

Moving Beyond the Pilot: Teaching Values and Ethics to Interprofessional Students While Underscoring the Social Worker Role

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Abstract: *Social workers play an essential role in team-based health care, a point underscored by recent efforts to address social determinants of health. This paper describes a case study of one module within a larger interprofessional education program, aimed at teaching learners at the beginning of various health professions programs about the contributions of social workers on the team. First, the paper will describe the pedagogy of a module based on the IPE Core Competency “Values and Ethics” in which learners participate in a simulated clinical case-based experiential learning activity utilizing standardized patients. Social determinants of health, a team assessment, and the skills of a social worker on the team are central to this activity. Second, the paper will describe the curriculum’s implementation in its pilot phase involving students across six academic colleges and its scale-up to full implementation. Finally, the paper will provide student and faculty evaluations for Cohort 2 and Cohort 5 with a comparison of items across implementation years. Implications for social work include growth in professional identity and recognition among other health professions students of the social workers role and contributions to team-based care.*

Keywords: *Ethics and values, interprofessional education, social determinants of health*

A growing and compelling body of evidence has demonstrated that health is determined, in part, by environmental, social, political, cultural, and economic influences known as social determinants of health (SDH; Craig et al., 2013). The World Health Organization (2026) defines SDH as, “the conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality of life outcomes and risks” (para. 1). Evidence does not deny that medical care influences health but suggests that it may be more limited than commonly thought, especially in determining who becomes sick in the first place (Glenn et al., 2024).

Social workers have a long history of addressing SDH (Rine, 2016). Indeed, the SDH perspective is grounded in social work core values of social justice, human rights, and equity, and seeks to address chronic social and environmental factors of health from a collaborative and holistic approach (Craig et al., 2013; National Association of Social Workers [NASW], 2021; Rine, 2016). A unique aspect of social work training relative to other health professions is in conceptualizing the patients’ social context, with a focus on

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person-in-environment perspective and the biopsychosocial factors that influence health (Craig et al., 2013; Zerden et al., 2018).

Health professionals benefit from being trained to effectively leverage social workers as partners. One recent study shows health professionals have rarely been introduced to the breadth and depth of social work expertise in their clinical training (Rubin et al., 2018). Transforming health education is critical to preparing future professionals to work together with social workers (Rubin et al., 2018). Interprofessional Education (IPE) is designed to expose students training in various health professions to team-based practice in preparation for effective collaborative practice (Guinat et al., 2025). When social work students are included in IPE, students from other disciplines gain a greater understanding of group processes, engage more constructively in difficult conversations, feel more confident when encountering situations of adversity, and have improved group decision-making abilities (Adamson et al., 2020). In fact, social work students provide an important and unique perspective on the intersectionality of social categorizations such as race, class, and gender and their relation to access to healthcare and healthcare outcomes (Adamson et al., 2020).

To date, several published studies have described programming and provided outcome data for training including social work students using diverse models of curriculum. In one published description of social work in IPE, students were provided foundational IPE competency training with an emphasis on social justice and SDH using a one-week intensive format. This graduate-level elective course was developed and taught by two professors with clinical experience in nutrition and social work. Students represented five health professions disciplines (social work, counseling, nursing, public health, and nutrition) with the majority of students from social work and counseling. Student training included scaffolding case analyses in small groups in the classroom, a group proposal for a new integrated health care program with a needs assessment for the targeted patient population, and online Screening, Brief Intervention, and Referral to Treatment (SBIRT) training (Bean et al., 2022). Halfway through the study, training shifted online and to a two-week format due to the COVID-19 pandemic. This course had six offerings over a three-year period with a total enrollment of 119 students. Results from semester-to-semester comparisons showed students' self-reported evaluations (qualitative and Likert pre- and post-tests) of the program indicated significant gains in knowledge regarding learning objectives (Bean et al., 2022).

In another study using a different model, high fidelity simulation and standardized patients were utilized to train 16 nursing and 24 social work students in a single interprofessional training experience to meet course requirements (Banks et al., 2019). In pretraining interviews, students in both disciplines verbalized uncertainty and confusion about the team process. An evaluation of students' post-training anecdotal comments indicated that students experienced an increase in confidence and felt more competent. Likewise, after the training, students voiced a strong appreciation for the interprofessional approach.

