*Meeting was called to order at 9:05am PST*

**Board Attendees**: Cheryl Resnik (Chair), Samantha Brown (Vice Chair), Kimberly Beran-Shepler (Secretary), Steve Jernigan (Director), Mary Sinnott (Director), Shelene Thomas (Director), Myla Quiben (Director) Dee Schilling (Outgoing Director), Nancy Kirsch (Outgoing Director), Beth Davis (Nominating Committee), Chad Lairamore (Nominating Committee), Pam Levangie (Board Liaison, ACAPT), Mary Blackinton, (Board Liaison, ACAPT)

**Other Attendees**: open to all NIPEC members and non-members attending ELC, sign up sheet was sent around

**Absent:** Holly Wise (Director), Bob Nithman (Outgoing Secretary), Amber Fitzsimmons (Nominating Committee)

**Minutes Recorder**: Kimberly

*Key points identified in today’s meeting:*

1. NIPEC Members (Cheryl)
   1. Working with ACAPT to allow non-ACAPT members to be able to join NIPEC without having to be partnered like in the Clinical Education Consortium
   2. We don’t have membership from schools/institutions, we just have individual members
2. NIPEC Webpage (Samantha)
   1. Discussion and demonstration of recent consortium website modifications and ongoing work with APTA webmasters, particularly with how to access resources and members list by states, will be going to automated membership application and IPE activities/projects summary
   2. Discussion page does not work on google Chrome
   3. Will investigate adding ELC IPE programing handouts on the NIPEC webpage
3. Work Groups Breakout Sessions (see a,b,c and d below for summary)
   1. **IPE Faculty Development and Scholarship**
      1. Attendees in Group:

* Erin Thomas (The Ohio State): grant funding with 10 modules on IPE; discussed question: does training in classroom have impact in clinical practice,
* Mitch Rauh (San Diego State, Program Director): Currently pushing for IPE in the college with speech & nursing. Activities in development,
* Pam Ritzline (Walsh University): team developed with education, RN, business, counselling, among others. Ethics as a core module across disciplines. Existing course for facilitators and a grading rubric for all discussion,
* Kimberly Morreli (Georgia state): has done many efforts, yet nothing has stuck; has involved RT, PT, nutrition, health informatics, OT (through HRSA grant). Discussed challenges with implementation of IPE activities,
* Gary Chleboun (Ohio University): Mandatory course on introduction to IPE; (completed grant funding). IPE currently embedded in colleges; students in IPE groups for clinical experiences; e.g. Botswana IPE experience. Reinforced the importance of debriefing, Sue Smith (Drexel, Associate Dean): 12 disciplines; IP collaborative challenges with workload exposure activities; 6 clinical practices; *IPE reviewers* needed,
* Carol Recker-Hughes, PT, PhD, MA (SUNY upstate, DCE): RN initiated IPE; mandated IPE but not collaborative – disaster. Find people who want to do it; good outcomes with developmental modules; FT director of IPE; select activities for points on IPE. FOCUS; Faculty and preceptor development with grant; 2-3 workshops (passport system) PTs teach MS content in curriculum,
* [Sue Paparella-Pitzel](http://profiles.rbhs.rutgers.edu/forms/View_Profile.cfm?OProfID=paparesu&CFID=74748146&CFTOKEN=42956092" \t "_blank) (Rutgers): IPEC; + online training; past 2 years: (PT) IPE dean for the school; look at skills in each program; (+) faculty development – depending on what each program needs. There needs to be one course that unites the topic,
* Kim Dunleavy (UFlorida): Family health program; 12 disciplines- dentistry, PT, PA, nutrition; team visits family and meet faculty mentors. Discussion: how do you keep it up? Recruit new faculty; need more. Central office; (+) faculty cheat sheet; developing scholarship,
* Myles Quiben (University of North Texas HSC): University initiative on IPE. TeamSTEPPS instructor, IPEC participation, CMS trainer for simulation within the PT Department. Discussed need for faculty buy-in, workload consideration, credit for faculty and students, clinical education piece – training & education of CIs,
* Renee Brown (Belmont University): All-year IPE orientation; YR 2 with all disciplines communication and YR 3 topics: end of life, discharge planning sim; PT, OT and RN simulation. Faculty training; TeamSTEPPS, debriefing training; scholarship with posters, presentation. Discussion on authorship with scholarly IPE activities,
* Beth Davis (Emory): Developed a facilitator handbook, training prior to IPE activities. Discussed importance of the interprofessional debriefing
  + 1. Discussion Summary
* **Faculty training** on IPE if it exists come in many forms of across programs & universities. These include CEU, formal training, facilitator handbooks, specific themes such as values, among others. Many activities exist, but no consistent coordination. Discussion on: the need for faculty training instructional design objectives to be connected to the activity; giving preceptors (CIs) CEUs for participating discussion; and CIs participate as part of their clinical ladder.
* Common theme across the universities: **Both academic and CI preceptor interprofessional education & communication training is necessary.**
* **Scholarship occurs in different levels**. At this point, some have scholarship built into IPE activities, some are yet to be developed.
* **Good to hear other initiatives across programs**. **Community partners** are critical to success of IPE initiatives. Discussion on the **focus on interprofessional communication** vs. ‘education’ per se.
* Discussed need to **share existing resources** such as training modules that have been developed and are in use.
  1. **Program Development and Assessment**
     1. Attendees in Group:
* (SJ) Steve Jernigan – Facilitator
* (SB), Samantha Brown – Scribe,
* (KS) Kimberly Beran-Shepler,
* (AM) Angie MacCabe,
* (MM) Michelle Masterson,
* (PM) Patricia McGinnis,
* (SG) Sara Gombatto,
* (TC) Tricia Catalino,
* (KD) Kate Divine,
* (SW) Sandy McCombe Waller
  + 1. Themes of Discussion
       - **Assessment**
         1. Create/compile post-graduate resources
         2. Create/compile site survey questions
         3. NEXUS is an amazing resource
       - **Theory**
         1. Utilize education faculty and other health professional program partners
         2. Use institution’s Center for Teaching Excellence
       - **Action Items** 
         1. Send in names of places where good collaborative practice is happening!
         2. Compile list of common IP outcomes questions used by different institutions
         3. Discuss assessment in terms of patient outcomes and perspective at next meeting
    2. Discussion Summary

**PROGRAM DEVELOPMENT**

IPE program development infrastructure currently available at respective institutions included: an IPE Center and Faculty Institute, IPE included and valued as part of caseload for P&T, and designated funding and grants for strategic planning.

Discussed challenges to program development at respective institutions including scheduling and funding.

Personal/institutional strategies shared to overcome stated implementation challenges included: a hybrid intro course that students complete as a team that is predominately online with 2 in-person classes, use of blackboard video conferencing, interprofessional faculty assigned to specific modules of a course that they created, use of TeamSTEPPS modules that students can complete individually as part of a team, insert IPE content into existing courses, college-wide blocked time designated for IPE activities, “passport” where students enroll in IPE courses that meet various IPE focused learning objectives, but not all students take the same courses (this also helps control for group/class size), offering an evening/weekend non-credit course without charging tuition, but does show up on transcript, Dean initiated 25% FTE for IPE work in each professional program, IPE endowed professor to work across all schools/departments, establishment of a center (can streamline tasks such as clinical site contracts for multiple health professional programs), establishment of an IPE council, etc.

**ASSESSMENT**

Discussion on Assessment and use of data to garner support and funding from leadership: Recent CAB conference focused on assessment. Assessing early, mid-program, and post-grad (down-stream effects). Assessment of individual activities, but also broader… such as pre-post clinical experiences and post-graduate (alumni) into their careers/residencies (e.g. How prepared were you? Expectations met? Change in institutional culture? Impact on organizational change?). Assess employer following new employee hire (e.g. How is the employee changing workplace culture? What can institutions do to better prepare future employees for collaborative practice? )

At KUMC have identified 5 community “hotspots” where students of various health programs are all at the same practice location, but are typically not connected or working together. Now, faculty go to these hotspot sites and train preceptors in interprofessional precepting. There is intentional effort to bring the interprofessional learners together and to be more explicit with interprofessional collaborative practice conversations and activity.

