AHECs Successfully Adapting to Meet the Nation’s Healthcare Needs Through Interprofessional Education
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Journal of the National AHEC Organization

Volume XXX

Spring 2014
AHECs Successfully Adapting to Meet the Nation’s Healthcare Needs Through Interprofessional Education

Robert J. Alpino, MLA; and Ronald E. Cossman, PhD

“The Team Can See You Now.” That was the headline in a February 2014 piece in The Wall Street Journal that profiled the Union Square Family Health Center in Somerville, Massachusetts. The article described how the Union Square facility utilizes a new approach to providing healthcare services for patients that the authors deemed “team-based care.” Of course, we recognize this approach to providing care to be what we, “in the business,” call “interprofessional collaborative practice, or IPCP.” While it is significant that the popular press is now picking up on this phenomenon, it is a phenomenon that certainly is not new to AHECs. In her lead article describing the new National Center for Interprofessional Practice and Education, Dr. Barbara F. Brandt, the Center’s director and former Program Director of the Minnesota AHEC Program, calls interprofessional education (IPE) “the forty year-old ‘new’ field.” Of course AHECs have been involved in what we then called “interdisciplinary education” for many years, even preceding the days of the Quentin N. Burdick Program for Rural Interdisciplinary Education in the 1990s. The question remains, though, if AHECs have been so involved in interprofessional education for so many years, why isn’t such practice yet the norm?

Achieving and sustaining a successful IPE program is very hard work and can be costly! One of us is involved in creating an IPE program as of this writing and can attest that there are myriad challenges involved with this effort—ranging from scheduling difficulties to varying educational philosophies to differing professional vocabularies—among many more issues. While we cannot do much to help the reader alleviate the cost aspects of such an effort, we think that this issue of the Journal of the National AHEC Organization can be of great help in making the introduction of IPE somewhat easier for you by providing success stories.

Dr. Brandt’s lead article describes how the new National Center can be a valuable resource to any person or organization contemplating an IPE program. The impact of the National Center cannot be overstated in the national effort to move IPE and IPCP forward to improve health care, as it will bring together in one place everything from research briefs, to validated evaluation instruments, to help you in developing and improving your IPE programs. Next, in response to the lead article, Dr. Richard D. Kiovsky, Program Director of the Indiana AHEC, has written a thoughtful article providing his vision on how the national AHEC network can respond to the tremendous opportunity that IPE represents.

Dr. Kiovsky’s article is one of a trio of articles that highlight AHEC successes in implementing IPE from the perspective of urban AHEC programs that are academic health center-based. These programs have the distinct advantage of having...
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Multiple health professions educational programs within close geographic proximity to each other, and, maybe even more importantly for the introduction of IPE, sometimes under the same dean or academic governance. In addition to the Indiana AHEC article, there is an interesting article from the South Carolina AHEC about their IPE efforts. It should be noted that the Indiana and the South Carolina AHEC Programs are two of eight member organizations that are part of the National Center’s Nexus Innovations Incubator Cohort (read the lead article by Dr. Barbara F. Brandt to learn more about the Nexus). This group of organizations serves as “applied testing laboratories” for the development and implementation of IPE educational programs and strategies. The third article in this section is from the St. Louis AHEC. While admittedly a lengthy article, we feel that this article will provide solace to those of you in the middle of implementing IPE, as it provides evidence not only of how difficult it can be to implement a successful IPE program, even in an urban environment, but also shows how such a process is often iterative in nature, requiring multiple, small, multi-year programmatic adjustments to achieve success.

The final trio of articles highlights successful IPE programs developed by AHECs that are rural and regional in nature. They point out that IPCP is almost a necessity in rural areas which may not have all of the various health professions disciplines found in urban centers represented in their care settings. These programs not only have to overcome the same basic challenges to IPE implementation that the urban and academic health center-based programs have, but they also have to deal with the issues of coordinating multiple educational institutions with programs and health professions students spread out over large geographical areas. These articles from Indiana, South Dakota, and Wisconsin demonstrate that these challenges can be overcome and result in a more qualified rural and regional healthcare workforce.

