprofessional education most closely mirrors the interdisciplinary model, whereas the majority of academic programs teach in a discipline specific or multidisciplinary model.

Pecukonis (2014) identifies theories that are barriers to interprofessional education, specifically Profession-Centrism and Social Identity Theory. Profession-Centrism refers to the specialization, more so isolation, of disciplines where members of the discipline have a high level of expertise on theory, language, practice behaviors, ethical standards, and unspoken "truths" about the profession. This high level of specialization is a potential barrier to interprofessional communication, as team members are unable to communicate effectively nor efficiently (Jones & Phillips, 2016; Pecukonis, Doyle, & Bliss, 2008). Social Identity theory posits current academic structure limits a student's voice on the interprofessional team as they are indoctrinated into the norms of the disciplines. Many professions are taught in silos, to learn about professional identity, mission, values, and norms of the profession. The term silo refers to students taking courses from a professor of the same discipline and with students of the same discipline, without interaction or instruction from other disciplines. Social work discipline may be better suited for interprofessional education as coursework and instruction fosters an inclusive

and collaborative educational environment (Butler, 1990 Oliver 2013; Sedikiedes & Strube 1997; Weiss, Gal, & Cnaan, 2004).

The CSWE (2015) *Annual Statistics on Social Work Education in the United States* shows an increase in the number of accredited programs offering IPE coursework. The caveat is that not all programs define IPE as defined above. For many of the programs, the IPE experience is a one time, 3-6-hour event. These programs provide students limited insight into, and an opportunity to explore how to approach interprofessional teamwork and communication. Most of these programs neither address the IPEC competencies of value/ethics nor roles/responsibilities among the professions (see Appendix B).

Social Work education is a costly venture for the bachelor and master level social work student. CSWE accredits 503 Baccalaureate and 242 Master level programs within the United States. In 2015, 63,000 students matriculated and 20,000 graduated with bachelor's degrees while over 60,000 students matriculated and over 25,000 graduated with master's degrees. Student loans are accumulated by 81.3% of bachelor graduates in excess of $28,000 and 78% of master graduates in excess of $40,000 (median) (CSWE, 2015). These statistics magnify the importance of these questions: Are students graduating with competent employable skills within the current healthcare market? Or do graduates need more training or education to be hired in the medical field? Healthcare is changing as the consolidations of insurance companies and healthcare providers negatively impact agencies. Due to these takeovers, budgets are drastically reduced. This reduction affects the money, time, and energy allocated to "training up" new employees (Ginsburg, 2016).

Interprofessional Education (IPE) can play an important role in developing social workers into collaborative practice leaders. Social workers are uniquely qualified to serve as

leaders on interdisciplinary teams, especially in diverse professional settings. As stated by Jones and Phillips (2016), “as a profession, social work is committed to interdisciplinary, collaborative, community-based practice that includes the multifaceted and sometimes dissonant aspects of the individual, family and environment” (p. 18). Giles’ (2016) study “found that, in comparison with other disciplines, social workers were more likely to have been trained to value interprofessional collaboration, had more knowledge of it, more experience and skills in collaboration, and held higher expectations of the value of working in teams and groups” (p. 25). Social workers gain IPE knowledge, but do they have the opportunity to use it in the field or with other professionals? Most often terms and theories are taught, yet they are taught in the vacuum of a siloed social work educational program. Social work students are taught by social work faculty and very few non-social workers are matriculating in the same classrooms. Therefore, although social workers may have the book knowledge, again, do they have the opportunity to hone these IPE skills?

The American Interprofessional Health Collaboration (AIHC) recognizes that “health professionals’ education remains isolated from practice realities and profession-specific learning does not prepare future and current health professionals for working together. We must transcend boundaries” (AIHC, 2017). This professional association is comprised of individuals and organizations, representing all health professions including social work, committed to influencing a more positive future. Transcending professional, organizational, educational, practice, research, and geographic boundaries is imperative for professionals to appreciate the perspective and contributions of interprofessional team members. IPE provides a platform for boundaries to be acknowledged and slowly broken down, thus providing a foundation for effective collaborative practice.

Although there is a push for IPE/PC in the medical field, as insurance companies and hospitals move toward a collaborative practice structure (Lecture UnitedHealth group, Dr. Sandy, 22 August 2017). It is a misconception to believe healthcare is the only collaborative practice in which social workers participate. Social workers participate in collaborative practice settings in a much broader context; for example, school social workers, child welfare social workers, and juvenile justice/probation social workers. These social workers also work in collaborative practice settings and are required to have the skills to interact with multiple professionals, different ethical frameworks, varied team composition, etc. The increase in collaborative practice preparedness is invaluable for all social workers, including those in general practice- based social work programs.

Interprofessional collaboration is not a new concept. The concept reaches as far back as World War II, when medical and surgical teams practiced in an interprofessional manner (Baldwin, 2007). Since then, a preponderance of evidence exists regarding the benefits of IPE, reflected through a decrease in medical errors, improved patient satisfaction and care, and knowledge and skills of professionals (Acquavita, et al, 2014; Nottle & Thompson, 1999; Poulton & West, 1993; Reeves Goldman, & Oandasan, 2007). To address the educational needs and training of students, it is recommended that academic institutions embrace an interprofessional education and training approach (McNair, 2005; Reeves, et al, 2007). This approach far exceeds the one-time only, time-limited, seminar style interaction; instead, a semester-long course or fully integrated IPE training institute to address the complexities of IPE is recommended.

In 2009, the Interprofessional Education Collaborative (IPEC) was formed to “promote and encourage constituent efforts that would advance substantive interprofessional learning

experiences to help prepare future health professionals for enhanced team-based care of patients and improved population health outcomes" (IPEC, 2016, p. 1). Six-national healthcare educational associations (American Association of College of Nursing, American Association of Colleges of Osteopathic Medicine, American College of Pharmacy, American Dental Education Association, Association of American Medical Colleges, and Association of Schools of Public Health) formed the IPEC and developed the four core competencies of IPE. These four core competencies include: 1. Values/Ethics for Interprofessional Practice, 2. Roles/Responsibilities, 3. Interprofessional Communication, and 4. Teams and Teamwork. In 2016, IPEC instituted an institutional membership, at which time the Council on Social Work Education (CSWE) signed the agreement to become a member (IPEC, 2016).

The availability of health-related IPE programs has been increasing, especially due to the World Health Organization's 2010 release of *Framework for action on interprofessional education and collaborative practice.* This document highlights the dire need for healthcare professionals to be competent in collaborative practice due to the impending healthcare professional crisis (healthcare worker shortage) and the need for professionals to be competent and comfortable working together.

The Council on Social Work Education (CSWE) is an association focused on developing sound social work education programs (2016). When the CSWE was established in 1952, the association accredited only Master's programs in social work, believing that professional social work preparation must take place at the master's level. Accreditation standards for social work curriculum content, staffing, and undergraduate level social welfare programs were issued in 1973. Curriculum policy statements are now called Educational Policy and Accreditation Standards (EPAS) and were last revised in 2015.

The 2015 EPAS strengthens the competency-based education framework that began with the 2008 revisions. The CSWE defines competency-based education as "the ability to integrate and apply social work knowledge, values, and skills to practice situations in a purposeful, intentional and professional manner to promote human and community well-being" (2015, p. 6). The calculated move from a focus on content to a focus on demonstration of student competence reinforces the need to research student's competence with practicing in collaborative settings.

Many schools of social work have adopted the generalist practice curriculum from the 1960's. This curriculum provides social work students a breadth of knowledge about social work practice without delving into the depth of specific tracks such as medical social work, school social work, community organization, and other specialties. Generalist curriculum teaches social work students the fundamentals of the Planned Change process. The first component of this process is engagement. The basis for all social work practice is to engage the client, engage with community resources, and engage professionals who are working toward the betterment of the patient/client. Through teaching students the plan change process, social workers are challenged and stretched to assess patients'/clients' issues on three levels: micro, mezzo, and macro. Schools that use this approach are providing the foundational skills to social workers from which social workers are expected to engage in life-long learning to apply skills into various practice settings, such as IPE/CP.

IPEC and CSWE Competency Overlap

There are numerous similarities among the IPEC four core (Appendix C) competencies and CSWE 2015 EPAs (Appendix D). The congruency of competencies strengthens the social work profession to be a leader in IPE/CP. One of the overlapping competencies, found within IPEC's domain one: Value / Ethics subset "VE 1: Place the interests of patients and populations

at the center of interprofessional health care delivery" (IPEC, 2010, p. 1), directly corresponds to CSWE EPAS competency 1: Demonstrate ethical and professional behavior to make ethical decisions based on the National Association of Social Workers (NASW) code of ethics 1.01 commitment to client as first priority and 1.02 patient's right to self-determination reinforcing commitment to client's needs and desires. Another overlapping competency is IPEC domain two: Roles / responsibilities, subset "RR 7: Forge interdependent relationships with other professions to improve care and advance learning" (IPEC, 2010, 1) and CSWE EPAs competency one, six, seven, and eight. These competencies are:

1. Social Workers also understand the role of other professions when engaged in interprofessional teams.
6. Social workers value principles of relationship-building and interprofessional collaboration to facilitate engagement with clients, constituencies, and other professionals as appropriate
7. Social workers recognize the implications of the larger practice context in the assessment process and value the importance of interprofessional collaboration in this process.
8. Social workers value the importance of interprofessional teamwork and communication in interventions, recognizing that beneficial outcomes may require interdisciplinary, interprofessional, and inter-organizational collaboration.

Social work education embeds the major themes of IPE/CP. Social workers learn about CSWE EPA competency one of professionalism by starting where the client is (IPEC VE 1, RR 1, CC 1, CC 4, CC 6, CC 8), making the clients the center of the therapeutic relationship (IPEC

VE 2, RR 1, CC 8), and treating all persons regardless if they are clients, families, communities, or professionals (IPEC VE 6, RR 7, RR 8, RR 9, CC 3). Social workers learn the importance of ethical conduct through competent practice (IPEC VE 7, VE 10, RR 2,), embracing diversity and individual differences on the micro, mezzo, and macro levels (IPEC VE 3, CC 7, TT 4), as well as acting with honesty and integrity in all settings (IPEC VE 9, TT 8). A more detailed comparison of IPEC and CSWE EPA competencies is located in Appendix E.

Conceptual Map

World Health Organization identifies Gaps in Healthcare: Need for Interprofressional Prepared Practitioners

Practice Trends:
Team Based

Education:
Discipline Specific

Social Workers Prepared to Practice In Interprofressional Settings?

Interprofessional Education Is Precursor To Interprofessional Practice

Do Social Workers Percieve Preparedness to Practice in Interprofessional settings?

Theoretical Underpinning

The problem domain of this paper, refers to the perceived preparedness of social workers to work in interprofessional practice. Social work education primarily happens in a vacuum. Social work students take classes with other social work students and are educated by social work educated faculty. This system provides social workers with discipline specific education, especially of foundational social work theories, values, and ethics. However, this isolated type of education misses out on "real world" experience to interact with other disciplines. This interaction has potential to increase other profession's knowledge and understanding of who and what social workers are capable of contributing to a team environment, more so to increase the confidence of social workers who are employed in a team-based environment to have a voice. Interprofessional education cannot take place in a vacuum or within siloed educational programs. Interprofessional education is built on the interactions of disciplines within the classroom, simulations, and workshops. Thus, Socio-Cultural Learning theory lends itself well to the study of interprofessional education.

The foundation of this research project is Socio-Cultural Learning. Vygotsky developed this theory to explore external influences on a student's construction of meaning (Hean & O'Halloran, 2009). Socio-cultural learning focuses on a learner's ability to construct meaning within a collaborative enterprise. When engaged in an IPE course, students may be influenced by faculty, interdisciplinary peers, and discipline specific language. All of these factors have the ability to impact a student's comprehension and internalization of the material; for example, IPEC's four core competencies. More succinctly, this learning theory addresses the difference between what a student can learn on their own versus what a student can learn when interacting with interdisciplinary faculty, peers, and presenters (Hean & O'Halloran, 2009).

Interprofessional education is a complex tapestry of learning theories. Socio-cultural learning is only one theoretical perspective used by IPE programs. For social work schools that educate only social work students, known as siloed education, social identity theory may be present. Jacobs (2014) outlined the importance of educating students to the values, ethics, and theoretical constructs that bounds each profession, prior to engaging in interprofessional education. More precisely, siloed education occurs when departments are discipline-specific, where only students from that discipline may take classes, and educators are all of the same discipline (Jacobs, 2014). Social identity theory posits students learn about other professions as is told to them through the lens of a professor of the same discipline, thus neither multidisciplinary nor interdisciplinarity.

Literature Review

The journal articles included in this research project were retrieved between August 27, 2016 to date. The narrowest query word of "social work educational perception IPE" were entered to start the Kutztown University (KU) library search and yielded no results. Afterwards, the search parameters were expanded to include "student perceptions," "educational perceptions," "IPE readiness," "employment preparation."

History

The current academic structure of disciplines or siloed professions is a barrier to true interprofessional education (Aldrich, 2014; Jacobs, 2013; Klein, 1996). Cahn (2014) studied the 35-year longitudinal journey of interprofessional education at Massachusetts General Hospital Institute of Health Professions (MGH-IHP). This historical perspective case study provides insights into barriers, successes, and attitudes associated with IPE at various points in time. MGH-IHP launched in 1977, with IPE as a mandatory requirement for students (medical, nursing, social work disciplines). Over the years this original mandate was changed to voluntary participation. As faculty turned over, and the administration delved into new programs, IPE became secondary to discipline specific curriculums. The most salient points from this case study include the importance of making IPE mandatory, educating faculty on IPE, using a team approach to champion the program (prevents dissolvement of the program when a faculty member changes positions or leaves the institution), and being aware of employers' demands (Cahn, 2014). In 2011, MGH-IHP ultimately added IPE to its mission statement to stress the importance of educating employment ready professionals into collaborative practice settings.

Oliver (2013) posits that professional identity is actively constructed through an interactional process of students with educators, materials, internships, personal values, and

mentors. A student's understanding and buy-in to a social work professional identity cannot simply be verbalized by an educator. Difficulties arise when students are employed in collaborative practice settings in which the social work profession is not understood, devalued, and the social worker is overlooked as a contributing team member (Hare, 2004; Healy 2014; Loseke & Cahill, 1986). Oliver (2013) proposes a change to the educational nomenclature of professional identity to that of boundary spanners. This term provides social workers the ability to hold onto professional values when entering collaborative practice settings.

Student Perspectives

There have been many studies in various programs to assess the student's perceptions and attitudes of Interprofessional Education. Foster and Clark (2015) assessed the perceptions and attitudes of students engaged in Common Learning (CL) curriculum. Common Learning commenced in 2003 when interprofessional education was embedded in the undergraduate Bachelors of Social Work (BSW) program. These students' pre-test and post-test scores were compared to students who entered the program in 2002 prior to CL curriculum. Data was gathered through self-completion questionnaires upon entrance into the program (time 1; T1) and in their final year of the program (time 2; T2). The comparison group included a population of 1108 (T1) and 672 (T2) students, whereas CL population included 1261 (T1) and 580 (T2) students. Of these respondents, there were 58 and 5 social workers in the study, CL and comparison, respectively. The data that specifically pertained to social work and leadership abilities remained stable over time and was not significant ($p<0.05$). The overall results of this study showed that over time, CL students' beliefs of other professions became less stereotyped and more realistic (Foster & Clark, 2015).

Not all social work programs provide students an opportunity to participate in IPE coursework. To address this barrier, Comer and Rao (2016) provide a framework for transforming the undergraduate social work group's class into an IPE primer for social work students. The University of Connecticut developed an Urban Service Track (UST) for students interested in interprofessional teamwork and willing to add a noncurricular activity to their schedules. These students met five times per year with prescribed learning objectives for each session. Second year students took leadership roles in the meetings which covered: 1. Introductions & establishing group and individual purpose/goals; 2. Critical role of teamwork revolving around importance of communication and conflict; 3. Understanding roles: social workers and healthcare; 4. Fieldtrip to integrated health program; and 5. Celebration and reflection of UST learning experience (Comer & Rao, 2016). Students reported an increase in their understanding of collaborative practice, their contributory role as social workers, and the importance of having a voice. Other than a few quotes from students, the article did not mention how many students completed the program.

The University of Louisville defined and refined an IPE curriculum focused on providing comprehensive care to persons affected by advanced cancer (Head, et al, 2014). Faculty from a core group of four disciplines (medicine, nursing, social work, and nutrition) came together and created a mandatory palliative care education program. Justification for the course development was proven through the needs assessment of 228 students revealing 71% had no previous IPE experience and over 80% believed IPE would enhance their learning. The core group of IPE developers discovered and acknowledged, through the pilot testing phase, their own lack of experience in designing an IPE course. Evaluation of students and the 16-week program was completed through the End-of-Life Professional Caregiver Survey (EPCS). This 28-question

quantitative survey was tested and validated at the Yale University School of Nursing. The Self-Efficacy for Interprofessional Experiential Learning Scales (SEIEL) uses a 16-question scale. Upon completion of clinical experience students wrote a critical reflection. In addition to measuring student learning, students and faculty engaged in efficacy testing through evaluating each of the 16 modules. Lessons learned from this case study include the need to remove profession-centrism, to focus on the student, and to acknowledge the critical role of the IPE champion who coordinates complex schedules, funding, and logistics (Head, et al, 2014).

Adding IPE to the curriculum, the University of Utah developed a hospice course for social workers, nurses, and pharmacists (Supiano & Berry, 2013). This course was designed to intermingle IPE core competencies as set forth by IPEC and allow for profession-centric time to ensure students obtain knowledge about discipline specific ethics, roles, values, and scope of practice. Five teams participated in interdisciplinary team work and data was gathered through phenomenological inquiry, which assumes "there is a structure and essence to shared experiences that can be narrated" (Marshall & Rossman, 2006, p. 104). Results from the 23 social work students (out of n=87) revolved around their initial apprehension of engaging, interacting, and contributing to the interdisciplinary team. Students also showed an increase in self-confidence/growth they experienced over the course of the semester in relation to being a social work professional. A social work student captured the essence of the findings from this study: "As social workers we are trained to look at the 'whole person' when assessing a client, and what better way to accomplish this than with a group of professionals, each using their skills and knowledge to reach the best outcome" (Supiano & Berry, 2013, p. 394).

To gauge student learning, several tools were developed. The most widely used instrument over the past decade has been the Readiness for Interprofessional Learning Scale

(RIPLS) (Appendix F). RIPLS is a 23 self-report questionnaire which has been validated and deemed a reliable quantitative research instrument utilized in many IPE research projects (Reid, Bruce, Allstaff, & McLemon, 2006). Acquavita, Lewis, Aparicio, and Pecukonis (2014) used RIPLS in addition to interviews to assess IPE experiences within the curriculum and within clinical settings. As IPE programs differ across the country, the researchers desired to capture the student perspective of "attitude, knowledge, experience, and receptiveness regarding IPE" (p. 32). Twenty-nine students (6 social workers) completed the RIPLS questionnaire and semi-structured interviews. The results of these encounters showed students believe many IPE opportunities were lost within the classroom, as communication, roles, and values were not addressed by the profession-centric guest speakers. Students responded that most interprofessional learning took place within their internships/placements. In conclusion, students requested more defined curriculum structures and formal placement experiences (Acquavita, et al, 2014).

Collaborative Practice Beyond Healthcare

Collaborative practice is not only important in the healthcare profession. Social workers engage in collaborative practice with numerous disciplines, for example criminal justice. Hean, Staddon, Fenge, Clapper, Heaslip, and Jack (2015) studied the importance of interprofessional education of students interested in working in the offender mental health system in the United Kingdom (UK). It is posited that the incidence of mental illness in prisons is almost 80% (Hean, et al., 2015). Therefore, it is vital for criminal justice and mental health (social work equivalent in UK) students to be learning together and from one another in a collaborative practice setting. A mixed method approach was used to track 52 self-selected students through use of a modified RIPLS instrument and an exploratory qualitative questionnaire. Results of this study included a

strong attitude toward shared learning, person centeredness (thinking about the mentally ill offender). According to Hean et al. (2015), "there were no significant differences between participants by gender, organization, county, age, sector or managerial position" (p. 7). Students added greatly to the evaluation of the program in terms of content, process, and constraints. Overall, the study found most students have a positive attitude toward interprofessional training and desired more opportunities for collaborative education.

Child welfare is another non-healthcare focused realm requiring interprofessional education. The University of British Columbia developed an IPE in Child Welfare course to address the need for effective communication among many professionals working toward the betterment of children and their families (Whiteley, Gillespie, Robinson, Wattts, & Carter, 2014). A mixed method approach with used with seven, five-point Likert scale questions related to the delivery of the workshop and one open-ended question "What were the most important things you learned today about interprofessional practice in child welfare?" This three-year study, 2008 (*n*=35), 2009 (*n*=120), and 2010 (*n*=140), encompassed nursing, social work, and teacher education students. Over 70% of the students reported obtaining a significant amount of knowledge about collaborative practice, especially surrounding roles/responsibilities and communication.

Institutional Insight

The evidence has suggested support for the benefits of IPE. However, resistance continues to plague the implementation of IPE at many universities. As Charles, Barring, and Lake posit, "this is partly due to the protection of professional turf" (p. 579). Profession-centric attitudes on behalf of administration and faculty are denying students the crucial experience of learning IPE within the curriculum. In 2003, 22 teams (*n*=120 students) from numerous

healthcare professions embarked on a three-month interprofessional team opportunity. These teams were placed within the community and were "expected to develop an understanding of roles and responsibilities of their sister profession by shadowing other members of their team and discussing common cases in order to identify potential areas of potential collaboration or conflict" (Charles et al., 2011, p. 581). Students were invited to answer a questionnaire in which 17 social workers engaged in interviews with the research team. Themes identified in this research were the importance of social workers participating on the interdisciplinary team and social work exposure to peer students. Leadership roles were often taken by social workers due to their inherent skills related to mediation, negotiation, and an understanding of group work/roles. Social workers are trained to address the holistic needs of the client, in contrast to allied health students educated in the medical model of treating a client based on presenting symptoms. In conclusion, social workers are leaders and need to have this strength reinforced throughout the educational process.

The voice of a social worker can be a powerful tool on an interdisciplinary team. As stated by Bolin (2015), "simulation training in an IPE model offers medical services students the opportunity to learn the expectation and choreography of teamwork in a clinical setting" (p. 25). Social workers are a vital, but often overlooked, part of this team. Social workers bring the "Person-in-Environment" perspective, often introducing medical professionals to the environmental and relational factors that influence a patient's care. Bolin (2015) gathered qualitative data from eight master level social work students who participated in an IPE simulation at the local medical school. The students wrote a self-reflection paper upon completion of the simulation, then debriefed with faculty. Social workers commented on the importance of including social workers on medical teams to reduce readmissions, and the

importance of social work education preparing students for collaborative practice. More importantly, students commented on the lack of knowledge by other health profession students on what a social worker does. Overall, social work students reflected positively on this experience as they employed their leadership skills to educate their peers about the social work role in medicine (Bolin, 2015).

Delving more into social work leadership, are social workers being educated appropriately to be leaders in interprofessional education/collaborative practice settings? There are few articles that discuss social work leadership, and even less so on the issue of preparedness to lead interprofessional teams. In 2016, the Council on Social Work Education developed an institute for MSW and BSW program directors to earn a "leadership" certificate. The prevalence of leadership continuing education opportunities points to either inadequate or non-existent leadership training within the academic curriculum (CSWE, 2017). The increase of Bryn Mawr's Nonprofit Executive Leadership Institute (NELI), and universities offering leadership masters and certificates offer more proof that social workers are obtaining leadership skills outside of the classroom (Bryn Mawr, 2017).

