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Development of an Interprofessional Competency Course Across Multiple Health Professions

Dana Bates, PhD, LAT, ATC*; Kathryn Bell, EdD†; Talina Corvus, PT, DPT, PhD*; Melissa Fryer, MA‡; Monica Sarmiento, BSDH§; Jeffrey Kawaguchi, PT, PhD, LAT, ATC*; Jessica Moore, EdD, LAT, ATC‖
*Physical Therapy and Athletic Training, †School of Healthcare Administration and Leadership, ‡School of Communication Sciences and Disorders, §School of Dental Hygiene Studies, Pacific University, Hillsboro, OR; ‖Norwich University, Northfield, VT

Context: Although interprofessional education (IPE) is not a new concept in health profession programs, the integration of this collaborative approach into athletic training education is still relatively new. Interprofessional education learning experiences can be embedded in a current course, presented in a stand-alone course, or integrated into service learning, simulation, or clinical education. Regardless of implementation strategy, IPE learning experiences should be adapted to each institution in response to program needs and resources available.

Objective: To describe the development of an IP course that includes 10 health profession programs.

Background: Although athletic training programs are required to implement IP collaborative practices, some institutions may experience challenges in developing strategies to meet this goal. Opportunities to engage in IPE initiatives may be present within your own college, institution, and community.

Description: We will describe the implementation of an IP course that included 10 health profession programs. The paper will outline the course design, course delivery, outcomes/data, and lessons learned along the way to support the continued advancement of IPE in athletic training programs. This course, through revisions, also included foundational understanding for concepts of cultural humility and the competence continuum along with strategies for respectful and effective team building in a diverse and IP environment.

Clinical Advantage(s): Through this course, athletic training students are able to interact and collaborate with students from varied health profession programs, which leads to an increased level of rapport among students as well as discussions and integration of diversity, equity, and inclusion. The course also provides athletic training students with opportunities to educate future health professionals about athletic training.

Conclusion(s): When contemplating implementing an IPE course, administrators should consider other health programming and students in their respective colleges, campuses, and communities. Other considerations for successful course development include administrative support and buy-in.

Key Words: Collaborative practice, curriculum, multidisciplinary, interprofessional education

Dr Bates is currently an Associate Professor in Physical Therapy and Athletic Training at Pacific University. Address correspondence to Dana Bates, PhD, LAT, ATC, Physical Therapy and Athletic Training, Pacific University, 190 SE Eighth Avenue, Hillsboro, OR 97123. dbates@pacificu.edu.

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KEY POINTS

- Implementing a university or college-wide interprofessional (IP) didactic course into curriculum can be a challenge, and programs should consider administrative support and buy-in during the course development process.
- A dedicated IP course that includes varied professional programs is a tremendous learning experience that can meet Commission on Accreditation of Athletic Training Education standards and allows varied health profession students time to dialogue and learn alongside other health professionals.
- Interprofessional courses should also consider current environmental events and students' needs. Through revisions, we included foundational understanding for concepts of cultural humility and the competence continuum along with strategies for respectful and effective team building in a multicultural and IP environment.

INTRODUCTION

Interprofessional collaborative practice occurs when multiple health workers from different professional backgrounds work together with patients, families, and communities to deliver care to patients.[1] For athletic trainers (ATs), interprofessional practice is considered a core competency and is described in the Commission on Accreditation of Athletic Training Education (CAATE) Professional Standards. Specifically, Standard 61 describes "practice in collaboration with other health care and wellness professionals."[2] In 2010, the World Health Organization issued a call for a health workforce that understands interprofessional collaboration and suggested interprofessional education (IPE).[1] The result of this call was the formation of the Interprofessional Educational Collaborative (IPEC), which defined the constructs of interprofessional practice based on the attainment of 4 core competencies. The first competency, values/ethics for interprofessional practice, encompasses the ability to work with individuals of other professions to maintain a climate of mutual respect and shared values. The next competency, roles and responsibilities, embodies the use of knowledge about one's own role and those of other health professions to appropriately address the health care needs of patients to promote and advance the health of populations. The third competency, interprofessional communication, stresses the importance of being able to communicate with patients, families, communities, and professionals in health and other fields in a responsive and responsible manner that supports a team approach to the promotion and maintenance of health and the prevention and treatment of disease. Finally, the fourth competency, teams and teamwork, describes the ability to apply relationship-building values and the principles of team dynamics to perform effectively in different team roles to plan, deliver and evaluate patient/population-centered care and population health programs and policies that are safe, timely, efficient, effective, and equitable.[1]