It is our hope that you find this issue informative and useful. Use the resources of the National Center to propel your IPE efforts forward and use the “lessons learned” from the various articles to reduce the number of “trial and error” mistakes in the course of IPE implementation.

Report Available Online: “Redesigning Health Professions Education and Practice to Prepare the Interprofessional Team to Care for Populations.” The Advisory Committee on Interdisciplinary Community-Based Linkages (ACICBL), which has several prominent AHEC leaders as expert advisors, has released the 12th in a series of reports to Health Resources and Services Administration focused on topics related to providers covered under Title VII. This latest report, “Redesigning Health Professions Education and Practice to Prepare the Interprofessional Team to Care for Populations,” is now available online and covers issues related to population health, cultural competency, health promotion, technology, and interprofessional teams. Download it at: http://www.hrsa.gov/advisorycommittees/bhpradvisory/acicbl/Reports/twelfthreport_.pdf

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National Center for Interprofessional Practice and Education: A Bold New Vision for Health

Barbara F. Brandt, PhD

Interest in interprofessional education (IPE) has exploded over the past several years. In response, Area Health Education Centers (AHECs), like other organizations, are implementing IPE strategies nationally and locally. This issue of the Journal of the National AHEC Organization represents a significant commitment to advancing AHEC’s role as a leader in IPE. Indeed, for AHECs, with their long history of connecting education and practice, IPE represents an opportunity to build upon long-standing expertise and experience.

The concerted efforts to improve the U.S. healthcare system over the past decade are fueling the interest in IPE (Institute of Medicine [IOM], 2001; IOM, 2003; IOM, 2010). For many involved in this movement, the call to action is the Triple Aim: (1) improving the patient experience of care; (2) improving the health of populations; and (3) reducing the per capita cost of health care (Berwick, Nolan, & Whittington, 2008; Institute for Healthcare Improvement, 2013). In education, the 2011 release of the Interprofessional Education Collaborative (IPEC) core competencies for interprofessional collaborative practice (IPCP) was an important stimulus for IPE nationally (IPEC, 2011). Importantly, the IPEC competencies, (i.e., values and ethics for interprofessional practice, roles, and responsibilities; interprofessional communication; and teams and teamwork) presented an opportunity to examine IPE’s role in clinical practice redesign (Cerra & Brandt, 2011; Cox & Naylor, 2013).

Today, little published evidence exists that directly links IPE and IPCP to improvement on the simultaneous goals of the Triple Aim (Brandt, Luftiyya, King, & Chioreso, 2014). In IPE, many studies indicate that little research has been conducted to demonstrate its relationship to learner outcomes (Reeves, Zwarenstein, Goldman, Barr, Freeth, Hammick, & Koppel, 2008; Reeves, Rice, Conn, Miller, Kenaszchuk, & Zwarenstein, 2009; Reeves, Perrier, Goldman, Freeth, & Zwarenstein, 2013). The surrounding issues are that we have not sustained the efforts nor conducted the evaluation and research to demonstrate the impact. That having been said, today many believe that pre-professional IPE and clinician point-of-care learning will accelerate change in health care, including an impact on the Triple Aim. This perspective is worldwide, and the U.S. efforts are propelled by a strong, growing international movement to define the field of IPE and collaborative practice while supporting its growth (World Health Organization [WHO] Department of Human Resources for Health, 2010; Bhutta, Z. A, Chen, L., Cohen, J., Crisp, N., Evans, T., Fineberg, H., Frenk, J., Garcia, P., Horton, R., Ke, Y., Kelley, P., Kistnasamy, B., Meleis, A., Naylor, D., Pablos-Mendez, A., Reddy, S., Scrimshaw, S., Sepulveda, J., Serwadda, D., & Zurayk, H., 2010).

What are interprofessional education and collaborative practice?

Interprofessional education “occurs when two or more professions learn about, from and with each other to enable collaboration and improve health outcomes.”