Finally, in a third study, two universities joined across three schools to develop an IPE training for 108 first year medical students, 49 first year pharmacy students, and 42 clinical year master of social work students in which interprofessional teams conducted clinical

interviews with a standardized patient (Wharton & Burg, 2017). The team was given 10 minutes to prepare for the interview and 20 minutes to conduct a team interview. After the interview, the teams discussed the patient interview and prepared a whiteboard summary before debriefing. The researchers used pre- and post-tests consisting of Likert scales to assess beliefs about other professions, attitudes toward team care as measured with the Attitudes Towards Interprofessional Health Teams Scale (Curran et al., 2010), and open-ended questions targeting students' learning and perceptions of the program. The results showed that students' attitudes and beliefs about interprofessional practice were significantly more positive following the exercise.

Results from the aforementioned studies highlight positive student feedback about attitudes regarding interprofessional practice, gains in knowledge, and confidence in interprofessional collaboration. However, the studies differ from the present study in that previous studies have fewer academic backgrounds represented in their IPE training experience and smaller numbers of overall students and faculty facilitators. Also, none of the previous studies demonstrate successfully moving from a small pilot to expansion in numbers of students, faculty facilitators, and health disciplines represented in the program.

Literature to date on social workers as partners in IPE efforts has provided innovative programs and preliminary evidence (i.e., pre-post self-report) that such training improves attitudes towards IPE, knowledge, and beliefs (Banks et al., 2019; Bean et al., 2022; Wharton & Burg, 2017). Innovation is important, particularly as IPE efforts grow nationally. That said, the sustainment and scale-up of complex IPE programming is a significant challenge. The purpose of this case study is to add to the existing literature on integrating social work students into an interprofessional education program by (a) describing a module for teaching the value of social work in the context of a larger IPE program, and (b) demonstrating the program's satisfactory scale-up and sustainment over four years.

Methods

Theoretical Framework

IPE can be examined through Bandura's (1979) social learning theory and Kolb's (1984) experiential learning theory. According to Bandura, new behaviors can be learned through direct experience, watching others in a social setting, or observing the outcomes of others' actions. These attributes are part of what makes IPE an effective learning strategy (Chen et al., 2022). Kolb's (1984) experiential learning theory suggests that knowledge is generated through the transformation of experiences, involving four critical stages: concrete experience, reflective observation, abstract conceptualization, and active experimentation. These two theories highlight that IPE is, in part, focused on process learning to develop interprofessional collaboration skills and behaviors. IPE uniquely increases students' understanding and appreciation of the various perspectives and roles of health science professions. In doing so, it emphasizes the development of interpersonal skills that are crucial for effective collaboration and communication.

The IPE program in this study provides opportunities for students from different health science programs to come together in both small interprofessional groups and large group learning to participate in standardized patient role plays and to observe each other's behavior. Throughout the IPE experience discussed in this article, students were given the opportunity to reflect on their contributions and team interactions in the standardized patient interview during the debrief sessions. In doing so, students increased their knowledge about the other professions represented in the small groups and how to collaborate to address SDH to improve patient care.

Program Description

Programming involved students and faculty from medicine, pharmacy, nursing, psychology, social work, public health, and clinical and rehabilitative health sciences (audiology, nutrition, physical therapy, and speech-language pathology) at a mid-sized, public university in south central Appalachia. All students were in the first year of their health professions program and were at graduate level except nursing students, who were in their junior year of undergraduate education. Specifically for social work, students were traditional master of social work students in their foundation year. In 2015, 2016, and 2017, students and faculty members from six colleges in the university participated in four day-long sessions over their first two years of study (one session per semester).

Students were randomly chosen by their respective programs after expressing interest in attending. Each session focused on one of the four Interprofessional Education Collaborative (IPEC; 2016) Core Competencies for Interprofessional Collaborative Practice that were in use at the time (and later updated in 2023): (a) Interprofessional Communication in fall of year one; (b) Values and Ethics for Interprofessional Practice in the spring of year one; (c) Teams and Teamwork in the fall of year two; and (d) Roles/Responsibilities in the spring of year two. Students were divided into six interprofessional groups of approximately eight students each and remained in the same groups for the entirety of their participation in the IPE program. Each interprofessional group was led by two faculty members from different disciplines within the health sciences. Students learned about the IPEC Core Competencies through didactic seminars and practiced IPE concepts through team building exercises and simulated clinical scenarios using standardized patients. A description of the competencies addressed in this curriculum as well as an alternate evaluation of learner outcomes has been published elsewhere (Polaha et al., 2019). See Table 1 for student counts by cohort.