Acceptance of interprofessional practice is widely recognized as best practice across virtually all health professions. In 2011, the professional representation and associations that collaborated to promote and encourage constituents efforts to advance interprofessional learning experiences included the Academic Consortium for Complementary and Alternative Health Care, the American Association of Colleges of Podiatric Medicine, the American Council of Academic Physical Therapy, the American Physical Therapy Association, the American Podiatric Medical Association, the American Psychological Association, the American Speech-Language-Hearing Association, the Association of Schools and Colleges of Optometry, the Association of Schools of Allied Health Professions, the Council on Social Work Education, the Physician Assistant Education Association, and the Society of Simulation in Healthcare. In 2016, other professions, specifically athletic training, joined the IPEC in support of interprofessional practice and reaffirmed the original competencies, grounded the competency model firmly under the singular domain of interprofessional collaboration, and broadened the competencies to better integrate population health approaches across health and partner professions.[3]

Interprofessional education occurs when students from 2 or more professions learn about, from, and with each other to improve collaboration and patient care.[1,2,4] Athletic training students develop skills necessary to practice in an interprofessional manner during matriculation through a CAATE-accredited educational program. This requirement is described in Standard 8 of the 2020 Standards.[2] This standard describes planned IPE that is incorporated within the professional program. Researchers in athletic training education has investigated benefits of IPE that have included increased knowledge, respect, and value of health professions.[5–8]

The purpose of this paper is to describe how one college with 10 health profession programs created a foundational IPE course to address needs across health profession programs. Presently 10 health profession programs are represented in this course: pharmacy, physician assistant, occupational therapy, physical therapy, athletic training, psychology, dental hygiene, audiology, optometry, and speech-language pathology. The course promotes the development of skills and attitudes needed to function effectively in an interprofessional health care community. A description of the evolution of the course design from inception to the present day, including course delivery, outcomes/data, and lessons learned along the way to support the advancement of IPE in athletic training programs, will be presented.

COURSE DEVELOPMENT

The original interprofessional competency course (IPC) started in 2009. The course was built around the IPEC core competencies for interprofessional practice: values and ethics, roles and responsibilities, teams and teamwork, and interprofessional communication.[1] The first permutation of the course was designed as a large (300+ student) class taught over 4

sessions, and administered solely for the College of Health Professions (CHP) schools and programs, including pharmacy, physical therapy, occupational therapy, athletic training, physician assistant studies, and dental hygiene. The dean of the CHP led the efforts over several years to establish protected IPE time in the college. This required coordination among deans and directors, as well as substantial organizational support by administrative staff. As the program developed over the years, positions were specifically dedicated to working on IPE at the associate dean level and also administrative staff. Buy-in for the IPC gradually evolved over time and was largely due to champions within each school and department who provided clarifying information, answered questions, and kept momentum moving. Most of these champions served on the Interprofessional Education and Practice Committee, a college-level committee, which had a representative from each of the schools in the CHP. Eventually, the Interprofessional Education Steering Committee was formed, which was established to provide guidance and oversight of IPE activities across the university.

Revisions to Course

The course underwent revision in 2016 to be taught in smaller sections, each facilitated by a pair of interprofessional instructors. Content was uniform across all sections to facilitate equity of student learning across groups. The university used Moodle (version 3.4; Martin Dougiamas, Course Management System) as the learning management software, and all readings, assignments, and additional discussions were loaded onto identical Moodle section pages. Faculty training on both course content and Moodle was provided before each year of the course. Class size in the sections was capped at approximately 40 students, and students worked together in preassigned interprofessional teams of 5 students. The class was held over 4 weeks, meeting for 1.5 hours per week. The course met during times that would allow students from the various health professional programs to attend clinical experiences. The course was 0.5 credits and graded on pass/no pass criteria. The course was typically offered to first-year, first-semester CHP students because of student availability, the newness of the content, and the desired impact on their future clinical learning. Faculty instructors were chosen from all programs based on interest in IPE and interprofessional practice and availability.