Collaborative practice “occurs when multiple health workers from different professional backgrounds provide comprehensive health services by working with patients, their families, carers (caregivers) and communities to deliver the highest quality of care across settings.”

(IFramework for Action on Interprofessional Education and Collaborative Practice, World Health Organization, 2010)

IPE: The 40-Year-Old “New” Field

AHECs and IPE can trace their roots back to the early 1970s. In the U.S., “interdisciplinary education,” the term originally used for IPE, was introduced in a 1972 IOM report, “Educating for the Health Team” (IOM, 1972). However, over the years, for a variety of reasons, IPE and IPCP have witnessed ebbs and flows of interest (Brandt & Schmitt, 2011). Neither has been mainstreamed in health professions education after many years of attempts. As a result, the 1972 IOM report reads like a contemporary document, a phenomenon that has been called the “long and winding road of IPE” (Hall & Weaver, 2001).

What is it going to take this time to sustain IPE and IPCP efforts? And, what role can AHECs play? One of the answers to these questions lies in the environment, which

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today is different than in the past. After years of documenting the problems in the U.S. healthcare delivery system, there appears to be a true effort, while imperfect, for transforming health care. In response, many are asking new questions about the fundamental approach to health professions education, believing the current problems in health care are related to how health professionals are educated. As Madeline Schmitt, PhD, RN, FAAN, University of Rochester (personal communication, April 9, 2009), eloquently emphasizes:

‘Can our graduates who do not value interprofessional working, know little about each other, may never have communicated with each other, haven’t been taught collaboration skills, and have no shared clinical experience as students be expected to practice effectively in the emerging healthcare system?’

In this environment, AHECs are well-positioned to link education with communities that are working to transform health care forever. It is not business as usual, and neither can be the solutions. The response cannot be merely to design a new IPE program or a single event to update information. To be relevant in IPE and IPCP, fundamental changes need to occur, and AHECs will need to be—and can be—the force for such a cultural change.

Opportunities abound. With their liaison role between underserved and rural communities and higher education, AHECs have both their ears to the ground in practice and walk the halls of universities and colleges. AHECs can serve as translators to align health professions education with the healthcare transitions that are characterized by moving from:

- non-integrated health systems to integrated ones characterized by new practice approaches such as patient-centered medical homes and incorporating population and public health into primary care;
- independent providers to providers employed by health systems;
- fee-for-service payment systems to new financial models, or what some call “volume to value,” rewarding outcomes;
- uninsured to insured populations, which will increase access to and demand for health care;
- an emphasis on disease and acute care to greater focus on health, wellness, and prevention;
- autonomous providers to interprofessional teams, necessitating new models of education and training;
- paper systems to healthcare delivery systems supported by real-time evidence-based decision-making, using health informatics technologies to create learning organizations.

These trends are rapidly pushing and redefining the century-old core principles of what it means to be a health professional; who should lead the healthcare team; how to shape new relationships and engagements with patients/people, families, and communities; and what governing structures need to be created to manage these transitions. Those who see opportunities in the environment will proactively lead these changes. Where will AHECs, as stewards of the public interest, fit in this new order?

The National Center for Interprofessional Practice and Education

The need for a national center to coordinate interprofessional education and collaborative practice evolved from the current environment of significant change. Foundations and public agencies that have funded past efforts in IPE and IPCP recognized that the waxing and waning of interest in the field and in funding have not resulted in permanent change in health care. To make a difference, and to capitalize on the energized environment, the federal Health Resources and Services Administration (HRSA) and four private foundations (Josiah Macy Jr. Foundation, Robert Wood Johnson Foundation, Gordon and Betty Moore Foundation, and the John A. Hartford Foundation) committed to funding a coordinating center for IPE and IPCP (U.S. Department of Health and Human Services, 2012).