Evaluate community partners and have them assess IPE students vs non-IPE students to see value (comparison groups). Rural partners have been particularly collaborative and help get the survey responses even from graduate student surveys.

Discussion on importance of matching students for similar levels of clinical practice education/knowledge when doing clinically based IPE activities, in an effort to help prevent negative implications that might inherently develop from having different levels of learners come together.

Assessment Resources: NEXUS published selection of validated tools on their site = a great resource. Additionally, they have published 8 guides to IPE, great foundational information. AIHC has a web series and podcasts on IPE and is working with National Center on a useful tool for programs developing IPE.

Group agreed it would be useful for NIPEC to facilitate a discussion among membership on common questions programs are asking for educational assessment related to IPE that we can come back and refine at our next meeting, with the hopes of creating a resource of some sort that could then be reviewed at the next ELC meeting. Everyone was interested in having some common questions to allow for aggregating data across institutions.

Discussion on adding IPE/CP questions to graduate assessment (or similar) to avoid “over” assessment of students. MUSC added a redcap survey to their clinical site assessment (this was published with permission by Deb Brown in the ELC 2016 presentation uploaded on NIPEC website. Additionally, there is an institutional readiness for IPE assessment in the same ppt: Interprofessional Education Assessment and Planning Instrument for Academic Institutions (survey of institutional preparedness for IPE)).

Discussion on how some institutions are considering moving away from the CPI as a clinical assessment tool since it has not been updated to reflect new standards in clinical education curriculum and CAPTE criteria. How can faculty assess if students are meeting objectives (SW has a great list/tool that she will share after requesting permission. This tool is given to CIs/sites and they report back with student objectives; found useful giving objectives ahead of time and integrating into site assessment).

Important to promote scholarship in the area (presentations, posters, etc.) can also use this data when requesting funding or establishing buy-in at an institution.

Would like to discuss Assessment in the context of patient care and best practices next time, which is where the focus is shifting to in the field of IPE assessment.

**LEARNING AND THEORY**

Discussion on learning and theory included: helpfulness of having someone from school of education on taskforce, having education students on IPE team thinking about PTs as educators, (if having trouble finding ed faculty that are interested, try special ed). Use Center of Teaching Excellence at your institution and get them involved. Teaching and learning piece helps with scholarship. Can get learning and theory ideas from colleagues in nursing, OT, etc. and at T3 workshop with emphasis on theoretical underpinnings.

* 1. **Strategic Partnerships with Community Sites** 
     1. Discussion Summary

Center of excellence grant through the University for IPE course that will incorporate cases re: pts being seen in the pro bono center. Youngstown University. There will be a lecture and lab component. Nancy Landgraff will share the syllabus.

FQHCs – providing IPE/P services within the centers

Students working with housing development for elder aging in place.

Engagement with the Corporation of Aging.

Michelle Masterson - U of Toledo : every Friday afternoon. 12 students on a team. Each team has a faculty facililtator. Take BP – everybody does it on each other. Then they learn about BP. Next, roles and responsibilities. SP for a wellness check – need to coordinate interview. Next COPD exacerbation 🡪 CVA 🡪 d/c planning. Patient safety horrors – they have 5 minutes to find what is wrong.

Community care clinic: student run pro bono center that partners with a local church who works with the uninsured/under-insured people.

Attendance at trauma rounds.

MOU with a county or Catholic health system. MOU – D’Youeville in New York (Lynn Rivers) doing simulations for the clinicians to become facilitators and debriefers. Catholic health askes that the school keep a certain # of students of all disciplines with in the system so that the students who are trained and could fast track onboarding. The Cis are working together as teams as are the students. The administration of the health system has bought in. Need to track how the patient outcomes are better. The students rotate across the health system continuum. Need to track patient outcomes so they can be shared with other community providers. Also, track hiring by the health system. Got faculty buy-in through scholarship.

