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From Classroom to Clinic: An Evaluative Study of Interprofessional Education (IPE) Frameworks and Collaborative Pedagogies in Shaping the Clinical Readiness of Allied Health Students

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Abstract

Interprofessional Education (IPE) provides opportunities for students from different healthcare professions to develop collaborative competencies in preparation for clinical practice. This study examined the perceived implementation of IPE frameworks, collaborative pedagogies, and clinical readiness among healthcare students. It also investigated the relationships among these variables, the predictive contributions of selected educational approaches, and differences in clinical readiness according to demographic characteristics and prior IPE exposure. A quantitative descriptive-correlational design was employed, involving 50 purposively selected healthcare students from selected higher education institutions in Region IV-A CALABARZON, Philippines. Data were analyzed using descriptive statistics, Pearson product-moment correlation, independent-samples t-tests, one-way analysis of variance, and regression analysis. The implementation of IPE frameworks obtained an overall mean of 3.20, while collaborative pedagogies obtained an overall mean of 3.26. Clinical readiness yielded an overall mean of 3.24. Significant positive correlations were found between IPE frameworks and clinical readiness ($r = .73$), ($p < .001$)), collaborative pedagogies and clinical readiness ($r = .81$), ($p < .001$)), and IPE frameworks and collaborative pedagogies ($r = .76$), ($p < .001$)). The regression model reportedly explained 76% of the variance in clinical readiness, with IPE frameworks, simulation-based learning, and joint clinical rotations identified as statistically significant predictors. Year level and prior IPE exposure were also significantly associated with differences in clinical-readiness scores. The findings suggest that favorable perceptions of interprofessional frameworks and collaborative learning experiences are associated with higher self-reported clinical readiness. Further research using broader samples and objective assessments is recommended.

Keywords: Interprofessional Education, collaborative pedagogies, clinical readiness, simulation-based learning, joint clinical rotations, healthcare students

INTRODUCTION

Healthcare delivery requires professionals from different disciplines to coordinate their knowledge, skills, and responsibilities to provide safe and effective patient care. Consequently, healthcare education must prepare students not only to develop discipline-specific competencies but also to communicate effectively, understand professional roles, collaborate with other practitioners, and participate in shared clinical decision-making. Preparing students for these responsibilities requires educational approaches that connect classroom learning with the collaborative demands of clinical practice.

Interprofessional Education (IPE) is an educational approach in which students from two or more professions learn with, from, and about one another to improve collaboration and the quality of care. Through structured interprofessional experiences, students may develop a better understanding of professional responsibilities, recognize the contributions of other disciplines, and strengthen their ability to work in multidisciplinary healthcare teams. The implementation of IPE frameworks can provide the structure and learning objectives necessary to guide these experiences.

Collaborative pedagogies are important in translating interprofessional learning principles into practical educational experiences. Simulation-based learning enables students to participate in realistic clinical scenarios within a controlled environment, while case-based learning encourages analysis, clinical reasoning, and collaborative problem-solving. Joint clinical rotations provide opportunities for students to observe and experience interprofessional collaboration in actual healthcare settings. These approaches may support students' development of teamwork, communication, decision-making, and confidence in clinical environments.

Despite the potential value of these approaches, students may still encounter challenges when transitioning from academic learning to clinical placements. Initial clinical exposure can involve unfamiliar responsibilities, anxiety, uncertainty, and the need to adapt to real patient-care situations. Clinical readiness therefore involves more than theoretical knowledge; it also encompasses perceived clinical competence, teamwork, interprofessional communication, professional confidence, and adjustment to clinical practice.

In this context, evaluating students' perceptions of IPE frameworks and collaborative pedagogies may provide useful information about how healthcare programs prepare students for clinical responsibilities. Examining the relationships among these educational experiences and clinical readiness may also help institutions identify strengths and areas requiring improvement.

This study examined the perceived implementation of IPE frameworks, collaborative pedagogies, and clinical readiness among healthcare students in selected higher education institutions in Region IV-A CALABARZON, Philippines. Specifically, it sought to:

1. Identify and Analyzing existing IPE frameworks currently implemented in allied health curricula.
2. Examine the Effectiveness of various collaborative pedagogies (e.g., simulation-based learning, case study competitions, and joint clinical rotations) in fostering teamwork competencies.
3. Assess the Correlation between exposure to IPE and self-reported/supervisor-rated clinical readiness.
4. Develop a Model for integrating evaluative feedback loops that help institutions refine IPE programs based on clinical performance data.

METHODS

Research Design

The study employed a quantitative descriptive-correlational research design. The descriptive component

was used to summarize respondents' demographic characteristics and their perceptions of IPE frameworks, collaborative pedagogies, and clinical readiness. The correlational component examined the strength and direction of relationships among the principal study variables. Regression analysis was also used to examine the statistical contributions of selected educational variables to clinical readiness. Because the study was nonexperimental, its findings were interpreted in terms of associations and statistical prediction rather than causal effects.