After a HRSA-sponsored competitive peer-reviewed application process, the National Center for Interprofessional Practice and Education was created in October of 2012 through a cooperative agreement with HRSA. The National Center is housed at the University of Minnesota to develop the public–private partnership as the sole center to provide “leadership, scholarship, evidence, coordination, and national visibility to advance interprofessional education and collaborative practice as a viable and efficient healthcare delivery model.” (University of Minnesota, 2012). All funders are actively engaged in the development of the National Center.

In our proposal to HRSA, the University of Minnesota presented a bold vision for the future, called the Nexus, to address the growing gap between higher education and health
systems (Figure 2). The Nexus represents a new partnership between education and practice through innovation to meet the transformational outcome of the Triple Aim. Much of our work is focused on strengthening the information, data, and evidence base to be actively used in practice to support the effectiveness of IPE and IPCP. The National Center is working to accomplish this by building capacity and a common language to guide program development, evaluation, and research with practicing communities. Several of our projects involve AHEC partnerships throughout the nation.

This vision is one in which AHEC leaders should see themselves proactively creating the new future of IPE and IPCP. In the Nexus, healthcare practice and education systems will be true partners, continuously learning and transforming together to improve health. And collaborative interprofessional teams, delivering high-quality care that meets the diverse needs of patients, families, and communities, will be the norm. The Nexus is intended to create a meaningful system at the practice/education interface that will, over time, demonstrate that learning together and collecting data together will have a positive impact on the Triple Aim. In the Nexus, higher education and health system stakeholders are engaged to test new ideas and to drive sustainable national change in both practice and education.

The ultimate goals are, that by aligning education and practice, the new Nexus will result in:

- Improved quality of experience for people, families, communities, and learners
- Shared responsibility between healthcare delivery entities and the health professions education community for achieving health outcomes and improving education
- Reduced cost and added value in healthcare delivery and education

The Stair Steps to Health: How Are We Going to Get to the Nexus?

To achieve the ultimate goals, the National Center is creating a learning system in which practice and education partners examine, reflect upon, and measure the value of their integration of IPE and IPCP to achieve the Triple Aim outcomes. To do so, the National Center is leveraging today’s informatics technology to lay the foundation for collecting education, practice, and financial data nationally in a return-on-investment model. We firmly believe that in order for IPE and IPCP to be sustained this time, people need evidence-based guidance on approaches. And, senior corporate leaders and university presidents will be seeking a business case in order to justify making and continuing their investments. This work is not for the faint-hearted, and a team of interdisciplinary experts (clinicians, epidemiologists, health economists, informaticians, educators, and evaluators, among others) are working with a group of innovation incubator sites throughout the country to develop an approach to data collection with longitudinal tracking.

Collecting data and evidence is a long-term vision and solution to sustainability of IPE and IPCP. This approach is intended to address past problems of the field. But, people want guidance to know what they can do today beyond innovation and an inefficient trial-and-error approach. Routinely, the National Center is asked questions such as: How do we start IPE? What approach should we take? When should IPE be introduced to learners? What is the best strategy going forward? Where are the best practices? What works?

For quite a while my colleagues and I have been thinking about how healthcare delivery and health professions education transformations can be linked to both improve health and learning outcomes. Opportunities for IPE present themselves in community-university partnerships linked to achieve health. We use the concept of developmental milestones, or “stair steps,” of multiple increasingly complex tasks that focus and guide programs to achieving the Nexus. AHECs are well-positioned to support the meeting of these milestones. Figure 3 is my representation of what these milestones are for achieving an integrated learning system, or what we now call the Nexus.

Many of the stair steps represent basic services that AHECs already provide and that can be strengthened to intentionally incorporate IPE strategies. For example, AHECs have long been conveners in communities to support people and groups to get to know each other. AHECs provide a key that “unlocks
the doors” of academic health centers for the community and links community preceptors. In promoting teamwork, AHECs have traditionally operated in an agnostic interprofessional manner with regard to training health professionals, not promoting any one health profession over another. Building on this strength, programs can be developed to teach teamwork and support community preceptors in role-modeling teamwork skills for students. AHECs can help develop strategies to teach patient safety and quality principles as students need to learn about transitions of care from acute care settings to underserved and rural communities.