Table 1. *Students By Discipline and Cohort (Year)*

Discipline	2015	2016	2017	2018	2019
Clinical & Rehabilitative Health Sciences	5	6	6	36	33
Medicine	12	12	12	67	73
Nursing	6	7	6	47	46
Pharmacy	12	12	12	82	72
Psychology	4	5	5	-	-
Public Health	4	6	5	37	33
Social Work	6	6	6	5	11
Total	49	54	52	274	268

In 2018, the program was scaled up to include all first-year medical and pharmacy students and volunteer participants from the other colleges. Most of these colleges increased their enrollment numbers for a total of 274 students. Of note, psychology discontinued their IPE participation in 2018 due to scheduling conflicts. Also, because of the number of social work students enrolled in IPE, some of the small groups did not have a social work student. Faculty facilitators (n=12) were recruited from the same colleges as participants. Though not ideal, Just-in-Time Training was provided one hour prior to students arriving to accommodate faculty schedules. Scheduling is a barrier previously noted by McNaughton et al. (2023). Just-In-Time Training is a learning strategy that provides focused, on-demand information immediately before or at the time of need, enabling learners to gain relevant knowledge in just a few minutes (Knutson et al., 2015).

In the context of expanding the program, three critical changes were made. First, in the expansion years, students attended a half-day session as opposed to the day-long sessions in the pilot. Second, to accommodate less class time, didactic material was condensed to 80 minutes (two 30-minute sessions and two 10-minute sessions), and the values assessment assignment was provided as pre-work to be completed online in advance. Finally, to accommodate increased student participation, a total of 47 faculty were recruited to facilitate groups (i.e., approximate four-fold increase). These faculty either volunteered or were chosen by their departments to facilitate the learning sessions. To ensure fidelity to programming and a high-quality experience, a full-day faculty development opportunity was provided to review the activities, teach the competencies, train interprofessional facilitation skills, and answer questions. A description of the faculty training curriculum has been published elsewhere (Williams et al., 2021).

This study examines evaluation data for the Values and Ethics training day from the second year of both the pilot (Cohort 2, n= 54 students, n=12 faculty) and the upscale (Cohort 5, n= 268 students, n=47 faculty) in 2016 and 2019 respectively to determine if the levels of engagement, informativeness, and satisfaction were sustained. These cohorts were chosen for comparison to reduce confounds arising from challenges related to initial implementation efforts in both the pilot and upscale. Potential confounds such as pre-training communication, logistics of the training and curriculum delivery and evaluation process were modified through continuous improvement processes between the first and second years of both the pilot and upscale.

Social Work Emphasis

A key focus for all interprofessional learners about the value of social workers on an interprofessional team occurred in the Values and Ethics module that is the focus of this study. While the role of social workers was highlighted during this session, it was also emphasized that understanding the contributions of and assessing for SDH is a professional responsibility for each student present. The specific learning objectives of focus were:

1. To identify one's own personal and professional values and how these relate to values and ethics in team care.

2. To discuss health care policy and best practices in the context of values in team care.
3. To explain what social determinants of health are and why they are part of ethical patient-centered care.
4. To demonstrate essential skills for exploring and addressing social determinants as a team.

The progression of activities designed to teach these competencies developed from abstract to specific. First, students individually completed a Good Project Values Card Sort (President and Fellows of Harvard College and Project Zero, 2025) and reviewed their professional code of ethics, thinking carefully about their personal and professional values, then sharing and discussing them as a group. Second, students worked in assigned interprofessional groups to complete a team code of ethics using silent consensus and debriefed with faculty by discussing the relationship between one's values and ethical practice. These activities were geared to develop students' sense of agency and a personal sense of motivation for addressing social determinants. Third, students were introduced to SDH in a short didactic adapted from materials from the Preceptors in the Nexus toolkit, including a discussion of the role of social workers in this context. This kit provides "tools that support and enrich interprofessional practice and education to enhance patient care and the learner experience" (National Center for Interprofessional Practice and Education, 2015, para. 1). Next, students were introduced to the IHELP screening tool, a mnemonic for Income, Housing, Education/Work, Legal status, and Personal safety that providers can use to address multiple domains of social determinants during a clinical interview (Berman et al., 2018; Kenyon et al., 2007). Finally, students applied their knowledge and skills in a simulated experiential learning activity. Students practiced a team interview using the IHELP tool with two different standardized patients, each presenting with significant social health needs.