Many IPE programs hold one large professional development event for all allied health disciplines (medicine, nursing, pharmacy, nutrition, social work, and others), but is this effective from a student perspective? Rosenfield, Oandasan, and Reeves (2011) utilized an interactionist approach for their exploratory case study of students who participated in a 3-hour, 1200-person IPE event. The focus groups were comprised of medical, pharmacy, dental, occupational therapy, and social work students. The event was held in 2007 (n=23) and 2008 (n=12), and both cohorts of students were asked a prescribed list of open-ended questions. In general, students believed IPE was important, however they felt this educational method of one 3-hour course for over 1000

students lacked the ability to educate on their professional role, interact as a team, and enhance communication skills among healthcare professionals. All students agreed this IPE was too large and desired small group interactions, and that IPE be incorporated longitudinally into the curriculum to ensure full integration (Rosendfield et al., 2011). This study adds to the existing literature which demonstrates that students believe IPE is valuable, yet this particular program could be reconfigured to allow for more interaction and less lecture.

At what point should students be introduced to IPE? In one large Canadian university system, first year health science students were engaged in an IPE forum. DeMatteo and Reeves (2013) qualitatively studied students' (*n*=234, 50 social workers) experiences. This study used three open-ended questions after a IPE seminar, which was heavily focused on educating students to "internalize responsibility for a sustainable health care system through acquisition of interpersonal knowledge and behaviors" (p. 27). Secondly, focus groups (*n*=30, 4 social workers) were conducted and through inductive analysis, five common themes emerged: "responsibilizing" the professional self, selling oneself to others, shifting professional "patient" relations, IPE as a tool of efficiency/excellence, and finding one's way in the enterprise clinic. Students commented on the misperceptions of their respective disciplines, the ability to be part of the team, and how the healthcare system in Canada is more business-like than healthcare focused (DeMatteo & Reeves, 2013).

Social workers are employed in various medical settings, one of which is hospice. Hospice services have increased 162% since 2000 (National Hospice and Palliative Care Organization, 2008). Wittenberg-Lyles, Oliver, Demiris, and Regehr (2010) employed a mixed methods research study to uncover perceptions of collaborative communication practices among team members at interdisciplinary team meetings which often included family members. Social

workers represented 3 of the 43 total participants. Hospice team members completed a Modified Index of Interdisciplinary Collaboration (MIIC) quantitative questionnaire followed by researcher review of videotaped team meetings. Results from this study support previous research that emphasizes the devaluation of social work and chaplain's contributions due to role ambiguity (Reese & Sontag, 2001; Wesley, Tunney, & Duncan, 2004; Wittenberg-Lyles, & Parker, 2007). Role ambiguity has been shown to be a major barrier to effective interprofessional collaboration, thus further research is needed on how team members view and respect their peers' roles.

International Impact of IPE

WHO (2010) identified the need for interprofessional education of professionals to interact on a global level. WHO predicts a shortage of collaborative practice-ready medical professionals in the near future. Giles (2016) conducted a case-study research of health social workers in New Zealand. Data was collected through eight in-depth interviews to assess the views of how the social workers view the functionality of their multidisciplinary team (MDT). MDT differs from interprofessional, within MDT professionals all have their own roles and are not expected to collaborate with other disciplines. As stated earlier, MDTs differ from interprofessional teams, yet Giles (2016) uses inter-disciplinary collaboration "to refer to the process of working together within an MDT" (p. 25). Social workers stated that a well-facilitated MDT was much more productive, not only with medical conditions but also with non-medical needs of the patient, through sound decision-making, team unity, valuing of each professional, and clear communication of goals for the patient. However, poorly facilitated MDTs led to a devaluation of non-medical issues, an unfocused team, and increase of stress for the patient. This may be a result of the current healthcare system, where "the impact of risk in health and social

policy promotes a greater emphasis on the defensibility of decisions rather than making good decisions" (Pollack, 2010, p. 1274).

Faculty Competence and Impact

Students are not the only participants in IPE, as faculty have an important role in developing, honing, and educating students on the intricacies of IPE. Curran, Sharpe, and Forristall (2007) captured the attitudes of faculty towards IPE. Three peer-reviewed questionnaires were used to quantitatively assess the attitudes of allied health faculty toward interprofessional education and learning. This study focused on adding information about the influence of gender, profession, and prior IPE experience to the literature. Surveys were sent to 308 faculty, of which 194 responded (social work *n*=10; 77% response rate). High internal validity was supported by Cronbach's alpha on all scales: Attitudes towards Interprofessional Health Care teams (0.88); Attitudes toward Interprofessional Education (0.92); and Attitudes toward Interprofessional Learning in the Academic Setting (0.81). Findings indicate gender and experience influenced the attitudes of faculty toward IPE within the academic setting (Curran, et al, 2007). This study emphasized the importance of understanding the culture of the faculty prior to implementing an IPE program at the institution. Faculty perception and comfort with IPE is important. Faculty have the ability to influence social work student's abilities of transfer foundational skills into other settings, such as social work administration or collaborative practice settings.

IPE Beyond Social Work

There are numerous programs that employ IPE outside the social work discipline. The University of Kansas Medical Center developed an interprofessional practice (IP) simulation for medical, nursing, and pharmacy students. Zaudke, Chestnut, Paolo, & Shrader (2016) researched

the impact of an IP program on communication and teamwork behaviors. Sixty-four students were exposed to a high-fidelity simulation experience called the interprofessional teaching objective structured clinical examination (iTOSCE). Students were assessed by peers and faculty preceptors before and after the simulation, using the iTOSCE rubric. Six weeks after this experience, students returned to lab for a second round of simulations. The assessments were conducted again, from which the researchers uncovered that the faculty scores increased more from pre- to post-test than the student scores, 20% to 8%, respectively. Results from this study add to the literature by showing an improvement in student communication and understanding of teamwork as a result of their participation in an interprofessional practice experience.

Conclusion / Implications

Critique of Literature: Strengths

The above literature is a sampling of journal articles that address the issue of interprofessional education. The empirical literature is vast in the study of IPE among medical professions, such as medical, nursing, pharmacy students, as healthcare collaborative practice is singlehandedly advancing the educational aspect of IPE. There are some healthcare-based studies that include social work as well as social work and other disciplines, such as criminal justice.

The literature addresses IPE from several vantage points: students, faculty, administrators, and curriculum. Even though this topic has been written about in journals for nearly 75 years, the literature over the past fifteen years has grown exponentially. In fact, there was a spike in IPE literature after the publication of the WHO (2010) Framework for Collaborative Practice.

Several articles test the reliability and validity of evaluative instruments. These studies test the instrument on different populations, such as gender, discipline, geographic location, type of collaborative practice, level of education or practitioner. The overall findings from these studies are positive; however, in 2015 a research team determined that the RIPLS instrument is not being used as it has been constructed. Rather than a simple pre-test only, the instrument has been used in a pre-post-test format for which it is not validated (Mahler, Berger, & Reeves, 2015).

Gaps in Literature: Needs

Although much literature has been produced, there are still gaps in the research. Further exploration is needed to assess social work educational preparedness for IPE/CP practice. The researcher did not find articles or studies that looked into the academic perception of preparedness of social workers, especially with the addition of interprofessional values added to the 2015 CSWE EPAS. The advancement of the social work profession hinges on a social workers' ability to translate and transfer fundamental social work skills into a variety of settings. The current literature only has a handful of articles to assess social worker preparedness for interprofessional education, through the use of the RIPLS instrument, but nothing that correlates CSWE EPAS and IPEC's four core competencies.

Another gap in the literature relates to social work field supervisor's competency and comfort supervising students within a collaborative placement while modeling IPE competencies. An exploration of the role of field supervisors is missing in the literature, yet they definitely play an important role in developing a student's professional self, as the signature pedagogy of the social work profession.

The literature is scant in assessing the needs of collaborative practice employers, both from a knowledge and skills perspective. Future employers have a unique practice perspective concerning the knowledge, skill, and abilities students must obtain for gainful employment upon graduating. Employers should understand the curriculum and engage with faculty, as they not only have the employability perspective, but also have awareness of the ever-changing healthcare field. This group of individuals can provide insight into changes in the healthcare environment must faster than academicians who are not practicing in a clinical capacity.

Literature is also sparse in assessing the competency of faculty to teach IPE courses. Faculty knowledge, skills, and abilities are critical to the IPE classroom environment, as they energize or bias students' views of interprofessional practice. Questions to explore include, 1. Does administration provide IPE for faculty to hone personal skills, 2. What are the attitudes of faculty who teach IPE, 3. Does faculty feel supported by administration, and 4. Are faculty given the time to develop, teach, and evaluate current IPE courses?

An increase in student research is necessary, especially among social work and non-allied health professions. Studies need to be conducted on social workers who interact with numerous other disciplines when working in settings of schools, the veteran's administration, community organizing, business (human resource or employee assistance roles), program development (i.e. engineering, finance), and information technology (website design, assistive technology).

Methodology

Purpose of Research

The literature review yielded no prior research on academic preparedness of social workers toward interprofessional practice. Literature revealed a handful of studies which studied individual discipline preparedness of students towards interprofessional education, however none of the studies looked at the social work discipline. Researchers (Reid, Bruce, Allstaff, & McLemon, 2006 and Acquavita, Lewis, Aparicio, and Pecukonis, 2014) used the RIPLS and other qualitative measures to investigate student's readiness to learn about interprofessional practice with multiple professions. Many of the research studies included in the literature review included social workers, but none were found to solely focus on social work education toward interprofessional practice. This research paper is the first to examine the relationship between a social worker's education and his/her perception of preparedness toward interprofessional practice. The hypothesis for this research is "do social workers perceive academic preparedness towards interprofessional practice."

Research Design

The research design is a mixed method model, according to Gay and Ariasian (2003) follows the QUAN-Qual model. The model collects quantitative data first and weight it more heavily than the qualitative data collected. The rationale for employing this method is to build research and knowledge on the topic of social work perception of preparation toward interprofessional practice.

Population and Sample

Purposive sampling was used to identify social work subjects, either student or professionals. All social workers and social work students, over the age of eighteen were invited

to participate in the study, whereby the criteria for selection was based on a non-probability sampling method of convenience. The researcher had access to this social work population.

The population for this study consists of 14 seasoned social workers for the pilot and 3951 NASW members of the Pennsylvania Chapter for the main study. Specific details about the sample will be discussed following the creation of the instrument. Due to development of an instrument, a pilot survey was completed prior to release to the membership of NASW-PA.

Instrument

After reviewing the literature, the researcher determined a new survey would need to be created to capture the academic preparedness perceived by social workers. Numerous studies listed in the literature review used the Readiness for Interprofessional Learning Scale (RIPLS). The RIPLS is a survey employed to determine if students are "ready" to enter into interprofessional education through a desire to work with other disciplines. The survey is neither reliable nor validated to be used in a pre-test / post-test design methodology. The RIPLS captures how a student feels rather than if they believe they were prepared through education. Thus, a new survey tool was developed called the Interprofessional Collaborative Practice Perception of Educational Preparation (ICPPEP).

The researcher developed a survey tool. The current survey materials available do not assess a social worker's perception of readiness toward interprofessional education/collaborative practice. The current studies assess students' and professional readiness toward practicing in a collaborative manner, yet nothing found assesses a social worker's perceived preparedness due to academic training.

The researcher developed a mixed method survey specific to the question of perceived academic preparedness toward practicing in an interprofessional collaborative practice setting

(Appendix G). Survey was designed as an adult (over age of 18), voluntary, online, self-report survey. The nineteen-question instrument was be disseminated via email blast and open to respondents for sixty-days, in the winter of 2017-2018. A purposive, only social worker, and convenience sample (NASW-PA membership) was used to capture responses. Per NASW research rules, there is only one opportunity to send the email blast thus all members of the National Association of Social Workers, Pennsylvania Chapter (NASW-PA) with emails will receive the survey request for completion.

Hypothesis

The hypothesis, *do social workers perceive academic preparedness toward interprofessional practice*, can be answered through descriptive statistics. Respondent's perception of interprofessional knowledge attainment can be described through descriptive analysis. Respondents marked all opportunities for interprofessional knowledge attainment; such as within the classroom, within field class, internship, not in classroom, not in educational program, and other. This question, alone, provides an answer to the hypothesis of social workers do not perceived educational preparedness to practice in interprofessional / collaborative practice settings.

Variables Independent

The independent variables relate to the respondent's demographic information and social work related experiences. Independent variables that reflect demographics include age, gender, and state of practice. Independent variables that reflect a respondent's educational experience are level of social work education attained, year of graduation, and enrolled in IPE program. To capture perception of preparedness, respondents were asked if their academic programs used multi / inter / trans terminology, engaged in interprofessional education, and if familiar with

interprofessional education, where was that information obtained. Respondents were questioned about their beliefs about the importance of IPE/CP skills with respect to social work leadership and CSWE adding to EPAS. Current practice questions included time in field, time in position, type of practice setting, do they engage in interprofessional practice, on the job training toward interprofessional practice, and qualitatively how much impact they have on their employment team. Lastly, the respondents answered a question that defined interprofessional education.

Variable Dependent

The dependent variable within this study was the accumulation of points on the IPEC competency standards, question thirteen on ICPPEP instrument. An IPEC competency standard total score was calculated for each respondent by adding scores of all thirteen questions. The maximum score that could have been achieved is sixty-five, with a range of thirteen to sixty-five. This IPEC competency standard total was used to determine significance from the independent variables. A higher level of competency was attained through a higher score on the IPEC competency standards.

Survey Instrument

The ICPPEP survey was developed by scaling down an existing tool: American Interprofessional Healthcare Collaborative (AIHC) Interprofessional Education Collaboration Competency Survey Instrument (IPECC) (Appendix H). The IPECC survey is broken down into four sections with about ten questions in each section to equal a total of forty-two questions. The researcher analyzed the forty-two questions and determined that most of the questions relate to the fundamental principles and ethical standards of the social work profession. The social work profession is built on six core values: service, social justice, dignity & worth of the person, importance of human relationships, integrity, and competence (NASW, 2017). Many, but not all,

of the questions in the IPECC survey would have been redundant to the central values of the profession, therefore these were left out of the survey instrument. However, some of the questions are seen as more specific to interprofessional practice and were added to the survey tool to assess social workers' academic preparedness toward interprofessional collaborative practice.

Values and Ethics Subsection

Values removed from the survey included any that are fundamental to the social work profession. This includes VE 1. Place the interest of the patients at the center of the interprofessional health care delivery as it directly correlates to ethical standard 1.01 Commitment to client and 1.02 Self-determination. Untactfully, if a survey respondent does not believe this to be important then they are in direct violation of the Social Work Code of Ethics. Another IPEC value removed from the survey is VE 10 Maintain competence in my own profession appropriate to my scope of practice of level of training. This directly correlates to ethical standards of 3.02 education and training, 3.08 continuing education and staff development, and 4.01 competence. These standards all correspond to the importance of staying current with education and best practices within a practitioner's area of practice.

The values and ethics subsection questions contained in the survey relate to the issues of respecting, working cooperatively, and managing ethical dilemmas with other professionals. These three are more value-laden than content specific. Values and ethics relate to how professionals interact with one another, more so how ethical standards are inherent in what each discipline brings to the team. These values are taught in social work curriculum, be it a standalone class, through field, or integrated into required classes. Thus, they are included in the survey.

Roles and Responsibilities Subsection

Roles and responsibilities relate to "use the knowledge of one's own role and those of other professions to appropriately assess and address the … needs of patients and populations served" (IPEC Core Competencies). Roles and responsibilities 11 is Communicate my roles and responsibilities clearly to parents, families, and other professionals, which directly relates to social work ethical standard 1.03 Informed consent. The overlap of these two standards is substantial, as social workers are educated to 1.03 (a) "use clear and understandable language to inform clients of the purpose of the service" (NASW, 2017, p. 8) and 2.03 (a) "contribute to decisions that affect the well-being of clients by drawing on perspectives, values and experiences of the social work profession" (p. 18).

The roles and responsibilities that are included in the study relate to a social worker's ability to recognize limitations, explain roles, use skills of other teammates, and communicate clearly each teammate's responsibility. These roles are more of a perception of a social worker's role on a team as well as their understanding of how the team has been formed, rather than directly related to educational courses within academia.

Interprofessional Communication Subset

Social workers are taught the importance of clear communication. This can be seen in all classes and includes both oral and written communication. The social work profession is based on communication with clients, within agency, to advocate, and in leadership positions. Thus, the communication subsets that were excluded from the study include active listening, respond feedback respectfully, and express opinions with clarity. The social work standards that address communication are numerous; 1.01 commitment to clients, 1.02 self-determination, 1.03 informed consent, 1.07 privacy/confidentiality, and 5.01 integrity of profession.

The communication values that were included in the study relate to how a respondent believes they were academically prepared to communicate in an understandable manner, give sensitive feedback to other professionals, and use respectful language within difficult situations. The basic tenets of these values are taught within the classroom but may not correspond to how confident a professional believes they are in communicating with other professionals. There is a hidden issue here, as the stereotype of social work professionals may impede or prevent them from speaking up, especially within a medical setting. In many medical settings, the hierarchy of professions continues to push social workers to the bottom of the ladder. This is changing slightly as Integrative care is catching on and being implemented by insurance carriers and some medical facilities.

Team and Teamwork Subset

Teamwork is the keystone aspect for interprofessional teams, as without teams there is no interprofessional education/collaborative practice. Many of the teamwork variables relate back to communication and the roles of interprofessional colleagues. The ability of a social worker to identify roles of other professionals, communicate own opinion, and share accountability of decisions, all have been addressed in other IPEC subsets above. Furthermore, this category delves into introspection of professionals to his/her own accountability as part of the team and decision-making process. The social work ethical standard that directly addresses this issue is 4.08: acknowledging credit and taking "responsibility and credit… only for work they have actually performed and to which they have contributed" (NASW, 2017, p. 26).

Values that were included in this study refer to the ability of social work professionals to engage other professional in problem-solving, apply leadership practices that support team effectiveness, and engage other professionals to constructively manage disagreements. These

again, are individualized to determine how well a social worker feels they are prepared through their educational training. Each value has an underpinning social work ethical standard; however, these connections may not be emphasized in educational curriculum.

This researcher-developed study was consistent with the IPEC's General Competency Statements and Specific Domain Competencies underlying the four core competencies (Appendix B). Not all of the statements were used within the newly designed survey. The rationale for removing a majority of the statements was due to the fact the statements are at the heart of social work philosophy, and therefore redundant.

Statistical Analysis

The Statistical Package for Social Sciences (SPSS) was used to analyze participant data and determine statistical significance, if any, with the above variables (Cronk, 2014). An independent statistician worked alongside the researcher to ensure the credibility of the data analysis. Descriptive statistics will describe the respondent's perception of academic preparedness toward interprofessional practice. Independent *t* test was used to determine statistical significance between the means of dependent variable (IPEC score summary) and independent variables with nominal level data. An independent *t* test is an important test to reduce Type I errors, as "the error that is risked when we have statistically significant results – and therefore reject the null hypothesis" (Rubin & Babbie, 2011, p. 579). For example, these tests were run on gender, enrolled in IPE program, ability to define IPE, and belief it is important for CSWE to add interprofessional language to the 2015 EPAS. Lastly, one-way Analysis of Variance (ANOVA) was used to determine statistical significance through comparison of means between the dependent variable (IPEC core competency score total) and independent variable

with more than two groups. ANOVAs were run for level of education, awareness of IPEC core competencies, and where interprofessional skills were attained, to name a few.

This research was important to understanding if adding interprofessional language in the CSWE 2015 EPAs had an effect on a social worker's perceived preparedness for collaborative practice. As reiteration, social workers work and intern in multi-professional settings and interprofessional settings. There are no social workers who do not interact with other people, even in private practice due to referrals, peer consultations with psychologists, professional counselors, education professionals, or medical personnel. Thus, social workers need to be educationally prepared to adapt the foundational social work skills of working in teams, effectively communicating, understanding one's own role and responsibilities at the micro, mezzo, and macro level, as well as respecting the values/ethics of all persons with whom they work. Communication, teamwork, roles/responsibilities, and values/ethics are the basis for IPEC four core competencies of how to social workers can effectively engage other discipline professionals within IPE/CP settings.

Pilot Study

Following research protocol, the research survey tool required testing for validity and reliability. The pilot study was emailed to twenty seasoned social workers (more than ten years' experience in the field) with Kutztown University IRB approval (Appendix N), instructions to complete the survey, immediately and again in twenty-one days. The survey was completed twice to determine reliability. Of the twenty social workers, fourteen surveys were completed at both time 1 and time 2.

Validity and reliability were run with SPSS software. The thirteen variables of IPECP were used in addition with three questions:

1. Social workers are educated to become leaders of interprofessional collaborative practice
2. It is not important for CSWE to add interprofessional language to 2015 EPAs
3. Interprofessional collaborative practice skills should be a priority for social work education.

Principle Component Analysis was used to determine variance (Appendix I) while reliability was determined using Cronbach alpha. The reliability statistic resulted in a Cronbach's Alpha of 0.809 (*n*=14 respondents and *n*=16 items). This means the instrument has interrelatedness of questions as measured by the pre/posttests. The high score is potentially impacted by the low number of respondents and begs further research to determine if the instrument is truly capturing the perception of interprofessional practice preparedness of social workers. As this is first instrument to capture this information, future replication and validation to strengthen the instrument is needed.

Pilot study participants (*n*=14) that completed both time 1 and time 2 were diverse. Age ranged from 36 to 71 with a median age of 52.9 years old, 8 females, all practicing within Pennsylvania. The educational attainment of participants ranged from one BSW to eight MSW/MSSP to five PhD/DSW with graduation years spanning 1973 to 2017 (x=1995). Most claimed a novice to intermediate awareness toward IPECP, as only two respondents were enrolled in an IPE program during social work coursework and five respondents knew the WHO definition of IPE while five did not; and four respondents were "not sure." These responses emphasize the need for this survey.

The pilot study participants were asked a handful of qualitative questions to assess the content validity of the study. The main concern was Interprofessional Education/Collaborative

Practice was not defined clearly in the introduction or on the consent form. This was purposefully done, as the study was designed to assess the social workers' knowledge about IPECP. Therefore, the study was based on the assumption that writing the definition into the consent form and introduction would skew the results of the study. The last question of the survey *19* demonstrates a respondent's understanding of interprofessional education: Interprofessional collaborative practice is learned by students when a guest lecturer attends class to provide information on a specific issue (i.e. disease progression by a nurse/doctor, what to expect in a court room by a lawyer/judge). The definition, as written earlier in this paper, is that Interprofessional education 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. 13). Pilot respondents who are familiar with IPECP answered NO, while those who asked for a clear definition of IPECP answered YES.

Most of the feedback from pilot participants was used to correct typographical errors and technical issues surrounding the survey monkey platform. Other comments were not directly related to the survey and have been aggregated (Appendix J).