*Health workforce development* is the raison d’etre of AHECs that have long been involved in improving access to care. In new models of care, AHECs are involved in developing the “new” health workforce with strategies such as incorporating community health workers into care provision to improve both access and culturally competent care. AHECs can incorporate interprofessional teams of students in translational science and community-based practice improvement research, or bench to bedside to community, to have an impact on community health outcomes. AHECs have traditionally created opportunities for teams of students to engage in service-learning projects. To demonstrate the value of these activities, community health outcomes can be tracked. As universities expand their IPE programs, AHECs can help offer efficiency models to support cost-effective operations that help to lower costs of supporting teams of students in practice.

**What is the National Center Doing Now to Help AHECs?**

The National Center priorities are to “connect, engage, inform, and advance.” Recently, a Resource Exchange has been launched to support linking many resources. The National Center is actively working to secure papers, reports, videos, and other items that represent excellent IPE programs—both currently and from the past. Colleagues in the field are encouraged to post interprofessional practice and education items. A Scholarly Trust will house articles and materials that will be peer-reviewed by an expert panel, so that—going forward—the National Center will host a more complete, living documentary of the field.

The National Center staff recently reviewed more than 130 IPE and IPCP measurement instruments and studied how they were validated and used in research. A manuscript summarizing the instruments’ validation processes is under peer-review. Twenty-six of these instruments were selected to be included on the Resource Exchange, and the collection will be updated regularly. A webinar series around the measurement instrument was launched in February of 2014.

An extensive review of recent IPE and IPCP literature (2008 to the present) has been completed. The review began in consultation with librarians who helped develop a rigorous analysis of the best terms and strategy to use. The search, which generated more than 1,200 articles, will result in products available to interprofessional educators and health professionals to promote productive collaboration and standardization in a field with many disparate sectors:

1. A searchable database on the National Center’s website with information on more than 500 articles that present and analyze empirical data, to be updated regularly.
2. A descriptive review of the current literature that highlights key findings for education, clinical practice, and the Nexus that raises issues for further interprofessional practice, education research, and program development.
3. A brief framing paper about the challenges and powerful potential of meaningful evaluation in the Nexus.
4. An approach to developing a national consensus on definitions, metrics, and indicators, led by colleagues with substantial experience in this area.

**Looking to the Future**

The National Center team has approached the field of IPE and IPCP as inextricably linked not only to learning but also to the health outcomes of the nation. The National Center team knows this is a tall order, a grand vision, and one that AHECs share. By connecting AHECs with the work of the National Center, we can achieve this vision together.

*The author acknowledges and thanks Robert J. Alpino, MIA; and Catherine Chioreso for their thoughtful feedback on this paper.*

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NAO State of the Union

H. John Blossom, MD, NAO President; and Robert M. Trachtenberg, MS, NAO Executive Director

We are speaking with one voice, as your NAO President and Executive Director, to share our thoughts about the future of our organization.

NAO is as strong as it has ever been and has had multiple successes the past year. Here is some evidence for that statement:

NAO, almost uniquely among Title VII Programs, not only achieved continued federal funding, but it even had a welcome increase in its congressional appropriation (for the FY14 year). Our presence on the Hill has been frequent and effective. Our Executive Director, current and past NAO Presidents, and advocacy activists have conducted many congressional visits coordinated by our excellent and cost-effective lobbying partner—The Health and Medical Counsel of Washington. Their impact has been amplified by the work of regional and local AHEC advocates from all over the country.

NAO conducted a Board of Directors meeting that was devoted solely to long-range planning. With Elizabeth Scott as our Consultant (as strategic planning facilitator), and Executive Director Rob Trachtenberg, and past NAO President Steve Shelton helping facilitate, we accomplished multiple forward-looking tasks whose details will be unfolding this coming year.

Our members are increasingly active in advocacy, educational innovation, and health professions support, all with an eye to topics of national importance such as community health worker training development, traumatic brain injury and post-traumatic stress disorder, and education for health professionals on Affordable Care Act insurance enrollment.