Research Locale and Respondents

The study involved 50 healthcare students purposively selected from selected higher education institutions in Region IV-A CALABARZON, Philippines. The respondents represented Nursing, Medical Technology, Physical Therapy, Pharmacy, Radiologic Technology, and Respiratory Therapy. The demographic profile included students aged 18 years and above, with respondents distributed across academic year levels and clinical internship status. Forty-two respondents (84%) reported prior participation in IPE activities, while eight (16%) reported no prior participation.

Purposive sampling was used to select respondents who met the study's inclusion criteria. The findings were therefore interpreted within the context of the selected sample rather than assumed to represent all healthcare students in the region.

Research Instrument

Data were collected using a structured questionnaire designed to assess the respondents' demographic profile, perceptions of IPE frameworks, experiences with collaborative pedagogies, and self-reported clinical readiness. The IPE framework section included statements on interprofessional learning, professional roles, teamwork, faculty support, alignment with clinical practice, and clarity of objectives.

Collaborative pedagogies were assessed through three dimensions: simulation-based learning, case-based learning, and joint clinical rotations. Clinical readiness was assessed through clinical competence, teamwork, interprofessional communication, professional confidence, and transition shock.

Before finalizing the manuscript, the researcher should specify the instrument's source, item-development process, response scale, interpretation ranges, validation procedures, and reliability coefficients. These details are necessary to establish the instrument's measurement quality and allow replication of the study.

Data-Gathering Procedure

After obtaining the necessary institutional permissions and informed consent, the researcher administered the questionnaire to eligible respondents. Participation was voluntary, and respondents were informed of the purpose of the study and the intended use of their data. Responses were collected, checked for completeness, coded, and prepared for statistical analysis.

The final manuscript should document the actual approval process, consent procedures, confidentiality safeguards, and data-collection period. These details should reflect the procedures that were actually implemented.

Statistical Treatment of Data

The collected data were analyzed using the following statistical techniques:

Frequency and percentage were used to describe the respondents' demographic characteristics and prior IPE exposure.

1. Weighted mean and standard deviation were used to summarize responses concerning IPE frameworks, collaborative pedagogies, and clinical readiness.

2. Pearson product-moment correlation was used to examine relationships among IPE frameworks, collaborative pedagogies, and clinical readiness, subject to the relevant assumptions.
3. Independent-samples t-test was used to examine differences in clinical-readiness scores according to sex and prior IPE exposure.
4. One-way analysis of variance (ANOVA) was used to examine differences in clinical-readiness scores across academic programs and year-level groups.
5. Regression analysis was used to examine the statistical contributions of IPE frameworks, simulation-based learning, case-based learning, and joint clinical rotations to clinical readiness.
6. Statistical significance was evaluated at the .05 level. Results reported by the statistical software as ($p = .000$) were expressed as ($p < .001$), provided that this was consistent with the original output. The direction of group differences and the assumptions of the statistical tests should be verified against the complete dataset and analysis outputs.

RESULTS

This chapter presents, analyzes, and interprets the data gathered from the respondents in relation to the objectives of the study. The findings are presented using appropriate statistical tools and organized into tables to facilitate the interpretation of the results and address the research questions.

1. Demographic Profile of the Respondents

1.1 Age

Age	Frequency (f)	Percentage (%)
18 years old	8	16%
19 years old	14	28%
20 years old	16	32%
21 years old	9	18%
22 years old and above	3	6%
Total	50	100%

Table 1. Frequency and Percentage Distribution of the Respondents

According to Age

Table 1 presents the distribution of respondents according to age. Among the 50 respondents, the highest frequency was recorded among 20-year-old students, comprising 16 respondents (32%). This was followed by 19-year-old students with 14 respondents (28%), while 21-year-old students accounted for 9 respondents (18%). Meanwhile, 18-year-old students comprised 8 respondents (16%), and only 3 respondents (6%) were 22 years old and above, representing the smallest proportion of the sample.

The findings indicate that most respondents were between 19 and 20 years old, which corresponds to the typical age of undergraduate allied health students entering advanced professional courses and beginning clinical exposure. At this stage, students are expected to participate in collaborative learning activities and develop competencies necessary for effective interprofessional practice. Consequently, the respondents belong to the age group most appropriate for evaluating the effectiveness of Interprofessional Education (IPE) frameworks and collaborative pedagogies in preparing students for clinical practice.

1.2 SEX

Sex	Frequency (f)	Percentage (%)
Male	20	40%
Female	30	60%
Total	50	100%

Table 2. Frequency and Percentage Distribution of the Respondents According to Sex

Table 2 presents the frequency and percentage distribution of the respondents according to sex. Out of the 50 respondents, 30 (60%) were female, while 20 (40%) were male. This indicates that female respondents constituted the majority of the study population.

The predominance of female respondents reflects the current enrollment trend in many allied health education programs, where females generally outnumber males. This demographic composition suggests that the findings of the study primarily represent the experiences and perceptions of female allied health students regarding Interprofessional Education (IPE) frameworks, collaborative pedagogies, and clinical readiness. Nevertheless, the inclusion of both sexes ensures that the study captures diverse perspectives relevant to interprofessional learning and clinical preparation.

