**NIPEC Annual Meeting - ELC 10.3.15**

**Breakout Session Minutes**

**Break Out Session: *Clinical Education/Collaborative Practice***

Facilitator – Nancy Kirsch

Note taker – Cheryl Resnik

**Q: Venues where IPP is occurring?**

* Ralph Utzman (West Virginia U) All students participate in didactic course in first year with Team STEPPS training. Grant funding for community falls screening including PT OT Pharm and nursing Medicine just added. We are using service learning as vehicle. Grant from higher ed for rural Falls Project. Time for 5 sessions is part of integrated clinical ed. PT faculty are present at all times. All students involved. Issue with having same students involved with each other every time.
* Leesa DiBartola (Duquesne U)– logistics are biggest issues.
* Jody Frost (APTA) – Faculty are not preceptors, clinical instructors are. Utilizing inpatient teams eg. liver team, transplant. Identify if your clinical sites are moving to collaborative practice models. You can utilize this aspect to integrate IPE. Consider having the same clinicians come into the classroom.
* Leslie Portney (MGH)- Dedicated education unit at Mass General – OT Speech, RN, PT – scalability is difficult and too expensive for hospital. Now doing guided observation, focus on IPEC competencies. 1 morning two weeks in a row, debrief.
* Sue Smith (Drexel U)– Several faculty run interdisciplinary faculty practice. Hard to get nursing and medicine. Using creative arts as well. Filming care delivery. Behavioral discipline inclusion is very important. Culture shift. Have done some sim. Patients agree to filming so that CI is not directly on site.

**Q: How may NIPEC contribute to education?**

* Models are needed
* MEdED Portal may be useful to feed questions
* Wellness centers and facilities other than primary care need to be identified. Identify the gaps where we need practitioners. ICU unit. Acute care is interprofessional but not very explicit.
* Shawne Soper (Virginia Commonwealth) -Use what we already have, have them reflect on experiences and what they saw. Can be a student and a practitioner with other disciplines. Have them recognize what is happening around them and what they are seeing.
* Post on ACAPT web site a request for models being used ;
* ACAPT fund some demonstration projects to develop models. How may we redefine primary care to integrate PT OT and speech. Nursing and medicine don’t see our role. We need to identify strategies to include PT.
* Nurse Practitioners may be a good group to partner with.
* Medicine and nursing don’t know about the ICF model.
* Family medicine residents in PT practice may be a workable model.
* NEXUS – excellent resource for building an IPE program, curriculum design.
* Macy grants must include medicine.
* Resources on Line-Would like list of the group and what they are doing and hyperlink to the individual who is doing the practice.
* Gayle NYMC - IPE with labs for MS patients and Labs in Neuro, MD’s and PT’s working together in Pediatrics, SLP working with PT students related to disabilities and collaboration.

**Break Out Session: *Scholarly Activity***

Facilitator - Dee Schilling

Note Taker - Amber Fitzsimmons

Attendees:

* Raine Osborne: Brooks Rehab and Univ of N Florida
* Laurel Abbruzzese: Columbia Univ
* April Newton: Rosalind Franklin Univ
* Rene Brown: Belmont Univ
* Lona Svien: Univ of S. Dakola
* Annette Iglarsh: Endicott Edu
* Alma Merians: Rutgers
* Janice Hulme: Univ of Rhode Island

**Q: What are you currently doing and how may NIPEC assist?**

* Laurel: IPC work in Elders in LGBT Community grant: need assessment outcomes focused on behaviors (not attitudes and perceptions) to compare against other interventions
  + April Newton: Assessment of Interprofessional Team Collaboration Scale (AITCS) development and testing of the instrument
  + Raine: Counting the number of interactions between practitioners (literature review shows observation and OSCE’s are the only two behavior related assessment tools)
  + Janice: Match student teams with seniors-do assessment and provide feedback and provide referrals (outcomes: perceptions around aging adult
  + Annette: U of Toronto and UBC—will share their assessment tools and help with assessment tools; they only ask for clean data back

**Q: Is there a topic or research question you would like NIPEC to take on?**

* Annette:
  + What is happening in the various jurisdictions where PT students are working in IP Teams—and what are the risks (legal and liability) of having PT students overseen from a preceptor OTHER than a PT? Or no faculty members at all?
  + Can PT students work within an IP team and operate only inside scope of practice or are boundaries being crossed? What are the licensing boards going to come down on specifically? Do the boards know about IP teams and what are their understandings and currently boards doesn't know what to do with it so far
  + Legal: Who can (what other professions) can supervise our PT students while they are working on IPE teams with patients directly (Falls Assessments via CDC website tools). Does a PT faculty member have to be present at all times?
  + Do institutions have Liability policies in place for IP collaborative care?