Our relations with the Health Resources and Services Administration (HRSA) are growing stronger and are effective. Recent meetings between NAO leaders and the new HRSA Bureau of Health Professions Associate Administrator, Rebecca Spitzgo, were candid, cheerful, and constructive. Meseret Bezuneh has proven herself to be an able and trustworthy AHEC Branch Chief and Federal colleague; she is well informed, committed, and delightful to work with. The institution of the “1st Wednesdays with the AHEC Branch” webinars and linkage of the AHEC thought leaders to this HRSA Division of Public Health and Interdisciplinary Education program has been a great first step in “de-siloing” HRSA programs and re-imagining the federal AHEC Program.

Now for some challenges. The NAO is poised to enter into a period of more rapid change and is facing tough issues:

1. Although the AHEC network seems to be sustained, it has shrunk. Unexpected adversity has closed the Iowa, Oklahoma, Mississippi, and Puerto Rico AHECs. There are no programs in Kansas, and Delaware. There currently is not enthusiasm at HRSA for a new competitive cycle, which could put AHECs in every state.
2. Although the President’s budget did not include us, Congress has increased our funding. However, many centers are hanging on by a financial thread.
3. Some of our newest activities, like Veterans’ Mental Health projects and Affordable Care Act education for health professionals, have achieved high visibility but are not sufficient nor sustainable sources of support for centers, though they may very well leverage other opportunities to utilize the national network for training purposes.
4. Both within and outside of HRSA our supporters and critics agree that the identity of AHECs across the nation is diffuse; this is hindering advocacy for want of simplicity and clarity. Recognizing that our diversity comes about in part because we are responding to community needs and not just the varied pursuit of financial resources to support our infrastructure, nonetheless, attention to standardization is timely and vitally important.
5. Consistent metrics, both quantitative and national, would be most helpful. How helpful would it be for advocacy and future collaborations if we were able to say... “all AHECs do x, y, and z as well as many other locally oriented health professions education programs?”
6. Our centers and programs differ markedly in budgetary support, producing AHEC “haves” and “have littles” and we are concerned that this trend will continue.
7. Although relations between center and program leadership have never been better within NAO, multiple programs and their centers are handicapped by poor relations.
8. Some academic AHEC leaders are relatively inactive. This constitutes a missed opportunity for centers, programs, NAO, and academic sponsoring institutions.
9. The NAO budget is malnourished. We are working with some evident success to increase support; more needs to be done.
10. There is increasing national and state recognition of the actual and potential value of our robust national network. Evidence has included the Amgen contracts, as well as many other locally oriented health professions education programs?
11. Our centers and programs differ markedly in budgetary support, producing AHEC “haves” and “have littles” and we are concerned that this trend will continue.
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14. The NAO budget is malnourished. We are working with some evident success to increase support; more needs to be done.
15. There is increasing national and state recognition of the actual and potential value of our robust national network. Evidence has included the Amgen contracts, as well as several other icons in the fire.
16. Similarly, NAO and its members have been increasingly identified as “go-to” partners for rapid national scale-up on activities to address emerging healthcare issues.
17. We are arguably the nation’s best coordinated and distributed tool to reach rural, frontier, and inner-city health providers.

Rob and I look forward to your thoughts on these comments!
The National AHEC Network: How Will We Respond to the National Interprofessional Education Movement?

Richard D. Kiovsky, MD

Editor’s Note: Indiana University/the Indiana AHEC Program was one of eight pioneer member institutions in the National Center for Interprofessional Practice and Education’s Nexus Innovations Incubator.

Even though interprofessional education (IPE) has been part of the Area Health Education Center (AHEC) federal requirements for almost 10 years, many AHECs across the national AHEC network report profound challenges to offering meaningful IPE to health professions students. Why? The main reason we’ve heard over the years is that IPE has not been required by accrediting bodies for health professions training programs. Some AHECs note that the curricula of health professions training programs are just “too packed” to introduce something new, particularly something that has yet to be proven effective in impacting patient outcomes. Well, as noted in Dr. Barbara F. Brandt’s lead article in this issue, all that is changing in 2014 as more and more accrediting bodies are now requiring IPE to be embedded into health professions training programs. How are we—the national AHEC network—to respond?

