Collaborative Teaching and Learning Project

Faculty of Health Science

DISCUSSION PAPER 2

Opportunities, Issues and Options

September 2008
Executive Summary

This paper recommends the preparation of guidelines (project plans) for developing and piloting collaborative teaching and learning, in the following areas of common learning:

- **Management of Chronic Illnesses** – A model similar to Rural Inter-Professional Program Emergency Retreat (RIPPER, UDRH) in simulation centres is proposed, for implementing the *Experiential Inter-Professional Education* (IPE) model. This is where students from 2 or more Schools learn with, from and about each other in a practical context.

- **Legal & Ethical Issues** – On-line interactive, media-rich modules are proposed, as an option for extending ‘Shared Learning’ within the Faculty. This is where students from different Schools learn together but in parallel. Students will engage in discussions, analysis of audio/visual presentations and reflection on the learning process, either on-line or in real time.

- **Safety and Quality** – This will be an example of ‘Common Resources’, where students learn separately but share learning & teaching products as well as teaching staff. Modules in ‘Safety and Quality’ could be developed across a range of common topics, based on the competencies and scenarios outlined in the National Patient Safety Education Framework. These ‘common resources’ will support teaching and learning in classrooms, on-line and/or in simulation/skills centres.

Also, currently available multi-media products for **E-Health** (UDRH) and **Rural Health** (University of Sydney) could be customised and promoted as additional **Common Resources** for use within Schools.

These recommendations were derived after identifying the main opportunities for growth and development of collaborative teaching and learning arrangements in the Faculty.

Successful current and past collaborations provide foundations for further initiatives. At least eight additional areas of common learning are identified, as feasible by 2010. With new and revised courses and simulation centres at three major campuses by 2010, the scope for collaboration will expand. Advances in on-line delivery and an increasingly ‘media-savvy’ student population also create new avenues for inter-professional learning experiences.

However, change will need to be slow and sensitive, because some 16 barriers to collaboration within the Faculty have been identified. These will need to be prioritised and addressed as new collaborative initiatives are rolled out. The main barriers are poor communications, a culture of independence and competition, ownership and control of intellectual property, differences in curricula, the geographical spread of campuses, disparate student populations and disproportionate numbers, differences in funding, student perceptions and expectations, staff workloads and difficulties in assessing values and group learning.

A range of options are presented for addressing key issues, including a register of teaching staff expertise, regional clusters and more learning in small groups of mixed cohorts of students (both on-line and in simulation and skills centres).

The preferred implementation strategy is to commence with the 3 initiatives most likely to succeed. If successful, these pilots will provide momentum for broader engagement and a greater willingness to tackle outstanding barriers. As a consequence, sustainability and further collaboration will follow, especially if supported by an appropriate governance structure.
1. Introduction

The Faculty of Health is undertaking a project, in 2008, to encourage and enhance collaboration in teaching and learning. It is one of several elements in the Faculty’s response to health workforce priorities emerging nationally through the Council of Australian Government’s initiatives, the National Health and Hospitals Reform Commission (NHHRC) and, within Tasmania, through the Tasmanian Health Plan (THP).

Emerging government imperatives to achieve health workforce reform and sustainability will demand new and different responses from the providers of education and training. To achieve a more flexible and multi-skilled health workforce, it is likely that both governments and accrediting bodies will be mandating change in health education and training over the next 5 years.

The UTAS Faculty of Health Science intends to be at the forefront of change and will support a range of initiatives in 2009, towards this end. For example, a Health Services and Workforce Education Unit (HSWEU) will be established within the Office of the Dean, as the University’s strategic development arm of the Partners in Health Agreement. In addition, in 2009, the Faculty will identify, support and assist in developing a range of initiatives in multi-professional teaching and learning.

2. Background

The 2008 Faculty Collaborative Teaching & Learning Project aims to foster multi-professional teaching and learning through increasing collaboration between the four Schools within the Faculty, the Rural Clinical School (RCS) and the University Department of Rural Health (UDRH), in undergraduate teaching and learning in an effective and efficient manner. The Schools within the Faculty are Nursing and Midwifery (SNM), Medicine (SOM), Pharmacy (SOP) and Human Life Sciences (HLS).