Through the 2016 revisions, the course continued to focus on the IPEC core competencies, culminating in an interprofessional case presentation. Throughout the 4 sessions of the course, students worked in their interprofessional teams completing activities and discussions tied to each of the interprofessional core concepts. During this time they were also provided with a simplified client/patient "case" with which they were required to build out clinical details and ultimately present as a grand rounds style presentation. This presentation was rated by faculty instructors and viewed by other students' teams. Assessment of student learning was captured using the Interprofessional Collaborative Competencies Attainment Survey (ICCAS).[9] This questionnaire is a retrospective pre-post (students score themselves for both precourse and postcourse after completion of the course) student self-report measure in which students rate their skills and abilities before the course and after the course.

Student feedback during the course demonstrated that working in small interprofessional teams and participating in the case presentation were positive. However, qualitative feedback from students indicated a low perceived efficacy in entry-level students' ability to discuss roles and responsibilities of their profession. Per this feedback and with approval of the registrar, in academic year (AY) 2019–2020 the course was moved to the spring semester. Concurrently, it was changed to a hybrid course (80% in person, 20% online) to better accommodate the structure of the course and facilitate specific content. Content that was moved online consisted of a prerecorded introduction lecture to calibrate foundational knowledge across multiple sections and increased use of interactive online discussion forums. This transition to hybrid precipitated a full transition to online learning in AY 2020–2021 because of the COVID-19 pandemic. That year the course was synchronous online, with one evening section.

Current Course Offering

The interprofessional course was redesigned again in 2020–2021, expanded into a 1-credit course, and renamed for launch in AY 2021–2022 as Foundations in Interprofessional Practice, Equity, and Inclusion (FIP). Because of COVID-19, the new course was conducted entirely through a virtual platform, using synchronous sessions over Zoom and asynchronous sessions with materials posted in Moodle. The expansion came in response to ongoing feedback from various interest groups, including students, faculty, and administration, that the course would benefit from specific curricular changes related to diversity, equity, inclusion, and social justice. Feedback was received via student course evaluations, direct student advocacy, discussions with course faculty instructors, and student and faculty focus groups conducted as part of an IPE program evaluation project. Course feedback, outcomes data, and data collection from the focus groups were all approved by the Pacific University Institutional Review Board with exempt status. Data from the student and faculty focus groups underwent grounded-theory qualitative analysis procedures, as described by Auerbach and Silverstein.[10]

The previous course acknowledged that health inequity, circumstances in which people or populations are limited in achieving their full health potential because of unfair access to health care, disadvantaged social positions, and/or marginalized living conditions, and its causes were related to interprofessional practice,[11] though there was little written on this relationship at the time. Addressing the needs of patients holistically often means multiple health professions collaborating and the recognition that systemic social factors are at play.[12] But, although the topics of implicit bias and health equity were touched upon in the original IPC, they were not explored in depth. Students stated that more exploration and integration of these topics was imperative to interprofessional practice, health care, and health equity. Heightened student advocacy for these changes aligned with the growing social justice movement in the summer of 2020 brought to the forefront by the murder of George Floyd. The year 2020 held several highly visible examples of anti-Black and anti-Asian violence, sparking conversations about systemic inequalities and inequities within our social systems, including health care.[13,14] Christian Cooper, a Black man, filmed a white woman threatening to call the police on him, emphasizing his race when threatening the force of the law against him.[15] Ahmaud Arbery, a young Black man out for a run, was chased down and killed by 3 white men.[16] Then George Floyd was detained on suspicion and forcibly restrained for more than 10 minutes, while he pleaded for release, until he died at the hands of a law enforcement officer

while bystanders also pleaded for his release.[17] Public outcry at these events was swift and it was loud, including in health professions.[14,18] Demands for our programs to acknowledge the impacts of historical trauma and social injustice on health grew. In this environment, it became clear that the sources of health inequities required direct and transparent instruction in the health professions and could be elevated through the IPEC core competencies in IPE, particularly when seen through the lens of cultural humility, which asks that we practice critical self-reflection, curiosity about others, and the recognition of the roles of power and accountability in providing health care.