1.3 Allied Health Program

Program	Frequency (f)	Percentage (%)
Nursing	15	30%
Medical Technology	10	20%
Physical Therapy	8	16%
Pharmacy	7	14%
Radiologic Technology	5	10%
Respiratory Therapy	5	10%
Total	50	100%

Table 3. Frequency and Percentage Distribution of the Respondents According to Allied Health Program

Table 3 presents the frequency and percentage distribution of the respondents according to their allied health program. Among the 50 respondents, Nursing had the highest representation with 15 respondents (30%), followed by Medical Technology with 10 respondents (20%). Physical Therapy accounted for 8 respondents (16%), while Pharmacy had 7 respondents (14%). Both Radiologic Technology and Respiratory Therapy were represented by 5 respondents (10%) each.

The findings indicate that nursing students constituted the largest proportion of the respondents. This distribution is expected, as nursing programs generally have higher enrollment than other allied health disciplines due to the increasing demand for nurses in both local and international healthcare settings. At the same time, the inclusion of students from Medical Technology, Physical Therapy, Pharmacy, Radiologic Technology, and Respiratory Therapy provides a multidisciplinary sample, which is appropriate for evaluating Interprofessional Education (IPE) frameworks and collaborative pedagogies. The representation of multiple allied health programs strengthens the study by capturing diverse

perspectives on interprofessional collaboration and clinical readiness across various healthcare disciplines.

1.4 Year level

Year Level	Frequency (f)	Percentage (%)
Third Year	18	36%
Fourth Year	20	40%
Clinical Intern	12	24%
Total	50	100%

Table 4. Frequency and Percentage Distribution of the Respondents According to Year Level

Table 4 presents the frequency and percentage distribution of the respondents according to their year level. Among the 50 respondents, 20 (40%) were Fourth Year students, representing the largest proportion of the sample. This was followed by 18 (36%) Third Year students, while 12 (24%) were Clinical Interns.

The findings indicate that the majority of the respondents were in their Fourth Year, suggesting that most participants had already completed a substantial portion of their academic coursework and had gained considerable exposure to clinical and interprofessional learning experiences. Students in the latter years of allied health education are more likely to participate in simulation-based activities, case-based discussions, and clinical placements, making them well-positioned to evaluate the implementation of Interprofessional Education (IPE) frameworks and collaborative pedagogies. The inclusion of Clinical Interns further enriches the study by incorporating the perspectives of students who have experienced actual clinical practice, thereby providing valuable insights into their level of clinical readiness.

1.5 Participation in Interprofessional Education (IPE)

Response	Frequency (f)	Percentage (%)
Yes	42	84%
No	8	16%
Total	50	100%

Table 5. Frequency and Percentage Distribution of the Respondents According to Participation in Interprofessional Education (IPE)

Table 5 presents the frequency and percentage distribution of the respondents according to their participation in Interprofessional Education (IPE). Out of the 50 respondents, 42 (84%) reported that they had participated in IPE activities, while 8 (16%) indicated that they had not participated in any IPE-related learning experiences.

The findings reveal that a substantial majority of the respondents had been exposed to Interprofessional Education. This suggests that IPE has been integrated into the curricula of the allied health programs represented in the study, providing students with opportunities to engage in collaborative learning experiences with learners from other healthcare disciplines. Such exposure is expected to enhance students' communication skills, teamwork, role clarification, and collaborative decision-making, all of which are essential competencies for effective clinical practice. Conversely, the smaller proportion of

respondents who had not participated in IPE indicates that opportunities for interprofessional learning may still vary across programs or academic levels.

1.6 Summary of the Demographic Profile

Variable	Category with Highest Frequency	Frequency	Percentage
Age	20 years old	16	32%
Sex	Female	30	60%
Program	Nursing	15	30%
Year Level	Fourth Year	20	40%
IPE Participation	Yes	42	84%

Table 6. Summary of the Demographic Profile of the Respondents

Table 6 presents the summary of the demographic profile of the respondents. The results show that the majority of the respondents were 20 years old (32%), indicating that most participants were within the typical age range of undergraduate allied health students preparing for clinical practice. In terms of sex, female respondents comprised the majority (60%), reflecting the prevailing enrollment pattern in many health-related academic programs. Regarding the allied health program, Nursing recorded the highest representation (30%), followed by Medical Technology and other allied health disciplines. Furthermore, Fourth Year students accounted for the largest proportion of the respondents (40%), suggesting that most participants had already acquired substantial academic knowledge and clinical exposure. Finally, 84% of the respondents reported having participated in Interprofessional Education (IPE), indicating that collaborative learning experiences were widely implemented among the respondents.

Overall, the demographic profile demonstrates that the respondents represent an appropriate population for evaluating the implementation of Interprofessional Education (IPE) frameworks and collaborative pedagogies in shaping clinical readiness. Their academic maturity, participation in clinical training, and extensive exposure to IPE activities provide meaningful insights into the effectiveness of interprofessional learning in preparing future healthcare professionals for collaborative clinical practice.

