**IPEC – 2/6/20**

**Present: N. Bennett, A. Flynn, L. Lange, T. Olsan, S. Peyre, C. Rasmussen, H. Miller, M. Schmitt, N. Poirier, (T. Vinciquerra, S. Mujezinovic, M. Spoto, A. Ratka – on the phone.)**

**Recorder: M. Ambrosi**

**Agenda**

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| Time | Topic | Facilitator |
| 8:00 AM:  | Welcome/Introductions/Review of 1st Meeting | Les |
| 8:15 AM:  | Review of Survey Responses | Marc |
| 8:30 AM: | Discussion Towards Reaching Agreement on our IPEC’s Work | All |
| 9:15 AM: | Who Else Should Be Here? / Next Steps | Les |
| 9:30 PM: | Close | Les |

**Item: Survey Responses/Discussion Towards Reaching Agreement on our IPEC’s Work**

**Discussion:** Open discussion reviewing the responses submitted to six questions regarding the consortium and continue to process of moving towards agreement on what the IPEC’s work can and should be. Comments from the group are listed below the survey responses.

1. **Overall Goal of Consortium?**
2. Use knowledge of one’s role and those of other professions to address healthcare needs
3. Greater awareness in the community of IPE and collaborative practice
4. HC professionals promote and engage IP team-based patient centered HC
5. Linking community need with professional schools (students)
6. Increase opportunities for IPE/collaborative practice training. Improve patient outcomes
7. Improve patient outcomes through increased interdisciplinary comm and collaboration

**Comments:**

* Community health, patient care, linking community need with schools were initially cited as important.
* Items 4/5 &2 were mentioned as important.
* In terms of #2 – much discussion around getting better awareness of what IPE and IPP models are being used in the community or what groups are undertaking this work? Assessment pieces, e.g., inventory.
	+ **DISCUSSION OF MODELS LIKE THE INTERPROFESSIONAL COMPETENCIES MODEL THAT WAS PUBLISHED IN 2010 [NATIONAL CENTER ALSO HAS A SOMEWHAT DIFFERENT MODEL], THE IPE RESEARCH MODEL THAT CAME OUT OF THE IOM, THE NEXUS MODEL FROM THE NATIONAL CENTER AND A CHANGE MODEL. WE ALSO REFLECTED A BIT ON THE PLACE OF RESEARCH IN OUR EFFORTS (PER Nanna Bennett’s comments). ALSO, THE WORK BEING DONE OF PROFESSIONAL ACCREDITORS ACROSS THE PROFESSIONS TO AGREE ON COMMON IPE ELEMENTS TO LOOK AT IN PROFESSIONAL PROGRAMS.**
* Scope question came up. What is the scope? How do the Social Determinants of Health fit in w/this work? Or, can we have an eye on health care w/out a focus on SDH?
* Approach of the consortium was mentioned. Should we adopt a change management approach (i.e., ADKAR Model)
1. **Focus of the IPEC? Top three?**

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| Recognize importance of IPE in HC practice | Focus on best practices | **Assess current status of efforts on interprofessional education and practice (e.g., initiatives, consortia, programs) in the local healthcare community.** | Clarifying purpose and goals and outreach to the community | **Identify currently available opportunities or develop new opportunities for IPE** | Determine existing barriers to effective interdisciplinary care of the patient; |
| Develop HC training simulations with local agencies | Where do we get the most “bang for the IPE buck?” | Educate local healthcare practitioners on principles and outcomes of interprofessional patient care. | **Review and evaluate current IPE efforts and discuss ways to expand** | Develop a list of expected learning outcomes (competencies) for participants, | Establish a common language through which we can communicate |
| Locate dedicated faculty to teach and coordinate |  | Support and promote interprofessional patient care in the Rochester area.  | (part of 2) Investigate if there is a possibility and value in creating a Club for Advancement of IP Practice and Education (CAIPE) 4. Host an annual community IPE/C conference  | align educational activities with expected learning outcomes | Develop short term and long-term plans for the Consortium |

**Comments:**

* Items in bold were pointed out as potential foci for the group. Assessment of current IPE and IPP practices and identifying new opportunities.
* Fundamental structure is assessment for now.
* Question? Do we focus first on collaborative care and then move to team-based care vis-a-vie how decisions are made?
* Can we seek to avoid the cheap-and-cheerful efforts or work products and move to that of something more sustainable or meaningful such as articulating or focusing on one’s professional identity?
* Should we ‘shoot for the stars’ and tackle something completely new or cutting edge in the field of IPE/IPP?
1. **Number 1 gap between teaching of IPE and clinical practice?**
2. Need more intentional bridging between the academic and application **QUITE A BIT OF RESONANCE WITH THIS ITEM.**
3. Lack of; perceived value, knowledge of other disciplines, turf protection, lack of buy-in
4. Attitudes of health professionals about IP teamwork
5. Courses/practicum exp that involve students across the professions, teach in silos and have on-off kinds of experiences
6. Knowledge of other profession’s roles, responsibilities, and expectations when it comes to IP practice
7. Lack of effective communication between team-members

