

NIPEC Membership Meeting

Annual Meeting – ELC 2018

Break-out Session Notes – 4 Topics

A. IPE Faculty Development and Scholarship

I. Attendees in Group

DB: (OK, Program Chair): grant funding initially for IPE activity; IPE office housed in the university @ provost level. All students released for 2 x day/online / IPEC website. OK Interprofessional Education and Practitioners Organization: 2-part training for preceptors; different levels of participation. Published 1 article, multiple posters, host IPEC meeting. Everyone has an accreditation requirement for IPE.

SP (Rutgers): IPE is a university initiative. (+) online training for faculty. Grant search underway to house a full event. PT clinic on site to open doors to other disciplines. Many activities at the exposure level

JB (Widener University): student run pro-bono clinic which serves a base for IPE activities; starting conversations across university. Preliminary stages for new building that will house the interprofessional clinic. Interprofessional ground rounds: each student speaks to the cases that involve multiple professions. Next question: how do we measure outcomes at the start of these initiatives?

TB. (PTA Program Director, Hutchinson Community College): most activities from a communication standpoint. Beginning stages on how to move forwards; not a university wide initiative; need to create the culture. Resources are different from a community college vs. university-wide initiative.

KD (UFlorida) established program initiated by the medical school with an IPE director with 2 social workers and admin support. Series for 2 semesters: students partner with a family with targeted topics; blended activities, meet with 3 other groups with 2 dedicated faculty. N=800+ students across all professions. Interprofessional learning and healthcare: year 2; opioid abuse case with panel for year 3. Peer learning in PTs and cross-learning with students and faculty with dental and nursing: wounds, assistive devices, etc. Pro bono clinic not accessed as much other than with observations. Some publications done.

JJ MT (Dept Chair, Nazareth College): liberal arts university. (+) Rehab wellness institute with a strategic plan to develop an IPE course; 5 Fridays for IPE activities with faculty across groups: IPEC competencies, SIM lab @ nursing. 4 overarching activities across courses. Module on CI credentialing utilized: how do we teach PTs to facilitate: affective domains and communication. Probono clinic: students work together with other disciplines for 2 semesters. Published on apprentice model.

PW (Clinician, NJ): teach as adjunct in 2 universities; nutrition and geriatrics. Spoke on student learning styles and learning in IPE environment. Generational characteristics that impact IPE.

CB (MC, Boston, MA): how are doctorate faculty taught IPE. Finishing publication. Grass root development for IPE group: large scale (900, 10 different health professions); small scale co-curricular). Dementia simulation, opioid crisis, SIM lab cases. Curriculum map across PT; thread as a resource. No dedicated office; all service. MAP: PT, Nursing, PA, dent

RB (Belmont U) Stream of IPE within PT with faculty across different departments. No dedicated IPE office; activities done as part of the service. Large IPE event: roles, communication: PT, OT, pharm, nursing. Moves into communication and med errors topic into the following year. Large acute care sim, end-of life simulation with chaplain counseling. Developing a consortium for IPE in TN.

SC (Hampton U, VA): just starting with IPE and developing activities and discussions. Currently, IPE developed in special topics for PT and speech communication. Pulling in pharm and nursing departments to expand the activities.

MQ (Interim Chair, UNT HSC, TX); University initiative on IPE. The university just started a faculty development program and will provide information on this when completed spring 2018. No specific grants from the department but funding is at the university-level. IPE activities involve many disciplines; still seeing challenges with health care faculty knowledge of other professions/PT, relevance of topics across the disciplines, scheduling, assessment of outcomes.

II. Discussion Summary

a. How to develop CHAMPIONS: how to develop?

- i. **Service.** Most faculty who are currently champions or are vested in IPE do so as part of the service to the department/university. Further discussion needed for recognition *and* support for efforts.
- ii. **Nature of PT practice.** It is innate as PTs that we
- iii. Develop faculty strengths.
- iv. **TeamSTEPPS training**
- v. Structure of active: foster administrative and organizational initiatives
- vi. **Faculty Development:** Well-designed instructional activity and tie with objectives.
- vii. Committee with regular meetings
- viii. **Formalized training**
- ix. **Accreditation**
- x. Nature of clinical practice, higher education; although it can go both ways
- xi. Further questions:
- xii. Scholarship: how to measure?
- xiii. Other health care professions

b. Grant Funding

- i. No specific grant funding consistently identified; some with funding at the university levels, some at department level.
- ii. Need to explore a repository of possible sources.

c. Useful Training

- i. Many different mechanisms for training; varied. No clear answer on best practices but many possibilities.

- ii. Need to continue the discussion on training opportunities.

B. Program Development and Assessment

I. Attendees in Group:

Participants in this break-out group were from both academic and clinical settings; academic institutions and health systems varied in size and were from across the country with IPE programming varying from well established, funded curriculum to newly developing IPE programs.

NIPEC Board Members

Steve Jernigan- Facilitator
Holly Wise-Scribe
Samantha Brown
Bob Wellmon

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Christine Schaub, Kessler Institute for Rehab. ceschaub@kesslerrehab.com

II. Discussion Summary:

- a) **Experiential Learning:** simulation, active observations, and hot spotting
All members of group discussion advised to submit their examples to NIPEC Resources;
active discussion on importance of debriefing with experiential learning
 - i. **Simulation Examples:** ranged from low fidelity (case studies, role playing, standardized patients/family) to high fidelity
 1. Domestic violence simulation with husband and wife present
 2. Simulation encounter with family member (standardized patient)
 3. Administration management scenarios
 4. Pediatric handoff to nurse with case of abused child
 5. Hospital discharge simulation for patient with multiple myeloma and acute pneumonia; also included virtual home assessment
 6. Code in acute care
 - ii. **Active Observations/Shadowing:**