2. Interprofessional Education (IPE) Frameworks

Item	Statement	Weighted Mean	SD	Interpretation
1	Learn with other health students	3.18	0.74	Agree
2	Understand professional roles	3.16	0.71	Agree
3	Teamwork is emphasized	3.24	0.69	Agree
4	Faculty encourage collaboration	3.16	0.73	Agree
5	IPE reflects clinical practice	3.18	0.72	Agree
6	IPE improves appreciation of teamwork	3.32	0.65	Strongly Agree
7	Objectives are clearly communicated	3.12	0.76	Agree

Item	Statement	Weighted Mean	SD	Interpretation
8	IPE prepares multidisciplinary teams	3.26	0.68	Strongly Agree
	Overall Mean	3.20	0.71	Agree

Table 7. Level of Implementation of Interprofessional Education (IPE) Frameworks

Table 7 presents the respondents' assessment of the Level of Implementation of Interprofessional Education (IPE) Frameworks. The findings yielded an overall weighted mean of 3.20 with a standard deviation of 0.71, interpreted as "Agree." This indicates that the respondents generally perceived that Interprofessional Education (IPE) frameworks were effectively implemented in their allied health programs. The standard deviation of 0.71 suggests a relatively low variation in responses, indicating that the respondents shared similar perceptions regarding the implementation of IPE frameworks.

Among the indicators, "IPE improves appreciation of teamwork" obtained the highest weighted mean of 3.32 with a standard deviation of 0.65, interpreted as "Strongly Agree." The relatively low standard deviation indicates a high level of agreement among respondents that IPE enhances appreciation for teamwork and collaborative practice. This was followed by "IPE prepares multidisciplinary teams" with a weighted mean of 3.26 and a standard deviation of 0.68, also interpreted as "Strongly Agree," demonstrating that respondents consistently recognized the role of IPE in preparing students to function effectively within multidisciplinary healthcare teams.

Meanwhile, "Objectives are clearly communicated" obtained the lowest weighted mean of 3.12 with the highest standard deviation of 0.76, interpreted as "Agree." Although respondents generally agreed that the objectives of IPE activities were communicated effectively, the relatively higher standard deviation suggests slightly greater variation in perceptions, indicating that some students may have experienced inconsistencies in how learning objectives were presented during IPE activities.

3. Collaborative Pedagogies

3.1 Simulation-Based Learning

Item	Statement	Weighted Mean	Interpretation
1	Simulation resembles actual practice	3.28	Strongly Agree
2	Simulation improves teamwork	3.26	Strongly Agree
3	Simulation builds confidence	3.30	Strongly Agree
4	Simulation improves communication	3.24	Agree
	Overall Mean	3.27	Strongly Agree

3.2 Case-Based Learning

Item	Statement	Weighted Mean	Interpretation
1	Case discussions encourage collaboration	3.22	Agree
2	Case analysis improves decision-making	3.28	Strongly Agree
3	Cases improve understanding of	3.20	Agree

Item	Statement	Weighted Mean	Interpretation
	professions		
4	Case-based learning develops critical thinking	3.26	Strongly Agree
	Overall Mean	3.24	Agree

Table 9. Level of Effectiveness of Collaborative Pedagogies in Terms of Case-Based Learning

Table 9 presents the respondents' assessment of the effectiveness of collaborative pedagogies in terms of case-based learning. The results reveal an overall weighted mean of 3.24, interpreted as "Agree," indicating that respondents generally perceived case-based learning as an effective instructional approach for promoting collaboration and enhancing clinical competencies among allied health students. Among the indicators, "Case analysis improves decision-making" obtained the highest weighted mean of 3.28 (Strongly Agree), suggesting that analyzing clinical cases enables students to develop sound clinical judgment and make informed decisions in patient care. This was followed by "Case-based learning develops critical thinking" with a weighted mean of 3.26 (Strongly Agree), indicating that respondents recognized the value of case discussions in strengthening analytical and problem-solving skills essential for healthcare practice. Meanwhile, "Case discussions encourage collaboration" received a weighted mean of 3.22 (Agree), while "Cases improve understanding of professions" obtained the lowest weighted mean of 3.20 (Agree). Although both indicators were positively evaluated, the findings suggest that greater emphasis may be placed on designing case-based activities that explicitly promote interprofessional role clarification and collaborative interaction among students from different health disciplines.

3.3 Joint Clinical Rotations

Item	Statement	Weighted Mean	Interpretation
1	Rotations improve collaboration	3.24	Agree
2	Gain experience with other professions	3.28	Strongly Agree
3	Rotations strengthen communication	3.26	Strongly Agree
4	Rotations prepare for practice	3.30	Strongly Agree
	Overall Mean	3.27	Strongly Agree

Table 10 presents the respondents' assessment of the effectiveness of collaborative pedagogies in terms of joint clinical rotations. The results yielded an overall weighted mean of 3.27, interpreted as "Strongly Agree," indicating that respondents perceived joint clinical rotations as a highly effective strategy for promoting interprofessional collaboration and enhancing clinical readiness among allied health students. Among the indicators, "Rotations prepare for practice" obtained the highest weighted mean of 3.30 (Strongly Agree), suggesting that students strongly believed joint clinical rotations effectively prepare them for real-world clinical responsibilities. This was followed by "Gain experience with other professions" with a weighted mean of 3.28 (Strongly Agree), indicating that respondents valued the opportunity to work alongside students and professionals from different healthcare disciplines. Likewise, "Rotations strengthen communication" received a weighted mean of 3.26 (Strongly Agree), reflecting the important role of clinical placements in developing effective communication and teamwork skills.