The only changes made to this curriculum during the 2018 scale-up was to move the individual portion of the Values Card Sort for students to pre-work and condense the didactic material. Students brought their results of the Value Card Sort to the IPE event to complete the team portion of the activity in person. Didactic material was revised to have a more concise and focused delivery with an emphasis on the IPEC (2016) Values and Ethics competency. Delivery of didactic material on SDH was framed around the IHELP tool, reducing the total amount of time previously spent discussing these topics independently in the pilot model. These changes were results of a continuous improvement process driven by faculty and student evaluations and a need for decreased time in order to deliver the experience to a greater number of students within the same physical space. A curricular guide and supplemental materials have been published elsewhere (Gilreath et al., 2024).

Measures

Students and faculty were asked to complete a short satisfaction survey after each IPE session. Student surveys used Likert scale ratings, were anonymous, and did not ask for

any identifying information. The first eight questions focused on each of the activities they completed during the session, asking how engaging and informative they were. Next, students were asked about their experience with standardized patients including whether they were realistic, whether they felt the experience would help their career, and whether it would improve their abilities. In 2018, given the necessity to train many more faculty to teach the material, five questions were added to the student survey asking them to rate faculty on five dimensions: preparedness, support, genuineness, respect, and coordination. Finally, students were asked about their satisfaction with the learning session using a series of open-ended questions.

The faculty survey had 10 questions during the pilot years, with two new questions added in 2018 about the new pre-work material (i.e., Values Card Sort completed prior to the training day). Faculty were asked about the appropriateness of learning objectives, the effectiveness of the activities in teaching those objectives, and their satisfaction with training and support in preparation to facilitate the groups. They were also given open-ended questions to provide additional feedback or suggestions for modifications.

Procedure

Across all years of programming, paper copies of the surveys were distributed to faculty and students after the final debriefing of the learning session, and all were encouraged to submit them before leaving for the day. Survey collection rates for Cohort 2 (C2), the second pilot year 2016, were 85% for students and 100% for faculty. For Cohort 5 (C5), the second expansion year 2019, rates were 98% for students and 100% for faculty. The current study was reviewed by the university's Institutional Review Board (IRB) and was determined not to constitute human subjects research because it involved the retrospective analysis of existing anonymous survey data collected for continuous improvement purposes; therefore, it did not require IRB oversight nor informed consent from participants.

Results

Student Results

Students evaluated activities, standardized patient interactions, and overall satisfaction using a Likert scale. All evaluations were based on a five-point Likert scale except for the standardized patient interactions (See Table 2) which used a four-point Likert Scale. Table 2 notes the organization and abbreviations of the student evaluation tool. Some survey questions from C2 and C5 differed slightly so only questions that were directly aligned were analyzed.

Table 2. *Abbreviations of Items for the Student Evaluation Tool*

Abbreviation	Dependent Variables
	Activities
Values/Engaging	Values Card Sort- How engaging?
Values/Informative	Value Card Sort - How informative?
Ethics/Engaging	Building an Interprofessional Ethics Code - How engaging?
Ethics/Informative	Building an Interprofessional Ethics Code - How informative?
SP/Engaging	Standardized Patient Interactions -How engaging?
SP/Informative	Standardized Patient Interactions - How informative?
Group Discussion/ Engaging	Whole Group Debriefing - How engaging?
Group Discussion/ Informative	Whole Group Debriefing - How informative?
	Standardized Patient Interactions
SP/Realistic*	The standardized patients' roles were realistic.
SP/Help Career*	Interacting with standardized patients and discussion will help me in my career.
SP/SDOH*	The standardized patients and discussion increased my ability to address social determinants of health, working with different members of an interprofessional team.
	Overall Student Satisfaction
Overall SAT	Overall, how would you rate your satisfaction with today's experience?

Note. All variables were assessed on a 5-point Likert scale except for those with an * which were assessed on a 4-point Likert scale.

The data were analyzed using mean scores for each of the items. On the five-point Likert scale ratings for the engaging and informative questions, scores were relatively high for C2 ranging from a low of $M=4.33$ (Group Discussion/Engaging) to a high of $M=4.64$ (Values/Engaging). On these same measures, mean ratings for C5 were overall lower than C2 but remained relatively high ranging from $M=3.81$ (Ethics/Engaging) to $M=4.84$ (SP/Engaging). Overall, the means decreased in C5 from C2 except for SP/Engaging, SP/Informative, Group Discussion/Engaging, Group Discussion/Informative, in which the means increased. The Overall SAT mean decreased from C2 ($M=4.87$) to C5 ($M=4.29$). The mean Likert ratings for SP/Realistic, SP/Help Career and SP/SDOH were also relatively high for both cohorts. The means for these measures for C2 were slightly higher than for C5. Means and standard deviations are reported in Table 4 and Table 5.