This is the second of two discussion papers for the project. The first discussed trends and drivers in health education, and canvassed a range of teaching and learning arrangements aimed at encouraging collaboration, including:

- **Networking** – comprising an informal web of communication amongst staff from different Schools (eg special interest groups on assessment/curriculum review/staff development etc.),
- **Common Resources** - where students from different Schools learn separately but staff and teaching and learning products are shared between Schools,
- **Shared Learning** – where students from different Schools are brought together to learn common content and/or learning outcomes. Students interact and share teaching staff and learning resources (in real time or on-line) but group interaction is not critical for learning,
- **Co-operative Inter-Professional Education (IPE)** - where small groups of students from more than one School learn with, from and about each other, to improve collaboration. Students participate in Case-Based Learning/Problem-Based Learning (CBL/PBL), to achieve a common goal through joint decision-
making. Skills in teamwork, communication and reflective reasoning are applied and assessed in a theoretical context; and

- **Experiential IPE** - similar to the Co-operative IPE model above, but occurs in a practical context and the focus is on patient care. It could be set in a simulation centre, the community or a clinical institution.

Discussion paper 1 is available at:

3. **Purpose**

The aim of this second paper is to identify opportunities for embedding these preferred approaches into the teaching and learning arrangements of the Faculty and to recommend strategies to facilitate their implementation. The paper will achieve this by outlining:

- Opportunities to expand collaboration,
- Issues limiting collaboration,
- Options for addressing barriers,
- Recommendations; and
- Implementation strategies.

4. **Methodology**

Information presented in the paper is sourced from:

- interviews with 44 staff from across the Faculty;
- 4 focus groups comprising 30 teaching and managerial staff;
- student evaluations from ‘Perspectives on Ageing’ (SNM, A. Robinson), Rural Inter-Professional Program Emergency Retreat (UDRH, J. Whelan, J. Spencer, K. Rooney) and the ‘HIV Infection & Other Unconquered Infections’, on-line unit, from UNSW (M.Cooley).

The paper is a synopsis and analysis of the findings, views and ideas canvassed. For privacy and confidentiality, the paper does not ascribe the material presented to specific individuals.

5. **Opportunities**

The Faculty is well positioned to make significant change over the next 3-5 years, due to anticipated developments in curriculum and technology. Successful current and past collaborations provide a solid foundation for further growth in collaborative teaching and learning.

5.1. **Foundations for Collaboration**

The following are examples of existing collaborations between Schools within the Faculty, in undergraduate programs that are already well established:

- ‘Perspectives on Ageing’ (SNM, A Robinson, J Walls). It is undertaken by students from three Schools (since 2007) who engage in a combination of face-to-face and asynchronous on-line learning (including on-line discussion groups),
• Rural Inter-Professional Program Emergency Retreat (UDRH, J.Whelan, J.Spencer, K.Rooney) was conducted as a 2 day workshop in 2006, 2007 and 2008 for students from 3 Schools,
• Extensive ‘service teaching’ and ‘teaching into’ units belonging to other Schools both within and outside the Faculty. For example, Bioscience in the Bachelor of Nursing is delivered by the School of Human Life Sciences,
• Shared teaching and learning resources for instruction and education in complementary and alternative medicines, indigenous health and E-Health (UDRH, S. Whetton),
• 24% of the training delivered by the Skills Centre at Rural Clinical School in 2007, for both undergraduates and post graduates, was multi-professional,
• The University Department of Rural Health supports more than 200 rural placements for students across 3 Schools, and service teaches into other Schools,
• Students in Health Science are enrolled in a Nursing unit ‘Legal and Ethical Issues in Health Care’ (CNA308) as an elective,
• First year medical, medical research and pharmacy students jointly undertake components of a unit in Human Biology,
• The School of Pharmacy organises placements for medical students in community pharmacies; and
• A wide range of health professionals are invited into Schools as guest presenters and lecturers.