1. IP practice instructors (IPIs) supervise IP students; students are to actively observe IPI interactions with patients and professionals; debriefing with IPIs making implicit explicit; reflection assignments help
 2. Observing IP interactions as part of quality improvement program helps students identify behaviors which can be barriers or facilitators to enhanced patient care, etc.
- iii. **Clinical Hot-Spotting:** intentional collaboration activities with students who are co-located for clinical practicums

b) **Professional Development & Preceptor Training:**

Importance of standardizing language; IP Practice Instructors

Reviewed key resources include Preceptors of Nexus Material on website: nexusipe.org; importance of standardizing language and ruthless information sharing; identification of self as IP educator who happens to be a physical therapists. Importance of integrating IP activities as part of annual review process with both academic and clinical partners

- c) **Assessment:** Emphasis on shift away from measurement of student attitudes to behavioral competencies in clinical settings, patient outcomes, and other downstream effects (ie. post-graduation impact of IPE)

C. Strategic partnerships with Community Sites

I. **Attendees in Group:**

				Member
Leigh Murray	Walsh University		Lmurray@walsh.edu	No
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Sinnott				
Susan Appling	OSU		susan.appling@osumc.edu	
No				

II. **Discussion Summary:**

- a) Involvement of the sections esp Private Practice. In 2020 CSM in Denver. Going to reach out to the Section presidents (HH, CP, acute, geriatrics, etc) and see if we can

have a multisection opening plenary session. Topics could include examples of collaborative practice and would also need to address payment.

- i. Tie the money into IPE esp post-acute. Goal is to present this as the need for collaboration especially given bundling.
 - ii. Talk to CSM planning committee at CSM
 - iii. Survey section presidents to identify collaborative initiatives they are doing with external groups for such things as clinical practice guidelines, IPCP, etc.
 - iv. Reimbursement will be an issue – have an APTA Payment specialist address these issues
 - v. We could be a collator of all the IPE initiatives that are happening across as well as among sections. May results in “cross-pollination”.
 - vi. Find out what the sections are doing as well as members that qualify as IPCP.
 - vii. It is difficult when we are working with partners that don’t bill and we do bill. Most IPCP are pro bono. Tanya Apke’s presentation re: productivity with CE
 - viii. Group in the mid-West collaborated with the ortho surgeons and negotiated with payers because their outcomes are better.
 - ix. Walt will find out if the section program chairs have a listserv.
- b) Table at CSM re: IPCP . Get clinicians as well as educators to staff the table. The emphasis will be on practice and not education.
- i. Get clinicians and educators in Denver or mountain region as exemplars. Denver peds
 - ii. Survey the sections for exemplars.
 - iii. Grants to fund lunches for clinicians or to fund clinical partners to come to NIPEC business meetings (local partners)
 - iv. Our language may be an issue for clinicians to recognize what they are accomplishing.
 - v. Get the perspective of the patient who has experienced true IPCP.
 - vi. CAB (Collaborating across borders) conference keynote speaker – husband’s CVA and all the mistakes.
 - vii. Chapter payment specialist involvement.
 - viii. Not all partners are clinicians.
 - ix. Gerard Brennan at Inter-Mountain Health Care (Cheryl has his email from Sue Appling)
 - x. Highlight reciprocity lectures between different discipline’s conferences.
- c) The hook to bring collaborative practice into the outpatient arena – need to include payers, case managers, etc.
- d) Private practice needs to see IPSP as a positive to their bottom line. Do we need to send out students with more education/skill with the communication iece? Business module in the Private Practice Section.
- e) Private Practice Section – bundled payment. Risks and opportunities. Re-hospitalization. Target a couple of conditions/ Home Health Section – care transitions. Complex conditions, PT may be the only clinician.
- f) State with home health. They already have an IPE focus. Safety is job one. CHF may be a good focus. Would also include CVP, peri, NIPEC.

- i. UC Denver has a funded project which is interprofessional and focuses on transitions of care with high acuity/frail older adults who have experienced a recent hospitalization and are referred to the home health setting. We developed a protocol to highlight the importance of increasing team communication to reduce adverse events and gaps in communication and ultimately to reduce hospital readmissions. Initial funding for the pilot project was with the HH Section so it would help those members see the outcomes of the pilot grant.
- ii. We have the team here in Denver including PTs so it would be a very low cost endeavor to show case this process at CSM 2020
- iii. Study PI is on board (as long as we don't reveal the data). We can talk bit picture, logistics, and implementation
- iv. Because the patient population includes frail older adults, we are including those with CHF.
- g) TK - \$, # of pts. APTA is funding with AAOD to create clinical practice guidelines. Accelerated rehab.
- h) Meeting at CSM to write proposal for CSM 2020. ID presenters. CSM is in Denver. Start with Section presidents.

D. Cross Disciplinary Supervision Meeting Notes

I. Attendees in Group

See scanned document;
From NIPEC: Shelene Thomas and Dee Schilling

II. Discussion Summary:

- a) Be aware of a shared accrediting document coming out later this year to combine the accreditation standards for the various disciplines.
- b) Consider looking at this article: Social Determinants of Health (by Kumagi out of Toronto)
- c) Consider areas to collaborate: like with respiratory therapy, having PTs teaching in RN labs on transfers, having PTs teaching PharmDs on equipment they may sell in their pharmacy.
- d) Assessments:
 - i. Look at the ICAS, PACT - Performance and Assessment of Communication and Teamwork
 - ii. Connect with NEXUS: if you are doing research that includes practice, you can be a part of the large data set that the NEXUS is creating.
 - iii. Connect with the faculty development opportunity within NEXUS.
 - iv. Nov is Education to Practice – a focus on faculty development
 - v. Dec is Opioid Epidemic and the Non pharmacological management of pain