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The **AGILE** project & Precepting Models

Advancing experiential learnin**G** **I**n institutiona**L** pharmacy practic**E**

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AGILE Project Lead

- AGILE Project Goal
  - To develop recommendations that will inform new approaches to institutional experiential pharmacy education in British Columbia
    - Address capacity concerns & associated challenges

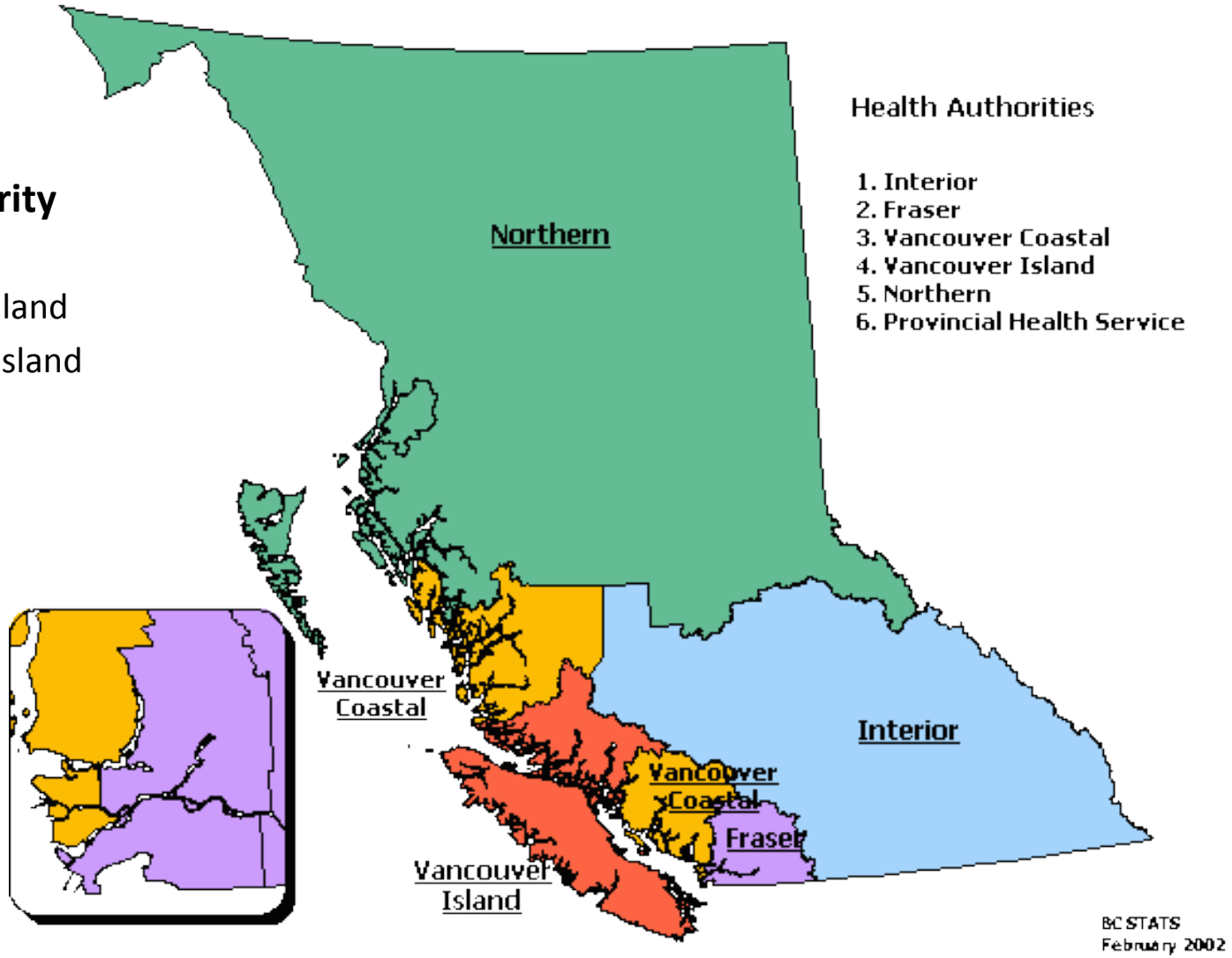
- Project Oversight
  - Initiated by the Faculty of Pharmaceutical Sciences at UBC
    - Steering Committee
      - Dr. Peter Zed, Dr. Peter Loewen, Dr. Angela Kim-Sing, Dr. Patricia Gerber
    - AGILE Project Lead (Dr. Michael Legal)
      - Health authority clinical pharmacist and experienced preceptor