5.2. Common Learning

One of the first steps in bringing students from different Schools together for learning is to identify where, in each curriculum, students are learning the same content or aiming for similar learning outcomes. These overlaps are referred to as ‘areas of common learning’.

More than 16 areas of common learning were suggested as worthy of investigation and the following, in descending order of preference, have emerged as those where collaboration is most likely to succeed:

• Chronic Diseases
• Legal and Ethical Issues,
• Safety and Quality,
• Health Promotion,
• Community Health/Therapeutics,
• E-Health,
• Rural Health
• Primary Health Care; and
• Research Methods.

The selection criteria used to identify these areas of learning were:
• the overlap in content & learning outcomes occurs in 2 or more Schools,
• the overlap is relatively concentrated, not diffused across years within different courses,
• the overlap could be segmented and imported into courses across Schools as discrete modules,
• foundations for collaboration exist, such as a pilot programs, multi-media learning materials, educational framework, etc.,
• no significant additional costs or physical barriers (timetabling, location or capacity) prevent delivery to mixed groups of students in either real or virtual time,
• potential to offer equitable & consistent learning experiences; and
• potential advocates identified to drive collaboration.

5.3. New and Revised Courses

As a result of recent changes in the MBBS and Bachelor of Nursing degrees, the alignment between these Schools in the teaching & learning of ethical and legal issues has moved closer together. Both Schools teach it in the same year of their respective courses and both are undertaking a revision and redevelopment of studies in legal and ethical issues. The SOM is considering offering ‘Law and Ethics’ as a selective unit in Year 3, semester 2.

Similarly, the School of Nursing and Midwifery traditionally delivers its law and ethics unit in Year 3, Semester 2 and is also reviewing, revising and broadening its unit. In conjunction with the School of Philosophy, an on-line multi-media and highly interactive unit comprising seven modules, is under development. Some Year 3 Health Science students (public health and lifestyle stream) are currently enrolled in this unit as an elective. There is enthusiasm from other Schools for further collaboration.

Pharmacy students also study legal & ethical issues in Year 3, but in Semester 1. This timing could be reviewed as part of a major curriculum review due by 2010 which could also impact the feasibility of collaborations in health promotion, primary health care, community health and research methods.

By 2010, the paramedics’ course will be a full-time 3 year degree. It will no longer be delivered by block training as an associate degree, for existing employees of the ambulance service. The new course will have synergies with the accelerated nursing program delivered in Hobart, and may be offered as a combined degree.

5.4. Simulation Centres

By 2010, the three largest campuses will have fully functioning Skills or Simulation Centres. These centres will present opportunities for mainstreaming learning experiences such as RIPPER. At present RIPPER is small-scale, expensive and staff intensive and is only possible with dedicated funding from UDRH.

However, the number of students could be significantly increased if it was conducted regularly, in dedicated learning spaces equipped with hi-tech audio/visual aids and specialist staff.

Average costs would decrease due to the economies of scale, if simulated IPE becomes the norm (rather than the exception).

Students would also experience more stimulating, equitable and consistent education. Offering regular one day workshops throughout the year, on a rotating basis, as a component of practical placement hours, could be considered as an option.
A simulated learning experience, based around scenarios (CBL) for chronic diseases rather than emergency care, may have wider appeal, especially for pharmacy and exercise science students.

This could be a measurable IPE experience, if guidelines for assessing the following were developed:

- IPE competencies such as:
  - Knowledge - of one’s own role and professional role of others,
  - Skills - in communications, negotiations, conflict resolution, leadership;
  - Attitudes - including respect, trust, tolerance and willingness to work with other health professionals,
- Group dynamics and performance, and
- Success in achieving a common goal related to patient care.

5.5. On-Line Delivery

On-line delivery can be stimulating and engaging if it is media-rich and highly interactive. It can immerse students in the gritty realities of applying abstract concepts in a clinical setting.

A legal & ethics unit with these features is under development for the summer semester, as a joint venture between the School of Nursing & Midwifery and the School of Philosophy. Some Health Science students are also enrolled in this unit as an elective. In 2009, the unit could be enhanced as a multi-professional learning unit if more Schools participated.