\*\*Side note: If the membership wants to move this forward as a scholarship activity, it is suggested that we include other faculty (less involved in IPE) to help on this to involve them and create inclusion around this topic with other faculty members?

**Q: Type of resources looking for on the web?**

* Rubrics
* Networking
* Grant opportunities
* Outcome measures: behaviors/skills-create a table listing current members of the group and which IPE projects they are doing and what outcome measures are being used
* In-2-Theory blended with GRIN (Global Research Interprofessional Network)
* Curriculum development ideas—put on our site
* Competencies-

\*Side note: NIPEC partnering with Mike Shelton (Dee and Mike will lead) collect data regarding which institutions are doing what activities/curriculum for which competencies. We can create an aggregate database of how the competencies are being captured in the varying educational programs.

**Break Out Session: *Academic Education***

Facilitator - Bob Nithman

Note Taker - Samantha Brown

**Q: How are your programs meeting the new IPE Standards from CAPTE?**

* *(Meryl Gersh from Eastern Washington University)*

IPE is integrated into 1st year ethics, values and responsibilities course.

IPE is integrated into 2nd year PT practice seminars (professional development and cultural competence). Curriculum looks at 3 major areas of communication (end of life, critical, and chronic care). Some classes include students from dental hygiene and some are PT students only. While not the most natural team, students experience a shared learning of understanding and empathy. They use a core text (*The Spirit Catches You and You Fall Down*). Seminars are 1.5 hrs long and in addition to discussion of the core text, student groups work on a case studies that have varying needs and all have cultural challenges.

This year piloting a “Death over Dinner” event open to all Health Science students (campus has 13 different health science programs and 3 different universities). Three different sessions of this 2-hour dinner experience are planned where the focus is a discussion on end of life care.

* *(Steve Jernigan from University of Kansas Medical Center)*

Students have switched to Integrated Clinical Experiences in their 1st year and professional communication has since become a major 1st year learning objective.

A campus wide IPE event is held for level 1 and 2 (with plans to include level 3). The level 1 event has a values and ethics focus and includes over 800 students. Students also attend IPE seminars hosted by geriatric medicine that include medicine, law, dietetics, etc and write reflections on their experience.

UK Medical Center has an IPE center with administrative support; however, courses operate on faculty donations of time. Fortunate to have an individual fund the director position, but there is minimal university commitment of financial resources for faculty.

**Q: How are your institutions facilitating faculty participation (“buy-in”)?**

* *(Joyce Maring from George Washington University)*

GWU promotes IPE without support of the institution. Buy-In and a culture of IPE are facilitated by CAPTE IPE requirements. A task-force was created with representatives from each of the participating programs. This task-force developed all of the case studies, learning activities, and outcome measurement tools. This is a formal committee appointment that has regular meetings. IPE products are then included within the scope of managing their own courses.

* *(Sheri Hale from Shenandoah University)*

SU also has a formal committee with a task-force; however the execution piece fell apart because no one was overseeing the schedule to help overcome barriers to implementation (e.g. set block of protected student time).

* *(Bob Nithman from Midwestern University)*

Perhaps formalizing IPE committee appointments at your respective institutions would promote faculty involvement and support the promotion and tenure process.

* *(Steve Jernigan from University of Kansas Medical Center)*

IPE started as a grass-roots effort and just now seeing recognition at the highest level. An IPE event hosted on the Friday afternoon after MLK day is required for students and was supported by the dean.

* *(Meryl Gersh from Eastern Washington University)*

EWU has about 50% faculty buy-in. The other half believes it is part of professional behaviors and/or think they are “already doing IPE.” Scheduling is thus difficult. Faculty don't understand what IPE is and the role of the student. The task-force at EWU was eye-opening because there was lack of understanding on a faculty level of professional roles/responsibilities, etc. The priority should be to educate the Faculty before we educate the students!