AHECs have an unprecedented opportunity before us to enhance the stature of our national network if we can assist health professions training programs by developing exemplary IPE training sites, particularly in underserved communities. But AHECs must get it right—our academic partners will not allow for anything less! This will require a well-orchestrated effort. AHEC leadership must partner with groups or organizations that are well-versed in IPE principles, policy, and practice such as the National Center described in Dr. Brandt’s article. It will be essential for the staff of AHEC Program Offices and AHEC Centers to be educated and trained in IPE. Our roles must be clearly articulated if we are to assist academic partners in building effective interprofessional, experiential learning environments in community-based settings.

Since late 2009, the Indiana AHEC Network Program Office has been working to define the role that our state network needs to play in assisting health professions training programs in IPE. If you were like us at that time, most Center Directors and Program Office staff knew little about IPE process and practice. In addition, most, if not all, healthcare providers in established AHEC clinical training sites across the state were not trained in an IPE model, nor were they practicing collaborative, team-based care. The Indiana AHEC Statewide Advisory Board wrestled with these challenges and recommended the creation of an AHEC Academic Committee to develop an IPE Action Plan for our network.

In early 2010, the Indiana AHEC Academic Committee, made up of educators from six health professions disciplines—nursing, medicine, dentistry, allied health, physician assistant, and pharmacy—met several times to formalize guidelines intended to assist Center Directors as they tip-toed into interprofessional, experiential learning in ambulatory clinical settings. With these guidelines in place, we began a three-month process of educating ourselves about all aspects of IPE. The Indiana AHEC Network Program Director and the Chair of the AHEC Academic Committee attended a national IPE conference. They returned filled with passion, and plans were soon in place to develop a statewide IPE initiative utilizing the Indiana AHEC Network.

Indiana AHEC had to get the word out. IPE and interprofessional collaborative care are the future of healthcare delivery. Indiana’s health professions training programs needed to understand the magnitude of change required to prepare future health professionals to practice in these dynamic environments. The Indiana AHEC Network hosted an international conference in Indianapolis.
in October of 2012 entitled “IPE: The New Foundation for Health Care Delivery.” Over the next two days, a Who’s Who of IPE experts spoke to nearly 100 educators from across the state, and everyone left the meeting energized. Indiana AHEC Center Directors were charged with identifying two ambulatory training sites in each of their regions that would be willing to tackle interprofessional education, and to work with those partners to develop IPE projects. Responses varied considerably, from an IPE Day to a project promoting IPE simulation activities. One Center Director took on the challenge of developing a four-week multidisciplinary clinical rotation in a Community Health Center located in a rural, underserved community. After 18 months of planning, in February of 2012, these health professions students from five disciplines (medicine, nursing, dentistry, social work, and pharmacy) took their IPE rotation. The trainees learned about each other’s disciplines, participated in case-based learning, and reviewed the core competencies of IPE. They learned about, with, and from each other while seeing patients in a team-based approach. This pilot was an immense success and it planted the seed: What if every AHEC Center in the United States developed similar resources, and thus provided health professions training programs with exemplary IPE training sites for learners?

AHEC Center Directors from across the nation have provided feedback to the national AHEC leadership that they need new and enhanced skills to achieve IPE success in their regions. They have raised a lot of questions and identified the challenges that accompany them:

1. Many community-based preceptors were trained in “silo” models of discipline-specific education. How do we successfully recruit and engage them in the transformative process of adopting a new model of interprofessional education aligned with IPE core competencies?

2. Although there are clinical sites that utilize multiple disciplines, there is little evidence that these sites practice in a collaborative, team-based care model. What strategies succeed in encouraging adoption of the principles of interprofessional collaborative care?