The cross-Faculty Unit ‘Perspectives on Ageing’ has pioneered asynchronous on-line discussion groups, to facilitate small group interaction between students based at different geographical locations. An additional benefit of this approach has been a reduction in the costs associated with delivering to large numbers of students who are geographically dispersed. The knowledge and skills gained from this innovation provides a platform from which to expand on-line delivery arrangements into other areas of study.

Students from different Schools could learn together on-line, by observing audio/visual presentations, analysing multi-professional teams at work, participating in on-line discussions and, finally, reflecting on the learning process.

The current generation of students is media-savvy and accustomed to communicating electronically. In general, students respond positively to on-line delivery if it is done well, but are scathing of poor quality presentations and unreliable technology.

Increasingly, future teams of health professionals will consult and communicate electronically. Therefore, skills developed in on-line discussion groups will be transferable.

Multi-media units are available both internally (in E-Health, UDRH) and externally (in Rural Health, University of Sydney) and could be used as common resources across all Schools. However, software licensing
agreements increase costs and restrict access to commercially available material. Licensing agreements for commercial products negotiated for, and by, the Faculty would improve access to and the viability of multi-media educational resources.

Some staff considered on-line delivery more appropriate after the first year of a course, to ensure a successful transition from secondary to higher education. To reinforce on-line multi-professional learning in the middle years, it is recommended that students participate in practical face-to-face multi-professional learning in clinical settings or simulated environments during their final year/s.

5.6. New Competencies and Common Skills

A National Patient Safety Educational Framework released by the Australian Council for Safety and Quality¹ in 2005 could underpin the development of shared or ‘common resources’ for teaching ‘Quality and Safety’. It is patient-centred and identifies the knowledge and performance required by all health care workers, in relation to patient safety.

The Framework presents 22 learning topics, embracing multi-professional teams involved in both acute and chronic care. The topics cover areas such as communicating effectively, managing risk, medicating safely, team work and leadership, using evidence and information, professional and ethical behaviour, maintaining fitness to work or practice and managing fatigue and stress. Each topic contains:

- A rationale
- Patient narratives (scenarios)
- Levels of knowledge and skill required for each category of health worker.

The unit could also include skills in taking case histories, completing an assessment and developing a management plan. Other Schools have identified these as critical common skills and particular strengths of the School of Nursing & Midwifery.

Multi-media modules/resources could be supported by a complementary and practical module for delivery in simulation/skills centres. As a result, students would learn and apply quality and safety competencies in a simulated learning environment. The Skills Centre at the Rural Clinical School is supportive of this initiative, especially for new interns and recently graduated nurses.

5.7. Service Teaching

By ‘service teaching’ units to students from other Schools and ‘teaching into units’ which belong to other Schools, the expertise of staff can be shared across the Faculty. These are common practices for many Schools but there is scope for expansion.

To facilitate an exchange of staff between Schools, a register of teachers with expertise of interest to other Schools and who are willing to participate in

¹ In 2006, the Council was rebadged as the Australian Commission on Safety and Quality in Health Care and released an Australian Charter of Health Care Rights in July, 2008.
service teaching, could be compiled and circulated to Heads of Schools at the start of each planning cycle. Staff would be shared between Schools on the basis of agreements negotiated by Heads of Schools.

5.8. Advocates

Change usually involves leaders and followers. To date, for this project, the leaders are the Schools of Nursing and Medicine along with UDRH and RCS. Other Schools may follow when there are demonstrable benefits and sustainability has been established.

Consistent with national imperatives for health workforce reform and future accreditation requirements, the Faculty of Health Science is committed to collaboration in teaching and multi-professional learning.

Typically, effective change is driven by committed individuals. Identifiable advocates are already emerging for collaboration in respect to legal & ethical issues, simulated learning and safety and quality competencies.

However, there are, as yet, no obvious advocates for collaboration in relation to health promotion, community health, primary health care, research methods or therapeutics, at present.

6. Issues

In order to realise the opportunities presented and maximise the benefits derived from collaboration, the challenges identified below will need to be addressed. They will need to be prioritised and resolved over time in conjunction with the roll out of new initiatives in collaboration.