Levene's test was calculated to ensure homogeneity of variance for each variable to guide further statistical analysis. Results can be found in Table 3. Levene's test was found to be violated for Values/Engaging, Values/Informative, Ethics/Engaging, Ethics/Informative, SP/Realistic, SP/Help Career, SP/SDOH and Overall SAT. Owing to this violated assumption, a Welch's-t statistic not assuming homogeneity of variance was computed for these variables.

Table 3. *Student Levene's Test*

Student Evaluation Tool	<i>F</i>	<i>p</i>
Activities		
Values/Engaging	4.89	.028*
Values/Informative	9.49	.002*
Ethics/Engaging	19.97	<.001*
Ethics/Informative	6.94	.009*
SP/Engaging	2.22	.137
SP/Informative	0.88	.350
Group Discussion/Engaging	0.17	.679
Group Discussion/Informative	0.51	.476
Standardized Patient Interactions		
SP/Realistic	6.36	.012*
SP/Help Career	28.46	<.001*
SP/SDOH	38.79	<.001*
Overall SAT	28.48	<.001*

* $p < .05$

Two-tailed independent t-tests (assuming equal variances) were conducted to examine statistical differences between cohorts for the following variables: SP/Engaging, SP/Informative, Group Discussion/Engaging, and Group Discussion/Informative (See Table 4). T-tests were evaluated at $p < .05$ significance level. Cohen's d (Cohen, 1992) was used to determine effect size (See Table 4). One item was significant, SP/Engaging, with a moderate to large effect size.

Table 4. *C2 and C5 Student Independent t-Test Results*

Survey Question	M (SD)		<i>t</i>	<i>df</i>	<i>p</i>	<i>d</i>
	C2 (n=54)	C5 (n=268)				
Activity						
SP/Engaging	4.55 (0.421)	4.84 (0.442)	-4.08	295	<.001*	.66
SP/Informative	4.61 (0.380)	4.77 (0.546)	-1.81	293	.071	.30
Group Discussion/Engaging	4.33 (0.826)	4.48 (0.838)	-1.10	279	.272	.18
Group Discussion/Informative	4.40 (0.849)	4.47 (0.846)	-.550	278	.583	.09

* $p < .05$ Note. All variables in this table were assessed on a 5-point Likert scale

Welch's t-tests (assuming unequal variances) were conducted to examine statistical differences between cohorts for the following variables: Values/Engaging, Values/Informative, Ethics/Engaging, Ethics/Informative, SP/Realistic, SP/Help Career, SP/SDOH, and Overall SAT (See Table 5). Welch's tests were evaluated at $p < .05$ significance level. Hedges' g correction was used to determine effect size. All Welch's t-tests were statistically significant except for SP/Realistic. Hedges' g results indicated a moderate effect size for all statistically significant differences except for the SP/Help Career variable which had a small to moderate effect size. The Overall SAT mean decreased from C2 to C5 with the Welch's t-test showing significance $t(147) = 8.21$, $p = <.001$, $g = .79$ with a large effect size.

Table 5. C2 and C5 Student Welch's T-Test Results

Survey Question	M (SD)		<i>t</i>	<i>df</i>	<i>p</i>	<i>g</i>
	C2 (n=54)	C5 (n=268)				
Activity						
Values/Engaging	4.64 (0.609)	4.05 (0.910)	5.56	82	<.001*	.68
Values/Informative	4.57 (0.587)	3.85 (1.03)	6.55	95	<.001*	.73
Ethics/Engaging	4.49 (0.549)	3.81 (1.06)	6.45	112	<.001*	.68
Ethics/Informative	4.58 (0.545)	4.10 (0.936)	4.73	90	<.001*	.54
Standardized Patient Interaction						
SP/Realistic**	3.87 (0.400)	3.76 (0.540)	1.60	77	.113	.21
SP/Help Career**	3.91 (0.285)	3.71 (0.547)	3.70	115	<.001*	.39
SP/SDOH**	3.93 (0.250)	3.69 (0.590)	4.78	153	<.001*	.45
Overall SAT	4.87 (0.341)	4.29 (0.781)	8.21	147	<.001*	.79

