

**ADFM Healthcare Delivery Transformation and Education Transformation Committees
Webinar on Interprofessional Education (IPE)
September 22, 2014**

CASE DESCRIPTIONS

	Case 1: Sidney Kimmel Medical College <i>(Chris Arenson & Chris Jerpbak)</i>	Case 2: USC <i>(Brian Prestwich)</i>	Case 3: University of New England <i>(Dan Mickool)</i>	Case 4: Old Dominion <i>(Carolyn Rutledge)</i>
Intro to program	<ul style="list-style-type: none"> Formal IPE began 2007 – Jefferson Center for InterProfessional Education Health Mentors Program – 2 year longitudinal patient-centered team curriculum at entry to 6 health professions programs Clinical Skills – TeamSTEPS, simulated discharge planning Clinical – Team rounds, Geriatric Assessment, Falls Risk Assessment, Family Medicine Student IPE Clinic 	<ul style="list-style-type: none"> Initial pilot located within a FQHC Teaching Center, Family Medicine Residency clinic. Team-Based Care models for care for: <ul style="list-style-type: none"> Perinatal Mental Health (Pre-conception through yr 1 of child’s life). Children 0-5 and their families. Seniors and Disabled Adults. Translated to pilot within Family Medicine faculty practice at Keck School of Medicine, Academic Medical Center (AMC) practice model. 	<ul style="list-style-type: none"> Formal IPE training provided to students and faculty The university houses an “IPE Center” with faculty and staff as dedicated resource. Annual IPE Clinical case workshop required by all health disciplines on campus DO, PharmD, MSW, DMD, OT,PT, Nursing, and PA. Round tables with a clinical case facilitated for communication and participation. Smaller monthly IPE events (voluntary attendance with cases) ((food provided!!!)) 	<ul style="list-style-type: none"> IPE began in 2012 with a \$1 million HRSA grant Funded 2014-2017 with \$1.2 million HRSA grant Is led by the School of Nursing at Old Dominion University Focus is on: <ul style="list-style-type: none"> Providing care to rural and underserved populations Using technologies such as Telehealth to connect healthcare professions to each other at a distance Managing patients with Multiple Chronic Conditions (MCC)
Number and types (medical/nursing/pharmacy/other) of students or residents who participate in the IPE activities and in which year of training	FY14 1,427 Students (MD, RN, NP, PharmD, PT, OT, Couple & Family Therapy, Rad Science, Biomedical Science) All years of training	FAMILY MEDICINE PRACTICES-FQHC: MS1-4, PA 1-2, Pharm D 1-2, OT 1-2, SW 2. Faculty Practice AMC: MS3-4, PA 2-3, Pharm D 3-4, OT 2, PT faculty, SW faculty, Dietary faculty.	<ul style="list-style-type: none"> Annual Clinical Symposium (reqd) Monthly IPE cases (elective) Practice sites developing IPE activities Participation varies by discipline. All health professions on campus participate to some degree 	<p>2012-2014: NPs (40), Clinical Nurse Specialists (8), Doctor of Nursing Practice (40), 2nd year Physical Therapists (45), MS & PhD Clinical Counselors (22), and MS Dental Hygienists (12)</p> <p>2014: added MS Speech Therapy (30) and 4th year medical students (144)</p>

Number and types of experiences offered during the past academic year and planned for the 14-15 academic year.	Wide variety of classroom, service learning, clinical simulation and clinical experiences	<u>FQHC</u> : Weekly 40 weeks at 1 FQHC site 2012-2014, Weekly 48 weeks at 2 FQHC sites 2014-2015. <u>AMC</u> : Daily 5 days/week 48 weeks 2013-2014, relocation to community-based non-FQHC site 2014-2015.	1 required campus activity and 9 elective opportunities for students to learn. Activities vary off campus based on the practice site	3 semester long didactic courses 1 daylong workshop 1 day of standardized patient encounters 3 interprofessional technology focused projects 4 modules On-going service learning activities
Are the experiences elective or required?	Both	<u>FQHC</u> : Elective. Selective process to participate. <u>AMC</u> : Clerkship rotations. Students choose to rotate at this clinical site.	Mix of each	Some are required and some elective depending on profession
If elective, what % of students from the various disciplines participate in at least one IPE learning experience (by school)? Are you considering developing required IPE curricula?	100% of students participate in at least 1 IPE experience in their professional program curricula	50% of students have at least 1 experience, many have a longitudinal experience. Faculty IPE Committee and Faculty IPE Expert Committee actively promoting required curriculum	Pharmacy and Medical education are changing to have required elements of IPE. Changes are now in progress. The other health disciplines are also in process of change	100% of Nurse Practitioners, Clinical Nurse Specialists, Physical Therapists, Speech Therapists, DNPs, and medical students 33% of Dental hygienists and clinical counselors
Lessons Learned/challenges				
Stakeholder buy-in	KEY – at the most senior levels (President, Dean), faculty leaders, faculty champions, and student levels. For us, having Health Mentors (patients) voice support has also been key	Crucial. Begins with interprofessional student commitment (students as “change agents”), highest level administration from each respective school, faculty “champions,” host clinic administration (preferably clinicians as well).	This was a key feature as the health system was convinced they were already doing this and IPE activities were re-dundant and not needed. After much convincing we were able to demonstrate some outcomes of why this model was different and more effective in the long run.	<ul style="list-style-type: none"> Senior levels at <u>ODU</u> (Dean of each College, Chair of each School) Senior level at <u>EVMS</u> (Leader of Predoctoral education) Faculty leaders, faculty champions, and student levels
Curriculum development	Curriculum needs to be developed by a team of faculty (and ideally students)	Faculty training (University of Toronto, Center for IPE). Emphasis on experiential	Minor changes were made to the curriculum to include a new orientation with “getting to	<ul style="list-style-type: none"> Faculty learn much about other professions as they work collaboratively to