Meanwhile, "Rotations improve collaboration" obtained the lowest weighted mean of 3.24 (Agree). Although still interpreted positively, this finding suggests that institutions may further strengthen collaborative activities during clinical rotations by increasing structured interprofessional interactions and shared patient-care responsibilities among students from different allied health programs.

Overall, the findings demonstrate that joint clinical rotations provide meaningful opportunities for students to apply theoretical knowledge in authentic healthcare settings while developing the communication, teamwork, and professional competencies necessary for collaborative practice. These experiences contribute significantly to students' preparedness for multidisciplinary healthcare environments.

Dimension	Mean	SD	Interpretation
Simulation-Based Learning	3.27	0.66	Strongly Agree
Case-Based Learning	3.24	0.69	Agree
Joint Clinical Rotations	3.27	0.64	Strongly Agree
Overall	3.26	0.66	Strongly Agree

Table 11. Summary of the Level of Effectiveness of Collaborative Pedagogies

Table 11 presents the summary of the respondents' assessment of the effectiveness of collaborative pedagogies implemented in the allied health programs. The findings yielded an overall mean of 3.26 with a standard deviation of 0.66, interpreted as "Strongly Agree." This indicates that the respondents perceived collaborative pedagogies to be highly effective in enhancing their learning experiences and preparing them for collaborative clinical practice. The relatively low standard deviation suggests that the respondents' perceptions were generally consistent across the different collaborative learning approaches.

Among the dimensions, Simulation-Based Learning and Joint Clinical Rotations both obtained the highest mean of 3.27. However, Joint Clinical Rotations recorded the lowest standard deviation (0.64), indicating the greatest consistency in respondents' perceptions regarding its effectiveness. These findings suggest that experiential learning opportunities, particularly those involving authentic clinical exposure and interaction with students from other health professions, play a significant role in developing teamwork, communication, and clinical decision-making skills. Simulation-Based Learning, with a standard deviation of 0.66, was likewise perceived as highly effective in providing realistic clinical experiences that build confidence and strengthen collaborative competencies.

Meanwhile, Case-Based Learning obtained a mean of 3.24 with a standard deviation of 0.69, interpreted as "Agree." Although this dimension received the lowest mean among the three collaborative pedagogies, respondents still acknowledged its contribution to developing clinical reasoning, critical thinking, and collaborative problem-solving skills. The slightly higher standard deviation indicates a modest variation in respondents' perceptions, suggesting that students may have experienced differences in the implementation or effectiveness of case-based learning activities.

4.Clinical Readiness

4.1 Clinical Competence

Item	Statement	Weighted Mean	Interpretation
1	Confident in clinical procedures	3.20	Agree
2	Apply theory in practice	3.24	Agree
3	Prioritize patient care	3.28	Strongly Agree
4	Make sound clinical decisions	3.22	Agree
	Overall Mean	3.24	Agree

Table 12. Level of Clinical Readiness in Terms of Clinical Competence

Table 12 presents the respondents' assessment of their clinical readiness in terms of clinical competence. The findings revealed an overall weighted mean of 3.24, interpreted as "Agree," indicating that the respondents generally perceived themselves as clinically competent and adequately prepared to perform essential responsibilities in healthcare settings.

Among the indicators, "Prioritize patient care" obtained the highest weighted mean of 3.28 (Strongly Agree), suggesting that respondents strongly recognized the importance of delivering safe, patient-centered, and high-quality care. This finding reflects the respondents' ability to identify patient needs and prioritize interventions appropriately during clinical practice. The indicator "Apply theory in practice" followed with a weighted mean of 3.24 (Agree), indicating that students believed they were capable of integrating classroom knowledge into clinical situations. Likewise, "Make sound clinical decisions" received a weighted mean of 3.22 (Agree), demonstrating respondents' confidence in using clinical reasoning to support patient care. Meanwhile, "Confident in clinical procedures" obtained the lowest weighted mean of 3.20 (Agree). Although still interpreted positively, this suggests that some respondents may require additional supervised clinical exposure and skills training to further strengthen their confidence in performing clinical procedures independently.

4.2 Teamwork

Item	Statement	Weighted Mean	Interpretation
1	Work effectively with healthcare teams	3.26	Strongly Agree
2	Value contributions of other professions	3.28	Strongly Agree
3	Contribute during team discussions	3.24	Agree
4	Cooperate to achieve patient goals	3.30	Strongly Agree
	Overall Mean	3.27	Strongly Agree

Table 13 presents the respondents' assessment of their clinical readiness in terms of teamwork. The findings yielded an overall weighted mean of 3.27, interpreted as "Strongly Agree," indicating that the respondents perceived themselves as highly prepared to collaborate effectively with other healthcare professionals in delivering quality patient car. Among the indicators, "Cooperate to achieve patient goals" obtained the highest weighted mean of 3.30 (Strongly Agree), suggesting that respondents strongly recognized the importance of working collaboratively to ensure positive patient outcomes. This

was followed by "Value contributions of other professions" with a weighted mean of 3.28 (Strongly Agree), reflecting the respondents' appreciation of the complementary roles and expertise of different healthcare disciplines. Additionally, "Work effectively with healthcare teams" received a weighted mean of 3.26 (Strongly Agree), indicating that students were confident in their ability to function as productive members of multidisciplinary healthcare teams.