**p*<.05 Note. All variables were assessed on a 5-point Likert scale except for those with an ** which were assessed on a 4-point Likert scale

Faculty Results

Faculty surveys were also collected from C2 (n=12) and C5 (n=47) at the end of each IPE learning experience. Of note, one faculty in C2 and four faculty in C5 were social workers. Faculty evaluation was based on seven questions that correlated to four objectives from the interprofessional simulation experience using a 10-point Likert scale. Table 6 notes the organization and survey question numbers on the faculty evaluation tool. Q1 through Q7 reference the learning objectives listed at the top of the table.

Table 6. Faculty Evaluation of IPE Experience Survey: Objectives and Feedback Questions

Objectives	
1.	To identify one's own personal and professional values and how these relate to values and ethics in team care.
2.	To discuss health care policy and best practices in the context of values in team care.
3.	To explain social determinants of health care and why they are part of ethical patient-centered care.
4.	To demonstrate essential skills for exploring and addressing social determinants as a team.
Faculty Feedback Questions	
Q1.	The objectives <i>as stated above</i> are relevant to real-world interprofessional clinical practice.
Q2.	The objectives <i>as stated above</i> are appropriate learning objectives for foundational learners (i.e., first year students in medicine, pharmacy, psychology, etc.).
Q3.	The objectives as stated above will prepare these learners for future training in clinics with a collaborative practice model.
Q4.	The value card sort effectively addressed objective one.
Q5.	The code of ethics activity effectively addressed objective one.
Q6.	The brief didactics around social determinants effectively addressed objectives three and four.
Q7.	The final debriefing effectively addressed objective four.

Discussion

Over the course of four years, the IPE program in this study was piloted and then scaled up to include 268 students and 47 faculty from various health science programs in C5. The results of this study show that Overall SAT ratings significantly decreased from C2 ($M=4.87$) to C5 ($M=4.29$). However, evaluation of ratings from students and faculty facilitators continued to indicate high satisfaction ratings from pilot years to the upscale expansion. Student ratings for C2 and C5 remained high for all learning activities in the Values and Ethics module with mean scores for C5 student ratings ranging from a low of 3.69 for SP/SDOH (four-point Likert scale) to a high of 4.84 on SP/Engaging (five-point Likert scale) as shown in Tables 5 and 4 respectively. Students rated their interaction with standardized patients as the most informative and engaging activity, with most students indicating their standardized patient interactions were realistic, increased their ability to address SDH within an interprofessional team, and would help them in their future careers.

Similar to student evaluations, faculty evaluation scores also slightly decreased from C2 to C5 when rating the accomplishment of learning objectives for the Values and Ethics session. However, only two of the seven measures (Q4 and Q6) were statistically significant. C5 faculty ratings remained high overall indicating both groups thought the objectives were well met. The mean scores for C5 faculty ratings ranged from a low of 8.83 on Q6 to a high of 9.43 on Q3 (10-point Likert scale) as shown in Table 9 and 8 respectively. Faculty ratings for C5 indicate that the learning session was relevant to real-world interprofessional clinical practice (Q1 $M=9.34$).

IPE student training incorporated different pedagogical strategies. Not surprisingly, student survey results indicate they found experiential learning more engaging than didactic learning, namely interactive experiences with standardized patients. Student evaluations indicated that most rated their interaction with the standardized patients to be somewhat to very engaging and informative. Evaluation scores for how engaging and informative students found the standardized patient experience increased from C2 to C5 as reflected through Likert ratings. Learning activities throughout the IPE day provided students with concrete and reflective experiences to couple with material taught during the didactic sessions and encouraged interdisciplinary learning.

Overall student satisfaction slightly decreased with the upscale; however, results indicate students remained satisfied with their learning experience. In C2, 85% of students rated their overall satisfaction as very satisfied and 15% as satisfied. In C5, 42% of students rated their overall satisfaction as very satisfied and 47% as satisfied. Several factors could have contributed to these results. As previously stated, students from the pilot years volunteered and were then selected to participate in the IPE program, indicating a high level of motivation for interprofessional learning. With the upscale in 2018, all medical and pharmacy students were required by their respective programs to participate, which increased the student numbers by five fold. Because of the requirement to attend despite their level of interest, C5 students may have differed as a cohort in their collective level of motivation for interprofessional learning. The combined effect of the increase in the number of students with differing levels of motivation for interprofessional learning may have collectively and negatively affected student ratings in C5, leading to the statistically

significant decrease in ratings from C2 to C5. According to adult learning theory, higher levels of initial motivation to engage in a learning experience are positively related to greater satisfaction with a learning experience (Wlodkowski & Ginsberg, 2017). Pre IPE measures of motivation and readiness for learning were not administered; therefore, it is uncertain if C2 and C5 cohorts differed in their level of readiness which may have impacted ratings of satisfaction.