The competency of roles and responsibilities asks that we engage with diverse professional perspectives to provide equitable care at the level of population health.[3] The competency of values and ethics asks that we embrace a diversity of personal and professional cultures to engage with ethical dilemmas. The competency of communication asks that we communicate respectfully, recognizing that the uniqueness of individuals and professions can contribute to effective working relationships. Lastly, the competency of teams and teamwork asks that we respect community values and hold ourselves accountable for the health of our communities.[3] Thus, the new FIP course evolved to use an 8-week model to guide students through each of the 4 IPEC core competencies and their relevance to effective and equitable practice using lecture, small-group discussion, critical self-reflection, case-based presentations, and a series of increasingly complex case studies that merged the need to exhibit skills in both interprofessional and equitable inclusion practices (Table 1). Student comprehension checks of online materials occurred through 2 channels: review of reflection assignments and in-class discussion. Reflection activities were assigned weekly to facilitate students' exploration of their knowledge of themselves, as well as others, related to the topic for each week. Class discussions provided an opportunity for students to ask questions and for faculty to facilitate discussions that integrated online content into the practical clinical cases while modeling self-reflection and interprofessional collaboration. Before the course, faculty were trained in the new goals and ideas of the course content, including cultural humility and the cultural competence continuum, and in facilitation techniques for the material, and were provided with additional self-study resources focused on equity and inclusion frameworks. During the course, faculty were provided weekly update emails, containing preparation prompts and guidance, and access to course facilitation materials.

OUTCOME DATA

Course outcomes have been tracked since its original inception. Validated scales used have included the Readiness for Interprofessional Learning Scale (RIPLS),[19] one of the earliest measures of interprofessional attitudes, which was used through 2016. The Attitudes Toward Health Care Teams Scale[20] was adopted for use over the years 2016 to 2020 in response to concerns raised regarding the RIPLS.[21] Finally, we transitioned to using the ICCAS,[9] which has been used since 2020. The decision to move to the ICCAS was made because the statements assess the students' perceptions of their skills and abilities, rather than their attitudes toward health care teams. Additionally, the retrospective pre-post design asks students to reflect back on how their skills have changed because of the completion of the course.

Kirkpatrick's Expanded Outcomes Typology (Table 2) is widely referenced as an outcome framework in IPE.[22] The RIPLS, Attitudes Toward Health Care Teams Scale, and ICCAS are all measures of student self-report—level 2a on Kirkpatrick's model. These measures consistently demonstrated positive gains precourse to postcourse in the expected directions on the questions/statements assessed. In 2021–2022, course administrators added the scoring of student team presentations to the official evaluation plan for the course, consistent with recommendations from IPE evaluation literature. This added an assessment measure that evaluated students' demonstration of behaviors, which is a level 2b assessment in Kirkpatrick's model.[22]

Interprofessional student teams presented their assigned cases to their mentors, and the mentors scored the teams using a 1 to 3 scale, where 1 was *below expected*, 2 was *at expected*, and 3 was *above expected*. The students were assigned one score as a team. Scoring was completed using the Modified McMaster-Ottawa Team Rating Scale.[23] Scores were submitted for 93 teams. Overwhelming majorities of student teams scored at or above expected levels, with a very small number demonstrating below expected performance.

Specific themes arose from student feedback after completion of the course in AY 2021–2022. Several health professional programs had offered courses on ethics and diversity before FIP, contributing to a feeling of redundancy of content for some student groups. Students also reported a desire for additional time learning with and from their interprofessional student partners and less "busywork" to complete offline. Finally, students expressed difficulty finding quiet spaces on campus to join their synchronous class during lunch time. In spring 2022, many health professional programs resumed on-campus classes, resulting in large numbers of students needing to find appropriate locations to join class.