6.1. Culture, Competition and Isolation

The Faculty is based on a tradition of independent and individual Schools. Generally, there is a well entrenched allegiance by staff to the School and one’s profession or discipline. This appears to have encouraged indifference towards other Schools and suspicion of the Faculty.

Competition for funding (especially research funding) and the high value placed on intellectual independence may have contributed to this culture.

Isolation is currently increasing, especially for the Schools of Medicine and Pharmacy, as a result of a new MBBS curriculum and the relocation of the School of Medicine away from the Sandy Bay Campus. Medical and Pharmacy students are similar cohorts and have been combined in the past for human biology. This was scaled back in 2006, when the new integrated MBBS curriculum was introduced, and will probably be discontinued when School of Medicine relocates to Hobart CBD in 2009.

A change towards a more collaborative culture will be slow and challenging.
6.2. **Ownership and Control of Intellectual Property**

In universities promotion, reputation and funding are largely dependent on ownership and control of intellectual property. Therefore, individuals can be very protective of intellectual property and disinclined to share it with others, who they fear may abuse or misuse it.

Academics invest much of themselves in innovative programs and it is often difficult for them to reduce or relinquish their sense of ownership and control.

Therefore, opportunities to expand and enhance pilot programs and embryonic ideas across the Faculty may be lost, unless innovators are willing to release and share intellectual property. Future progress may be contingent upon providing these academics with a guaranteed leadership role, protection of intellectual property and recognition of their initial contribution.

6.3. **Communications**

Good communication is a pre-condition for effective collaboration and networking. Currently, communication between Schools is difficult and time consuming, resulting in cancelled/rescheduled meetings, poor attendances, lateness and bottlenecks in the flow of information. This is due to:

- incompatible software and hardware,
- inflexible teaching schedules,
- large part-time workforce,
- limited communications protocols and disregard for protocols; and
- ethos of independence and nonconformity.

6.4. **Geographical Distribution**

Students are widely dispersed across four campuses in Tasmania and Sydney. Increasingly, future growth may be sourced both nationally and internationally.

As from 2009, students in Hobart will be geographically dispersed and separated across four locations, one for each cohort (medical, paramedical, pharmacy and nursing students).

When students are located on separate campuses, it is logistically difficult, costly and time consuming to combine several cohorts of students in real time (for lectures, tutorials etc). It is also difficult to maintain equitable and consistent learning experiences across campuses.

6.5. **Differences in Curriculum and Pedagogy**

All Schools except Medicine have traditional discipline-based curricula. In 2006 a new MBBS curriculum was introduced, which integrates disciplines around five themes and weekly Case-Based Learning (CBL). It is difficult to attempt to align learning across very different curricula.

Hence, there is a preference to expand multi-professional education by embedding it within existing curricula as modules, rather than as additional
units. The challenge lies in intertwining and integrating IPE into already crowded curricula.

A further complication is that traditional discipline-based curricula do not entirely segment topics into discrete units/modules, but interweave them across years. Each School approaches this differently. For example, health promotion is a discrete second year unit and a third year elective in the Bachelor of Health Science, while it is segmented across two broader units in first & third years of the Bachelor of Nursing. Simultaneous timetabling is, therefore, problematic.

Even when units appear similar, the orientation and emphasis varies across Schools. For example, research methodology in some Schools is mainly quantitatively based while in other Schools, both qualitative and quantitative methods are emphasised.

For most Schools in the Faculty, courses are orientated around the patient and the particular requirements of relevant professional bodies, but not in the School of Human Life Science where employment outcomes are very different.

Differences in enrolment policy and selection criteria create distinct student populations for each school, with unique characteristics in terms of interests, capabilities and learning needs. For this reason, basic sciences are tailored to the needs of individual Schools. There has, therefore, been a shift away from common learning in the basic sciences, to address individual differences in student populations across the Schools.

6.6. Disproportionate Numbers and Diverse Student Populations

If groups of students from different schools are combined and there are significantly unequal numbers, group dynamics can be impacted and there is a danger that the minority groups may feel overshadowed or overlooked.