	from the outset – retrofitting usually does not work	learning. Formal curriculum development will follow, too many logistical barriers to delay implementation of an experiential opportunity for the students that begins day 1 of their graduate program.	know you” exercises, shared presentations through the rotation, reflective exercises, and defining of roles and the addition of a home visit program	<p>develop curriculum</p> <ul style="list-style-type: none"> • Curriculum must be developed and taught jointly • All professions must have an equal say • Meeting the requirements of various programs can be challenging and requires creativity
Venues	Clinical simulation and clinical venues most highly valued by students	Working clinics are preferred. Family Medicine is optimal to provide experience across the life-cycle and create a culture of “Family-Centered Care.”	Family Medicine Clinic and Maine General Health	Students become most engaged when faced with clinical simulation and practical experiences. Using technology such as telehealth can enhance the ability of students to collaborate
Financing	IPE is not cheap; accreditation requirements are strengthening support from schools but we need to develop sustainable strategies for maintaining effective IPE – faculty volunteerism will only go so far for so long	<p>Our FQHC model was supported by a HRSA grant that covered cost of 1 Family Medicine and 1 PA faculty. However, FQHC “cost-based reimbursement” (CBR) makes this a financially sustainable model, as in FQHC-based residency training clinics. CBR also supports an interprofessional staffing model.</p> <p>The AMC pilot required 8 hours/week of dedicated time for 1 Pharm D faculty.</p> <p><i>*Sustainable within a team-based staffing model environment, easily justified in emerging value-based payment markets and expanding integrated care networks (including AMC-based networks).</i></p>	Faculty pharmacist position was funded. The clinic allocated 8hrs/wk of DO time for home visits which are billed to offset cost.	<ul style="list-style-type: none"> • The two HRSA grants have been invaluable in allowing for the development of the IPE programs and standardized patient (SP) encounters. • Students lab fees can be used to subsidize the SP experiences. • As programs are developed, they can become ongoing parts of the existing curriculum. • Having various professions share the cost and responsibility of various courses and experiences can decrease the burden on a single profession

Relationship Management	Steering Committee, Jefferson IPE Curriculum Committee, IPE Retreats, Student Liaison Groups, Student-run Newsletter	<p>FQHC- Strong endorsement from Deans, structured faculty supervision of student leadership, peer-defined selective process for student participation.</p> <p>AMC- Formal approval from CEO, Director of Primary Care, Chair of FM (Med Dir participant), Clinical Directors. Monthly IPE/IPC meetings of directors and lead clinicians.</p>	Some students have not welcomed this style of learning but by the end of rotation saw benefit. Initial work of clarification of roles and responsibilities helped overcome this.	Monthly meetings of the IPE committee, Collaboration with consultants, Leadership workshop, IPE College retreats (IPE has become a central theme in the College of Health Science at ODU)
Defining roles and responsibilities of learners and teachers	clear, carefully vetted course documents reviewed by faculty and students	<p>FQHC- Student developed, faculty endorsed role definitions/care pathways for clinic visits. Formative learning by faculty and students.</p> <p>AMC- Student roles defined by Clerkship, clinical roles formative, faculty roles formative.</p>	Roles and responsibilities are covered in the orientation process. Students are given an opportunity to “play-act” their patient encounters with each other to be prepared for the real thing. A script is provided as a start point.	<ul style="list-style-type: none"> • Following the IPEC domains • Allowing the faculty member with the greatest expertise in each area take the lead • Dividing up responsibilities equally • Clear expectations tied to each IPE experience
Interface with regulatory bodies	IPE is a real strength at program accreditation visits	<p>FQHC- Affiliation agreements between each school and FQHC. Monthly SRC agenda item in clinic operations meetings. Activity recognized by schools as formal component of respective curriculum activities. HRSA site visit resulted in formal recognition by HRSA and invitation to discuss model on HRSA sponsored national webinar.</p> <p>AMC- All care provided by interprofessional teams meets compliance for</p>	Now a requirement for accreditation in medical education. The health system is now reporting results to TJC.	IPE is being identified by the regulatory bodies as a need/requirement in many of the health professions

		student/supervision, billing, and care guidelines to drive QI and optimal performance on PQRS measures.		
Other	We have an Evaluation and Research Committee and have generated over 60 publications			<p>Programs and experiences are evaluated using both quantitative and qualitative measure.</p> <ul style="list-style-type: none"> • Changes in interprofessional attitudes, beliefs, and performance are evaluated using standardized measures • Performance on projects and with standardized patients is evaluated by faculty and SPs • Both self and peer evaluations are used • We have been actively involved in publications, presentations, pre-conferences, student research, and funded research grants