Meanwhile, "Contribute during team discussions" recorded the lowest weighted mean of 3.24 (Agree). Although this rating remains positive, it suggests that some respondents may benefit from additional opportunities to actively participate in interprofessional case conferences, collaborative decision-making activities, and team-based clinical discussions to further strengthen their communication and leadership skills.

4.3 Interprofessional Communication

Item	Statement	Weighted Mean	Interpretation
1	Communicate clearly	3.26	Strongly Agree
2	Listen respectfully	3.28	Strongly Agree
3	Express professional opinions	3.22	Agree
4	Resolve misunderstandings	3.24	Agree
	Overall Mean	3.25	Agree

Table 14. Level of Clinical Readiness in Terms of Interprofessional Communication

Table 14 presents the respondents' assessment of their clinical readiness in terms of interprofessional communication. The results yielded an overall weighted mean of 3.25, interpreted as "Agree," indicating that the respondents generally perceived themselves as competent in communicating effectively with members of multidisciplinary healthcare teams.

Among the indicators, "Listen respectfully" obtained the highest weighted mean of 3.28 (Strongly Agree), suggesting that respondents highly value active listening and respect for the perspectives of other healthcare professionals during collaborative practice. This was followed by "Communicate clearly" with a weighted mean of 3.26 (Strongly Agree), indicating that respondents were confident in conveying relevant clinical information accurately and effectively. These findings underscore the importance of respectful and clear communication in promoting coordinated, patient-centered care.

On the other hand, "Resolve misunderstandings" received a weighted mean of 3.24 (Agree), while "Express professional opinions" obtained the lowest weighted mean of 3.22 (Agree). Although both indicators were rated positively, they suggest that respondents may benefit from additional opportunities to develop assertiveness, conflict resolution, and confidence in expressing professional judgments during interprofessional discussions and clinical decision-making.

4.4 Professional Confidence

Item	Statement	Weighted Mean	Interpretation
1	Prepared for clinical practice	3.24	Agree
2	Confident working in teams	3.26	Strongly Agree
3	Adapt to clinical situations	3.22	Agree
4	Provide safe patient care	3.28	Strongly

Item	Statement	Weighted Mean	Interpretation
			Agree
	Overall Mean	3.25	Agree

Table 15. Level of Clinical Readiness in Terms of Professional Confidence

Table 15 presents the respondents' assessment of their clinical readiness in terms of professional confidence. The findings yielded an overall weighted mean of 3.25, interpreted as "Agree," indicating that the respondents generally perceived themselves as professionally confident and adequately prepared to perform their roles in clinical settings.

Among the indicators, "Provide safe patient care" obtained the highest weighted mean of 3.28 (Strongly Agree), suggesting that respondents expressed a high level of confidence in delivering safe, ethical, and quality healthcare services. This was followed by "Confident working in teams" with a weighted mean of 3.26 (Strongly Agree), reflecting the respondents' confidence in collaborating effectively with healthcare professionals from different disciplines. These findings demonstrate that the respondents recognize the importance of teamwork and patient safety as essential aspects of professional practice. Meanwhile, "Prepared for clinical practice" received a weighted mean of 3.24 (Agree), while "Adapt to clinical situations" obtained the lowest weighted mean of 3.22 (Agree). Although both indicators were interpreted positively, the results suggest that some respondents may still require additional clinical exposure and experiential learning opportunities to further enhance their adaptability and confidence when managing diverse and complex clinical situations.

Dimension	Mean	SD	Interpretation
Clinical Competence	3.24	0.67	Agree
Teamwork	3.27	0.65	Strongly Agree
Interprofessional Communication	3.25	0.68	Agree
Professional Confidence	3.25	0.66	Agree
Transition Shock	3.17	0.74	Agree
Overall	3.24	0.68	Agree

Table 16. Summary of the Level of Clinical Readiness of Allied Health Students

Table 16 presents the summary of the respondents' assessment of the level of clinical readiness of allied health students. The results revealed an overall mean of 3.24 with a standard deviation of 0.68, interpreted as "Agree." This indicates that the respondents generally perceived themselves as clinically ready to meet the demands of professional practice. The relatively low standard deviation further suggests that respondents had consistent perceptions regarding their level of clinical readiness.

Among the five dimensions, Teamwork obtained the highest mean of 3.27 with the lowest standard deviation of 0.65, interpreted as "Strongly Agree." This finding indicates that respondents consistently perceived themselves as capable of working effectively with members of multidisciplinary healthcare teams. The high rating reflects the positive influence of collaborative learning experiences and Interprofessional Education (IPE) in developing teamwork competencies, which are essential for delivering safe and patient-centered healthcare.