- Project Deliverable
  - A report providing recommendations in several key areas (November 2013)
    - Preceptor-learner models
    - Supports for preceptors and learners
    - Learning facilitator duties and responsibilities
    - Preceptor training and credentialing
    - Knowledge resources
    - Preceptor incentives

Institutional Pharmacy Practice in BC

800 health authority pharmacists

- 70% Lower mainland
- 15% Vancouver Island
- 10% Interior
- 5% North



http://www.health.gov.bc.ca/socsec/provmap.html

- Institutional placements for pharmacy experiential programs in BC
  - UBC Faculty of Pharmaceutical Sciences
    - BSc Pharmacy program
      - One 4 week rotation (4th yr) per student (X 156→226)
    - Post graduate Doctor of Pharmacy Program
      - 8 students X 12 rotations per student
  - BC Pharmacy Practice Residency Program
    - UBC affiliated- health authority funded/administered
      - 30+ residents X 8 + rotations per resident

- Challenges
  - Limited capacity
  - Preceptors have competing demands
    - Existing responsibilities
    - Limited access to supports

Factors to Consider

Capacity

↑ enrolment

E2P PharmD program

Learner needs

Workload

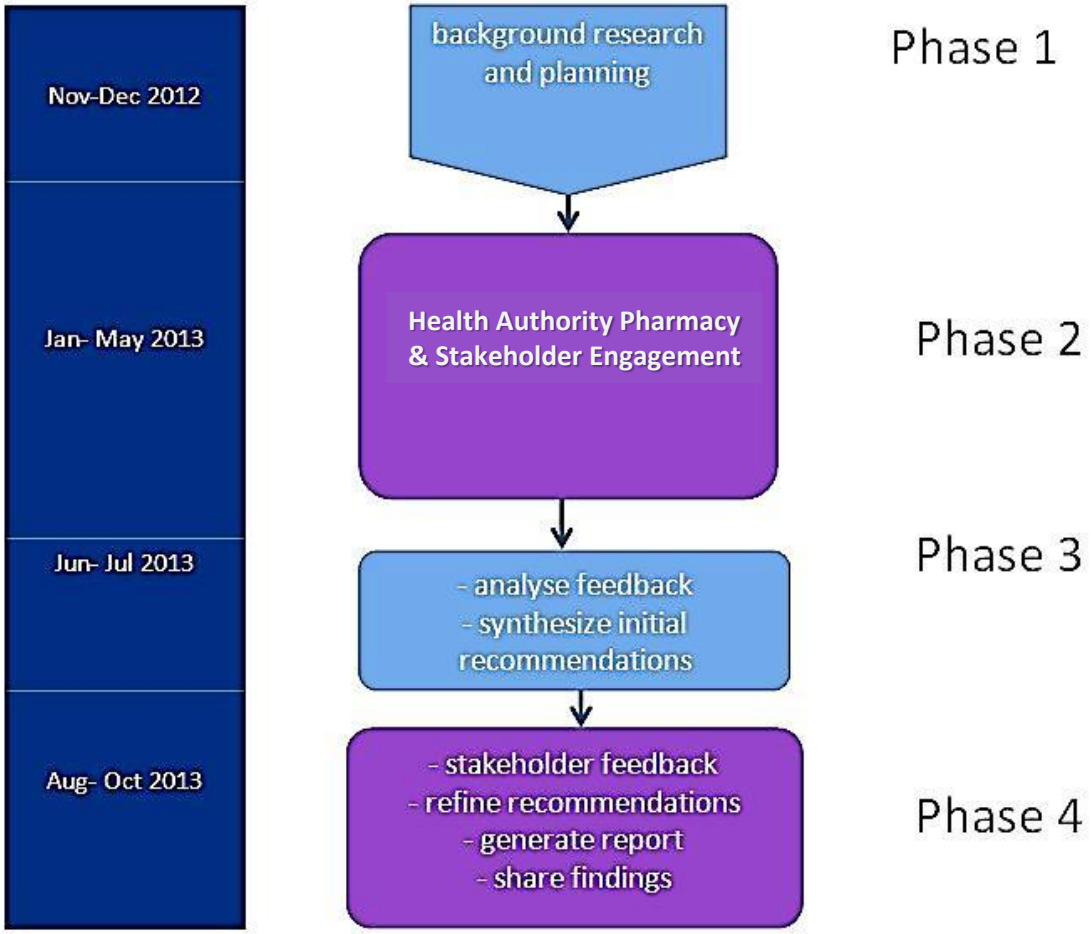
Preceptor needs

Support

Rotation models

Peer-assisted learning

Project Overview- Phases and Timeline



- Methods
  - Qualitative research approach
    - Stakeholders
      - Preceptors, learners, faculty, HA leadership
    - Multiple engagement methods
    - Identify themes from feedback
      - Barriers and possible solutions
    - Develop recommendations
      - Stakeholder feedback + proven strategies (literature & experience elsewhere)

- Engagement methods

Focus groups

Electronic Survey

One on one interviews

Experiential learning working groups

Website discussion

http://agile.pharmacy.ubc.ca

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AGILE

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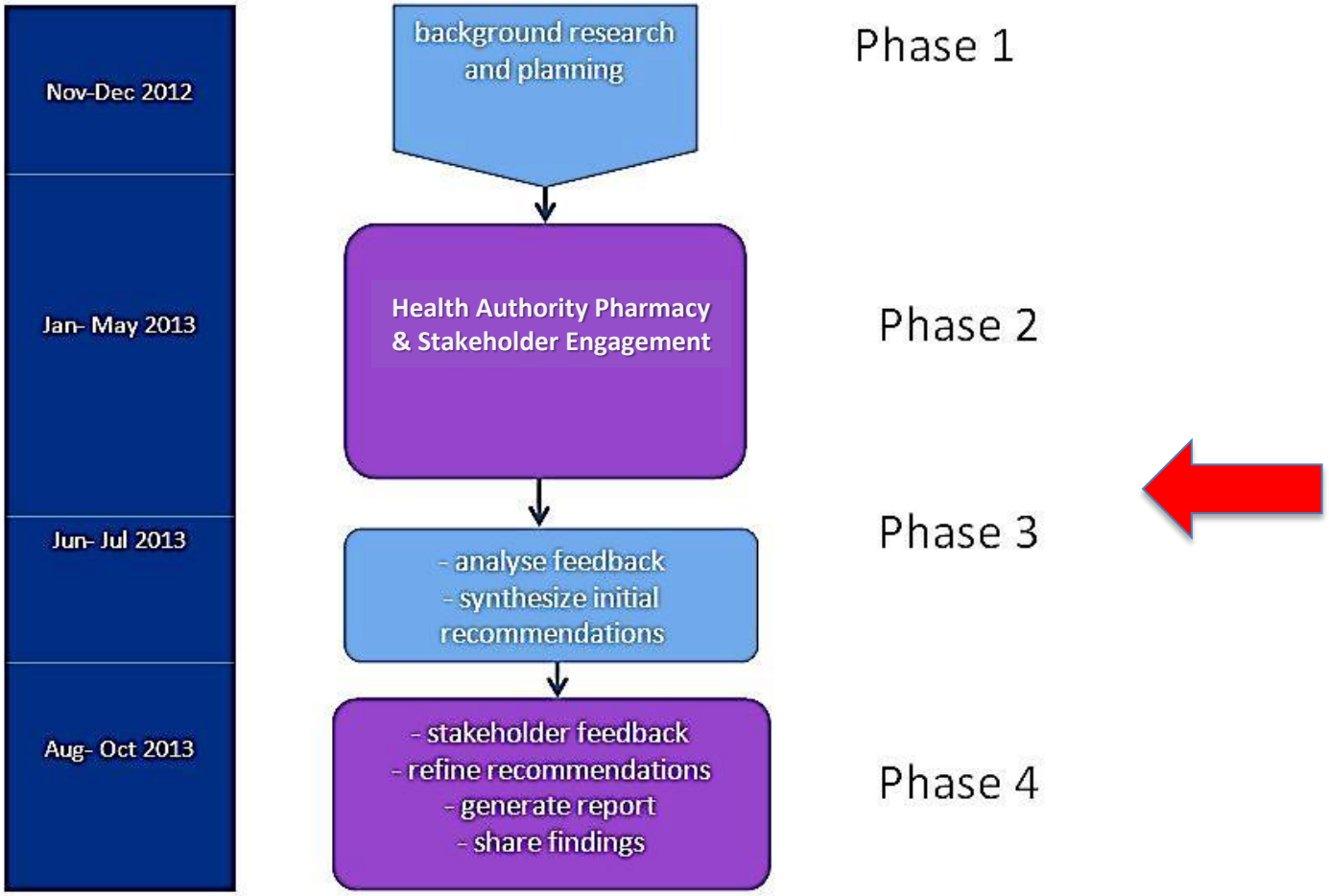
The Site | Join the Conversation | Visit Schedule