Identify practices in the community that are practicing collaborating.

The use of ZOOM as a team building exercise.

There is a need for the use of standardized language. How to build collaborative practices into outpatient venues. Ira Gorman HPA working with the Sections. Where is collaborative practice happening in the community that is not connected with a college/university? School-systems and birth -3, early childhood services. Home health

* 1. **Policies Regarding Cross Disciplinary Supervision/CAPTE**
     1. Discussion Summary

We have been trying to develop a home assessment where we send out teams - for every student where you have to have a person who was licensed. Someone at CAB is doing home evaluation - they say that they have a nurse on an iPad that supervises everyone/all professions. Another person is working through telehealth, if they have supervision, but each is with their own professon. Others do all professions in person with all supervisors (7-8 people in the home at a time) - they use a 2:1 model for PT students. They do it as part of their ICE - assessments, implementation and home evaluations, etc. Sometimes they do follow up visits or recommend out. Another is doing wellness evaluations with a homeless populations but is struggling with finding faculty time to supervise. Another is sending students out to homes in IP groups with no supervision, but utilizing “mentors” as opposed to patients. Western U shuts down the university every wed from 3-5 and they do IPE they do cross profession supervision IPE activities- on campus and off but they are not medical visits, more about the communication side of it. This is university driven for them - have institutional buy in and financial support.

Takeaway - supervision requirements are a wording game to find loopholes on how to make it legal. Significant variability state to state

For clinical education IP - to get our people bought in to it, we may need to offer online CCUs for IPE content to encourage them to gather that content. Other professions have more of a hook since they are paid. Some schools are doing webinars, which seem to be easier to watch/listen to rather than sit and read and that has been a hit with the CIs. Pennsylvania does not allow CCUs for their CI training - even the APTA CI training course - they consider it as administrative. Encouraged to push back on that.

Discussion about license reciprocity - how will this work with CCUs when they are all different requirements. We need to push for policy on some simplistic guidelines for CCUs - need national guidelines as opposed to state by state.

Would be nice to have grants tied to IPE success and loan forgiveness in rural areas (or everywhere!)

There is nothing on the CPI that specifically asks about IPE. PT MACS has a specific skill. Hesitant to give additional IPE assessment on top of CPI, as CIs are already so overloaded with paperwork.

Discussion of assessment tools for IP: ICAR - inter professional collaborative assessment rubric - matches the CAPIE competencies - but it is reliable and valid. There are others that are trying to come out - an inter professionalism professionalism that Jody Gandy is working on. Also JTOG app that allows assessment by other professions and the patient.

OT’s for affiliation 1, they can have any profession supervise them - maybe this is something we could push for ICE experiences - at this point we are pushing for communication teamwork etc, so this might be a good time for cross disciplinary supervision

CAPTE has written the guidelines broadly (they only say supervising person is qualified), but it looks like each state has separate rules in the way their practice act is written

Some universities are partnering with others in the area or with community colleges to make sure they have all disciplines included.

Some universities have a director of IPE and then have liaisons from each profession. Assignments are graded cross-professionally.

For clinical education – one school looks at when students from multiple professions are going to the same site and they report on IPE activities that are happening with each site - each student has to have one of those types of opportunities on one of their rotations. All preceptors have access to syllabi, know what student IPE training is, they use the same sites over and over. Clinical education team has to very carefully monitor this - they have a lot to work on with this. It would be great if we could have greater communication and trust between DCEs so that we could help one another to make sure that quality is good and IP is present.

CAB - Collaborating Across Borders. Bringing the patient in as part of the team. Outcomes - the tail is not going to wag the dog - we have to change and build community partners and deliver outcomes and metrics that matter to people that make the policy and procedures

Discussion surrounding the need to even break down our intra-professional silos. If we are not working together as a profession, between schools and sharing resources, then how are we going to work inter professionally