Both Interprofessional Communication and Professional Confidence obtained a mean of 3.25, with standard deviations of 0.68 and 0.66, respectively, and were interpreted as "Agree." These findings suggest that respondents generally believed they possessed effective communication skills and sufficient confidence to perform their professional responsibilities in clinical settings. Likewise, Clinical Competence recorded a mean of 3.24 with a standard deviation of 0.67, indicating that respondents considered themselves capable of applying theoretical knowledge, performing clinical procedures, and making appropriate clinical decisions. In contrast, Transition Shock obtained the lowest mean of 3.17 and the highest standard deviation of 0.74, although it remained within the "Agree" interpretation. This result suggests that while respondents generally believed they were able to adapt to clinical practice, their experiences varied more widely than in the other dimensions. The higher variability may be attributed to differences in individual clinical experiences, learning environments, and levels of preparedness during initial clinical placements.

2. Transition Shock

Item	Statement	Weighted Mean	Interpretation
1	Confident during first clinical placement	3.16	Agree
2	Adapted quickly to clinical environment	3.18	Agree
3	IPE reduced clinical anxiety	3.14	Agree
4	Emotionally prepared for clinical duties	3.20	Agree
	Overall Mean	3.17	Agree

Table 17. Level of Effectiveness of IPE training in Reducing the Transition Shock During the Initial Clinical Placements

Table 17 presents the level of effectiveness of IPE training in reducing the transition shock experienced by allied health students during their initial clinical placements. The findings revealed an overall weighted mean of 3.17, interpreted as "Agree," indicating that the respondents generally agreed that Interprofessional Education (IPE) helped lessen the challenges associated with transitioning from classroom learning to clinical practice.

Among the indicators, "Emotionally prepared for clinical duties" obtained the highest weighted mean of 3.20 (Agree), suggesting that respondents felt emotionally equipped to handle the responsibilities and demands of clinical work. This was followed by "Adapted quickly to the clinical environment" with a weighted mean of 3.18 (Agree), indicating that students believed they were able to adjust effectively to real healthcare settings. "Confident during first clinical placement" received a weighted mean of 3.16 (Agree), reflecting that respondents generally felt confident during their initial clinical exposure.

Meanwhile, "IPE reduced clinical anxiety" recorded the lowest weighted mean of 3.14 (Agree). Although still interpreted positively, this finding suggests that while IPE contributed to reducing students' anxiety during clinical placement, some respondents continued to experience apprehension when encountering actual patient care and unfamiliar clinical situations. This indicates that additional support mechanisms, such as structured mentoring, simulation activities, and comprehensive clinical orientation, may further minimize transition shock.

Variables	r	p-value	Interpretation	Decision
IPE Frameworks and Clinical Readiness	0.73	0.000	Strong Positive	Significant
Collaborative Pedagogies and Clinical Readiness	0.81	0.000	Very Strong Positive	Significant
IPE Frameworks and Collaborative Pedagogies	0.76	0.000	Strong Positive	Significant

Table 18. Relationship Between Variables

Table 18 presents the results of the Pearson Product-Moment Correlation analysis conducted to determine the relationships among Interprofessional Education (IPE) frameworks, collaborative pedagogies, and clinical readiness of allied health students. The results revealed a strong positive correlation between IPE Frameworks and Clinical Readiness ($r = 0.73$, $p = 0.000$). Since the p-value is less than the 0.05 level of significance, the relationship is statistically significant, leading to the rejection of the null hypothesis. This finding indicates that higher levels of implementation of IPE frameworks are associated with higher levels of clinical readiness among allied health students. As students experience more structured interprofessional learning opportunities, their preparedness for clinical practice likewise increases.

The analysis also showed a very strong positive correlation between Collaborative Pedagogies and Clinical Readiness ($r = 0.81$, $p = 0.000$). This represents the strongest relationship among the variables examined. The statistically significant result suggests that effective collaborative teaching strategies, such as simulation-based learning, case-based learning, and joint clinical rotations, are strongly associated with students' clinical competence, teamwork, communication skills, professional confidence, and smoother transition into clinical practice. This finding underscores the important role of active and experiential learning in preparing allied health students for professional healthcare environments. Furthermore, the findings demonstrated a strong positive correlation between IPE Frameworks and Collaborative Pedagogies ($r = 0.76$, $p = 0.000$). The significant relationship indicates that well-established IPE frameworks are closely associated with the effective implementation of collaborative pedagogical approaches. Institutions that integrate comprehensive IPE frameworks are more likely to provide collaborative learning experiences that support interprofessional competencies and enhance educational outcomes.

Predictor	Beta (β)	t-value	p-value	Interpretation
IPE Frameworks	0.29	2.45	0.018	Significant
Simulation-Based Learning	0.38	3.62	0.001	Significant
Case-Based Learning	0.16	1.88	0.066	Not Significant
Joint Clinical Rotations	0.34	3.21	0.002	Significant

Table 19. Regression Analysis

The regression model explained 76% of the variance in clinical readiness ($R^2 = 0.76$). Simulation-Based Learning and Joint Clinical Rotations emerged as the strongest significant predictors, while Case-Based Learning did not significantly predict clinical readiness.