Study

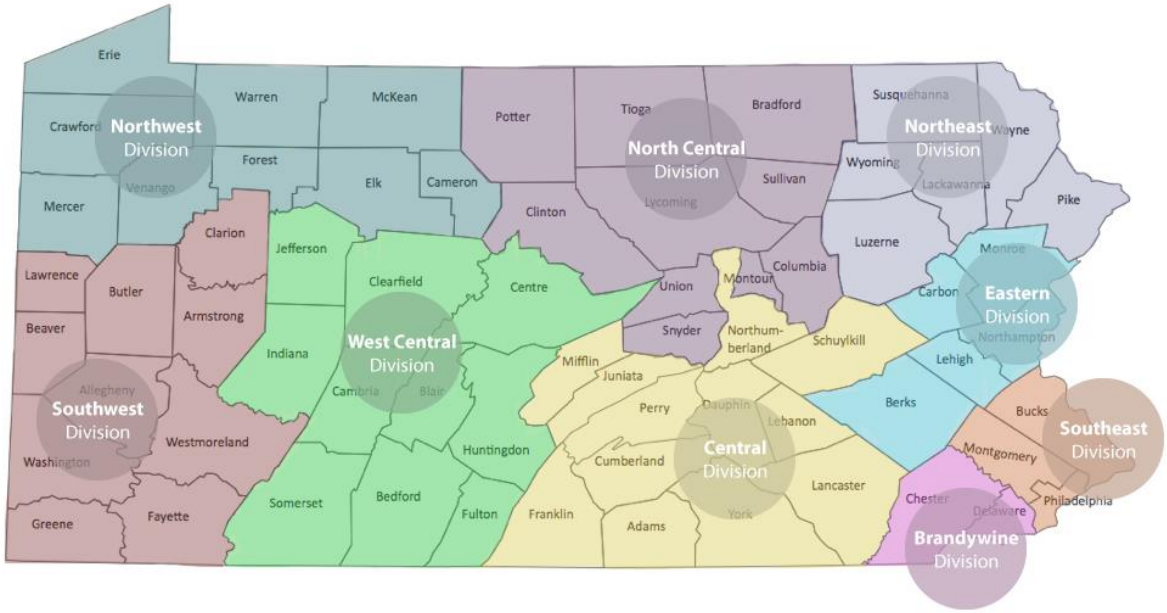
The survey asked all but two close-ended questions to social workers who had the option of participating in the voluntary, anonymous study. An electronic survey through survey monkey was disseminated to social workers who were members, with email blast permission, of the National Association of Social Workers Pennsylvania Chapter (NASW-PA). There was 24/7 availability for the instrument online and was open to participants for a two-month timespan of December 17, 2017 through February 17, 2018.

Sample

Sampling method for this mixed method study was a purposive sampling of NASW-PA members. Purposive sampling was used as the researcher believes that social workers would be the most appropriate group of participants to provide insight on their educational preparedness and experience for collaborative practice. The intent of this research project was to glean insight on the educational preparedness perceptions of social workers to practice in IPE/CP settings. This non-probability sampling method captured responses from as a certain group of people, social workers. Cohen's *d* was calculated to determine effect size. The sample size was calculated based on the number of Interprofessional Collaborative Practice Perception of Educational Preparation (ICPPEP) survey emailed to NASW-PA members.

The proposed sample size was calculated from 3951 members at a confidence level of 95% with a margin of error of 5, to equal 350 responses. The sample of 3951 NASW-PA members was represented by78% females and 69% MSW, 9% BSW, and 4% DSW/PhD. The geographic representation of the membership was 26.2% Southeast, 18.5% Southwest, 15.6% Central, 10.8% Eastern, 10.8% Brandywine, 5.2% Northeast, 4.7% West Central, 4.6% Northwest, and 3.5% North Central (Figure 1). Researcher was not privy to other demographic data for the members.

Figure 1: NASW-PA Membership Regions



Population Access

NASW-PA leadership was telephoned from the researcher's office phone on September 5, 2017 and mailed a formal letter (Appendix K) to gain access to the membership. The leadership of NASW-PA had never collaborated with the researcher on a research project, but there was familiarity of one another through other ventures, not related to research. Once approval was received from NASW-PA leadership, the communications director was contacted. The communications director was responsible for disseminating the participant ask letter (Appendix K) and link to the electronic survey via survey monkey to their membership through an email blast. There was no separate consent form, as the researcher completed the *Waiver of Requirement to Obtain Signed Informed Consent Request Form* (Appendix L) and embedded the consent form as part of the instructions as the first page of the electronic survey.

There was a glitch in the timing of this process. NASW-PA leadership contacted the researcher, in January 2018, that NASW required their own Internal Review Board application.

The researcher completed application and submitted Kutztown University IRB letter from December 2017 (Appendix N). Approval was gained within twenty-four hours. The NASW IRB (Appendix O) was forwarded to NASW-PA communications director to schedule dissemination to membership.

The NASW-PA communications manager used the email blast platform of Your Membership (YM) to send out one email to all members. Therefore, the researcher was not directly involved with sending the information out to the membership. Participants were asked to click a link to enter into the survey, therefore the researcher had no knowledge of persons who completed the survey. As mentioned above, the survey link was provided to all members of NASW-PA who had email addresses and had not "opted out" of emails from the communications director of NASW-PA.

Data Collection

The survey was disseminated to NASW-PA members in the following manner. The e-blast with survey link was emailed to the NASW-PA communications staff person, in addition to NASWs IRB approval. The e-blast communication was queued into NASW-PA's membership platform of Affiniscape for automatic dispersal to NASW-PA members with email permissions on the third Friday of January, at 4 pm. The survey portal on Survey Monkey was open to collect responses for 2 months, December 17th through February 17th.

Anonymous

The social work Interprofessional Collaborative Practice Perception of Educational Preparation (ICPPEP) survey was designed by this researcher to capture non-identifiable demographics of participants. The internet tool did not ask personal questions, such as name, license number, address, or email address. The Survey Monkey tool had a built in "making

responses anonymous" (www.help.surveymonkey.com, retrieved 4 August 2017) tool that was turned on as a second layer of protection for participants to have their personal information (name, email address, and IP address) not collected. The benefits of turning on this feature is to protect the participants from the researcher having access to his/her URL address, and thus, not allowing the researcher to be able to glean the identity of research participants. This program was purchased by the researcher to increase security of the data, although there was no identifiable information within the data set.

Respondent Restrictions

In order to be included in this study, participants must have been an adult (over 18 years of age), a social worker (educated at a CSWE accredited school), and also consented to participate voluntarily in the survey by clicking on the study link and completing the survey. There were no foreseeable negative consequences of opting out of study participation, other than bringing up previously felt inadequate educational preparedness (i.e., waste of money for school). The researcher did not have power or control to modify the membership of any participant or nonparticipant of the survey. As a staff member at NASW-PA, the researcher had access to the membership list for NASW – Pennsylvania Chapter (NASW-PA). The researcher did not have influence over providing or revoking membership to any person as fiscal responsibility of membership is controlled at the National (NASW) office in Washington, DC.

To determine the efficacy of the survey, it was given to four social work professionals. This is consistent with how nurses have determined efficacy in Poreddi et al. study (2016). This provided necessary feedback to determine the face validity of the instrument: did it measure what it intended to measure (Rubin & Babbie, 2011). In addition to the survey, five questions were added to the pilot study to gain information about the experience regarding completion of the

survey. Questionnaire responses were used to modify the instrument prior to dissemination to all social workers. Reliability of the instrument was assessed through measuring the internal consistency, which "assumes that the instrument contains multiple items, each of which is scored and combined with the scores of the other items to produce an overall score" (Rubin & Babbie, 2011, p. 219) for the fourteen time one/time two pilot study responses.

Bias

Potential bias issues within a purposive sampling method include researcher bias as to participants' inclusion based on attaining clinical social worker status, the limited pool of participants, and results which may not be generalizable to entire population of social workers. A major bias and concern of this study is the non-probability sampling methodology, as not all social workers were not given the opportunity to participate in this research project. If social workers were not connected to NASW-PA, a Pennsylvania-based School of Social Work, attendee of continuing education program, or received the request to complete the survey, that social worker may not be represented in the final sample.

Ethical Considerations

The survey was distributed to adults (over 18 years of age), thus participants were not part of a protected class, per IRB regulations. The survey was voluntary without distinctive identifying information to protect social workers from any foreseen potential risks. There may have been unintended emotional or psychological distress if participants viewed the research as something they should have learned through their CSWE-based educational journey, which is not the intent of the study. The intent of the study was to gain insight on the personal reflections of educational preparedness to enter into collaborative practice.

Anonymity was maintained for research participants as names, addresses, or overtly

identifiable information will not be collected. The research participants entered data via survey monkey from which the researcher was not able to access individual IP addresses. There was minimal to no risk of IP addresses being linked from participant to data, as a waiver not to collect a consent form was completed with the IRB application. The waiver wass intended for research projects that are minimal to no risk to participants as the consent form is the only piece of information that can be linked to the data provided by participants.

Measure

The IPECP survey instrument was disseminated to NASW-PA membership (Appendix M). The overall survey was designed to collect the same information as outlined in the pilot study, however a few minor spelling corrections were made for this version. The dependent variables for this survey instrument include perception of educational preparedness in practice, importance of adding interprofessional verbiage to CSWE EPAs, and knowledge of IPE definition. Independent variables related to the social worker's personal characteristics of age, gender, educational attainment, practice history, and practice setting.

The purpose of this study was to examine if social workers perceive they are academically prepared to practice in an interprofessional collaborative setting. The survey instrument developed attempts to capture this information. Furthermore, the survey tool gathered information from social workers to potentially address the question of "Is curriculum keeping up with the demands of the workforce?"

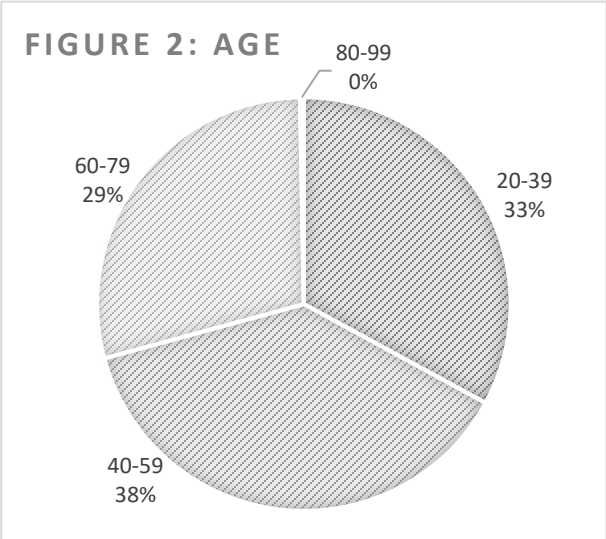
Results

The purpose of this study was to interpret the academic preparedness of social workers for interprofessional education / collaborative practice (IPECP). It further examined whether age, gender, years of practice, year of social work graduation, and participation in IPE focused educational curriculum affected a social worker's self-assessment on several items from the IPEC core competency scale.

Descriptive Statistics - Demographics

The IPECP survey was electronically delivered to 3951 members of the National Association of Social Workers, Pennsylvania Chapter (NASW-PA). Three hundred and four (*n*=304) surveys were returned within the sixty-day survey window. The completion rate was seven-point seven percent (7.7%). The sample size (n = 304) is close to the recommended 294 sample size calculation. This number was calculated from 3951 members at a confidence level of 95% with a margin of error of 5.5.

The overall characteristics of the respondents were as follows. The sample was comprised of 79% female and 0.3% "other" gender which was not categorized as male or female. Pennsylvania was the primary state of practice for respondents at 96.7%. The remaining ten respondents were from Delaware, New Jersey, and New York, recoded as "outside of Pennsylvania."



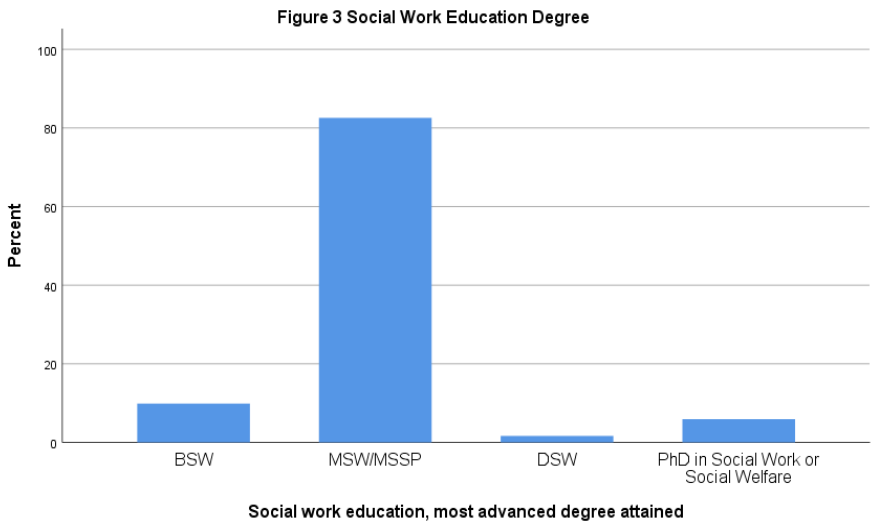
Respondents entered their age into the survey and ages were recoded into categories. The categories spanned twenty- year age increments. The first category was "under twenty." The age categories progressed to the last group of "80-99 years." The largest age category is that of 40-59 (*n*=115, 37.8%), followed closely by the age group category of 20-39 (*n*=100, 32.9%) (figure 2). There are no respondents in the youngest category and one respondent in the oldest category (0.3%). Individually, the ages of 50 and 58 shared highest number of individuals with a mean of 48.7 and median of 53 (range 22-84).

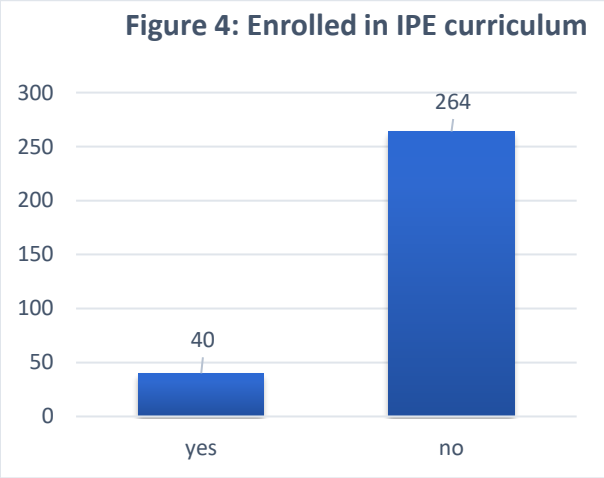
Lastly, located in Appendix P, table 1: Demographics and Employment Characteristics of Sample (n=304) was years in practice. Respondents years in practice reflected 25% of respondents practicing less than 10 years, 16.5% practicing between 10 – 20 years, 20.4 % practicing between 20 – 30 years, 14.9% practicing between 30 – 40 years, and 13.5 % practicing over 40 years.

Descriptive Statistics - Education

Descriptive statistics for education (Appendix P, table 2) captured educational attainment and is social work the respondent's first profession? The majority of respondents (57.7%) graduated with their highest level of social work degree since 2000 while 32.2% graduated between 1980-1999. Eighteen respondents did not answer this question.

The greatest number of respondents (*n*=40) graduated in the years 2016 and 2017. Educational attainment of the respondent's most advanced social work degree was 82.6 % MSW / MSSP, 9.9% BSW, and 5.9% PhD/ DSW (figure 3). Most advanced degree was used as many respondents reported all social work degrees and years; researcher removed lower level of social work attainment to keep the most advanced level. This was done, for example, when a respondent reported BSW 1999 and MSW 2009; the MSW 2009 was coded as the respondent's educational attainment. Furthermore, only 13% (n=40) of the respondents claimed to have been enrolled in an IPE focused curriculum (figure 4).





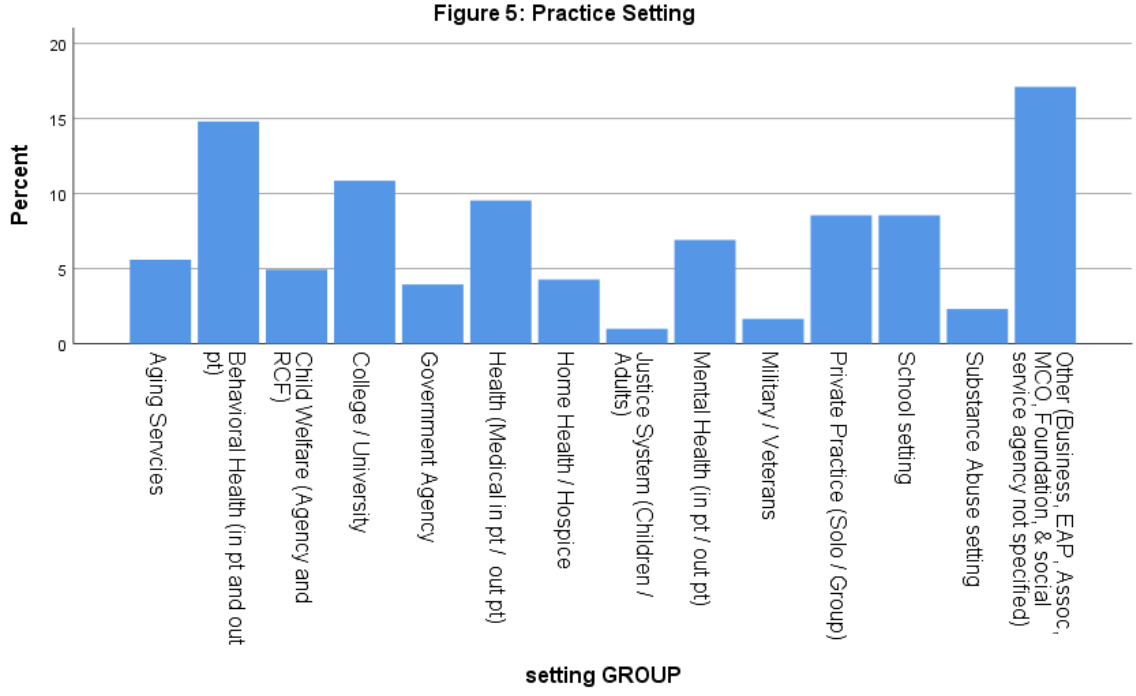
Social work was claimed to be the first profession for 65% of the sample (Appendix P, table 2). Thirty-five percent of the respondents (n=107) entered social work as a second profession. The professions were recoded into seven categories; medical (included nurse, EMT, doctor), psychology / counseling, business (marketing, accounting), retail/restaurant, education, criminal justice, and other. When social work was not a persons' first profession, 20.4%

practiced in psychology / counseling fields, 3.9% were categorized as education, and 3% were in the medical field.

Descriptive: Fields of Practice

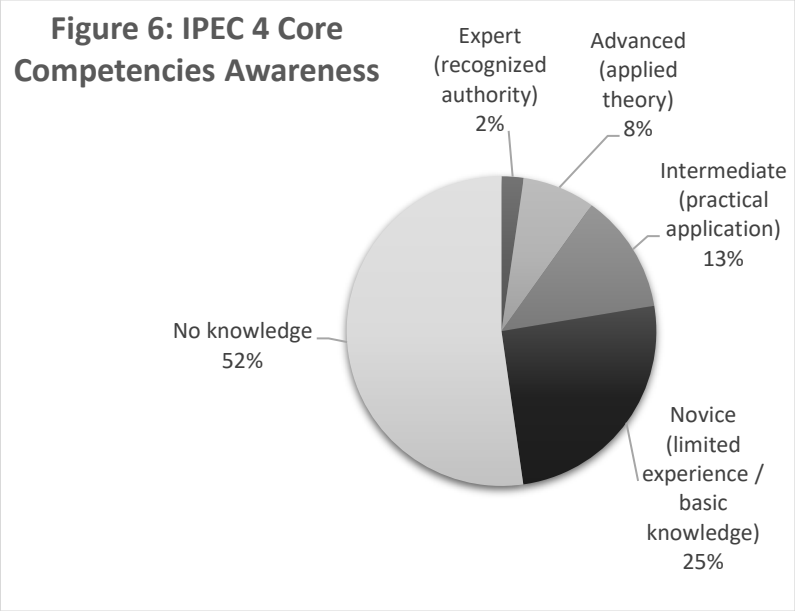
The descriptive statistics of social work practice setting (Appendix P, table 4) was reduced from 29 categories as outlined by NASW to 14 categories. The fields of practice were diverse and greatly varied; the top four were Behavioral Health (11.5%), College/ University (10.7%), School Social Work (8.6%), and Other (7.9%). Respondents had a finite choice list of thirty options that mirrored the practice settings outlined by the National Association of Social Workers (NASW). Options were recoded into 14 categories (figure 5). These category changes included lumping behavioral health in-patient services with behavioral health outpatient services; creating a medical social work category to include home health, hospice, and hospital services; and aging services which encompassed residential care for the elderly, skilled nursing homes, and assisted living.

Figure 5: Practice Setting



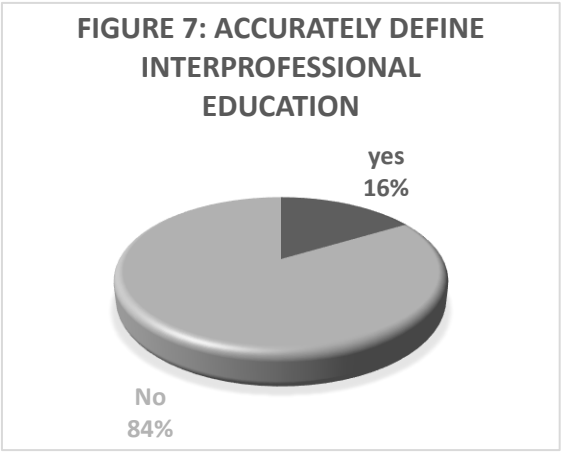
The category of "other" encompassed foundation, association, managed care organization, employee assistance programs, and business. "Other" is larger than expected as social service agency adds a generic category which encompasses many of the already defined categories of child welfare, aging, or mental health agencies.

Descriptive Statistics: IPE/CP Awareness



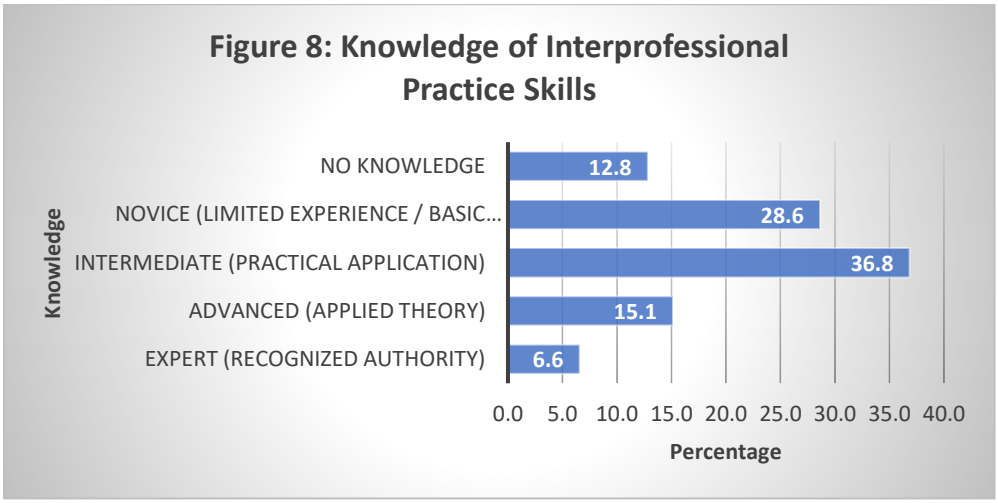
The survey was fashioned around IPEC's four core competencies. Respondents were asked to self-report the level of awareness they possess with respect to knowing the Interprofessional Education Collaborations' Four Core Competencies for interprofessional practice. Figure 6 shows over 75% of the respondents having "little" to "no knowledge" of these IPE core values.