There were also programing changes between C2 and C5 that may have impacted overall satisfaction. Students in C2 completed the IPE program in two academic years with one module per semester, while students in C5 completed all four modules in a single academic year (two modules in each fall and spring semesters). Students in C2 had a full day of learning while students in C5 arrived for lunch followed by an afternoon of learning.

Of note, there were no significant differences between C2 and C5 on the Whole Group Discussion measures; this included the engaging as well as the informative variable. Both C2 and C5 rated this portion of the learning activity high with the C5 means being higher (Group Discussion/Engaging $M=4.48$ and Group Discussion/Informative $M=4.47$) though not significantly higher than C2 means (Group Discussion/Engaging $M=4.33$ and Group Discussion/Informative $M=4.40$). This could be accounted for by the change in the debriefing process that occurred with the upscale in C5. Faculty were provided with a debriefing sequence: first with students who engaged in the simulation, then with students who observed the simulation, and with standardized patients third. Faculty were asked to add their observations and tie up loose ends by contributing to the discussion last. Faculty were also provided a list of suggested debrief prompts as part of a detailed facilitation guide. This structured approach may have accounted for the students' higher ratings in the C5 cohort on the Whole Group Discussion variable.

As with students, faculty feedback was slightly less positive after the upscale. Faculty came to IPE with varying levels of interest in participating as facilitators. Because there was no screening process, their experience with interprofessional collaboration and teaching interprofessional competencies also differed. However, feedback from C2 faculty indicated they experienced higher levels of engagement and that they better understood their role as facilitator than faculty from C5. The upscale necessitated new processes for recruiting and training faculty to manage the tremendous growth of the program. C2 faculty had readily volunteered to facilitate and voiced a strong passion for interprofessional practice. C5 faculty were recruited to accommodate the larger number of students now required to participate. Some faculty were encouraged to participate and may not have come to IPE with the same level of readiness and motivation for interprofessional work. Faculty feedback indicated that many of them thought the student training day could be improved with better organization and preparation.

As part of the continuous improvement process, the faculty skills training became more refined for the C5 cohort to improve consistency in facilitation. In the pilot years, faculty participated in a Just-in-Time Training that occurred one hour before students were scheduled to arrive. With the upscale in 2018, changes were made to faculty training to better prepare them for their role and responsibilities during the student training day. Faculty were asked to complete the same pre-work that students had completed and were

invited to a Faculty Development Day, an all-day event that intended to (a) introduce faculty to the agenda and activities for the IPE student training; (b) standardize IPE teaching practices, ensuring fidelity to the IPE model; and (c) impassion faculty for IPE (Williams et al., 2021).

Implications for Social Work Education

The Council on Social Work Education's (CSWE, 2022) Educational Policy and Accreditation Standards (EPAS) and the NASW Code of Ethics (2021) both identify interprofessional education as a key component of social work education and future practice. Both the CSWE EPAS and the NASW Code of Ethics have been updated since the data were collected; however, the findings remain consistent with and are reinforced by the current standards. The Values and Ethics module used in IPE aligns with the core values of the profession, namely competence, integrity, dignity and worth of the person, importance of human relationships, and service (NASW, 2021). These competencies directly connect with the social work emphasis on dignity and relationships. The expectation that social workers collaborate with other professionals to deliver patient-centered care reflects a commitment to competence and integrity, ensuring social work students bring their knowledge, skills, and ethical lens to team-based work. The value of service is also reflected in the social work role by advocating for patient needs and promoting equity within interprofessional teams. IPE provides a useful structure for social work students to apply ethical principles while collaboratively working with others.

Social work representation in IPE carries several important implications for both education and practice. First, it gives social work students the opportunity to better understand the roles of other healthcare professions. At the same time, it helps other health science students understand the unique value social workers bring to the team (Rishel et al., 2020). These shared learning experiences help break down common stereotypes that social workers face (e.g., social workers only do case management) and challenge the traditional hierarchies that often exist in healthcare.