Numbers in the Bachelor of Nursing exceed the total of all other undergraduates in the Faculty. For example, in Launceston, students in any Human Life Science course would be significantly outnumbered if combined with any year in Nursing. The effectiveness of mixed discussion or tutorial groups is reduced. Inevitably, groups would be either unbalanced or many would comprise nursing students only.
2008 Undergraduate Enrolments by Course, Campus & Year

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*H= Hobart  *For HLS, n/a = not applicable as course does not extend to those years

6.7. Cost and Complexity of Small Group Learning

When student numbers are large, geographically dispersed and unevenly distributed across campuses, it is difficult and costly to organise effective small group learning. Yet this is the preferred delivery mode for inter-professional education. Programs such as RIPPER are effective but, at a cost of $10,000 for 30 students (in 2007), it is not viable for all students and inequitable if offered only to a select few. Consistent with its brief to promote rural health, UDRH is able to conduct and fund RIPPER effectively on a small scale in rural areas.

On-line discussion groups as pioneered in the unit ‘Perspectives on Ageing’ have increased the efficiency of delivering to small groups\(^2\).

6.8. Funding and Allocation of Load

When students undertake common units or modules, issues related to funding and teaching load arise, principally because Schools are funded at different rates and there is no one funding model for collaborative units. Units are assigned to Schools, not Faculties, and this determines the allocation of load and administrative functions associated with maintenance of the unit.

Currently, issues related to funding and load are determined on a case-by-case basis.

\(^2\) Refer to Section 5.5 p.7
6.9. **Assessment**

If assessment is not uniform across cohorts for a common module/unit, different cohorts of students may value the same learning experience differently. Yet, uniform criteria may not be appropriate or feasible if modules/units are imported from other Schools.

Inter-professional competencies may involve assessing not only an individual’s knowledge, skills and values, and their contribution to the group dynamics, but also the extent to which the group achieved a common goal. None of these is easily assessed.

6.10. **Timetabling**

The length of the semester, including commencement and completion dates, and the timing of exams and clinical placements are not uniform across Schools. For example, in an academic year, Nursing can have either 2 or 3 semesters, while the paramedic course is delivered in 3-4 discrete blocks.

Without flexible delivery, the timetabling of common learning across schools is problematic. This becomes increasingly complex as the number of students and schools increase. Eventually, co-ordination at the Faculty level is required.

6.11. **Student Perceptions**

To date, student evaluations of collaborative learning reveal that it is not highly valued, unless it is perceived as stimulating and relevant and that the composition of the learning group is balanced and complementary.

For students undertaking collaborative learning as modules within a pre-existing unit, HECS is another anomaly if different rates apply for students undertaking the same learning experience. Differences in HECS for common learning modules are perceived as inequitable.

6.12. **Infrastructure Capacity**

Opportunities to combine groups of students are constrained by the capacity of the available lecture theatres. Health promotion is a potential area of common learning for Health Science and Nursing students at Newnham Campus, but the Faculty has no lecture theatre large enough to take both groups simultaneously.

Similarly, the capacity of the largest lecture theatre in the new School of Medicine is only 170, which would insufficient for combined groups of medicine and pharmacy students.

6.13. **Change Threshold and Change Management**

The Faculty of Health Science is growing fast and undergoing significant change. The new MBBS course will not be full implemented until 2010 and the next 2 years will be a challenging transitional phase for clinical schools. Also, over the next 2 years, several major infrastructure programs will be
completed. These include an extension to the School of Pharmacy, re-location of the School of Medicine and the commissioning of simulation centres in Launceston and Hobart.

Staff members are already facing change fatigue. Further change, such as collaborative teaching and learning, is not welcome. Change management will be difficult to achieve over the next 2 years and will need to be slow and sensitive.

6.14. Staff Workload

Teaching staff report an environment of increasing workloads mainly due to, they feel, the growth in student numbers. Given this pressure, any additional projects with a collaborative focus will need to be planned with this in mind.