Similarly, respondents were given a teaching scenario of "interprofessional collaborative practice is learned by students when a guest lecturer from another discipline, attends class to provide information on a specific issue (i.e. disease progression by a nurse/ doctor, what to expect in a court room by a judge)." The responses were recoded to reverse the answers from "yes" and "not sure" to

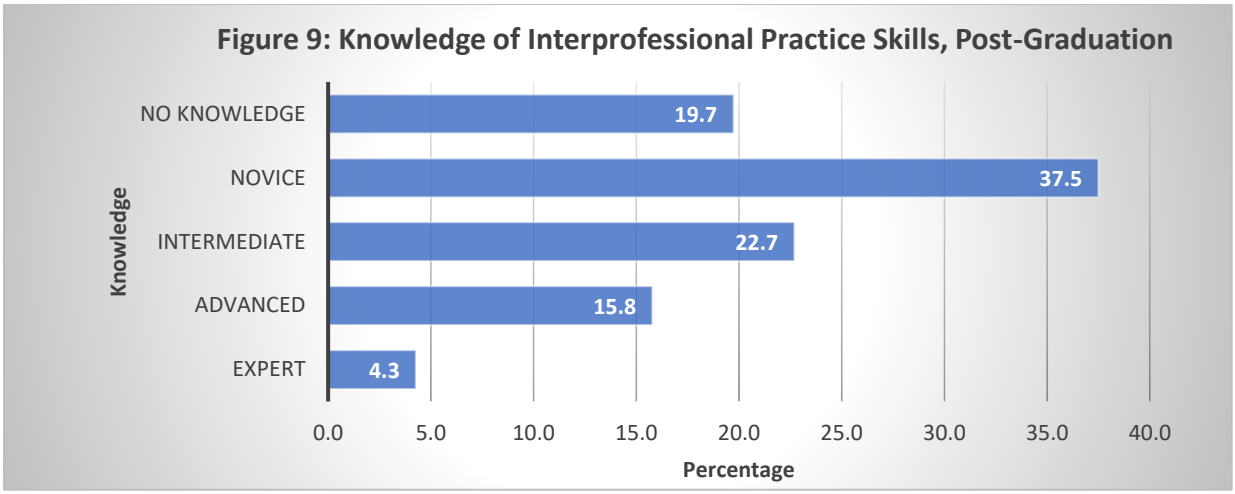


"no" and "no" to "yes". The question did not provide the accurate definition of interprofessional education, as defined by the World Health Organization (WHO) in both 1998 and again in 2010 (figure 7). Sixteen percent of the sample recognized that this question does not represent a true interprofessional learning environment.

A question related to the respondent's current level of knowledge toward IPECP was asked to establish a baseline score for the respondent. Five responses were offered which ranged from "expert" to "no knowledge" (figure 8). Fundamental and novice categories were merged (recoded) because the definitions of limited experience and basic knowledge are similar and extensive definitions were not provided neither within the question nor survey instructions. Forty-one (41.4%) of the sample relate to "novice" and "no knowledge", while the most responses reflected "intermediate" and "practical application" (*n*=112, 36.8%).



The ICPPEP instrument had clarification question which asked if respondents became more knowledgeable with interprofessional practice, after graduation. The latter sample differs with a marked increase of the "novice" and "no knowledge" category (*n*=174, 57.2%) (Figure 9). The intermediates category, after graduation, reduced from 36.8% to 22.7%.

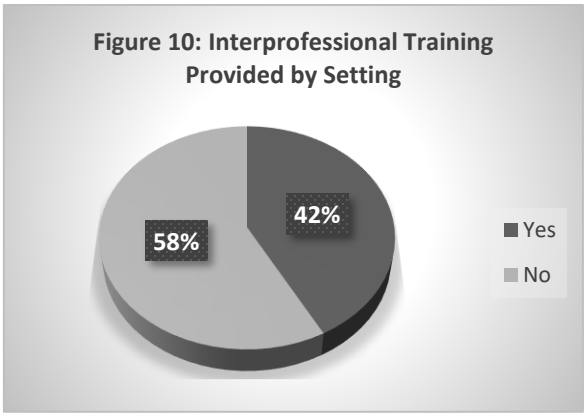


Within the literature review, there were articles that described and explained the difference in terminology between "multi," "inter," and "trans professional or disciplinary" practice. A survey question was written to determine if social workers were introduced to any or all of these terms while matriculating through their social work program. The respondent could mark as many terms as appropriate or had the choice of "none of the above." This question was recoded to capture respondents who were familiar with more than one term, such as "multi and inter," or "inter and trans" (Table 5).

Descriptive Statistics: Employment

Employment questions yielded a diversity of results. Over 13% of the survey respondents report being in social work practice for over 40 years. The largest category of years in practice was "under five" with 22% (M = 19.26, *sd* 14.648, range 0-53). Further, honing in on a respondent's current length of employment, 22% have been employed for less than five years (M=8.36, *sd* 9.124, range 0-45) (Appendix P, table 3). To compare years in practice, the data was recoded from respondent's self-report of years and months into categories of five-year intervals; "less than five years," "5-10 years," through "over forty years" of practice.

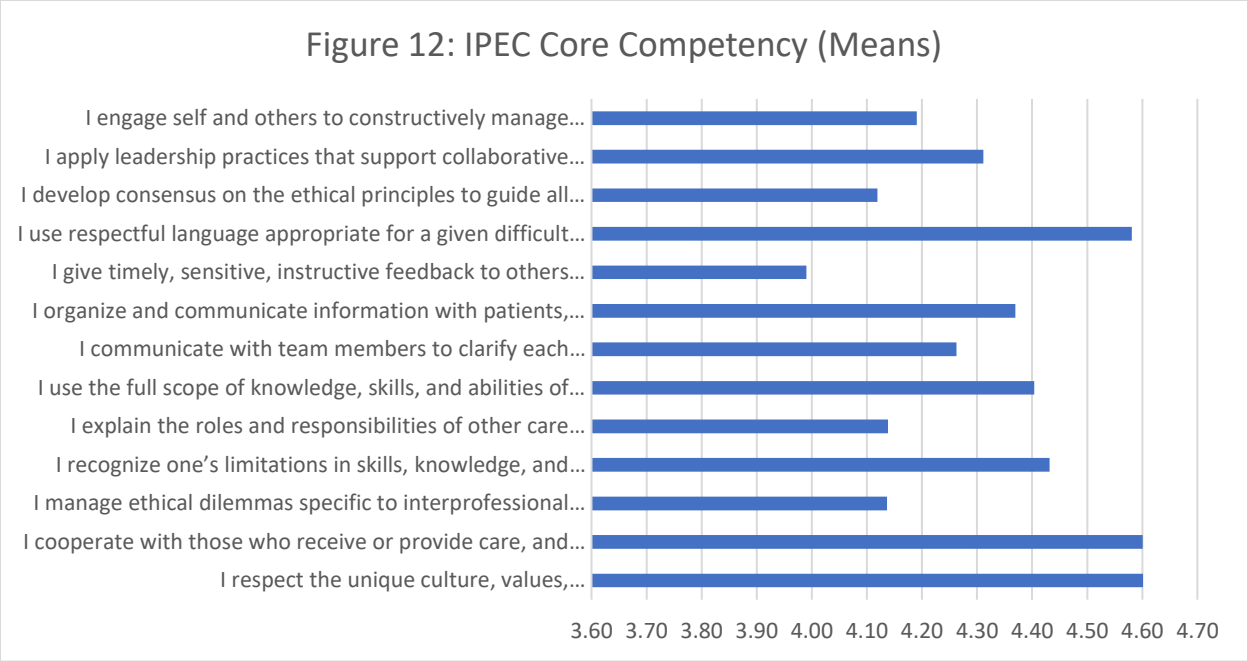
Respondents self-reported on two questions about the level of interprofessional integration within their current employment settings. Overall, the respondents reported their current practice setting does not provide (57.9%) training or orientation related to interprofessional practice (figure 10). Seventy-five percent of the sample believe they are engaged in interprofessional/collaborative practice within their employment (figure 11).



These two questions underwent recoding. Respondents who answered "not sure" were recoded into the "no" category. Thus, there were two categories to compare the respondents who agreed with the question (yes) and the respondents who disagreed with the question (no).

Descriptive Statistics: IPEC Core Competency Scores

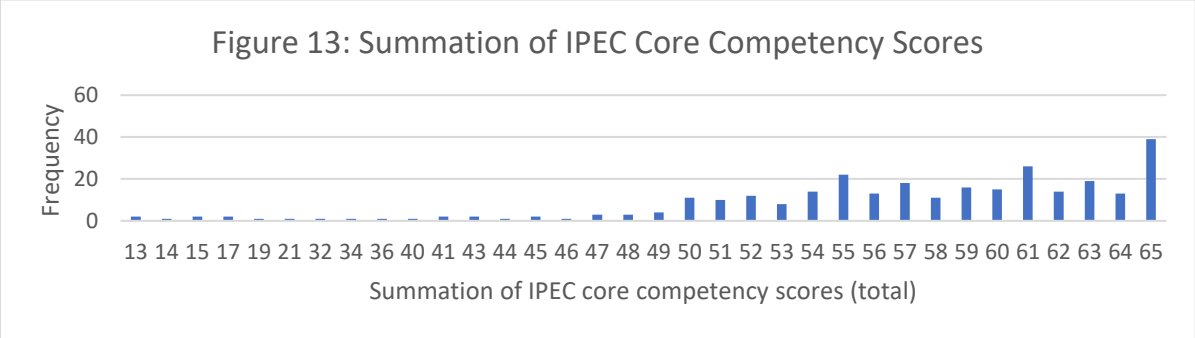
Respondents self-reported, via a 1-5 likert scale, their agreement or disagreement to statements that align CSWE EPAS and IPEC four core competencies. Figure 12 shows the aggregated data for all respondents. All but one of the scores had a mean over 4 or agree to strongly agree. An interesting finding that came out of this question, the lowest mean related to social worker's self-report of providing timely, sensitive, and instructive feedback to teammates and receiving feedback from interprofessional teammates. Further research is necessary for this question, as it may be impacted by professional stratification.



The dependent variable within this study was the accumulation of points on the IPEC competency standards. An IPEC competency standard total score was calculated for each respondent by adding scores of all thirteen questions. The maximum score that could have been achieved is sixty-five, with a range of thirteen to sixty-five. This IPEC competency standard total was used to determine significance from the independent variables. A higher level of competency was attained through a higher score on the IPEC competency standards.

The dependent variable for this survey revolved around a respondent's ability to answer the thirteen Likert scale questions that relate to IPEC four core competencies (table 7). These questions were re-coded by adding all thirteen values to give a total score. The highest score a respondent could receive was sixty-five (figure 13). The questions all referred to social work core values and standards of practice, as outlined in chapter three, thus it was optimal for all social workers who are practicing to receive a high score. A perfect score of sixty-five was achieved by 13.4% of the respondents while sixty-one and fifty-five (8.9% and 7.5%,

respectively) rounded out the top three (n=292). Over 43.2% of the respondents accrued sixty or more points on this scale whereas 3.1% accrued less than thirty points.



Descriptive Statistics: Perception of Social Work Profession Focus

The last three survey questions captured a respondent's belief in the importance of interprofessional preparedness. Importance was defined in three different ways; the perceived educational preparedness to become interprofessional leaders, importance of adding interprofessional to CSWE's 2015 EPAS, and belief interprofessional skills should be a priority for social work education (Appendix P, table 6).

All of the questions on this table were recoded to merge "strongly disagree" with "disagree" as well as merge "strongly agree" with "agree." Three categories were compared "strongly/disagree," "neutral," and "strongly/agree." Furthermore, the question relating to adding interprofessional into the 2015 EPAS was inverted because the original question was presented in a negative format. Survey respondents overwhelmingly (76.3%) believed interprofessional skills to be a priority for social work education and "strongly/agree" (58.2%) that it was important for CSWE to include interprofessional language in the 2015 EPAs.

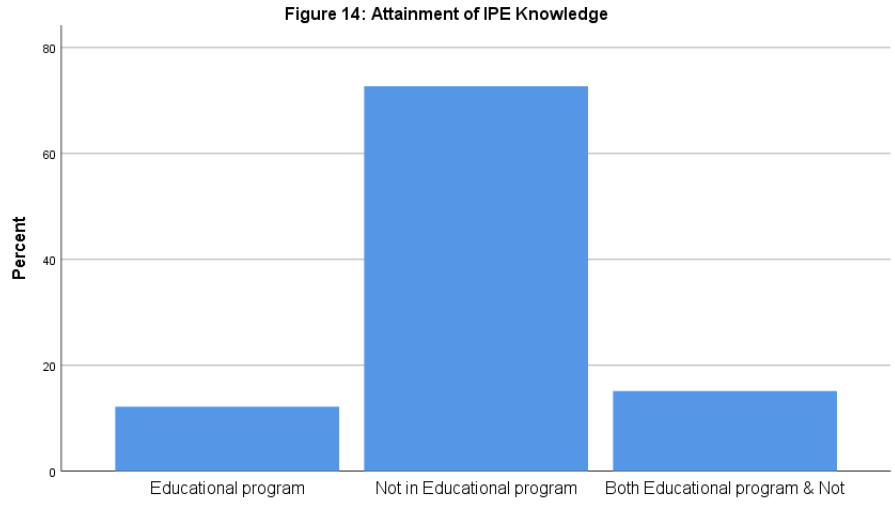
The social work profession lends itself well to practice on interprofessional teams and in interprofessional practice settings. However, are social workers gaining the necessary skills,

through educational programs, to become leaders of interprofessional teams? Four out of every five survey respondents (83.2%) claimed “social workers are not educated to become leaders of IPECP teams.” The large number of respondents who proclaim lack of interprofessional leadership education supports the hypothesis that social workers do not perceive they are academically prepared to practice in interprofessional settings.

Hypothesis: Descriptive Analysis

The majority of survey respondents claimed to have gained their interprofessional knowledge outside of their social work educational program (72.7%) (figure 10). They reported obtaining interprofessional education collaborative practice skills through non-curriculum and non-internship experiences. Thus, the null hypothesis is supported that social workers do not perceive academic preparedness toward interprofessional practice.

The interprofessional knowledge question was recoded from the original survey data. Respondents could answer with as many categories as they felt reflected where they learned IPECP. The categories provided on the survey were: classroom (field class), classroom (non-field class), internship, or not in educational program. These categories were recoded to reflect three possible interactions of these four variables; "educational program," "not in educational program," or "both educational and non-educational program" (figure 14). No statistical significance is found with these variables.



Secondary Analysis of Data

As the hypothesis was "answered" through descriptive statistics. Secondary analysis was undertaken to look at the relationship, without predicting which ones effect the hypothesis. These computations were completed through the use of one-way ANOVAs and Independent *t* tests. The dependent variable was the IPEC core competency score total and the independent variables were: age, gender, years in profession, years in current position, setting of position, year of graduation, highest social work degree attained, knowledge of IPEC core competencies, attainment of IPE skills, fatigue, and perception of social work education through leadership, EPAS, and definition of IPE. Thus, secondary analysis sought to highlight independent variables that effected or impacted the dependent variable, in what direction.

Statistical Significance

Statistical significance was found between the dependent variable of IPEC core competency score total and the independent variables of gender, level of degree, and interprofessional knowledge sought after graduation. The variable of gender was found to be statistically significant via an independent *t* test with a significance level of less than 0.05. The remaining two variables were found to be statistically significant via one-way ANOVAS to a significance level of under 0.05.

Gender: Independent *t* test

Figure 15: Comparison of Gender via Independent *t* test

	F	Sig.	T	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	95% Confidence Lower	95% Confidence Upper
Equal variances assumed	15.060	.000	2.182	289	.030	2.936	1.345	.288	5.584
Equal variances not assumed			1.573	68.517	.120	2.936	1.867	-.788	6.661

Gender was found to be statistically significant. To run this computation the one "other" was removed from the sample to enable computation to be run between "female" and "male." Significant difference was found ($t(2) = 2.182$, $p < 0.03$) (figure 15). The mean of the IPEC core competency standards for "female" respondents (M=56.97, sd = 7.655) was significantly different from the mean of the "male" respondents (M=54.03, sd = 13.925).

A one-way ANOVA was initially computed for gender, including the "other" category This independent variable was found to be statistically significant as ($F(2, 289)$ 3.746, $p < .025$). Calculating the tukey post-hoc was unsuccessful, as a "warning" appeared in the output log. The warning stated "post hoc tests are not performed for Summation of IPEC core competency scores because at least one group has fewer than two cases" (SPSS, 2018).

Education: One-Way ANOVA

A one-way ANOVA (Appendix P, table 2) was computed to compare the interprofessional core competency standard total among four levels of educational attainment; Bachelor, Master, DSW, and PhD. A significant difference was found among level of social work degrees ($F(3,288) = 3.143$, $p < 0.026$). Tukey's HSD was used to determine the nature of

the differences between degrees (Figure 16). This analysis revealed Master level educated social workers ($M = 56.88$, $sd = 8.621$, $p < 0.035$) scored significantly higher than the Bachelor level educated sample ($M = 52$, $sd = 9.717$). No other statistical significance was found amongst the four groups; DSW ($M = 61$, $sd = 3.24$) or PhD ($M = 54.31$, $sd = 16.6$).

Figure 16: Comparison of Attained Degree via Tukey HSD

Degree attained	Comparison degree	Mean Difference	Std. Error	Sig.	95% Confidence Interval Lower Bound	95% Confidence Interval Upper Bound
BSW	MSW/MSSP	-4.884*	1.795	.035	-9.52	-.25
	DSW	-9.000	4.478	.187	-20.57	2.57
	PhD in SW/S Welfare	-2.313	2.870	.852	-9.73	5.10
MSW/MSSP	BSW	4.884*	1.795	.035	.25	9.52
	DSW	-4.116	4.189	.759	-14.94	6.71
	PhD in SW/S Welfare	2.571	2.393	.705	-3.61	8.76
DSW	BSW	9.000	4.478	.187	-2.57	20.57
	MSW/MSSP	4.116	4.189	.759	-6.71	14.94
	PhD in SW/S Welfare	6.688	4.750	.495	-5.59	18.96
PhD in SW/S Welfare	BSW	2.313	2.870	.852	-5.10	9.73
	MSW/MSSP	-2.571	2.393	.705	-8.76	3.61
	DSW	-6.688	4.750	.495	-18.96	5.59

**. The mean difference is significant at the 0.05 level.*

IPE/CP Knowledge: One-Way ANOVA

Statistical significance was found between perceived knowledge of IPECP and IPEC core competency score as evidenced through an ANOVA calculation ($F(4,287)$ 2.624, $p < .035$) (Appendix P, table 2). A post hoc test of Tukey's HSD was run but no statistical significance was found among the groups as the sample is unevenly distributed.

Furthermore, an ANOVA was run and found statistical significance ($F(4,287)$ 3.381, $p < .010$) between IPEC core competency score and post-graduation knowledge accumulation (Appendix P, table 2). A post hoc algorithm of Tukey HSD was run and further determined the

difference was between “advanced” and “fundamental awareness” (figure 17). The results indicate that respondents who claim to be “advanced” (M = 60.70, *sd 4.039)* in their understanding of interprofessional education scored higher on IPEC core competency score than “fundamental awareness” (M = 54.85, *sd* .849). Significance was not found between the other categories “no knowledge” (M = 55.86, *sd* 9.940), “intermediate” (M = 56.39, *sd* 10.171), and “expert” (M = 58.38, *sd* 13.985).

Figure 17: Post Graduation Knowledge, Tukey
Summation of IPEC core competency scores (missing data scores removed)

Tukey HSD[a,b]

After graduating with my social work degree, I have become knowledgeable about the term interprofessional collaborative practice, to what degree?	N	Subset for alpha = 0.05
		1
Fundamental Awareness/Novice	113	54.85
No knowledge	56	55.68
Intermediate	67	56.09
Expert	13	58.38
Advanced	43	60.70
Sig.		.062

Means for groups in homogeneous subsets are displayed.

a. Uses Harmonic Mean Sample Size = 35.258.

b. The group sizes are unequal. The harmonic mean of the group sizes is used. Type I error levels are not guaranteed.

Non-Statistical Significance

Several questions from this study did not yield statistical significance, when SPSS was used to run one-way ANOVAs and Independent *t* tests.

Demographics: ANOVA

No other independent variable within demographics was found to be statistically significant, other than gender. Age is not found to be statistically significant with respect to a respondent "total" score on the interprofessional core competency statements ($F(3, 288)$ .770, $p > .05$) (Appendix P, table 2). State of practice variable yielded no statistical significance to IPEC core competency score total, for respondents as evidenced by an ANOVA calculation (F(1,290) 0.916, p > 0.05 (Appendix P, table 2).

Education: ANOVA & Independent *t* test

As previously outlined there was statistical significance found between educational attainment and IPEC core competency score total, however no other educational independent variable yielded significance. Year of graduation ($F(5,270)$ 1.384, $p > 0.05$) and first professional identify ($F(7,284)$ 1.024, $p > 0.05$) were not significant when compared with IPEC core competency score (Appendix P, table 2).

IPE educational program data was recoded to run a *T-test*. The respondents who reported they were "not sure" if they were enrolled in an IPE program were recoded to the "no" category. An independent-sample *t* test was calculated comparing the mean score of the participants who identified themselves as enrolled in an IPE academic curriculum to those are not enrolled in IPE social work curriculum. No significant difference was found ($t(2) = 1.560$, $p > 0.05$). The mean of the IPE enrolled program students (M=58.05, sd = 1.294) was not significantly different from the mean of the non-IPEC enrolled students (M=55.38, sd = .0636).

Practice: ANOVA and Independent *t* test

Independent variables related to a respondent's practice yielded no statistical significance with respect to the IPEC core competency standards total score. Neither a respondent's length of

time in the field (F(8,283) 1.709, p > 0.05) nor years in current practice setting (F(9,282) 1.214, p > .05) were found to be statistically significant (Appendix P, table 2). An ANOVA was calculated and found no statistical significance between practice setting and the IPEC core competency standards total (F(13,278) 0.396, p > 0.05).

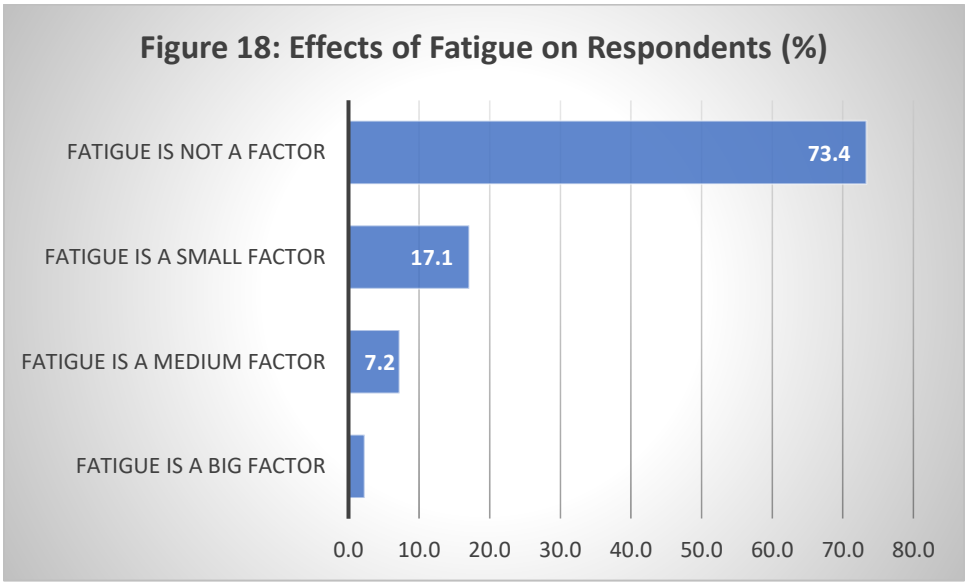
Statistical significance was not found through t tests comparing IPEC core competency and interprofessional training provided by setting (t(248) 1.802, p > .05) or belief respondent is engaged in interprofessional practice (t(249) 1.528, p> .05) (Appendix P, table 2).

IPE/CP: ANOVA and Independent *t* test

Respondents self-reported the use of the terminology of inter, multi, and trans within their educational program. All combinations of the original four responses were transformed into eight categories for comparison. An ANOVA test was conducted which resulted no statistical significance (F(4, 287) 1.655, p > .05) (Appendix P, table 2).

An independent-samples t test was calculated comparing the mean score of participants who were identified as knowing the accurate definition of interprofessional education to the mean score of respondents who did not know the definition of interprofessional education (Appendix P, table 2). No significant difference was found (t(290) = -1.418, p > .05). The mean of the group that accurately defined interprofessional education (M = 58.08, sd = 1.039) was not significantly different from eh mean of respondents who did not know the definition of interprofessional education (M = 55.97, sd = .622).