This website is dedicated to being an online resource and discussion forum for the AGILE project. Additional content will be added over time so please check back regularly.

Welcome to AGILE

AGILE stands for Advancing Experiential LearninG In InstitutionaL Pharmacy PracticE. The goal of AGILE is to develop recommendations that will inform a redesign of institutional experiential pharmacy education in British Columbia.

Project Overview- Phases and Timeline



- Some of what we've learned so far…
  - Strong commitment to experiential education
  - Competing demands on preceptors' time
  - Limited physical space
  - Student preparation for institutional placement is a challenge (especially in BC context)
  - Preceptors & learners seem open to alternate precepting models but additional support needed

Precepting Models in Pharmacy: What can we learn from other health disciplines?

- Limited availability of clinical placements
  - Common problem
  - Strategies
    - Strengthen and formalize faculty-site partnerships
    - Alter experiential program model
    - Adopt novel precepting models
    - Integrate learners into the workflow of the site

Am J Health-Syst Pharm 2008; 65:e53-71

J Allied Health 2010; 39:e11-16

- Terminology
  - Experiential program model
    - The larger context in which placements occur
      - Number, duration of rotations, co-op programs
  - Precepting model
    - The configuration of the team of preceptor(s) and learner(s) during the placement
  - Preceptor to learner ratio
    - 1:2 (1 preceptor with 2 learners concurrently)

- Tiered models
  - 2 or more learners of different levels
  - Senior learner precepts junior learner(s)
- Extension
  - Learners provide patient care that
    - "extends" reach of care to more patients
    - Is more comprehensive

- Pharmacy Precepting Model
  - Master-apprentice model (1:1)
    - Dominant model in Canada
      - Traditional roles
      - Finite, technical knowledge
      - We teach how we were taught
      - Little impetus to change

- Why does the model matter?
  - Limitations to traditional model (1:1)
    - Inflexible
      - Enrolment, E2P PharmD programs
    - Limited peer-assisted learning
  - U.S. residency capacity stakeholder meeting
    - #1 Recommendation: “Adopt a medical model with an attending pharmacist and delegated responsibilities to residents”

Am J Health-Syst Pharm 2011; 68:1843-9

- "Medical Model"
  - Tiered learning
  - Team of learners with hierarchy
    - Attending physician
    - Senior resident
    - Junior residents, medical students
  - Teaching hospitals
  - Service component

Am J Health-Syst Pharm 2011; 68:1542-9

- Medical Model cont'd
  - Advantages
    - Efficient- concurrent service and learning
    - Attending physician does not have to be present continuously (research, clinic work)
  - Disadvantages
    - Service versus education
    - Hierarchy, variable oversight

Am J Health-Syst Pharm 2011; 68:1542-9

Experiential Models in Nursing

Model	Ratio	Advantages	Disadvantages
Faculty Supervised Practicum "mother goose model"	1: 6+	• Efficient teaching of basic and technical skills • Minimal impact on clinician workload (faculty instructor)	• Not part of existing team • Instructor not always familiar with site/unit • Not suitable for advanced skill development
Preceptorship	1: 1	• Clinician models practice • Learner is part of the team • Responsible for patients	• Requires ++ preceptors • Preceptor burnout/ competing workload
Collaborative Education Unit	2+: 2+	• Learners work with different preceptors • Peer assisted learning • Faculty-clinician collaboration	• ++ organization & coordination • Communication: learners & multiple preceptors

Nurse Education Today 2008;28:273–83

- Occupational Therapy & Physiotherapy Models
  - Multi-placements (1:2, 1:3, 2:2)
  - Other models
    - Student as educator (tier)
    - Role emerging
  - Systematic review 2007:
    - "No 'gold standard' model for clinical education."