Second, the IPEC (2016) Competencies emphasize critical communication skills that support effective teamwork. These are skills social work students will first apply during their field placements and continue to use in their professional careers. Third, social work students gain leadership experience in interprofessional settings, learning how to bring different perspectives together and guide teams toward shared goals, which meet EPAS competencies of ethical and professional behavior and intervening with individuals, families, groups, organizations, and communities (CSWE, 2022).

Learning alongside students from other disciplines also encourages creativity and critical thinking. Social work students are exposed to different ways of approaching challenges, which leads to stronger, more well-rounded problem-solving. Even for social work students who do not go on to work in clinical settings, the skills developed through IPE, such as communication, collaboration, leadership, may translate well to other interprofessional or community-based environments by promoting the navigation of organizational culture, an understanding of work with marginalized populations, and the

recognition of systematic issues that require large-scale interventions (Oudbier et al., 2024).

This study adds to social work education by demonstrating how IPE, especially through the Values and Ethics module, can support students in developing competencies tied to the CSWE EPAS and the NASW Code of Ethics. Based on the results, when students are part of experiential IPE activities like working with standardized patients, they report feeling more confident in their ability to address SDH and collaborate across disciplines.

This study also points to the importance of curriculum design and strong faculty facilitation in sustaining quality IPE, even as programs grow. Documenting both the benefits and challenges of scaling up IPE, this study offers helpful insights for social work educators. It underscores the importance of faculty development and attention to how IPE is structured in the classroom; key pieces in preparing students for the realities of team-based care in complex systems.

Limitations and Future Research

This study was a retrospective analysis of self-report and program evaluation data. Evaluation tools were not initially designed with a research study in mind. Surveys were amended between C2 and C5, which did not allow us to directly compare all questions during data analysis. Evaluation surveys were anonymous with no demographics collected for students or faculty; therefore, we were unable to report descriptive statistics or compare responses between different programs.

It is also important to note that there was a difference in delivery from C2 to C5. Although the formalized curriculum and number of student training days remained the same, they were condensed from one per semester (two academic years) to two per semester (one academic year) and from a full day to a half day experience with the 2018 upscale. Similarly, with increased number of faculty, even though there was improved training that accompanied the increase, there may have been problems with fidelity to the delivery method intended across larger numbers of faculty. This difference in delivery could have impacted student evaluations of the learning experience and differences in evaluations may not necessarily be related to the curriculum itself.

A major limitation of this study was that not all small groups had a social work student. While all students received the same instruction around SDH and values and ethics in healthcare, not all had the advantage of learning with and from social work students. Future studies might study knowledge and skills acquisition between groups with and without social work students.

Future research may include collecting demographic and program of study information from students. Further, the use of a validated tool to assess competency attainment, such as the Interprofessional Collaboration Competency Attainment Survey (Schwindt et al., 2017) would strengthen the research design. In addition, adding focus groups would allow for a mixed methods study providing opportunity for formal analysis of student qualitative feedback on their understanding and valuing of social work students on the interprofessional team.

Conclusions

This study described one university's efforts for teaching the social work role as well as the value of and skill around addressing SDH in team-based care. Further, this study demonstrated the program's satisfactory upscale across four cohorts. Finally, the Values and Ethics IPEC competency can serve as a framework to teach both the role of social workers and the importance of addressing SDH within the context of a larger IPE program.

When this program moved from voluntary participation to mandatory completion of IPE, student and faculty evaluations of the program remained high but were significantly lower on some measures than the voluntary student cohort. This suggests that IPE programs should be aware of motivational factors that impact student engagement and intentionally build in structures that address varying levels of preparedness for interprofessional learning, especially when students are required to participate. Other schools who expand their IPE programs can expect to do so with a potential decrease in overall satisfaction scores in student and faculty evaluations.

The Values and Ethics IPEC competency can serve as a framework for teaching beginning learners in their respective health sciences programs to understand the role of all members, including social workers, on a healthcare team and how to address SDH. Aggregate self-report data in this study suggests students across disciplines experienced increased ability to address SDH as a team. Regardless of the number of students participating, small group experiential engagement between interprofessional student groups and standardized patients provides effective opportunities for students to practice addressing social health. While some groups without a social work student still learned about SDH and the social work profession, other groups had the additional advantage of learning with, from, and about social work team members.

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