Fatigue



In an attempt to increase the reliability of this survey, a question was added asking respondents about their level of fatigue (figure 18). Fatigue was found not to be a factor (M = 3.62, sd = .722). An ANOVA was calculated and found no statistical significance comparing IPEC core competency scores and fatigue (F(3,288) 1.609, p > .05) (Appendix P, table 2).

The ICPPEP survey was updated to mirror the results section, of this document. The changes directly relate to the recoding of certain questions, such as removal of "not sure." Other changes to this survey included removal of the open-ended question on age that was replaced with twenty-year age group option (Appendix Q). These changes were completed in effort to make it easier to replicate the study.

Qualitative Findings

Qualitative findings are reported from an open-ended question of "what your impact on the IPE team is?" The results were coded into twelve themes based on words provided by respondents. The themes emerged from half (N=153) of the respondents who chose to answer this question. The most frequent themes that emerge from this sample is "high impact," "equal impact," "some impact," and "little to no impact." A portion of the sample claimed to have "impact only on certain issues" (*n*=11), citing "psychological input," "discharge planning," or "advocacy." Impact is not defined and left to the discretion of the respondent as to its personal meaning.

Some respondents (*n* = 59) answered the impact question as to their role and not their amount of contribution or impact to the team. Twenty-two respondents replied they were responsible for the client / patient's plan of care, discharge planning, and working with families. Sixteen replied responsibility for coordination of care among professionals, twelve were advocates for client / patients' rights and or voice, and nine stated they were the leaders.

There were a handful (*n*=12) of responses that indicated a lack of awareness or understanding of interprofessional / collaborative practice, listing answers such as "Never heard of IPE" and "don't understand term." Other responses did not fit into a category, such as "all psychologists", "no such thing at my agency."

Again, as mentioned in the methodology section, the term interprofessional education and collaborative practice were not clearly defined. Providing the definition may have unduly influenced a respondent's answer to a question. The purpose of this study was to determine the social worker's perception of preparedness and knowing what IPECP refers to is central to the study.

The implications gleaned from this question relate to issues of leadership and professional stratification. When social workers do not feel they are heard or asked for their opinion to contribute to a patient / client's care, professional stratification is a barrier for social workers to advocate. Professional stratification refers to power and control based on title and position, such as doctors have the "final say" in treatment of patients within a medical facility or lawyers dictate direction of children and youth cases. These decisions are usually done without significant input from other disciplined professionals who may be working with the patient or client.

A social worker's perception of not having a voice on a team also relates to leadership. Oliver's article *Social workers and boundary spanners: Reframing our professional identity for interprofessional practice* emphasizes the educational background and skill-based preparedness for social workers to be leaders is immense. The current environment, in many agencies, prevents the assentation of social workers into leadership roles. The inability of social workers to become leaders on interprofessional teams feeds directly into and reinforces the stratification of professions.

Implications and Limitations

The purpose of the study was to identify social worker's perceptions of academic preparedness to practice in IPECP settings. The hypothesis of perceived academic preparedness was supported through statistically significant variables of gender and social work degree attained, primarily Masters compared to Bachelors. The hypothesis was supported through descriptive statistics of attainment of interprofessional knowledge outside of the educational setting (72.7%), social worker's inaccurately defining interprofessional education (84%) and perception that social workers are not educated to become leaders of interprofessional teams (84%). Yet, 75% of the respondents claimed they were engaged in interprofessional practice in their current setting and 76.3% of the respondents "strongly / agree" interprofessional skills should be a priority in social work education.

The hypothesis did not correlate as statistically significant with all other independent variables. The non-significant variables were age, years in practice, year of graduation, type of practice setting, enrollment in an interprofessional curriculum, social work as first profession, knowledge level of IPEC four core competencies, practice setting training opportunities. The hypothesis does not claim these variables and therefore their lack of significance does not contradict the hypothesis.

The predominant finding is that social workers do not perceive their educational curriculum prepared them for interprofessional practice. Three other questions were raised within this research project and relate to secondary findings. These findings refer to advocacy and value loss of social work profession as many respondents believe they are engaged in interprofessional practice yet have no "voice" on their team. This relates to the social work profession's loss of value as leaders on interprofessional teams and the perpetuation of professional stratification, in

the majority of respondent's practice settings. Lastly, is CSWE curriculum keeping up with current employment trends does not have a straight answer or finding. The EPAS were changed in 2015, therefore most of the respondents were not educated under this expectation to have interprofessional competence. The supporting finding of respondents seeking out interprofessional skills and knowledge supports the need for interprofessional skills for employment.

Limitations

This study has six limitations.

Limitation number one questions the validity of the ICPPEP instrument. Is the survey measuring what it is meant to measure? Although the Cronbach Alpha was within range for the pilot study (0.809), this number may have been inflated as there were only fourteen respondents who completed the survey at the pre and post-test times. Some respondents revealed they had to look up the definition of interprofessional education to complete the survey. The pilot study participants recommended adding the definition of interprofessional in the instructions or on the consent page. The definition was not added for the study as that would have directly impacted the outcome of the survey, more specifically can social workers recognize interprofessional education, as in the last question on the survey. The pilot participants raise an interesting question concerning the reliability of how respondents answer if they are unsure of the terminology. This may have impacted the results; however, this supports the hypothesis of social worker's perceived lack of preparedness for interprofessional practice.

A second limitation is the size of the sample. A response rate of 7.7% is small. The sample may not be representative of social workers outside of NASW-PA membership and therefore limits the generalizability of this study to other states and non-NASW populations. The

small sample size may be due to name recognition of the researcher, even though the researcher put safeguards in place to secure anonymity of the sample.

Another limitation is access to NASW-PA membership. NASW-PA's policy of blasting out questionnaires is limited to one email blast (e-blast) with no option for reminders. The researcher does not have access or control of the list of members from which reminders could be sent to increase sample size. The e-blast was sent out on a Friday afternoon at 4 pm. The timing of dissemination was not controlled by the researcher. This timing was less than desirable and may have gotten buried under a weekend of emails in the potential respondent's inbox.

The survey was a voluntary, electronic self-report. These factors may impact the response rate. A person must have self-selected to complete the study which could bias the results in either a positive or negative manner. Positive bias results when a respondent responds favorably possibly due to familiarity with the researcher or the topic. While negative bias is the opposite, or prevents a potential respondent from opening the survey, at all. Respondents voluntarily gave of their time to complete the survey, as remuneration was not provided. Lastly, this study uses a lot of technology, from the e-blast announcing the survey to the construction of the online survey tool on Survey Monkey platform. Technology reduces time and cost of mailing surveys. However, the completion rate may have been negatively impacted if potential respondents were not technically savvy, did not have access to a computer, or had no desire to answer online surveys.

The generalizability of this research to the general population is questionable. Cohen's *d* was calculated. The results of this calculation provided the researcher with a "very low" generalizability of results ($d = 0.20$). This can be strengthened through future research of using a representative sample from the general population of NASW-PA membership. Due to the

limitations of accessing NASW-PA membership, this option was not implemented during this study.

In conclusion, the last limitation is the clarity of terminology. Although a majority of social workers responded that they practice in an interprofessional manner, it comes into question if this is accurate. Accuracy is questioned when most of the respondents could not identify the correct definition of interprofessional practice. This observation calls into question the validity of the study, more so, are social workers truly engaged in interprofessional or simply multiprofessional practice. Through not wanting to bias the respondents by giving definitions of multi, inter, and trans professional practice, the researcher questions the results of the survey.

Discussion & Implications

Education

Statistical significance is found between social work degree attainment and IPEC core competency scores. The Master level practitioners perceives themselves to be more prepared than Bachelor prepared practitioners. This finding substantiates the literature review that references social workers to be a good fit for engaging in interprofessional practice. Master level prepared practitioners are required to complete a greater number of internship hours than the Bachelor student, which may introduce more master level students to interprofessional practice.

This survey superficially demonstrates the complexity of training every social worker to be proficient in all settings; micro, mezzo, and macro. The model that is utilized to address the educational complexity of preparing all social workers for practice is the Generalist Practice Model. CSWE reports that the majority of the social work programs utilize the Generalist Practice Model. Through the use of this model, students are educated to understand fundamental social work values and skills. These skills are then transferred to many different practice settings,

including levels of practice such as micro, mezzo, and macro. The importance of the transferability of skills is to ensure social work students are prepared for a wide range of practice settings.

To strengthen social workers employability and knowledge of interprofessional practice, CSWE added interprofessional terminology into the 2015 EPAS, two years after being granted membership in IPEC. CSWE accredited programs are in the process of transitioning to the new EPAS as some programs have yet to convert to new EPAS of adding interprofessional terminology into the curriculum. Interestingly, CSWE does not prescribe how to teach, what to teach, or how much of interprofessional education to add to the curriculum. This may lead to varied experiences and exposure toward interprofessional discussions and practice. Coordination of a unified social work profession toward interprofessional practice may be streamlined through use of IPEC four core competencies as a roadmap. The diversity or non-standardization of interprofessional education, and as a result interprofessional practice, could lead to confusion especially between interprofessional and multiprofessional practice. This confusion was evident in the study as respondents claim to practice in interprofessional settings but could not define the interprofessional education.

A hallmark of interprofessional education is the cross-learning of students from two or more disciplines. A great number of complications arise when colleges and universities are developing joint programs or curriculums that span several disciplines. True interprofessional educational experiences requires a person, be it a professor or director of a program, to be the champion or person responsible for developing an inclusive program. This inclusive program encourages disciplines to share knowledge, built communication skills, and interact in a way that

models, for students, interprofessional skills of recognizing strengths of each profession, ethical values, and roles they fill on the team.

While interprofessional education and practice may be important to the WHO and insurance companies who are transitioning toward collaborative practice models, it may not be viewed as important to educational programs. This viewpoint is discussed in the literature. It may be due to many barriers that interfere with developing interprofessional programs. Barriers include, but are not limited to funding issues, tuition allocation, instructor case load, location of classes, acceptance into the program, discipline that controls the curriculum, which department gets credit for the enrolled students, and evaluations. Politics of departments and of accrediting bodies influence the development of interprofessional programs. Politics can spur the creation of programs or delay them. The direction depends on the intensity of the issue, in this case is interprofessional education and practice more ideal than real. Whereby the urgency is not communicated by CSWE to change curriculum within accredited programs.

Regarding elaborating on ideal versus real: Are social workers truly working in interprofessional settings that they are in need of this knowledge or skills gained through this type of education? Are settings that utilize interprofessional practice models void of hierarchical structures and all team members have equal input to care for the patient or client? Within the literature review, some research concluded the hierarchy, or professional stratification, within the organization translated into the hierarchy on the team, i.e. doctors held most power and were looked to be the leaders on interprofessional teams within a medical facility. These questions of interprofessional practice utilization within social workers employed agencies, deserves further research. Secondly, further research could be directed toward field placement agencies and agencies that hire social workers. The focus of this research could be the use of interprofessional

skills, hierarchy within the agency, and identify the leader of interprofessional teams. This would strengthen current research to determine if adding interprofessional skills to social work curriculum is important.

Social workers do not perceive educational preparedness toward interprofessional practice, as evidenced by the findings of this study. The variable of practice setting, years in practice, or if social work was a respondent's first profession yielded no statistical significance. This research did not exclude respondents who identified non-medical settings as their place of employment, especially as social workers are employed in a wide variety of settings. Further research could continue to explore the knowledge and practical application of interprofessional education within the numerous social work areas of practice.

Interprofessional education and practice is a "hot" topic as WHO outlined its importance in both 1998 and 2010. Research studies conducted on interprofessional teams frequently focus on medical-based teams; hospitals, clinics, hospice. Further research is necessary to focus on other populations with whom social workers interact; children & youth, justice system, school system, and government agencies. These studies could be used to determine if social workers are better able to transfer basic social work skills into settings that are non-medical in nature.

Interestingly, understanding the purpose behind each of the social work degrees, may shed light on the finding that DSW respondents, overall scored higher than all other educational categories on IPEC core competency values. Due to the small number of respondents within this category, statistical significance was not found. This non-statistical finding may be due to the strong practical application focus of this degree or the realization that the Kutztown / Millersville Universities DSW program has a focus on leadership. The focus of educating students to lead organizations may have provided the necessary education to better understand interprofessional

practice, however not perceive preparedness to practice. Difference between educational attainment warrants further study.

Of interest, but without statistical significance, was comparison of respondents who were enrolled in an IPE program versus were enrolled in standard social work curriculum. This suggests the sample size was too small for comparison, there is a lack of consistency among IPE focused programs, or social work programs are teaching these skills, yet students may not be fully able to incorporate it into their professional self. This is an area for future study which may include comparing social work programs that are generalist focused versus specialty focused (ie. Macro / community organization, clinical, school, or military social work).

Gender

Gender was found to be statistically significant. This may be due to the overwhelming majority of the sample checking the female box. The gender characteristic warrants further study.

Terminology

As evidenced by this study, many social workers perceive they engage in interprofessional practice. Due to the lack of ability to define interprofessional education, do social workers truly work in interprofessional settings or are they engaged in multiprofessional settings? How can social workers claim to practice in an interprofessional setting, when they cannot define it? The researcher was purposeful not to add the definition of interprofessional to the consent form or the instructions of the study, as that may have unduly influence the answers. Several persons in the pilot study reported they researched the definition of interprofessional versus multiprofessional to complete the survey. The survey was not designed, except in the pilot, to receive feedback on what outside resources are used to complete the survey.

This study found, although not statistically significant, that respondents were introduced to the terminology of multiprofessional and interprofessional. Familiarity with these terms may be more of an ideal than a real understanding of the terminology, as most of the respondents could not define interprofessional. Interprofessional education is not a recent or "new" term. IPEC developed guidelines that describe the skills necessary for interprofessional competence. These IPEC skills are the basis for the IPEC core standards questions asked within this survey. The core standards skills mirror the fundamental values of the social work profession. Nonetheless, the respondents overwhelmingly reported "no knowledge" or "novice" knowledge as their knowledge of interprofessional collaborative practice.

Survey findings indicate respondents receive most of their interprofessional education outside of the classroom. To address the perception of unpreparedness, social work programs make changes to the curriculum, especially related to transferability of social work skills and practice. Transfer of skills occurs in other contexts such as in programs without "specific" policy or macro class. Foundational social work skills are taught then students learn how to extrapolate their skills and overlay them in different practice settings and or populations. The transferability of skills is of great import to the viability and sustainability of the social work profession, especially when more programs are moving toward Generalist Practice Model; teaching social workers to be employed at the micro, mezzo, and macro settings.

Interprofessional Training

Social workers in this sample believe they engage in interprofessional practice. Yet, respondents of the survey report they do not receive interprofessional training or orientation in their practice setting. This finding raises the question: are practice settings truly utilizing interprofessional practice or are they employing multiprofessional practice expectations? There

is a stark difference between the independent discipline approach of multiprofessional practice and the interrelatedness of disciplines through the interprofessional approach to practice.

According to IPEC, the purpose of interprofessional education is to prepare social workers to engage and interact with other discipline professionals over four areas; communication, teamwork, roles/responsibilities, and values/ethics. Thus, interprofessional education is much more than a guest lecturer providing information on a disease. The conversations should go deeper and address ethical codes that conflict or contradict amongst professionals on the team.

Professionals who feel they are not receiving agency training or orientation toward interprofessional expectations at the agency could benefit from continuing education workshops. These workshops could be created to address the fundamentals of interprofessional practice. Utilizing IPEC four core standards as a framework, participants would gain knowledge and skills in the areas of communication, values/ethics, teamwork, and roles/responsibilities. These training sessions would address the disconnect of social workers' perception of preparedness to practice in interprofessional settings as well as the respondent's lack of ability to define interprofessional education.

Leadership

Interprofessional leadership is a skill that many within the sample did not believe was being communicated effectively through their social work curriculum. There was no statistical significance between a respondent who believed interprofessional leadership was taught in school versus those who did not feel interprofessional leadership was taught in school and the IPEC core competency standards. To increase social work preparedness in interprofessional settings, educational workshop could be developed to identify leadership qualities and skills

unique to working with multiple disciplines. However, are there interprofessional leadership positions to be occupied by social workers? Is this a necessary skill to teach social workers when in reality the opportunity for interprofessional team leadership is not available?

As the literature suggests, social workers are well-suited to be leaders in collaborative practice settings. Social workers are boundary spanners. The social work profession shares almost all of the values as outlined by IPEC in the four core competencies. Research could further explore social workers' perception of leadership training within academic programs, post-graduation training on leadership, and the skills or knowledge they feel are more important as leaders. Taking leadership, a step farther, research could explore the hierarchical structure of agencies and professions that impede a social worker to transcend into leadership positions.

Regulations

It will be important to monitor if CSWE 2015 EPAS changes are making an impact on social workers' perception of academic preparedness toward interprofessional practice. This study or one like it, could be repeated, in five years. Five years was chosen to reflect the changeover of programs adherence with the 2015 EPAS and would capture social work students who matriculate through a program that converted to the 2015 EPAS that include interprofessional language. The research project can focus specifically on graduating social workers to ensure they were educated under the governing attributes of the 2015 EPAS. To ensure social work programs are adhering to updated EPAS, CSWE could hold responsibility to replicate this study idea. A CSWE study could determine if the change of language in the EPAS to add interprofessional was effective at increasing social worker's knowledge and skills of interprofessional practice.

Interprofessional practice is a hallmark for the social work profession. It remains important for social workers to be adequately prepared or the future of the profession is at stake. The profession does not always keep up with employment needs of the day which has cost the profession jobs, especially in medical settings where care managers (i.e. leader of interprofessional team) are registered nurses and not social workers. It is imperative for the social work profession to, at the very least, educate students on how to transfer fundamental social work skills into the interprofessional practice settings.

Conclusion

This study provides evidence that social work respondents do not perceive they are prepared to practice in interprofessional settings. This study and many of the suggestions are addressing this issue through suggested changes in the curriculum or a bottom up approach to change. This is in contrast to changing social worker's perspective from the top down, as the WHO does not have much authority on the educational system within the United States. The WHO may make recommendations; however, it is primarily addresses international issues.

Within the United States, effecting change may lie with the insurance companies. Some insurance companies are restructuring payment schedules to reward agencies that utilize interprofessional teams. The use of interprofessional teams is to provide comprehensive patient care and to reduce re-admission rates in hospitals and urgent care settings. Therefore, the insurance company has the ability to influence social work education to stay current with employment skills and trends. The potential problem with this returns to the issue of profession hierarchy within medical facilities. Are social workers seen as an equal on the team?

Understanding the necessary skills of social workers to become employed, questions remain about the viability of interprofessional education. If most agencies are not utilizing

interprofessional teams, would teaching interprofessional skills take away valuable class time from other important knowledge areas or skills? This study suggests that although the definition of interprofessional education eludes most of the respondents, the terminology and skills for interprofessional and multiprofessional practices are a necessary part of the curriculum. Most of the respondents claim to practice in an interprofessional setting, which may truly have been multiprofessional. Either way, it is important for social workers to have the skills and knowledge to interact on the micro, mezzo, and macro level with other disciplines.

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Appendix A
Employability of Social Work Graduates

Employability of Social Work Graduates (Student Loan Debt)

Student Loan Debt by Program Level

Student Loan Debt	Program Level	Baccalaureate	Programs Reporting (N) Master's	Programs Reporting (N)	Practice Doctorate	Programs Reporting (N)	PhD	Programs Reporting (N)
Percentage of students with loan debt	81.3	337	77.7	147	71.0	3	63.1	23
Median amount of loan debt	$28,000	311	$40,815	138	$40,000	3	$42,804	21

(CSWE, 2015, p. 13)

Appendix B
IPEC Competencies

Interprofessional Collaborative Practice Competencies

1. (Values/Ethics for Interprofessional Practice)

Work with individuals of other professions to maintain a climate of mutual respect and shared values.

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.

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.

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.

Appendix C
IPEC Competency Statements

General Competency Statements and Specific Domain Competencies:

Domain 1: Values/Ethics for Interprofessional Practice General Competency Statement: Work with individuals of other professions to maintain a climate of mutual respect and shared values.

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 cultural diversity and individual differences characterizing patients, populations, and health care teams.

VE4: Respect the unique cultures, values, roles/responsibilities, and expertise of other health professions.

VE5: Cooperate with those who receive or provide care, and others who contribute to or support healthcare.

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 teambased 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.

Domain 2: Roles/Responsibilities General Competency Statement: 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.

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.

Domain 3: Interprofessional Communication General Competency Statement: 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.

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.

CC8: Communicate consistently the importance of teamwork in patient-centered and community-focused care.

Domain 4: Teams and Teamwork General Competency Statement: Apply relationship-building values and principles of team dynamics to preform effectively in different team roles to plan and deliver patient-/population-centered care that is safe, timely, efficient, effective, and equitable.

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.

Appendix D
Council on Social Work Education: 2015 Educational Policy and Accreditation Standards

Competency 1: Demonstrate Ethical and Professional Behavior

Competency 2: Engage Diversity and Difference in Practice

Competency 3: Advance Human Rights and Social, Economic, and Environmental Justice

Competency 4: Engage in Practice-informed Research and Research-informed Practice

Competency 5: Engage in Policy Practice

Competency 6: Engage with Individuals, Families, Groups, Organizations, and Communities

Competency 7: Assess Individuals, Families, Groups, Organizations, and Communities

Competency 8: Intervene with Individuals, Families, Groups, Organizations, and Communities

Competency 9: Evaluate Practice with Individuals, Families, Groups, Organizations, and Communities

Competency 1: Demonstrate Ethical and Professional Behavior

Social workers understand the value base of the profession and its ethical standards, as well as relevant laws and regulations that may impact practice at the micro, mezzo, and macro levels. Social workers understand frameworks of ethical decision-making and how to apply principles of critical thinking to those frameworks in practice, research, and policy arenas. Social workers recognize personal values and the distinction between personal and professional values. They also understand how their personal experiences and affective reactions influence their professional judgment and behavior. Social workers understand the profession's history, its mission, and the roles and responsibilities of the profession. ***Social Workers also understand the role of other professions when engaged in interprofessional teams.*** Social workers recognize the importance of life-long learning and are committed to continually updating their skills to ensure they are relevant and effective. Social workers also understand emerging forms of technology and the ethical use of technology in social work practice.

Social workers:

• 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;

• use reflection and self-regulation to manage personal values and maintain professionalism in practice situations;

• demonstrate professional demeanor in behavior; appearance; and oral, written, and electronic communication;

• use technology ethically and appropriately to facilitate practice outcomes; and

• use supervision and consultation to guide professional judgment and behavior.

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. The dimensions of diversity are understood as the intersectionality of multiple factors including but not limited to age, class, color, culture, disability and ability, ethnicity, gender, gender identity and expression, immigration status, marital status, political ideology, race, religion/spirituality, sex, sexual orientation, and tribal sovereign status. Social workers understand that, as a consequence of difference, a person's life experiences may include oppression, poverty, marginalization, and alienation as well as privilege, power, and acclaim. Social workers also understand the forms and mechanisms of oppression and discrimination and recognize the extent to which a culture's structures and values, including social, economic, political, and cultural exclusions, may oppress, marginalize, alienate, or create privilege and power.

Social workers:

• apply and communicate understanding of the importance of diversity and difference in shaping life experiences in practice at the micro, mezzo, and macro levels;

• present themselves as learners and engage clients and constituencies as experts of their own experiences; and

• apply self-awareness and self-regulation to manage the influence of personal biases and values in working with diverse clients and constituencies.

Competency 3: Advance Human Rights and Social, Economic, and Environmental Justice

Social workers understand that every person regardless of position in society has fundamental human rights such as freedom, safety, privacy, an adequate standard of living, health care, and education. Social workers understand the global interconnections of oppression and human rights violations and are knowledgeable about theories of human need and social justice and strategies to promote social and economic justice and human rights. Social workers understand strategies designed to eliminate oppressive structural barriers to ensure that social goods, rights, and responsibilities are distributed equitably and that civil, political, environmental, economic, social, and cultural human rights are protected.