General feedback from faculty was positive; however, specific constructive feedback about course facilitation was received. Some faculty reported difficulty encouraging students to actively participate in virtual breakout-room discussions and in properly monitoring those rooms. They also described challenges adequately covering the breadth of serious content while also achieving the overall objectives of the course, even in an 8-week format. The course will continue to undergo revisions to address concerns in response to student, faculty, and administrator feedback collected after the 2022 course run. The returned to face-to-face instruction in 2022–2023.

CLINICAL ADVANTAGES

As athletic training educators, we have found that the course has been a valuable learning experience for our students and has provided an essential opportunity for growth and development. Our college houses 10 health professional programs. It would be a challenge, outside of this course, to provide such a rich exposure to a wide variety of students from other health profession programs and foster an increased level of rapport among students. As reflected in the 2020 CAATE standards, IPE must be integrated into accredited programs. Although meeting CAATE standards may be a main objective for many program administrators, we found that this course further supported accomplishing its primary objective of introducing the collaborative care concept and offered a forum to incorporate critical self-reflection, cultural humility, and some of the issues surrounding diversity, equity, and inclusion facing athletic training and the health professions overall.

Table 1. Eight-Week Outline of Course and Topics Covered

Week	Topic
1	Course introduction, values and ethics, and roles and responsibilities • Introduction to IPE competencies • Introduction to DEI concepts • Introduction to the history and practices of bias in health care Goals: Introduce foundational concepts in DEI and explore the impacts of bias and discrimination on health care providers and patients. Sample activities: Reflection activity (class activity): Reflect on past experiences with oppression or discrimination, as a recipient and/or participant. Using language and concepts from class, explain what happened, how you felt as it was happening, and how you feel reflecting on it now.
2	Communication • How to ask questions • Language and communication: differences vs disorders • Code switching Goals: Increase our understanding of the role of communication in DEI, explore the way bias is present in communication, and introduce tools for anti-racist and culturally responsive communication. Sample activities: Reflection activity (class activity): Effective communication with our patients and clinical teams is critical to our ability to provide good care. Reflect on the meanings you attach to the speech, language, and accent patterns of people who do not speak the way you do. What personal or cultural factors contribute to your biases and what impacts can those biases have on the way you provide health care? What steps do you need to take to address those biases?
3	Teams and teamwork • Cultural competence continuum • Cultural humility • Avoiding stereotypes Goals: Provide a foundational understanding for concepts of cultural humility and the competence continuum along with strategies for respectful and effective team building in a multicultural and interprofessional environment. Sample activities: Reflection (class activity): Culture is an enactment of learned beliefs, practices, and/or behaviors that are unique to a group of people. Culture is sometimes consistent along racial, ethnic, or even professional categories, but is highly variable within them. If we do not recognize this, we run the risk of perpetuating stereotypes. Take a moment to reflect on some of the beliefs you have about cultures you are not a part of. What are they and how might they impact the way you interact with other health care professionals?
4	DEI in IPE skills debrief • How to intervene in conflict • Additional resources on communication and teamwork • Discussion and case study–based application of concepts. Sample activities Case study role play (class activity)
5	Review of IPE core competencies and practices and introduction to cases Goals: Apply IPE and cultural awareness skills to engage in a collaborative approach to create case details and prepare for team presentation.

Table 1. Continued

Week	Topic
6	Case presentations
7	IPE cases • ICC-style case collaboration
8	IPE cases and debrief • ICC-style case collaboration

Abbreviations: DEI, diversity, equity, and inclusion; ICC, interprofessional case conference; IPE, interprofessional education.