6.15. Clinical Placements

The idea of placing mixed teams of students on simultaneous clinical placements is appealing as an IPE experience. However, potentially, this will be difficult due to the complexities of achieving appropriate placements for mixed cohorts of students, the limited capacity of available placements and the need for co-ordination across schools. The School of Pharmacy reported that attempts in 2007 to place medical students in community pharmacies were ‘frustrating, time consuming and administratively challenging’.

The recent implementation of the Student Placement Management System (SPMS) will ease the complexity and frustration experienced by Schools in the past. However, centralised co-ordination may be required to facilitate the placement of mixed teams of students in the future.

6.16. Access to Health Professionals

Programs exposing students to other health professions are valuable, but health professionals have limited time and are mostly volunteers. Student evaluations of the involvement of other health professionals in the RIPPER program were positive, but in 2007 the RIPPER program involved 11 volunteer health professionals from Launceston General Hospital and the Scottsdale community, for only 30 students.

The UDRH is funded to provide these opportunities in a rural context, but similar funding is not available for a parallel program in an urban setting.

An urban program and increasing student numbers would test the goodwill of participating health professionals.

7. Options

The following are offered as options for reducing the impact of the barriers to collaborative teaching and learning identified above.
7.1. Funding

Currently, the financial arrangements for collaborative teaching and learning initiatives are negotiated on a case-by-case basis. This offers the flexibility to tailor arrangements to specific and unique circumstances. To date, a number of successful funding arrangements have been negotiated in this way, including a ‘buy-in’ model for the ‘Perspective on Ageing’ unit.

7.2. Dispersion & Diversity

The Faculty is widely spread geographically, both across and within 4 major population centres. It spans from Hobart to Sydney and will have 4 separate campuses in Hobart by 2010. There is no consistency across Schools in the timing or duration of semesters and holidays, or the scheduling of exams or placements.

Options for addressing these challenges include:

7.2.1. A Register of Teaching Staff Expertise

A register of teaching staff with particular expertise, which may be of interest to other Schools, could be collated and circulated to Heads of Schools annually, at an appropriate time in the planning cycle.

Where opportunities were identified, Heads of Schools and relevant staff would negotiate the terms of the exchange, including availability and the value of the expertise provided.

The register would be updated annually, after ascertaining that nominated staff members were willing to participate.

7.2.2. On-line Delivery

On-line delivery offers flexibility and minimises issues related to timetabling, physical proximity and ongoing access to volunteer health professionals.

Although initial production costs for stimulating and highly interactive on-line material may be high, it can be reused and replayed. Scenarios, guest speakers and real-life teams of health professionals can be videoed and presented as stimulus material, especially for on-line discussion groups.

High level technical support is required to support these delivery arrangements and provision would need to be made for access to broadband on-campus for some students.

On-line and electronic communications are essential elements of daily life for the majority of the student population. Increasingly, teams of health professionals will also manage complex, community-based health care on-line.

On-line delivery can provide more consistent and equitable learning experiences, irrespective of location and time if access to broadband is readily available on campus.
7.2.3. Regional Clusters

Collaboration based around regional clusters is limited by the number and type of undergraduates within a region, particularly in Burnie and Sydney. As a consequence, students in different locations may not be able to access similar learning experiences, raising concerns about consistency and equity. Nevertheless, programs recommended for skills centres and simulation centres will need to be based on regional clusters.

7.2.4. Education Software

Collaboration to improve access to available educational software would improve the efficiency and effectiveness of teaching & learning across Schools. For example, units and modules are available for E-health from UDRH and for Rural Health from University of Sydney. There is also a range of similar commercial products.

For individual Schools, the cost of purchasing or producing & maintaining multi-media products is high. Access to high quality products could be improved, if the costs of purchasing educational software could be shared across a number of interested Schools, as a result of Faculty-wide arrangements. Access to commercial educational software would improve, if the Faculty negotiated ‘umbrella’ licensing agreements for shared products.

7.3. Staff Workload and Incentives

Workloads are changing due to changes in technology, student populations and government funding. To encourage collaboration, a number of interviewees suggested a review of workload allocations and staff incentives. The following options were recommended for consideration:

7.3.1. Workloads

Workloads of teaching staff may impact their capacity to commit to developing and piloting collaborative teaching and learning initiatives. Staff may wish to include a discussion of involvement in proposed collaborative initiatives when negotiating future workloads.