Social workers:

• apply their understanding of social, economic, and environmental justice to advocate for human rights at the individual and system levels; and

• engage in practices that advance social, economic, and environmental justice.

Competency 4: Engage In Practice-informed Research and Research-informed Practice

Social workers understand quantitative and qualitative research methods and their respective roles in advancing a science of social work and in evaluating their practice. Social workers know the principles of logic, scientific inquiry, and culturally informed and ethical approaches to building knowledge. Social workers understand that evidence that informs practice derives from multi-disciplinary sources and multiple ways of knowing. They also understand the processes for translating research findings into effective practice.

Social workers:

• use practice experience and theory to inform scientific inquiry and research;

• apply critical thinking to engage in analysis of quantitative and qualitative research methods and research findings; and

• use and translate research evidence to inform and improve practice, policy, and service delivery.

Competency 5: Engage in Policy Practice

Social workers understand that human rights and social justice, as well as social welfare and services, are mediated by policy and its implementation at the federal, state, and local levels. Social workers understand the history and current structures of social policies and services, the role of policy in service delivery, and the role of practice in policy development. Social workers understand their role in policy development and implementation within their practice settings at the micro, mezzo, and macro levels and they actively engage in policy practice to effect change within those settings. Social workers recognize and understand the historical, social, cultural, economic, organizational, environmental, and global influences that affect social policy. They are also knowledgeable about policy formulation, analysis, implementation, and evaluation.

Social workers:

• Identify social policy at the local, state, and federal level that impacts well-being, service delivery, and access to social services;

• assess how social welfare and economic policies impact the delivery of and access to social services;

• apply critical thinking to analyze, formulate, and advocate for policies that advance human rights and social, economic, and environmental justice.

Competency 6: Engage with Individuals, Families, Groups, Organizations, and Communities

Social workers understand that engagement is an ongoing component of the dynamic and interactive process of social work practice with, and on behalf of, diverse individuals, families, groups, organizations, and communities. Social workers value the importance of human relationships. Social workers understand theories of human behavior and the social environment, and critically evaluate and apply this knowledge to facilitate engagement with clients and constituencies, including individuals, families, groups, organizations, and communities. Social workers understand strategies to engage diverse clients and constituencies to advance practice effectiveness. Social workers understand how their personal experiences and affective reactions may impact their ability to effectively engage with diverse clients and constituencies. ***Social workers value principles of relationship-building and interprofessional collaboration to facilitate engagement with clients, constituencies, and other professionals as appropriate.***

Social workers:

• apply knowledge of human behavior and the social environment, person-in-environment, and other ***multidisciplinary theoretical frameworks*** to engage with clients and constituencies; and

• use empathy, reflection, and interpersonal skills to effectively engage diverse clients and constituencies.

Competency 7: Assess Individuals, Families, Groups, Organizations, and Communities

Social workers understand that assessment is an ongoing component of the dynamic and interactive process of social work practice with, and on behalf of, diverse individuals, families, groups, organizations, and communities. Social workers understand theories of human behavior and the social environment, and critically evaluate and apply this knowledge in the assessment of diverse clients and constituencies, including individuals, families, groups, organizations, and communities. Social workers understand methods of assessment with diverse clients and constituencies to advance practice effectiveness. ***Social workers recognize the implications of the larger practice context in the assessment process and value the importance of interprofessional collaboration in this process.*** Social workers understand how their personal experiences and affective reactions may affect their assessment and decision-making.

Social workers:

• collect and organize data, and apply critical thinking to interpret information from clients and constituencies;

• apply knowledge of human behavior and the social environment, person-in-environment, and other ***multidisciplinary theoretical frameworks*** in the analysis of assessment data from clients and constituencies;

• develop mutually agreed-on intervention goals and objectives based on the critical assessment of strengths, needs, and challenges within clients and constituencies; and

• select appropriate intervention strategies based on the assessment, research knowledge, and values and preferences of clients and constituencies.

Competency 8: Intervene with Individuals, Families, Groups, Organizations, and Communities

Social workers understand that intervention is an ongoing component of the dynamic and interactive process of social work practice with, and on behalf of, diverse individuals, families, groups, organizations, and communities. Social workers are knowledgeable about evidence-informed interventions to achieve the goals of clients and constituencies, including individuals, families, groups, organizations, and communities. Social workers understand theories of human behavior and the social environment, and critically evaluate and apply this knowledge to effectively intervene with clients and constituencies. Social workers understand methods of identifying, analyzing and implementing evidence-informed interventions to achieve client and constituency goals***. Social workers value the importance of interprofessional teamwork and communication in interventions, recognizing that beneficial outcomes may require interdisciplinary, interprofessional, and inter-organizational collaboration.***

Social workers:

• critically choose and implement interventions to achieve practice goals and enhance capacities of clients and constituencies;

• apply knowledge of human behavior and the social environment, person-in-environment, and other ***multidisciplinary theoretical frameworks*** in interventions with clients and constituencies;

• ***use interprofessional collaboration as appropriate to achieve beneficial practice outcomes;***

• negotiate, mediate, and advocate with and on behalf of diverse clients and constituencies; and

• facilitate effective transitions and endings that advance mutually agreed-on goals.

Competency 9: Evaluate Practice with Individuals, Families, Groups, Organizations, and Communities

Social workers understand that evaluation is an ongoing component of the dynamic and interactive process of social work practice with, and on behalf of, diverse individuals, families, groups, organizations and communities. Social workers recognize the importance of evaluating processes and outcomes to advance practice, policy, and service delivery effectiveness. Social workers understand theories of human behavior and the social environment, and critically evaluate and apply this knowledge in evaluating outcomes. Social workers understand qualitative and quantitative methods for evaluating outcomes and practice effectiveness.

Social workers:

• select and use appropriate methods for evaluation of outcomes;

• apply knowledge of human behavior and the social environment, person-in-environment, and other multidisciplinary theoretical frameworks in the evaluation of outcomes;

• critically analyze, monitor, and evaluate intervention and program processes and outcomes; and

• apply evaluation findings to improve practice effectiveness at the micro, mezzo, and macro levels.

Appendix E
IPEC / CSWE Competency Comparison

General Competency Statements and Specific Domain Competencies:

Domain 1: Values/Ethics for Interprofessional Practice General Competency Statement: Work with individuals of other professions to maintain a climate of mutual respect and shared values.

IPEC core competencies	CSWE EPAS competency
VE1: Place the interests of patients and populations at the center of interprofessional health care delivery.	1, 2, 3, 6, 7, 8, 9
VE2: Respect the dignity and privacy of patients while maintaining confidentiality in the delivery of teambased care.	**1, 3**
VE3: Embrace cultural diversity and individual differences characterizing patients, populations, and health care teams.	1, 2, 3, 5
VE4: Respect the unique cultures, values, roles/responsibilities, and expertise of other health professions.	1, 2, 3, 5
VE5: Cooperate with those who receive or provide care, and others who contribute to or support healthcare.	**1, 5, 6, 7, 8**
VE6: Develop a trusting relationship with patients, families, and other team members (CIHC, 2010).	1, 6
VE7: Demonstrate high standards of ethical conduct and quality of care in one's contributions to team based care.	1
VE8: Manage ethical dilemmas specific to interprofessional patient/population centered care situations.	**1,**
VE9: Act with honesty and integrity in relationships with patients, families, and other team members.	1, 7, 8
VE10: Maintain competence in one's own profession appropriate to scope of practice.	1

Domain 2: Roles/Responsibilities General Competency Statement: 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.

IPEC core competencies	CSWE EPAS competency
RR1: Communicate one's roles and responsibilities clearly to patients, families, and other professionals.	1, 2, 7, 8
RR2: Recognize one's limitations in skills, knowledge, and abilities.	**1**
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.	6, 7, 8, 9
RR4: Explain the roles and responsibilities of other care providers and how the team works together to provide care.	**1, 2**
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.	**1, 7, 8**
RR6: Communicate with team members to clarify each member's responsibility in executing components of a treatment plan or public health intervention.	1, 2, 7, 8
RR7: Forge interdependent relationships with other professions to improve care and advance learning.	6, 7, 8
RR8: Engage in continuous professional and interprofessional development to enhance team performance.	1, 6, 7, 8, 9
RR9: Use unique and complementary abilities of all members of the team to optimize patient care.	7, 8

Domain 3: Interprofessional Communication General Competency Statement: 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.

IPEC core competencies	CSWE EPAS competency
CC1: Choose effective communication tools and techniques, including information systems and communication technologies, to facilitate discussions and interactions that enhance team function.	1, 6, 7, 8

CC2: Organize and communicate information with patients, families, and healthcare team members in a form that is understandable, avoiding discipline-specific terminology when possible.	**1, 2, 6, 7, 8, 9**
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.	1, 6, 7, 8,
CC4: Listen actively and encourage ideas and opinions of other team members.	1, 6, 7, 8
CC5: Give timely, sensitive, instructive feedback to others about their performance on the team, responding respectfully as a team member to feedback from others.	**1, 6, 7, 8,**
CC6: Use respectful language appropriate for a given difficult situation, crucial conversation, or interprofessional conflict.	**1, 6, 7, 8,**
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.	1, 2, 3, 6, 7
CC8: Communicate consistently the importance of teamwork in patient-centered and community-focused care.	1, 6, 7

Domain 4: Teams and Teamwork General Competency Statement: Apply relationship-building values and principles of team dynamics to preform effectively in different team roles to plan and deliver patient-/population-centered care that is safe, timely, efficient, effective, and equitable.

IPEC core competencies	CSWE EPAS competency
TT1: Describe the process of team development and the roles and practices of effective teams.	6, 7
TT2: Develop consensus on the ethical principles to guide all aspects of patient care and team work.	**1, 6, 7**

TT3: Engage other health professionals—appropriate to the specific care situation—in shared patient centered problem-solving.	1, 6, 7, 8
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.	1, 2, 3, 6, 7, 8
TT5: Apply leadership practices that support collaborative practice and team effectiveness.	**1, 6, 7, 8**
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.	**1, 2, 3, 6, 7, 8**
TT7: Share accountability with other professions, patients, and communities for outcomes relevant to prevention and health care.	1
TT8: Reflect on individual and team performance for individual, as well as team, performance improvement.	9
TT9: Use process improvement strategies to increase the effectiveness of interprofessional teamwork and team-based care.	4, 9
TT10: Use available evidence to inform effective teamwork and team-based practices.	4
TT11: Perform effectively on teams and in different team roles in a variety of settings.	1

Appendix F

Readiness for Interprofessional Learning Scale (RIPLS) Questionnaire

The purpose of this questionnaire is to examine the attitude of health and social care students and professionals towards interprofessional learning. Your name: (develop your own 'personal code' by using the following formula):

First 3 letters from your first name: □ □ □ Last 3 letters from your last name: □ □ □

Year of birth: 19 □□ Your discipline: _____

Gender: □M □ F Have you completed the RIPLS questionnaire before? □ Yes □ No

If you answered yes to the previous question please indicate how long ago you last completed the questionnaire: □ 1 – 3 months □ 3 – 6 months □ 6 – 12 months □ 1 – 2 years □ 2-3 years □ 3+ years

Have you had previous experience of interprofessional teaching? □ Yes □ No

If you answered yes to the previous question please give a very brief statement of what this IPE teaching was and any impact it may have had.

_____

_____

_____

Please complete the following questionnaire.

Strongly Agree, Agree, Undecided, Disagree, Strongly Disagree

1. Learning with other students / professionals will make me a more effective member of a health and social care team

2. Patients would ultimately benefit if health and social care students / professionals worked together

3. Shared learning with other health and social care students / professionals will increase my ability to understand clinical problems

4. Communications skills should be learned with other health and social care students / professionals

5. Team-working skills are vital for all health and social care students / professionals to learn

6. Shared learning will help me to understand my own professional limitations

7. Learning between health and social care students before qualification and for professionals after qualification would improve working relationships after qualification / collaborative practice.

8. Shared learning will help me think positively about other health and social care professionals

9. For small-group learning to work, students / professionals need to respect and trust each other

10. I don't want to waste time learning with other health and social care students / professionals

11. It is not necessary for undergraduate / postgraduate health and social care students / professionals to learn together

12. Clinical problem solving can only be learnt effectively with students / professionals from my own school / organization

13. Shared learning with other health and social care professionals will help me to communicate better with patients and other professionals

14. I would welcome the opportunity to work on small group projects with other health and social care students / professionals

15. I would welcome the opportunity to share some generic lectures, tutorials or workshops with other health and social care students / professionals

16. Shared learning and practice will help me clarify the nature of patients' or clients' problems

17. Shared learning before and after qualification will help me become a better team worker

18. I am not sure what my professional role will be/is

19. I have to acquire much more knowledge and skill than other students / professionals in my own faculty / organization

If you have any further comments regarding interprofessional education please enter them in the box below

Thank you for completing this survey. The data will provide us with an understanding of the influence of the Interprofessional Collaborative Practice program that we are facilitating or implementing.

Appendix G
ICPPEP Survey Instrument - PILOT

Pilot study consent

Amy Sagen, LSW, MSG, DSW Candidate
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Kutztown University IRB approval 01092017

Pilot Study for an "Interprofessional Collaborative Practice Perception of Educational Preparation (ICPPEP) Survey

Online Consent Form

You are invited to take part in a research survey about your perceptions of academic preparedness toward interprofessional /collaborative practice. Your participation will require approximately ten minutes and is completed online at your computer. There are no known risks or discomforts associated with this survey.

Taking part in this study is completely voluntary. If you choose to be in the study you can withdraw at any time without adversely affecting your relationship with anyone at Kutztown University. Your responses will be kept strictly confidential, and digital data will be stored in secure computer files. Any report of this research that is made available to the public will not include your name or any other individual information by which you could be identified.

If you have questions or want a copy or summary of this study's results, you can contact the researcher at the email address above. Please feel free to print a copy of this consent page to keep for your records.

Clicking the "OK" button below indicates that you are 18 years of age or older and indicates your consent to participate in this survey.

OK

*** 1. Age**

*** 2. Gender**

Female

- Male
- Other

*** 3. Years practicing as a social worker?**

*** 4. State of practice**

*** 5. Social work education, year graduated with most advanced SW degree**

*** 6. Social work education, most advanced degree attained**

- BSW
- MSW/MSSP
- DSW
- PhD in Social Work or Social Welfare

*** 7. Social work education, I was enrolled in an IPE program at my college/university**

- Yes
- No

*** 8. Is social work your first degreed profession?**

- Yes
- If no, please specify

*** 9. How long have you been employed in your current practice setting?**

*** 10. In what type of setting do you currently practice (majority of your time/focus)? (added clarification for one answer only)**

- Assisted Living Residence
- Behavioral Health- Inpatient
- Behavioral Health – Outpatient
- Business or Industry
- Child Welfare Family Agency
- College / University
- Criminal Justice System – Adults
- Employee Assistance Program
- Foundation
- Government Agency
- Health – Inpatient / Hospital
- Health – Outpatient / Community Setting
- Home Health
- Hospice
- Juvenile Justice System - Youth
- Justice System - Adults
- Managed Care Organization
- Mental Health – Outpatient
- Military
- Nursing Home / Long Term Care
- Other
- Private Practice – Group

- Private Practice – Solo
- Professional Association
- Residential Care Facility – Adults
- Residential Care Facility – Children
- School – Elementary / Middle / High
- Social Service Agency
- Substance Use – Outpatient
- Veterans Services

*** 11. Does your practice setting provide training or orientation related to interprofessional collaborative practice?**

- Yes
- No
- Not sure

*** 12. Do you believe you are engaged in an Interprofessional / collaborative practice?**

- Yes
- No
- Not sure

*** 13. My current knowledge of interprofessional collaborative practice is . . .**

- Expert (recognized authority)
- Advanced (applied theory)
- Intermediate (practical application)
- Novice (limited experience)
- Fundamental Awareness (basic knowledge)

- No knowledge

*** 14. My knowledge of interprofessional collaborative practice was obtained from or through which of the following?**

- Classroom – Field Class
- Classroom – Non-field class
- Internship
- Not through educational program
- Other (please specify)

*** 15. Fatigue is affecting my responses to this survey?**

- Fatigue is a big factor
- Fatigue is a medium factor
- Fatigue is a small factor
- Fatigue is not a factor

*** 16. During my social work education, the following terms were used (in class or internship).**

- Multidisciplinary / multiprofessional
- Interdisciplinary / interprofessional
- Transdisciplinary / transprofessional
- None were used.

*** 17. After graduating with my social work degree, I have become knowledgeable about the term interprofessional collaborative practice, to what degree?**

- No knowledge
- Fundamental Awareness

- Novice
- Intermediate
- Advanced
- Expert

*** 18. I am knowledgeable with Interprofessional Education Collaboration (IPEC) 4 core competencies for interprofessional practice.**

- Expert (recognized authority)
- Advanced (applied theory)
- Intermediate (practical application)
- Novice (limited experience)
- Fundamental Awareness (basic knowledge)
- No knowledge

*** 19. Answer the following questions using this key, as it best reflects your professional self. (removed healthcare from this questions.)**

	Strongly Disagree	**Somewhat Disagree**	**Neutral**	**Somewhat Agree**	**Strongly Agree**
I respect the unique culture, values, roles/responsibilities, and expertise of other professions	I respect the unique culture, values, roles/responsibilities, and expertise of other professions Strongly Disagree	I respect the unique culture, values, roles/responsibilities, and expertise of other professions Somewhat Disagree	I respect the unique culture, values, roles/responsibilities, and expertise of other professions Neutral	I respect the unique culture, values, roles/responsibilities, and expertise of other professions Somewhat Agree	I respect the unique culture, values, roles/responsibilities, and expertise of other professions Strongly Agree
I cooperate with those who receive or provide	I cooperate with those who receive or provide care,	I cooperate with those who receive or provide care,	I cooperate with those who receive or	I cooperate with those who receive or provide care,	I cooperate with those who receive or provide care,

	Strongly Disagree	Somewhat Disagree	Neutral	Somewhat Agree	Strongly Agree
care, and others who contribute to or support clients/patients.	and others who contribute to or support clients/patients. Strongly Disagree	and others who contribute to or support clients/patients. Somewhat Disagree	provide care, and others who contribute to or support clients/patients. Neutral	and others who contribute to or support clients/patients. Somewhat Agree	and others who contribute to or support clients/patients. Strongly Agree
I manage ethical dilemmas specific to interprofessional patient/population centered care situations.	I manage ethical dilemmas specific to interprofessional patient/population centered care situations. Strongly Disagree	I manage ethical dilemmas specific to interprofessional patient/population centered care situations. Somewhat Disagree	I manage ethical dilemmas specific to interprofessional patient/population centered care situations. Neutral	I manage ethical dilemmas specific to interprofessional patient/population centered care situations. Somewhat Agree	I manage ethical dilemmas specific to interprofessional patient/population centered care situations. Strongly Agree
I recognize one's limitations in skills, knowledge, and abilities.	I recognize one's limitations in skills, knowledge, and abilities. Strongly Disagree	I recognize one's limitations in skills, knowledge, and abilities. Some what Disagree	I recognize one's limitations in skills, knowledge, and abilities. Neutral	I recognize one's limitations in skills, knowledge, and abilities. Some what Agree	I recognize one's limitations in skills, knowledge, and abilities. Strongly Agree
I explain the roles and responsibilities of other care providers and how the team works together to provide care.	I explain the roles and responsibilities of other care providers and how the team works together to provide care.	I explain the roles and responsibilities of other care providers and how the team works together to provide care.	I explain the roles and responsibilities of other care providers and how the team works together to provide care. Neutral	I explain the roles and responsibilities of other care providers and how the team works together to provide care.	I explain the roles and responsibilities of other care providers and how the team works together to provide care. Strongly Agree

	Strongly Disagree	**Somewhat Disagree**	**Neutral**	**Somewhat Agree**	**Strongly Agree**
	Strongly Disagree	Somewhat Disagree		Somewhat Agree	
I use the full scope of knowledge, skills, and abilities of available professionals to provide care that is safe, timely, efficient, effective, and equitable.	I use the full scope of knowledge, skills, and abilities of available professionals to provide care that is safe, timely, efficient, effective, and equitable. Strongly Disagree	I use the full scope of knowledge, skills, and abilities of available professionals to provide care that is safe, timely, efficient, effective, and equitable. Somewhat Disagree	I use the full scope of knowledge, skills, and abilities of available professionals to provide care that is safe, timely, efficient, effective, and equitable. Neutral	I use the full scope of knowledge, skills, and abilities of available professionals to provide care that is safe, timely, efficient, effective, and equitable. Somewhat Agree	I use the full scope of knowledge, skills, and abilities of available professionals to provide care that is safe, timely, efficient, effective, and equitable. Strongly Agree
I communicate with team members to clarify each member's responsibility in executing components of a treatment plan or intervention.	I communicate with team members to clarify each member's responsibility in executing components of a treatment plan or intervention. Strongly Disagree	I communicate with team members to clarify each member's responsibility in executing components of a treatment plan or intervention. Somewhat Disagree	I communicate with team members to clarify each member's responsibility in executing components of a treatment plan or intervention. Neutral	I communicate with team members to clarify each member's responsibility in executing components of a treatment plan or intervention. Somewhat Agree	I communicate with team members to clarify each member's responsibility in executing components of a treatment plan or intervention. Strongly Agree
I organize and communicate information with patients, families, and	I organize and communicate information with patients, families, and	I organize and communicate information with patients, families, and	I organize and communicate information with patients, families, and	I organize and communicate information with patients, families, and	I organize and communicate information with patients, families, and

	Strongly Disagree	Somewhat Disagree	Neutral	Somewhat Agree	Strongly Agree
team members in a form that is understandable, avoiding discipline-specific terminology when possible.	team members in a form that is understandable, avoiding discipline-specific terminology when possible. Strongly Disagree	team members in a form that is understandable, avoiding discipline-specific terminology when possible. Somewhat Disagree	team members in a form that is understandable, avoiding discipline-specific terminology when possible. Neutral	team members in a form that is understandable, avoiding discipline-specific terminology when possible. Somewhat Agree	team members in a form that is understandable, avoiding discipline-specific terminology when possible. Strongly Agree
I give timely, sensitive, instructive feedback to others about their performance on the team, responding respectfully as a team member to feedback from others.	I give timely, sensitive, instructive feedback to others about their performance on the team, responding respectfully as a team member to feedback from others. Strongly Disagree	I give timely, sensitive, instructive feedback to others about their performance on the team, responding respectfully as a team member to feedback from others. Somewhat Disagree	I give timely, sensitive, instructive feedback to others about their performance on the team, responding respectfully as a team member to feedback from others. Neutral	I give timely, sensitive, instructive feedback to others about their performance on the team, responding respectfully as a team member to feedback from others. Somewhat Agree	I give timely, sensitive, instructive feedback to others about their performance on the team, responding respectfully as a team member to feedback from others. Strongly Agree
I use respectful language appropriate for a given difficult situation, crucial conversation, or	I use respectful language appropriate for a given difficult situation, crucial conversation, or interprofession	I use respectful language appropriate for a given difficult situation, crucial conversation, or interprofessional conflict. Somewhat Disagree	I use respectful language appropriate for a given difficult situation, crucial conversation, or interprofession	I use respectful language appropriate for a given difficult situation, crucial conversation, or interprofessional conflict. Somewhat Agree	I use respectful language appropriate for a given difficult situation, crucial conversation, or interprofession

	Strongly Disagree	Somewhat Disagree	Neutral	Somewhat Agree	Strongly Agree
interprofessional conflict.	al conflict. Strongly Disagree		al conflict. Neutral		al conflict. Strongly Agree
I develop consensus on the ethical principles to guide all aspects of patient care and team work.	I develop consensus on the ethical principles to guide all aspects of patient care and team work. Strongly Disagree	I develop consensus on the ethical principles to guide all aspects of patient care and team work. Somewhat Disagree	I develop consensus on the ethical principles to guide all aspects of patient care and team work. Neutral	I develop consensus on the ethical principles to guide all aspects of patient care and team work. Somewhat Agree	I develop consensus on the ethical principles to guide all aspects of patient care and team work. Strongly Agree
I apply leadership practices that support collaborative practice and team effectiveness.	I apply leadership practices that support collaborative practice and team effectiveness. Strongly Disagree	I apply leadership practices that support collaborative practice and team effectiveness. Somewhat Disagree	I apply leadership practices that support collaborative practice and team effectiveness. Neutral	I apply leadership practices that support collaborative practice and team effectiveness. Somewhat Agree	I apply leadership practices that support collaborative practice and team effectiveness. Strongly Agree
I engage self and others to constructively manage disagreements about values, roles, goals, and actions that arise among professionals and with patients and families.	I engage self and others to constructively manage disagreements about values, roles, goals, and actions that arise among professionals and with patients and families.	I engage self and others to constructively manage disagreements about values, roles, goals, and actions that arise among professionals and with patients and families.	I engage self and others to constructively manage disagreements about values, roles, goals, and actions that arise among professionals and with patients	I engage self and others to constructively manage disagreements about values, roles, goals, and actions that arise among professionals and with patients and families.	I engage self and others to constructively manage disagreements about values, roles, goals, and actions that arise among professionals and with patients and

Strongly Disagree	Somewhat Disagree	Neutral	Somewhat Agree	Strongly Agree
Strongly Disagree	Somewhat Disagree	and families. Neutral	Somewhat Agree	families. Strongly Agree

20. If you are currently work within an interprofessional collaborative practice, briefly describe your role on the team.