* *(Michael Majsak from New York Medical College)*

IPE is easy and natural for some and not others. IPE is not IPP—our goal is to learn a topic by identifying and building an infrastructure. Need institutional buy-in for faculty resources. Need to send faculty to development courses (such as IPEC) as a team so they can learn the constructs that drive IPE. These courses are expensive, but worth it. At IPEC, for example, your group takes on a project and can model it back at home institution. Need to have a critical starting point and can come back with a tangible. NYMC came up with 3 year plan that included faculty development and resource management. Get some pilot data to show proof of concept. Medical school needed teachers, so had PT students teaching medical students. 2 PT students per 5 medical students. PT has resources that they can offer- the key is to figure out what others need. The medical students love anything clinical in those 1st two years. Free cost. Reinforcing PTs can teach med students. Stakeholder approach.

Other IPE approaches-- students are assigned to teams for an ethics course that include students from PT, medicine, and SLP and they rotate cases. These are teams that they can go to if they wanted for any class activity. Trying to build in relationships.

* *(Sheri Hale from Shenandoah University)*

Case design has to be followed with faculty education on facilitation-- they need to be trained so that students have a successful experience.

* *(Steve Jernigan from University of Kansas Medical Center)*

UKMC has 80 faculty with facilitator training (half day sessions). Faculty development helps because faculty realize the benefits that flow into other areas of their work. Package it in a way to show the everyday value. They have accomplished entire faculty training at Baptist College in Memphis and the Des Moines Area Interprofessional Education Collaborative.

* *(Tony Brosky at Bellarmine University in Lowville)*

Fee for service model is about to change. Bundled payment may be a way to explain to others why IPE is important. Training is expensive. Is there a pre-conference course that we could go to for faculty training and development (such as IPEC)?

* *(Heidi Eigsti from Regis University)*

IPE started conveniently with an ethics course including students from nursing, PT pharmacy, healthcare administration and others. Course taught by IP team and class held from 5:30-9:30PM. Successful with good outcomes and data and research. Got some workload relief, which helped. Challenge of IPEC committee is that there is excitement with students, so mapped core competencies against each of the students’ core professions. And now trying to make the right fit and see who needs to be where and when.

* *(Lisa Dutton from St. Catherine University)*

IPE at institution is not structured into hierarchical system (e.g. Bloom’s Taxonomy). How much is enough? What kinds of experiences are the best? Clarity on tenure and promotion would be great, so that it is not seen as a “soft skill”. Helpful now that can leverage CAPTE requirement.

* *(Tony Brosky at Bellarmine University in Lowville)*

At recent curricular retreat faculty were asked to write an IP objective for each course - this hold everyone accountable.

When considering staging or placement of the competencies - Role delineation or even a non-academic ice-breaker is easy to start with and build up to something like conflict resolution.

* *(Heidi Eigsti from Regis University)*

Regis uses a simulation lab, and a campus clinic, and students work with mentors from one of the professions, and the students go out in clinical teams to work with clinical teams. Piloted clinical teams with only a few students initially going to hospitals, children’s hospitals, etc., and with clinics that already take students. CPI has (2?) items that relate to IPE indirectly. Can create mini-goals and combine with IPEC competencies.

* *(Michael Majsak from New York Medical College)*

DON'T REINVENT THE WHEEL! Use resources available, such as AAMC’s med ed portal (e.g. module called ”got ethics?”). Ethics is a shared code across disciplines and a great competency to bring people together for first IPE experience. CAIPE has a handbook on tools to measure IPE and IPP effectiveness. Take a moment to look at what’s out there. Great shared forum for research. Top 21 tools. On NEXUS there are research outcome tools and can filter by practice.

Would be nice if NIPEC could ID a set of tools to use - divide labor - outcome measurement tools for effective communication, etc. Capitalize on what’s happening at Nexus incubator sites. University of Washington looks at research outcomes and maps to competencies. Need cross-institutional outcomes. Could NIPEC create a table with outcome measures being used for research at current member sites of this group and include a hyperlink to the actual outcome measure?