Demographic Variable	Statistical Test	Test Statistic	p-value	Decision	Interpretation
Age	Pearson Correlation	r = 0.18	0.214	Fail to Reject H_0	Not Significant
Sex	Independent Samples t-test	t = 1.12	0.268	Fail to Reject H_0	Not Significant
Program	One-Way ANOVA	F = 2.31	0.058	Fail to Reject H_0	Not Significant
Year Level	One-Way ANOVA	F = 4.76	0.013	Reject H_0	Significant
IPE Exposure	Independent Samples t-test	t = 3.14	0.003	Reject H_0	Significant

Table 20. Relationship Between Demographic Profile and Clinical Readiness

The analysis showed that year level and participation in Interprofessional Education (IPE) were significantly associated with clinical readiness ($p < .05$). This suggests that students with more advanced academic standing and those who had participated in IPE activities tended to report higher levels of clinical readiness.

Conversely, age, sex, and program did not show statistically significant relationships with clinical readiness ($p > .05$), indicating that these demographic characteristics were not associated with differences in students' perceived readiness for clinical practice in this sample.

DISCUSSION

The study examined how respondents perceived IPE frameworks and collaborative pedagogies in relation to their clinical readiness. Overall, the findings revealed favorable ratings across the three main areas of interest. The significant positive correlations suggest that students who reported more favorable IPE frameworks and collaborative learning experiences also tended to report greater readiness for clinical practice.

The overall mean of 3.20 for IPE frameworks suggests that respondents generally viewed their interprofessional learning experiences positively. The highest rating for appreciation of teamwork indicates that respondents recognized the value of collaboration in healthcare education. However, the lower rating for the communication of IPE objectives suggests that institutions may need to provide clearer explanations of learning goals, professional roles, and expected outcomes. Clear objectives can help students understand how interprofessional activities relate to their clinical preparation.

The findings for collaborative pedagogies also suggest that respondents valued experiential and collaborative approaches. Simulation-based learning and joint clinical rotations received the highest overall means among the three pedagogies. Simulation may provide opportunities to practice clinical communication and teamwork in a controlled setting, while joint clinical rotations may expose students to the coordination required in multidisciplinary healthcare environments. Nevertheless, the descriptive results reflect student perceptions and do not independently demonstrate that these approaches improved objectively measured performance.

The positive correlation between collaborative pedagogies and clinical readiness ((r = .81)) was the strongest relationship among the variables examined. This suggests a close association between favorable experiences with collaborative teaching strategies and higher self-reported readiness. The relationship between IPE frameworks and clinical readiness ((r = .73)) similarly indicates that more favorable perceptions of structured interprofessional learning were associated with greater perceived preparedness. The correlation between IPE frameworks and collaborative pedagogies ((r = .76)) further suggests that students' perceptions of the educational framework and the learning activities were closely related.

The regression findings add another perspective by identifying simulation-based learning, joint clinical rotations, and IPE frameworks as statistically significant predictors within the reported model. Case-based learning did not reach the .05 significance threshold after accounting for the other predictors. This does not mean that case-based learning is ineffective; its unique statistical contribution may be influenced by shared variance with other educational variables, sample size, measurement characteristics, or other factors. Because the sample included only 50 respondents, the regression estimates should be interpreted cautiously and ideally validated in a larger sample.

The clinical-readiness findings showed that teamwork received the highest mean, while transition shock received the lowest. This pattern suggests that respondents felt relatively prepared to collaborate with healthcare teams but may still face difficulties adjusting to initial clinical placements. Institutions could therefore consider strengthening clinical orientation, supervised simulation, mentoring, reflective debriefing, and support during the transition to patient care. The interpretation of transition shock must, however, be checked against the instrument's scoring direction before concluding that a lower mean indicates greater difficulty.

The demographic analyses showed significant differences according to year level and prior IPE exposure, but not according to age, sex, or academic program. The year-level result suggests that clinical readiness may vary across stages of academic preparation. The IPE-exposure result likewise indicates that respondents with and without prior exposure differed in their readiness scores. However, the direction of these differences cannot be established from the reported test statistics alone. Group means and post hoc comparisons are needed before concluding that more advanced students or IPE participants reported higher readiness.

Several limitations should be considered. First, the study involved a purposive sample of 50 students from selected higher education institutions, which limits the generalizability of the findings. Second, the principal measures relied on self-reported perceptions, which may not correspond fully to actual clinical competence or observed teamwork performance. Third, the correlational design does not establish causal relationships between IPE experiences and clinical readiness. Finally, the regression model and group comparisons require confirmation against the complete statistical output, including relevant assumptions, confidence intervals, and post hoc tests.

Despite these limitations, the findings provide useful preliminary evidence that favorable perceptions of IPE frameworks and collaborative pedagogies are associated with self-reported clinical readiness. They also identify areas for educational improvement, particularly the communication of IPE objectives and support during initial clinical placements. Future research using larger and more diverse samples, longitudinal designs, and objective clinical assessments could help clarify how interprofessional learning experiences relate to students' readiness for collaborative healthcare practice.

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