**Comments:**

* Number 5 seems quite important. Definition of roles and responsibilities is needed. Can RAOM set-up panels of professionals to review their roles on film and create a library for all to use? Make it a broad-based digital platform.
* How does my profession inform your profession for better, patient-centered care?
1. **One IPE Best Practice?**
2. Helping students understand their own professional identity as well as other professionals’ roles on a HC team
3. Providing a strong foundation in IP principles w/many opportunities for authentic IP exp
4. In education: sims w/standardized patients and sim lab sessions on mannequins
5. Faculty and student experiences that are led/taught/facilitated by faculty from different professions
6. Identify common competencies at the onset between different professionals and offer educational experiences to mee the needs of the learners
7. …involves discussing a patient’s plan of care in a huddle with the ‘home team’ (interdisciplinary team)

**Comments:**

* #1, #2, #5 seemed to be most important.
* Strong vote given for #4.
* Are their potentially other benefits that can be gained from IPEC’s work e.g., dealing with clinician burnout and stress?
* How about building an IP Escape Room? (All liked this idea).
1. **Measure success?**
2. Explicit IPE learning outcomes should include learning activity; exposure, immersion or competence and then be mapped onto IPEs core competencies and match to IPE learning outcomes
3. Depends on what we are measuring 😊
4. Develop or adopt an assessment tool to gather baseline and post intervention data to measure e.g., patient satisfaction, cost effectiveness, provider satisfaction
5. Measurable improvements in student learning, faculty collaboration, and ultimately the health and HC of the community
6. By evaluating the learning outcomes, participation over time and level of satisfaction of participants
7. Try it quarterly, gather data now and then later

**Comments:**

* #2 carried the moment for obvious reasons.

**6. How to present our work as we move forward?**

1. Educational seminars, having an initial IPE community engaged curriculum concludes w/student presentations
2. Workshops presenting other interested groups, involving student groups, CAIPE etc.
3. CE programs for IP practitioners, seminars, workshops, online courses, newsletters, conferences (local/national)
4. Press, webpages, work w/ schools and organizations to issue press releases, submit abstracts to national conferences, invite established collaboratives to join us in a conference call to discuss their data repository and how we could be part of it
5. Short presentations and local conferences, posters, publications on the subject
6. RAOM talk, grand rounds, visit nursing homes, schools, med schools, pharm schools etc. to establish interdisciplinary discussions early on

**Comments:**

* It’s wide open here in terms of how can broadcast this work. Elements of each bullet can be tools to use. More on that later.

**Decisions:**

* Group agreed that an assessment and presentation of one’s own IPE or IPP best practice would be useful as a start of the process.
* Group also agreed that developing an inventory of IPE tools that are being used to help promote better IPP would be useful as well.
* Group also felt having this group go through an Escape Room experience would be useful.

**Action Items:**

* Group agree that at the next meeting, each member would have a turn in describing their IPE/IPP best practice. (Sarah P. to provide templates for this item and the next bullet.)
* Group agreed to fill out a template listing the tools or resources they use or are aware of to help the IPEC build an inventory in these areas.
* Group also agreed to hash-out and develop an Escape Room at the next meeting. (Sarah P. to help with this).

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**Item: Who else should be here and next steps.**

**Discussion:** Wide ranging discussion on who else should be invited to join this consortium.

* Need more practitioners, need more students. Non-professional front-line workers, MDs, SWers, Chaplain, Nutritionist, Members from the Warner School of Education, Dentists, Insurers, Psychiatrists and the list goes on. (Brent Robbins, Michael Apostolakos, Bridgett Wiefling, Susan McDaniel, Colleen Fogarty etc.)

**Decisions:**

* Group agreed of the need to increase the membership of the committee as stated above.

**Action Items:**

* Marc to create a chart and populate with names that the group provides and share with IPEC prior to March meeting. To be discussed at the next meeting

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**Item: Next steps.**

**Discussion:** Group felt meeting every month would be necessary to build momentum. Review best practices and building the inventory is critical. Escape Room is going to be helpful

**Decisions:**

* Group agreed to meet third Thursday of the month with the exception of March which will be on March 12th.

**Action Items:**

* Marc to send out meeting request.

**End.**

**Ambrosi.**