21. If you currently work within an interprofessional collaborative practice, briefly describe your impact on team decisions.

*** 22. Social workers are educated to become leaders of interprofessional collaborative practice.**

- Strongly agree
- Agree
- Neutral
- Disagree
- Strongly disagree

*** 23. It is not important for Council on Social Work Education (CSWE) to add interprofessional language to 2015 Educational Policy and Accreditation Standards (EPAS).**

- Strongly agree
- Agree
- Neutral
- Disagree
- Strongly disagree

*** 24. Interprofessional collaborative practice skills should be a priority for social work education.**

- Strongly disagree
- Disagree
- Neutral
- Agree
- Strongly agree

*** 25. Interprofessional collaborative practice is learned by students when a guest lecturer from another discipline, attends class to provide information on a specific issue (ie. disease progression by a nurse/ doctor, what to expect in a court room by a judge / lawyer).**

- Yes
- No
- Not sure

*** 26. Thank you for participating in the first step of piloting this survey. Please answer the following questions based on your experience of taking this survey.**

1. Briefly describe the overall theme of the survey.

*** 27. 2. Do the questions flow well? If not, provide specifics for non-flow questions.**

*** 28. 3. Questions were easy to understand? Easy to provide an answer? (language, double barreled, wordy, etc)**

*** 29. 4. Without factoring in the past 4 questions on improving the survey, how long did it take you to complete questions 1-25?**

*** 30. 5. In your professional opinion, do the questions relate to perceptions of educational preparedness for interprofessional collaborative practice?**

31. 6. Other comments for researcher... pertaining to this survey?

Appendix H

ICCAS – Interprofessional Collaborative Competency Attainment Survey

Please answer the following questions by filling in the circle that most accurately reflects your opinion about the following interprofessional collaboration statements:

1 - strongly disagree
2 - moderately disagree
3 - slightly disagree
4 – neutral
5 - slightly agree
6 - moderately agree
7 - strongly agree
Na - not applicable

Please rate your ability for each of the following statements:

Before participating in the learning activities, I was able to: 1 2 3 4 5 6 7 na

After participating in the learning activities, I am able to: 1 2 3 4 5 6 7 na

1. Promote effective communication among members of an interprofessional (IP) team*

2. Actively listen to IP team members' ideas and concerns

3. Express my ideas and concerns without being judgmental

4. Provide constructive feedback to IP team members

5. Express my ideas and concerns in a clear, concise manner

6. Seek out IP team members to address issues

7. Work effectively with IP team members to enhance care

8. Learn with, from and about IP team members to enhance care

9. Identify and describe my abilities and contributions to the IP team

10. Be accountable for my contributions to the IP team

11. Understand the abilities and contributions of IP team members

12. Recognize how others' skills and knowledge complement and overlap with my own

13. Use an IP team approach with the patient** to assess the health situation

14. Use an IP team approach with the patient to provide whole person care

15. Include the patient/family in decision-making

16. Actively listen to the perspectives of IP team members

17. Take into account the ideas of IP team members

18. Address team conflict in a respectful manner

19. Develop an effective care*** plan with IP team members

20. Negotiate responsibilities within overlapping scopes of practice

*The patient s family or significant other, when appropriate, are part of the IP team. **The word ‘‘patient’’ has been employed to represent client, resident, and service users. ***The term ‘‘care’’ includes intervention, treatment, therapy, evaluation, etc.

Appendix I
PILOT Study: Factor Analysis

Communalities

	Initial	Extraction
respect other professions	1.000	.585
cooperate with others	1.000	.941
manage ethical dilemmas	1.000	.908
recognize limitations of skill	1.000	.729
explain roles and how team works together	1.000	.868
use full scope of other professionals to provide care	1.000	.803
communicate with team members to clarify each members responsibility	1.000	.782
organize and communicate clearly without discipline specific language	1.000	.735
give instructive feedback	1.000	.824
use respectful language in difficult situations	1.000	.912
develop consensus on ethical principles	1.000	.941
apply leadership practices to support collaborative practice	1.000	.927
engage self and other to constructively manage disagreements	1.000	.832
Social workers are educated to become leaders of interprofessional collaborative practice.	1.000	.626
It is not important for Council on Social Work Education (CSWE) to add interprofessional language to 2015 Educational Policy and Accreditation Standards (EPAS).	1.000	.413
Interprofessional collaborative practice skills should be a priority for social work education.	1.000	.770

Extraction Method: Principal Component Analysis.

Total Variance Explained

Component	Initial Eigenvalues			Extraction Sums of Squared Loadings		
	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %
1	5.926	37.040	37.040	5.926	37.040	37.040
2	3.276	20.477	57.516	3.276	20.477	57.516
3	1.982	12.390	69.907	1.982	12.390	69.907
4	1.412	8.826	78.732	1.412	8.826	78.732
5	.949	5.931	84.663			
6	.905	5.657	90.320			
7	.627	3.916	94.236			
8	.398	2.490	96.726			
9	.292	1.826	98.552			
10	.162	1.012	99.564			
11	.037	.229	99.793			
12	.026	.160	99.953			
13	.008	.047	100.000			
14	5.247E-16	3.279E-15	100.000			
15	-7.420E-17	-4.638E-16	100.000			
16	-4.034E-16	-2.521E-15	100.000			

Extraction Method: Principal Component Analysis.

Component Matrix[a]

	Component			
	1	2	3	4
respect other professions	.410	.423	.381	-.304
cooperate with others	.861	-.222	-.253	-.294
manage ethical dilemmas	.488	-.396	.692	-.185
recognize limitations of skill	.578	.544	-.114	-.293

explain roles and how team works together	.648	.264	.102	.607
use full scope of other professionals to provide care	.708	-.515	-.133	-.135
communicate with team members to clarify each members responsibility	.764	-.436	.085	.024
organize and communicate clearly without discipline specific language	.461	-.521	.498	.054
give instructive feedback	.567	.207	.098	.671
use respectful language in difficult situations	.463	.374	.745	.055
develop consensus on ethical principles	.861	-.222	-.253	-.294
apply leadership practices to support collaborative practice	.776	.426	-.378	.011
engage self and other to constructively manage disagreements	.696	.529	-.249	-.077
Social workers are educated to become leaders of interprofessional collaborative practice.	-.146	.772	.088	-.029
It is not important for Council on Social Work Education (CSWE) to add interprofessional language to 2015 Educational Policy and Accreditation Standards (EPAS).	.379	.519	-.009	-.005
Interprofessional collaborative practice skills	.445	-.489	-.397	.419

should be a priority for social work education.				

Extraction Method: Principal Component Analysis.

a. 4 components extracted.

Reliability

Scale: ALL VARIABLES

Case Processing Summary

		N	%
Cases	Valid	14	100.0
	Excluded[a]	0	.0
	Total	14	100.0

a. Listwise deletion based on all variables in the procedure.

Reliability Statistics

Cronbach's Alpha	N of Items
.809	16

Appendix J
Pilot Study Qualitative Data

All respondents answered the “purpose of the study” with terms related to interprofessional education / collaborative practice, education, and awareness.

Comments on survey:

1. I had to look up the definition (of IPECP)
2. Should be a definition at the beginning of IPECP
3. If you don’t know what IPECP is, the survey would not necessarily help you.
4. Several comments on typographical errors

Appendix K
Letter to NASW-PA

September 1, 2017

Dear Ms. Johanna Byrd,

My name is Amy Sagen and I am a third year doctoral in social work student at Kutztown/Millersville University. I am requesting the National Association of Social Workers – Pennsylvania Chapter (NASW-PA) disseminate my dissertation survey to all members via an individual email blast (September 17, 2017) and addition into two monthly e-blasts (October and November 2017).

My dissertation is titled *Do social workers perceive they are educated to practice in collaborative settings?* The intent of the research question is to engage social worker on their belief and perception of preparedness for interprofessional education / collaborative practice (IPE/CP). This short survey, about 10 min, is a voluntary and anonymous. The survey will be accessible for a 2-month period of September 17 through November 17, 2017. The researcher designed the survey to not obtain personal identifiable data from participants and added a second layer of anonymity from the internet data collection platform of survey monkey.

Participants who wish to complete the survey will remain anonymous to the researcher as written consent is not being captured (Waiver approval from Kutztown University Institutional Review Board, IRB). Consent will be given by participants when they decide to complete the survey.

At the completion of the survey, participants may enter into a drawing for a $50 Visa gift card. The information provided to survey monkey will not be accessible by the researcher.

The researcher does have name recognition at NASW-PA. This name recognition may increase participation by members or may decrease participation by members but has no impact on the persons' membership status within NASW. Membership is located at the National level and not the state level, which is another protection for participants.

Thank you for your time and attention to this request.

My contact information is 717-695-0411 and I will come to your office to pick up an official letter on NASW-PA letterhead with your blessing and signature, on Wednesday, September 6, 2017 at 10 am.

Sincerely,

Amy Sagen, DSW candidate

Kutztown University / Millersville University

E-blast attachment, included

NASW-PA EBLAST

Your input is sought!

Fellow NASW-PA members, I am Amy Sagen, a DSW candidate at Kutztown University / Millersville University and humbly ask for your assistance to gather data for my dissertation. I am disseminating a survey to gauge social workers perception of educational preparedness towards interprofessional collaborative practice (ICP). This is a voluntary survey designed for social workers (professionals or students), takes about 7 minutes to complete, and is designed for persons over the age of 18. There are no foreseen adverse effects to participating in the study or to declining participation in the study. Please disseminate the link to your classroom and colleagues as it will be open until February 2018.

Your responses are helping to advance social work research related to social work education preparedness to collaborative practice. Understanding the perceptions of social workers with regards to educational preparedness is an important first step, may influence the Council on Social Work Education Educational Policy and Accreditation Standards, and provide direction for continuing education courses to fill any gaps that are identified by practitioners.

Click here to participate in the survey. https://www.surveymonkey.com/r/SWIPECP

Kutztown University IRB approval #IRB01122017.

Thank you for your time!

If you have any questions upon completing the survey, contact asage933@live.kutztown.edu

Appendix L
Waiver to IRB: No Consent Form

Kutztown University Institutional Review Board

Waiver of Requirement to Obtain Signed Informed Consent Request Form

An IRB may waive the requirement for the investigator to obtain a signed informed consent form for subjects, if it finds statement 1 or 2 below to be true for the proposed research (45 CFR 46.117). If the investigator proposes to obtain informed consent without obtaining a participant's signature, the investigator must complete this form to request a waiver and submit it to the IRB for review. A waiver may be useful in research where a signed consent could have a negative consequence for participants, or for some telephone and internet survey procedures.

Waiving the requirement to obtain signed informed consent does not eliminate the requirement for informed consent. If the investigator would like a waiver of informed consent, a *Waiver or Alteration of Informed Consent Request Form* must be completed and submitted to the IRB.

Title of study: Academic Preparedness of Social Workers for Interprofessional Education Collaborative Practice (IPECP)

Principal investigator: Amy Sagen, LSW, MSG

Please provide a specific response to either statement 1 or 2, explaining why the statement is true for the proposed research.

2. That the research presents no more than minimal risk of harm to participants and involves no procedures for which written consent is normally required outside of the research context.

Respondents are voluntarily providing responses to questions about their perception of preparedness toward interprofessional education / collaborative practice. If written informed consent is obtained from participants, this document would be the only link data to respondents, whereby removing anonymity from the survey. The survey is voluntary which consent can be provided if a respondent chooses to complete the survey. There is minimal harm to participants as they have the ability to not answer the survey with no repercussions from researcher.

I assure that all information provided on this form is accurate.

Amy Sagen 27 November 2017

Principal Investigator - Amy Sagen, DSW Candidate Date

Appendix M
ICPPEP Survey Instrument (NASW-PA Membership Dissemination)

Demographics

1. Age # (year)

2. Gender
   i. Female
   ii. Male
   iii. Other

3. Years practicing as a social worker # (year)
4. State of practice
   i. State
5. Social work education
   a. Year graduated (most advanced)
      i. Year
   b. Degree
      i. BSW
      ii. MSW
      iii. PhD
      iv. DSW
   c. Enrolled in interprofessional educational program at college/university
      i. Yes
      ii. No
6. Is social work your first professional career?
   i. Yes
   ii. No

   What was previous profession? (ie nursing, teacher, etc)

7. Current, Practice setting
   a. Length of time # of years
   b. Type of setting
      i. Assisted Living Residence
      ii. Behavioral Health- Inpatient
      iii. Behavioral Health – Outpatient
      iv. Business or Industry
      v. Child Welfare Family Agency
      vi. College / University
      vii. Criminal Justice System – Adults
      viii. Employee Assistance Program
      ix. Foundation
      x. Government Agency

xi. Health – Inpatient / Hospital
xii. Health – Outpatient / Community Setting
xiii. Home Health
xiv. Hospice
xv. Juvenile Justice System - Youth
xvi. Justice System - Adults
xvii. Managed Care Organization
xviii. Mental Health – Outpatient
xix. Military
xx. Nursing Home / Long Term Care
xxi. Private Practice – Group
xxii. Private Practice – Solo
xxiii. Professional Association
xxiv. Residential Care Facility – Adults
xxv. Residential Care Facility – Children
xxvi. School – Elementary / Middle / High
xxvii. Social Service Agency
xxviii. Substance Use – Outpatient
xxix. Veterans Services
xxx. Other

c. Does your practice setting provide training or orientation related to interprofessional collaborative practice?
    i. Yes
    ii. No
    iii. Not sure
d. Do you believe you are engaged in an Interprofessional collaborative practice?
    i. Yes
    ii. No
    iii. Not sure

8. My knowledge of interprofessional collaborative practice
    i. Expert (recognized authority)
    ii. Advanced (applied theory)
    iii. Intermediate (practical application)
    iv. Novice (limited experience)
    v. Fundamental Awareness (basic knowledge)
    vi. No knowledge

9. My knowledge of interprofessional collaborative practice was obtained from or through which of the following?
    i. Classroom – Field Class
    ii. Classroom – Non-field class
    iii. Internship
    iv. Embedded into educational program

v. Mentor / Advisor
vi. Did not attain this knowledge

10. Fatigue is affecting my responses to this survey?
i. Fatigue is a big factor
ii. Fatigue is a medium factor
iii. Fatigue is a small factor
iv. Fatigue is not a factor

11. During my social work education, the following terms were used (in class, internship, by an advisor, field instructor, field supervisor) (choose all that apply)
i. Multidisciplinary / multiprofessional
ii. Interdisciplinary / interprofessional
iii. Transdisciplinary / transprofessional
iv. None were used.

12. After graduating with my social work degree, I have become knowledgeable about the term interprofessional collaborative practice
i. No knowledge
ii. Fundamental Awareness
iii. Novice
iv. Intermediate
v. Advanced
vi. Expert

13. I am knowledgeable with Interprofessional Education Collaboration (IPEC) 4 core competencies for interprofessional practice.
i. Expert (recognized authority)
ii. Advanced (applied theory)
iii. Intermediate (practical application)
iv. Novice (limited experience)
v. Fundamental Awareness (basic knowledge)
vi. No knowledge

14. Answer the following questions using this key, as it best reflects your professional self.

1. Strongly Disagree
2. Disagree
3. Neutral
4. Agree
5. Strongly Agree

Code	Question	1	2	3	4	5
V 1	I respect the unique culture, values, roles/responsibilities, and expertise of other health professions					
V 2	I cooperate with those who receive or provide care, and others who contribute to or support healthcare.					

V 3	I manage ethical dilemmas specific to interprofessional patient/population centered care situations.					
R 1	I recognize one's limitations in skills, knowledge, and abilities.					
R 2	I explain the roles and responsibilities of other care providers and how the team works together to provide care.					
R 3	I 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.					
R 4	I communicate with team members to clarify each member's responsibility in executing components of a treatment plan or public health intervention.					
C 1	I organize and communicate information with patients, families, and healthcare team members in a form that is understandable, avoiding discipline-specific terminology when possible.					
C 2	I give timely, sensitive, instructive feedback to others about their performance on the team, responding respectfully as a team member to feedback from others.					
C 3	I use respectful language appropriate for a given difficult situation, crucial conversation, or interprofessional conflict.					
T 1	I develop consensus on the ethical principles to guide all aspects of patient care and team work.					
T 2	I apply leadership practices that support collaborative practice and team effectiveness.					
T 3	I engage self and others to constructively manage disagreements about values, roles, goals, and actions that arise among healthcare professionals and with patients and families.					

15. If you currently work within an interprofessional collaborative practice, briefly describe your role and impact on team decisions.

16. Social workers are educated to become leaders of interprofessional collaborative practice.

i. Strongly Agree
ii. Agree
iii. Neutral
iv. Disagree
v. Strongly Disagree

17. I feel it is not important for CSWE added interprofessional language to the 2015 Educational policy and accreditation standards, competencies?

i. Yes
ii. No
iii. Unsure

18. Interprofessional collaborative practice skills should be a priority for social work education.

i. Strongly Agree
ii. Agree
iii. Neutral
iv. Disagree
v. Strongly Disagree

19. Interprofessional collaborative practice is learned by students when a guest lecturer attends class to provide information on a specific issue (i.e. disease progression by a nurse/ doctor, what to expect in a court room by a lawyer / judge)

i. Yes
ii. No
iii. Not sure

Appendix N
IRB approval for Pilot Study

KUTZTOWN
UNIVERSITY

INSTITUTIONAL REVIEW BOARD
262 Old Main, PO Box 730, Kutztown, PA 19530
(484)-646-4167

DATE:	September 26, 2017
TO:	Dr. Edward Hanna, Social Work Department Ms. Amy Sagen
FROM:	Jeffrey Warner, Chairperson Institutional Review Board
STUDY TITLE:	Pilot Study for an "Inter-professional Collaborative Practice Perception of Educational Preparation (ICPPEP) Survey"
IRB NUMBER:	IRB01092017
SUBMISSION TYPE:	Initial Application
REVIEW TYPE:	Expedited
EXPEDITED CATEGORY:	2g
ACTION:	Approved
APPROVAL DATE:	September 26, 2017
EXPIRATION DATE:	September 26, 2018

The Kutztown University IRB has approved the initial application for your research study. Approval is for the period of one year. Your research study has been assigned the IRB Number IRB01092017. This number must be referred to in any future communications with the IRB.

Research must be conducted in accordance with this approved submission. You must seek approval from the IRB for changes and ensure that such changes will not be initiated without IRB review and approval, except when necessary to eliminate apparent immediate hazards to the subjects. You must submit the Application for Revisions / Changes form to the IRB, prior to making changes.

IRB approval for Study

KUTZTOWN
UNIVERSITY
INSTITUTIONAL REVIEW BOARD
262 Old Main, PO Box 730, Kutztown, PA 19530
(484)-646-4167

DATE:	December 14, 2017
TO:	Dr. Edward Hanna, Social Work Department Ms. Amy Sagen
FROM:	Jeffrey Werner, Chairperson Institutional Review Board
STUDY TITLE:	Academic Preparedness of Social Workers for Inter-Professional Education/Collaborative Practice (IPE/CP)
IRB NUMBER:	IRB01122017
SUBMISSION TYPE:	Initial Application
REVIEW TYPE:	Exempt
EXEMPT CATEGORY:	1b
ACTION:	Approved
APPROVAL DATE:	December 14, 2017

The Kutztown University IRB has approved the initial application for your research study. Your research study has been assigned the IRB Number IRB01122017. This number must be referred to in any future communications with the IRB.

Research approved as **Exempt** will have no expiration date. However, any revisions/changes to the research protocol affecting human subjects may affect the original determination of exemption and therefore must be submitted for review and subsequent determination.

Research must be conducted in accordance with this approved submission. You must seek approval from the IRB for changes and ensure that such changes will not be initiated without IRB review and approval, except when necessary to eliminate apparent immediate hazards to the subjects. You must submit the Application for Revisions / Changes form to the IRB, prior to making changes.

Appendix O
IRB approval for Study from NASW

Institutional Review Board Research Application

This form is to be used when submitting a research application to the National Association of Social Workers (NASW) Institutional Review Board. All submissions must be sent electronically via email.

Please be sure to complete the full application in as much detail as necessary. **Incomplete applications will not be reviewed.**

All applications must include the following attachments:

- copy of the institution's IRB approval
- copy of the survey to be used

Only information on the application and requested attachments will be reviewed initially. Please do not send additional information/attachments. NASW will request more information if needed.

Date of request:

Contact Information

Name:	Amy Sagen
Address:	526 Spring House Road, Camp Hill, PA 17011
Email Address:	Asage933@live.kutztown.edu
Phone Number:	717-695-0411

Information regarding the study

Name of Study: Academic Preparedness of Social Workers for Interprofessional Education / Collaborative Practice (IPECP)

Purpose of study: To assess social worker's perceptions of readiness to practice in interprofessional settings.

Who will be studied? Social Workers (anyone who is currently matriculating through a program or graduated from a CSWE accredited program.

Number of people to be studied: 500+

Is this study part of a dissertation? YES

Has this study gained IRB approval from the researcher's institution? YES

If so, please provide the institution's name and contact information and attach of copy of the document:

Kutztown University of Pennsylvania
Jeffrey Warner | Director, Grants & Sponsored Projects
Academic Affairs
Kutztown University of Pennsylvania

Institutional Review Board Research Application

This form is to be used when submitting a research application to the National Association of Social Workers (NASW) Institutional Review Board. All submissions must be sent electronically via email.

Please be sure to complete the full application in as much detail as necessary. **Incomplete applications will not be reviewed.**

All applications must include the following attachments:

- copy of the institution's IRB approval
- copy of the survey to be used

Only information on the application and requested attachments will be reviewed initially. Please do not send additional information/attachments. NASW will request more information if needed.

Date of request

Contact Information

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Academic Affairs
Kutztown University of Pennsylvania

Confidentiality explanation to participants:	This is a voluntary, online survey that takes about 7 minutes to complete. Respondent's personal identifying information will not be collected (name, address, email, license information) as well as a secondary safeguard built into survey monkey of anonymity, is turned on.
Risks to participants:	There are no known risks or discomforts associated with this survey.
Time frame of study:	December 17 through February 28, 2018

What is your request from NASW?

Send out electronically to members (who have given permission to receive emails from NASW).