Beyond addressing CAATE standards, addition of this course within the athletic training curriculum provided a forum for our students to educate future health professionals from other professions about athletic training and exposed students across 10 health professional programs to a safe space for dialogue with future interprofessional colleagues. Integration of a wide variety of health professional programs allowed students to learn about, from, and with each other. As students interacted with course content in interprofessional teams, they shared their professions' foundational and unique knowledge, skills, and abilities. While this promoted newfound awareness of professional knowledge and expertise inherent to each profession, it also afforded students the opportunity to educate and dispel incorrect or preconceived notions (eg, educational differences, independent professional practice or need for medical oversight, depth and breadth of professional practice settings and patient populations). Facilitating students cooperating as interprofessional health care teams and applying knowledge and skills to patient case scenarios promoted buy-in to seeking collaborative means to identify and endorse quality patient, family, and community care decisions. Furthermore, the course redesign and deeper exploration of implicit bias, equity, diversity, and inclusion allowed students to integrate this knowledge during various experiential learning activities aimed at guiding interprofessional care rooted in equitable health care delivery.

However, the gains made have not been without some difficulty. Completing an interprofessional course before learning foundational professional knowledge and skills may be a barrier to students visualizing how to collaborate on interprofessional case-based scenarios.[24] Students also struggled to work through patient scenarios in the case-based presentations. Because the profession of athletic training focuses so specifically on the health and well-being of active individuals, athletic training students felt challenged and unsure of how to integrate their knowledge and skills into patient case scenarios, perceiving these scenarios as not always applicable to the scope of practice of an AT. This did generate opportunities for student discussion with faculty and peers that stretched student understanding and brought awareness to additional avenues by which ATs can support patient care. The current faculty have also proposed cases that include patients with intellectual disabilities, such as athletes who participate in the Special Olympics. The introduction of this patient population was also helpful in exposing the athletic training student to the important role that sports play in inclusion. The Special Olympics organization defines *inclusion* as accepting all people as equals and ensuring that everyone has access to the same opportunities.[25] Expanding case-based patient characteristics allowed additional avenues to facilitate critical thinking and realization of means to support interprofessional patient care and health equity across a diverse patient spectrum of health, wellness, and ability.

Interprofessional collaboration is a foundational concept in health care education and delivery. Interprofessional educational opportunities equip students across health professions with enriched understanding of professional knowledge, skills, and abilities and experiential learning opportunities as collaborative team members.[26] Avenues to create and integrate interprofessional learning and collaborative occasions with students across health professions cultivates realization of opportunities to support patient-centered care before professional practice.[5,6,27] Developing and enriching students' awareness and knowledge to champion equity, diversity, and inclusion during all patient interactions can foster a network of ATs and health professionals more adept at supporting the needs of diverse patient populations. Administrators investigating ways to implement an IPE course should consider other health programs or students on campus, as well as administrative support and buy-in for the course development process.

CONCLUSIONS

As programs look to integrate IPE in the curriculum, they should be strategic and purposeful. Partners in IPE may be found through other health programming at one's institution or

Table 2. Kirkpatrick's Expanded Outcomes Typology[22]

Level	Description
1. Reaction	Learner's views on the learning experience and its interprofessional nature.
2a. Modification of attitudes/perceptions	Changes in reciprocal attitudes or perceptions among participant groups. Changes in perception or attitude towards the value and/or use of team approaches to caring for a specific client group.
2b. Acquisition of knowledge/skills	Including knowledge and skills linked to interprofessional collaboration.
3. Behavioral change	Identifies individuals' transfer of interprofessional learning to their practice setting and their changed professional practice.
4a. Change in organizational practice	Wider changes in the organization and delivery of care.
4b. Benefits to patients/clients	Improvements in health or well-being of patients/clients.

within the community who may have a vested interest in IPE. After these partners are identified, working on objectives can commence, with the overarching goal of students from varied health programs working together to learn from, with, and about each other and their respective professions. Although IPE can occur in many forms, we highlighted a dedicated course for 10 programs at one institution that had administrative and logistical support, faculty development, curricular planning, and time for focus on redesign as needed. We have learned, both from student and faculty feedback, that redesign of the IPE course with consideration of concurrent social justice events and students' needs provided foundational understanding for concepts of cultural humility and the competence continuum along with strategies for respectful and effective team building in a multicultural and interprofessional environment.

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