Australian J Physiother 2007;52:19-18

Experiential Models in OT and PT

Model	Advantages	Disadvantages
Traditional 1:1	• Individualized rotation for learner & dedicated preceptor attention • **Preferred by advanced learners**	• Learner dependent on one educator for their learning • ↑ direct time commitment by preceptor than other models
Multi-placement 1:2/1:3	• ↑number of placements • More desirable to students • ↑ cooperation, peer learning and independence	• Personality conflict, competition • ↑ planning and paperwork • May not be suitable for all areas
Team 2:1/2:2	• Shared responsibility for teaching • Adaptable (preceptor absence) • Exposure to different approaches	• Complex to coordinate and to evaluate • Communication/ consistency

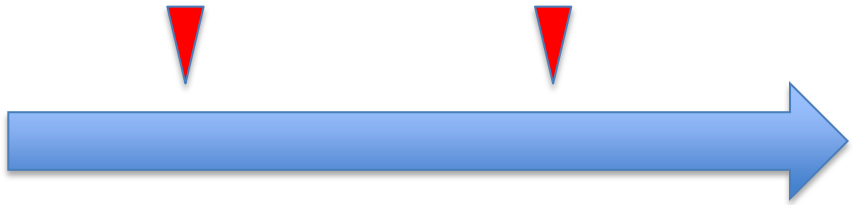
Australian J Physiother 2007;52:19-18

- Other OT & PT precepting models
  - Role emerging placement
    - Work to organize, communicate expectations, monitor learner progress
- Technologically assisted models
  - Videoconferencing, “Skype”
    - Added benefit in remote areas
  - Virtual learning teams
    - Social media

- Summary
  - Variety of models used across disciplines
    - 1:1
      - Dominant model
      - May be preferred by advanced learners
    - Multi-placements 1:2-1:3
      - Learners prefer this model over 1:1 (1:2>1:3)
      - ↑ peer-assisted learning, ↑ capacity
      - ↑ planning, competition among learners
    - High ratio models (1:6 to 1:8)
      - May be useful for introductory experiences where "exposure" is goal and basic skills taught

- Tiers
  - ↑ capacity, learners develop precepting skills,
  - ↓ teaching burden for 1˚ preceptor
- Shared precepting (2+:2+)
  - Preceptors can “tag-team”
- Role emerging placements
  - Extend service, develop autonomy of learner
  - Oversight may be a challenge

- Other important considerations
  - Extension and provision of service
    - Valuable when possible (mutual benefit)
      - Relates to learner practice-readiness
      - Learner site/environment-readiness



Observer **Learner-practitioner**

- Experiential program structure
  - Rotation blocks schedule
  - Overlap of rotations
  - ↑ rotation length
  - Multiple rotations at same site

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Development and Evaluation of a Student Pharmacist Clinical Teaching Unit Utilizing Peer-Assisted Learning

Adrienne J Lindblad, Jason M Howorko, Richard P Cashin, Cornelius J Ehlers, and Cheryl E Cox

CJHP 2012;64:446-50

A Collaborative Approach to Improving and Expanding an Experiential Education Program

Cheryl E. Cox, MBA,[1] Adrienne J. Lindblad, PharmD[1,2]

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Am J Pharm Educ 2012;76:1-5

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Implementation of a Near-Peer Teaching Model in Pharmacy Education: Experiences and Challenges

Christine Leong, Marisa Battistella, and Zubin Austin

CJHP 2012; 65:394-98.

- What might work in BC?
  - New default model for E2P students 1:2?
  - Use “small” tiers (2-3) when it makes sense
    - Physical space is a barrier for larger tiers
    - Include a precepting rotation in residency programs
  - Preceptors should choose and adapt models that work for them e.g. 2:2 shared precepting
  - Consider “mother goose” model for future IPPEs

- AND
  - ↑ support for preceptors and learners
  - Intensive orientation to prepare learners for institutional placement
  - Moving forward
    - Curriculum redesign
    - Leverage technology
    - Pilot and study models!

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Thank you!

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