By signing below, if NASW IRB approval is obtained, you agree to state clearly on the survey instructions that the institution named above and NASW has granted IRB approval as well as, state that the study is NOT endorsed by NASW.

Amy SAGEN — Printed Name

Signature

23 JAN 2018 — Date

FOR NASW USE ONLY PLEASE DO NOT WRITE BELOW THIS LINE

Name of Applicant: Amy Sagen

Title of Study: Academic Preparedness of SW's for Interprofessional Educational Collaborative Practice (IPECP)

NASW ✓ Approves _____ Denies this request.

Any changes made to this study requires further approval from the NASW IRB before they can be implemented in your study.

1-23-2018 — Date

Sharon Bretsche, LICSW, LCSW-C, ACSW, DCSW
Senior Practice Associate/ IRB Chair
National Association of Social Workers
750 First Street, NE, Suite 800
Washington, DC 20002
202-336-8268
IRB@naswdc.org

Appendix P
Results

Table 1: Demographic and Employment Characteristics of Sample (N=304)

		n	%
Sex (N=304)	Female	240	78.9
	Male	63	20.7
	Other	1	0.3
Age (N=304)	20 to 39	100	32.9
	40 to 59	115	37.8
	60 to 79	88	28.9
	80 to 99	1	0.3
State (N=304)	PA	294	96.7
	Outside PA	9	3.3
Year of Practice (N=304)	under 5	67	22.0
	5 to under 10	39	12.8
	10 to under 15	24	7.9
	15 to under 20	26	8.6
	20 to under 25	34	11.2
	25 to under 30	28	9.2
	30 to under 35	19	6.3
	35 to under 40	26	8.6
	40 and over	41	13.5

Table 2: Secondary Statistical Computation (Results)

A: Gender

Comparison of IPEC Core Competency Score to Gender

	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	645.919	2	322.960	3.746	.025
Within Groups	24916.721	289	86.217		
Total	25562.640	291			

B: State of Practice

Comparison of IPEC Core Competency Score to State of Practice

	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	80.506	1	80.506	.916	.339
Within Groups	25482.134	290	87.869		
Total	25562.640	291			

C: Degree Attained

Comparison of IPEC Core Competency Score to Degree Attained

	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	810.456	3	270.152	3.143	.026
Within Groups	24752.184	288	85.945		
Total	25562.640	291			

D: Graduation Year

Comparison of IPEC Core Competency Score to Graduation Year (in Decades)

	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	555.097	5	111.019	1.384	.230
Within Groups	21651.899	270	80.192		
Total	22206.996	275			

E: Profession

Comparison of IPEC Core Competency Score to SW is Respondents First Profession

	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	629.557	7	89.937	1.024	.414
Within Groups	24933.083	284	87.793		
Total	25562.640	291			

F: Years in Practice

Comparison of IPEC Core Competency Score to Number of Years in Practice

	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	1177.799	8	147.225	1.709	.096
Within Groups	24384.842	283	86.166		
Total	25562.640	291			

G: Current Employment Years

Comparison of IPEC Core Competency Score to Number of Years in Current Employment Setting

	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	953.185	9	105.909	1.214	.286
Within Groups	24609.456	282	87.268		
Total	25562.640	291			

H: IPEC Competency Scores

Summation of IPEC core competency scores (missing data scores removed)

	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	2073.525	14	148.109	1.772	.043
Within Groups	23075.135	276	83.606		
Total	25148.660	290			

I: IPEC Knowledge

Comparison of IPEC Core Competency Score to Knowledge of Interprofessional Practice

	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	902.007	4	225.502	2.624	.035
Within Groups	24660.633	287	85.926		
Total	25562.640	291			

J: Setting Provides Training

T-test: Practice setting provide interprofessional training

	Setting provide training?	N	Mean	Std. Deviation	Std. Error Mean
	Yes	126	57.29	9.188	.819
	No	125	55.46	9.851	.881

K: Belief Engaged IPP

Comparison (t test) belief engaged in interprofessional practice and IPEC core competency

	believe engaged in an Interprofessional / collaborative practice?	N	Mean	Std. Deviation	Std. Error Mean
	Yes	220	56.71	9.355	.631
	No	30	53.37	10.877	1.986

J: IPEC Knowledge: Post Graduation

Comparison of IPEC Core Competency Score to Post Graduation Knowledge of interprofessional practice

	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	1150.374	4	287.594	3.381	.010
Within Groups	24412.266	287	85.060		
Total	25562.640	291			

Tukey HSD Comparison between IPEC Core Competency Score and Knowledge Attained Post Graduation

(I) After graduating with my social work degree, I have become knowledgeable about the term interprofessional collaborative practice, to what degree?	(J) After graduating with my social work degree, I have become knowledgeable about the term interprofessional collaborative practice, to what degree?	Mean Difference (I-J)	Std. Error	Sig.	95% Confidence Interval	
					Lower Bound	Upper Bound
No knowledge	Fundamental Awareness/Novice	.829	1.507	.982	-3.31	4.97
	Intermediate	-.411	1.670	.999	-5.00	4.17
	Advanced	-5.019	1.870	.059	-10.15	.11
	Expert	-2.706	2.839	.876	-10.50	5.09
Fundamental Awareness/Novice	No knowledge	-.829	1.507	.982	-4.97	3.31
	Intermediate	-1.240	1.422	.907	-5.14	2.66
	Advanced	-5.848*	1.653	.004	-10.38	-1.31
	Expert	-3.535	2.701	.686	-10.95	3.88
Intermediate	No knowledge	.411	1.670	.999	-4.17	5.00
	Fundamental Awareness/Novice	1.240	1.422	.907	-2.66	5.14
	Advanced	-4.608	1.802	.081	-9.56	.34
	Expert	-2.295	2.795	.924	-9.97	5.38
Advanced	No knowledge	5.019	1.870	.059	-.11	10.15
	Fundamental Awareness/Novice	5.848*	1.653	.004	1.31	10.38
	Intermediate	4.608	1.802	.081	-.34	9.56
	Expert	2.313	2.919	.933	-5.70	10.33
Expert	No knowledge	2.706	2.839	.876	-5.09	10.50
	Fundamental Awareness/Novice	3.535	2.701	.686	-3.88	10.95
	Intermediate	2.295	2.795	.924	-5.38	9.97
	Advanced	-2.313	2.919	.933	-10.33	5.70

*. The mean difference is significant at the 0.05 level.

K: Terminology

Comparison of IPEC Core Competency Score and Terminology

	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	576.325	4	144.081	1.655	.161
Within Groups	24986.316	287	87.060		
Total	25562.640	291			

L: IPE Definition

Comparison of IPEC Core Competency Score and Definition of Interprofessional Education

IPE definition grouped	N	Mean	Std. Deviation	Std. Error Mean
yes / not sure	244	55.97	9.718	.622
No	48	58.06	7.200	1.039

M: Fatigue

Comparison of IPEC Core Competency Score and Fatigue

	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	421.389	3	140.463	1.609	.187
Within Groups	25141.251	288	87.296		
Total	25562.640	291			

Table 3: Education

		n	%
Year of SW Graduation (N=286)	1960-1969	2	0.7
	1970-1979	27	9.4
	1980-1989	42	14.7
	1990-1999	50	17.5
	2000-2010	52	18.2
	2010-2020	113	39.5
SW Degree (N=304)	BSW	30	9.9
	MSW/MSSP	251	82.6
	DSW	5	1.6
	PhD	18	539
First Profession (N=304)	social work	197	64.8
	Medical (Nurse, EMT, Doctor)	9	3.0
	Psychology / Counseling	62	20.4
	Business (marketing, accounting)	2	0.7
	Retail or Restaurant	1	0.3
	Education	12	3.9
	Criminal Justice	8	2.6
	Other	13	4.3

Table 4: Social Work Practice Settings (N=304)

		n	%
Setting (N=304)	Aging Services	17	5.6
	Behavioral Health (in pt. and out pt.)	45	14.8
	Child Welfare (Agency and RCF)	15	4.9
	College / University	33	10.9
	Government Agency	12	3.9
	Health (Medical in pt. / out pt.)	29	9.5
	Home Health / Hospice	13	4.3
	Justice System (Children / Adults)	3	1.0
	Mental Health (in pt. / out pt.)	21	6.9
	Military / Veterans	5	1.6
	Private Practice (Solo / Group)	26	8.6
	School setting	26	8.6
	Substance Abuse setting	7	2.3
	Other (Business, EAP, Association, MCO, Foundation, & social service agency not specified)	52	17.1

Table 5: IPECP Knowledge Attainment

Attainment of IPECP Knowledge	*n*	*%*
Educational Program (only)	37	12.2
Not in Educational Program	221	72.7
Both (combination)	46	15.1

Terminology – note the term Trans is not recorded in any respondent's answer.

	n	%
Multi	85	28.0
Inter	63	20.7
Multi and Inter	113	37.2
All of the above	9	3.0
None of the above	34	11.2

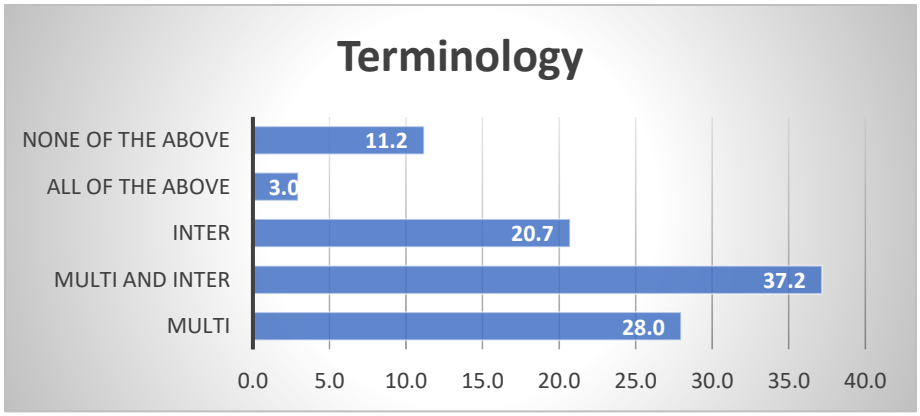
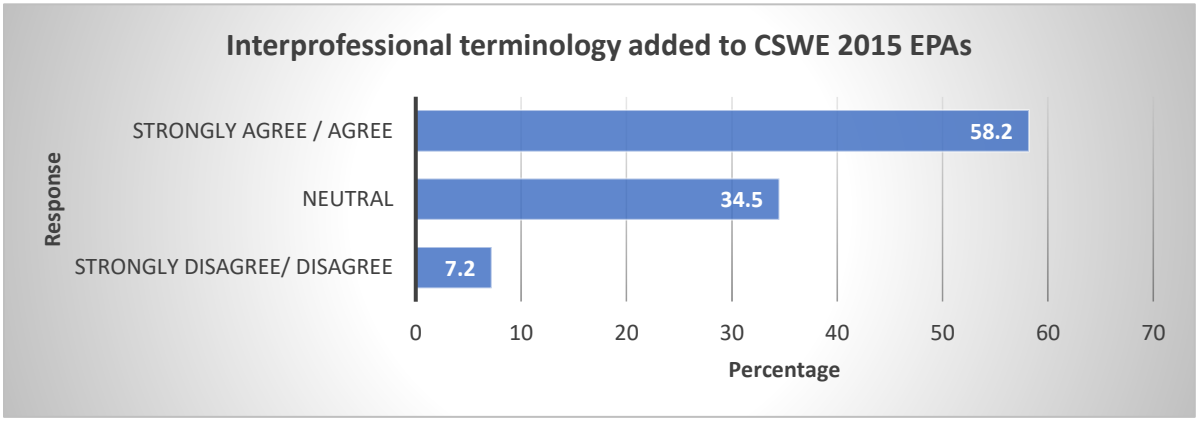
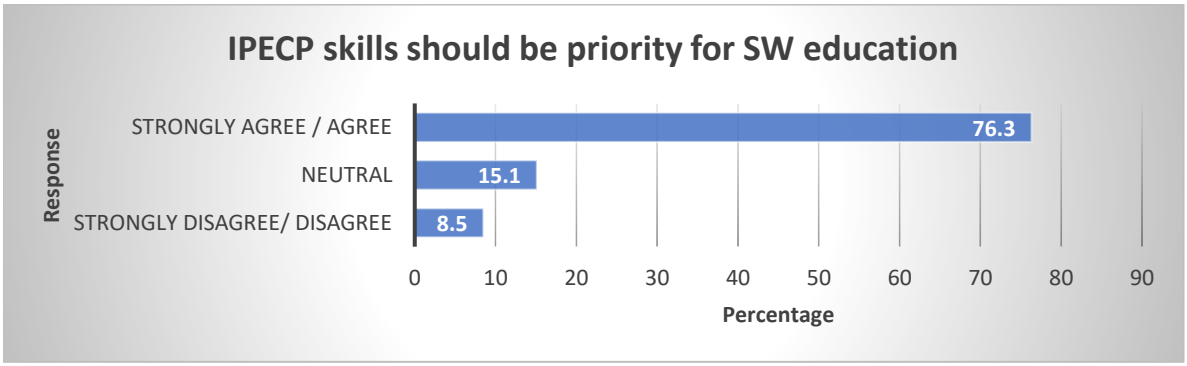


Table 6: Importance of IPECP within social work education



Interprofessional collaborative practice skills should be a priority for social work education.

	n	%
Strongly disagree/ Disagree	26	8.5
Neutral	46	15.1
Strongly agree / agree	232	76.3



It is not important for Council on Social Work Education (CSWE) to add interprofessional language to 2015 Educational Policy and Accreditation Standards (EPAS).

	n	%
Strongly disagree/ Disagree	22	7.2
Neutral	105	34.5
Strongly agree / agree	177	58.2

Social workers are educated to become leaders of interprofessional collaborative practice.

	n	%
Strongly disagree/ Disagree	181	59.5
Neutral	72	23.7
Strongly agree / agree	51	16.8

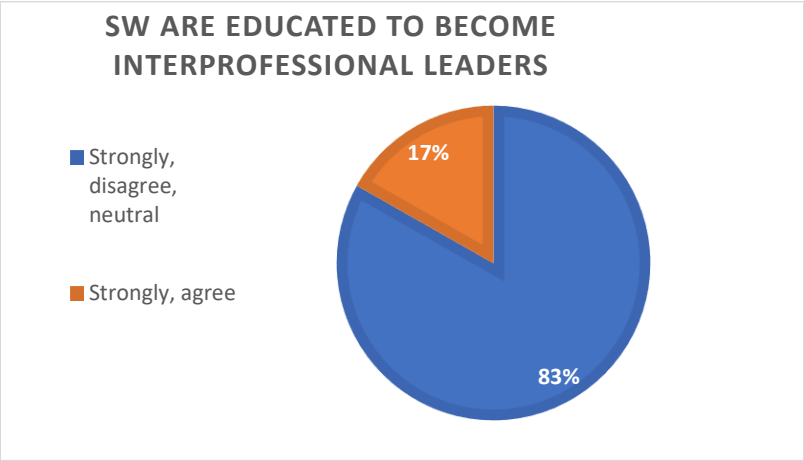


Table 7: IPEC Core Competency Subcategories

	I respect the unique culture, values, roles/responsibilities, and expertise of other professions	I cooperate with those who receive or provide care, and others who contribute to or support clients/patients.	I manage ethical dilemmas specific to interprofessional patient/population centered care situations.	I recognize one's limitations in skills, knowledge, and abilities.	I explain the roles and responsibilities of other care providers and how the team works together to provide care.	I use the full scope of knowledge, skills, and abilities of available professionals to provide care that is safe, timely, efficient, effective, and equitable.	I communicate with team members to clarify each member's responsibility in executing components of a treatment plan or intervention.	I organize and communicate information with patients, families, and team members in a form that is understandable, avoiding discipline-specific terminology when possible	I give timely, sensitive, instructive feedback to others about their performance on the team, responding respectfully as a team member to feedback from	I use respectful language appropriate for a given difficult situation, crucial conversation, or interprofessional conflict.	I develop consensus on the ethical principles to guide all aspects of patient care and team work.	I apply leadership practices that support collaborative practice and team effectiveness.	I engage self and others to constructively manage disagreements about values, roles, goals, and actions that arise among professionals and with patients and
Valid N	301	298	300	301	304	302	301	303	303	303	302	302	304
Missing	3	6	4	3	0	2	3	1	1	1	2	2	0
Mean	4.60	4.60	4.14	4.43	4.14	4.40	4.26	4.37	3.99	4.58	4.12	4.31	4.19
Std. Error of Mean	0.050	0.049	0.059	0.050	0.060	0.051	0.058	0.053	0.059	0.050	0.057	0.054	0.055
Median	5.00	5.00	4.00	5.00	4.00	5.00	5.00	5.00	4.00	5.00	4.00	5.00	4.00
Mode	5	5	5	5	5	5	5	5	4	5	5	5	5
Std. Deviation	0.872	0.852	1.021	0.868	1.044	0.891	1.004	0.925	1.024	0.872	0.995	0.945	0.959
Variance	0.761	0.726	1.041	0.753	1.090	0.793	1.008	0.856	1.050	0.761	0.989	0.893	0.921

Table 8: IPEC Core Competency Score (Total)

	n	valid %
13	2	0.7
14	1	0.3
15	2	0.7
17	2	0.7
19	1	0.3
21	1	0.3
32	1	0.3
34	1	0.3
36	1	0.3
40	1	0.3
41	2	0.7
43	2	0.7
44	1	0.3
45	2	0.7
46	1	0.3
47	3	1.0
48	3	1.0
49	4	1.4
50	11	3.8
51	10	3.4
52	12	4.1
53	8	2.7
54	14	4.8
55	22	7.5
56	13	4.5
57	18	6.2
58	11	3.8
59	16	5.5
60	15	5.1
61	26	8.9
62	14	4.8
63	19	6.5
64	13	4.5
65	39	13.4
Total	292	100.0
Missing	12	

Appendix Q
ICPPEP Survey Instrument (Updated)
(Updated for ease of replication)

Demographics

1. Age
    i. under 20
    ii. 20-39
    iii. 40-59
    iv. 60-79
    v. 80-99

2. Gender
    i. Female
    ii. Male
    iii. Other

3. Years practicing as a social worker
    i. Under 5
    ii. 5 to under 10
    iii. 10 to under 15
    iv. 15 to under 20
    v. 20 to under 25
    vi. 25 to under 30
    vii. 30 to under 35
    viii. 35 to under 40
    ix. 40 and over

4. State of practice
    i. PA
    ii. Outside of PA

5. Social work education
    i. Year graduated (most advanced)
        1. 1960 – 1969
        2. 1970 – 1979
        3. 1980 – 1989
        4. 1990 - 1999
        5. 2000 – 2010
        6. 2010 – 2020
    ii. Degree
        1. BSW
        2. MSW

3. PhD
4. DSW

iii. Enrolled in interprofessional educational program at college/university
    1. Yes
    2. No

6. Is social work your first professional career?
    i. Social Work
    ii. Medical (Nurse, EMT, Doctor, etc)
    iii. Counseling (psychology, therapist, religious counseling, etc)
    iv. Business (marketing, accounting, human resource, etc)
    v. Retail or Restaurant
    vi. Education (teacher, administrator, Home-school visitor, etc)
    vii. Criminal Justice (probation, parole, etc)
    viii. Other (does not fit in an above category)

7. Current, Practice setting
    i. Length of time
        1. No time (ie in school, disability, retired, etc)
        2. Under 5 years
        3. 5 to under 10
        4. 10 to under 15
        5. 15 to under 20
        6. 20 to under 25
        7. 25 to under 30
        8. 30 to under 35
        9. 35 to under 40
        10. 40 and over
    ii. Type of setting
        1. Aging Services
        2. Behavioral Health (in & out patient)
        3. Child Welfare (agency and residential care facility)
        4. College / University
        5. Government Agency
        6. Health (Medical in and out patient)
        7. Home Health / Hospice
        8. Justice System (children & adults)
        9. Mental Health (in & out patient)
        10. Military / Veterans
        11. Private Practice (solo & group)
        12. School Setting
        13. Substance Abuse Setting

14. Other (association, business, EAP, foundation, MCO, etc)

iii. Does your practice setting provide training or orientation related to interprofessional collaborative practice?
    1. Yes
    2. No

iv. Do you believe you are engaged in an Interprofessional collaborative practice?
    1. Yes
    2. No

8. My knowledge of interprofessional collaborative practice
    i. Expert (recognized authority)
    ii. Advanced (applied theory)
    iii. Intermediate (practical application)
    iv. Novice (limited experience)
    v. Fundamental Awareness (basic knowledge)
    vi. No knowledge

9. My knowledge of interprofessional collaborative practice was obtained from or through which of the following?
    i. Educational program (class, internship, etc)
    ii. Not in Educational program (mentors, on the job, etc)
    iii. Both educational program and outside of educational program

10. Fatigue is affecting my responses to this survey?
    i. Fatigue is a big factor
    ii. Fatigue is a medium factor
    iii. Fatigue is a small factor
    iv. Fatigue is not a factor

11. During my social work education, the following terms were used (in class, internship, by an advisor, field instructor, field supervisor)
    i. Multidisciplinary / multiprofessional
    ii. Interdisciplinary / interprofessional
    iii. Transdisciplinary / transprofessional
    iv. Multi and Inter
    v. Multi and Trans
    vi. Inter and Trans
    vii. All of the above
    viii. None of the above

12. After graduating with my social work degree, I have become knowledgeable about the term interprofessional collaborative practice
    i. No knowledge
    ii. Fundamental Awareness
    iii. Novice
    iv. Intermediate
    v. Advanced
    vi. Expert

13. I am knowledgeable with Interprofessional Education Collaboration (IPEC) 4 core competencies for interprofessional practice.
    i. Yes (Expert / Advanced)
    ii. No (Intermediate / Novice / No knowledge)

14. Answer the following questions using this key, as it best reflects your professional self.

1. Strongly Disagree
2. Disagree
3. Neutral
4. Agree
5. Strongly Agree

Code	Question	1	2	3	4	5
V 1	I respect the unique culture, values, roles/responsibilities, and expertise of other health professions					
V 2	I cooperate with those who receive or provide care, and others who contribute to or support healthcare.					
V 3	I manage ethical dilemmas specific to interprofessional patient/population centered care situations.					
R 1	I recognize one's limitations in skills, knowledge, and abilities.					
R 2	I explain the roles and responsibilities of other care providers and how the team works together to provide care.					
R 3	I 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.					

R 4	I communicate with team members to clarify each member's responsibility in executing components of a treatment plan or public health intervention.					
C 1	I organize and communicate information with patients, families, and healthcare team members in a form that is understandable, avoiding discipline-specific terminology when possible.					
C 2	I give timely, sensitive, instructive feedback to others about their performance on the team, responding respectfully as a team member to feedback from others.					
C 3	I use respectful language appropriate for a given difficult situation, crucial conversation, or interprofessional conflict.					
T 1	I develop consensus on the ethical principles to guide all aspects of patient care and team work.					
T 2	I apply leadership practices that support collaborative practice and team effectiveness.					
T 3	I engage self and others to constructively manage disagreements about values, roles, goals, and actions that arise among healthcare professionals and with patients and families.					

15. If you currently work within an interprofessional collaborative practice, briefly describe your impact on team decisions.

16. Social workers are educated to become leaders of interprofessional collaborative practice.

i. Strongly Agree
ii. Agree
iii. Neutral
iv. Disagree
v. Strongly Disagree

17. I feel it is not important for CSWE added interprofessional language to the 2015 Educational policy and accreditation standards, competencies?

i. Yes
ii. No

18. Interprofessional collaborative practice skills should be a priority for social work education.

i. Strongly Agree
ii. Agree
iii. Neutral
iv. Disagree
v. Strongly Disagree

19. Interprofessional collaborative practice is learned by students when a guest lecturer attends class to provide information on a specific issue (i.e. disease progression by a nurse/ doctor, what to expect in a court room by a lawyer / judge)

i. Yes
ii. No