7.3.2. Time Release

If ‘advocates’ could be allocated dedicated time for development and implementation of collaborative initiatives at critical times, a major impediment could be addressed.

7.4. Assessment

Assessing changes in values inherent in IPE competencies and group outcomes is challenging. Therefore, the alternatives are:
7.4.1. To Assess

Assessment is a process for demonstrating effective learning and evaluating outcomes. Without assessment, it is difficult to determine if students are learning with, from and about each other. For many students, learning is perceived as ‘not important’ unless it is assessed. Assessment is a powerful motivator.

7.4.2. OR, Not To Assess

Some argued that IPE competencies cannot be effectively assessed, especially for undergraduates, and that the impact of IPE only becomes apparent later in their professional lives. Assessment can also inhibit IPE, if it restricts freedom of expression and encourages competition.

7.5. Communications

Last, but not least. Communication is a pre-condition for collaboration and there are systemic problems inhibiting effective communications in the Faculty. The options for improving communications include:

7.5.1. Electronic diary/resource management system

Electronic systems such as MS Outlook are used almost universally to facilitate the scheduling of meetings. User groups are established, and have the capacity to view each others’ outlook diaries and the bookings for meeting rooms. Identifying common free time is quick and easy. This significantly improves efficiency when planning meetings, especially if there are well established and implemented communication protocols.

A pilot for Microsoft ‘Share Point’ is being conducted by the University, at present. Future expansion of this facility will be considered following an evaluation of the pilot.

7.5.2. Performance plans

Assessable staff performance plans that included standards and targets for effective communications would reinforce the use of communication systems and protocols. Accompanying staff development is also beneficial.

8. Recommendations

That the Steering Committee supports:

A. The preparation of three proposals as guidelines (project plans) for developing and piloting:

1. ‘Experiential IPE’ in the ‘Management of Chronic Illnesses’, involving students in ‘RIIPPER’ style workshops located in skills/simulation centres. It will provide students with opportunities to learn with, from and about each other in a practical context;
2. ‘Shared Learning’ in ‘Legal & Ethical Issues’, where students from two or more Schools learn together either on-line and/or in real time; and

3. ‘Common Resources’ whereby multi-media modules in ‘Safety and Quality’ (based on the National Patient Safety Education Framework) are developed for delivery in the classroom, on-line and/or in simulation/skills centres.

B. An investigation to identify sources of funding to support the initiatives proposed in Recommendation A.

C. In conjunction with UDRH, an investigation into the interest in, and options for, promoting currently available software for E-Health and Rural Health as ‘Common Resources’ for the Faculty in 2009.

D. The preparation of a register of teaching staff with special expertise which may be of interest to other Schools, for distribution to Heads of Schools, for use in the next planning cycle.

E. Identification and ongoing support for existing FHS IPE workplace-based learning and scoping of options for IPE workplace-based initiatives into the future

9. Implementation

The change management strategy is to commence with only those proposals that have widespread support. If successful, these pilots will provide the momentum for greater engagement and a willingness to tackle outstanding barriers. As a consequence, further collaboration will follow.

The intention is to implement the guidelines for the recommended proposals in 2009. The syllabus and learning experiences for each of the recommended collaborative initiatives would be developed in the first half of the year and piloted in the second half.

The UDRH has offered financial support, to assist with the development and implementation of proposals with a rural dimension, if commenced before 2009.

To support the implementation of the Rural Health Plan (2008-2010), multi-media learning products in Rural Health and E-Health could be customised and promoted in 2009 as ‘Common Resources’ within Schools.

If the pilots are successful, the models would be used to extend collaborative teaching and learning into other areas such as Health Promotion, Community Health, Primary Health Care and Research Methodology. Another aim for 2010 is to enhance the ‘Shared Learning’ pilot in legal and ethical issues, into an example of ‘Co-operative IPE’.

To ensure sustainability, a governance arrangement which has the capacity to identify and support other collaborative initiatives in 2009 and beyond may be required.