3. How is a clinical site’s “IPE-readiness” to be assessed? What tools can communities and AHECs use to identify sites that are not prepared for IPE and those that are exemplary IPE training sites? Who does the assessment? If AHEC Centers are asked to play this role, who will provide the needed training for AHEC personnel?

Change always creates challenges, but dream for a moment. Imagine that every AHEC Center is trained to address these challenges. Imagine the excitement of students from different disciplines immersed together in well-prepared IPE clinical training sites delivering innovative IPE curricula. Imagine the impact the national AHEC network could have with better health professions training, stronger healthcare delivery, and improved patient outcomes emerging from collaborative, team-based care.

There are some wonderful leaders in AHEC all across this nation who have the skills and determination needed to make this dream come true. What would it take? First, the National Center as a resource to assist us. Second, the National AHEC Organization could seek out funding from a partner organization that shares its interprofessional objectives and realizes the potential of the national AHEC network in bringing about needed changes. Third, a small team of AHEC collaborators who already have some expertise in IPE could develop training modules and toolkits (“train-the-consultant”) that equip AHEC Centers and staff with the skills needed to take on IPE-development challenges. Fourth, several AHEC Centers willing to pilot the IPE initiative who would participate in the evaluation of this pilot initiative.

Can the national AHEC network accomplish this? Yes we can! Will you join in this effort?

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An AHEC’s Role in Moving Interprofessional Education from the Classroom into the Community

Deborah Stier Carson, PharmD; Ragan DuBose-Morris, EdS, MA; and David Ross Garr, MD

Editor’s Note: The Medical University of South Carolina/the South Carolina AHEC Program was one of eight pioneer member institutions in the National Center for Interprofessional Practice and Education’s Nexus Innovations Incubator.

Introduction
Interprofessional education (IPE) is increasingly being recognized as an essential component of healthcare workforce development. For more than half of its 42-year history, the South Carolina Area Health Education Consortium (South Carolina AHEC), housed on the campus of the Medical University of South Carolina (MUSC) in Charleston, has been actively engaged in IPE activities and partnerships designed to increase collaborative practice. The national visibility of IPE has increased with the establishment of the National Center for Interprofessional Practice and Education, as discussed in the lead article of this issue, (www.nexusipe.org) and the American Interprofessional Education Collaborative (www.aihc-us.org).

IPE learning is transformative. Students learn new roles and encounter new ways of acting and interacting. Progress in IPE occurs along a continuum of learning and increases in sophistication and application over time and with experience. This article describes how classroom learning about IPE is being integrated into community practice in South Carolina; provides an overview of the IPE activities at our host institution; describes the role our AHEC has played in supporting the IPE activities of our host institution; and provides some lessons learned as a result of involvement with IPE initiatives.

Interprofessional Framework and On-Campus Activities
Several staff members in the South Carolina AHEC Program Office are faculty members in one of the six MUSC health professions colleges. MUSC strongly encourages the development and provision of interprofessional courses that are designed to instill the knowledge, skills, and values shared by all health professionals. MUSC established an Office of Interprofessional Initiatives, which includes a focus on interprofessional efforts in education, patient care, and research known as Creating Collaborative Care (C3) that is designed to achieve the goals described in the Interprofessional Collaborative Practice Competencies for students in all six academic colleges at MUSC (http://academicdepartments.musc.edu/c3). In addition, it houses “Junior Doctors of Health” (JDOH), a grant-funded program focused on collaborating with public schools to teach students healthy habits (http://academicdepartments.musc.edu/idoh). Several interprofessional courses at MUSC are open to all students and are typically taught by a team of faculty members from two or more disciplines. They present opportunities for dialogue and collaboration that focus on effective professional performance in an ever-evolving healthcare environment.

MUSC On-Campus Signature Programs and Activities for Students
Interprofessional education on the MUSC campus is available in several formats, including required and elective coursework, competitions, scholarly studies, and an annual campus-wide Interprofessional Day.

Curricular Domain
The major focus of the C3 curricular domain is to enhance interprofessional education opportunities so students can learn from, with, and about each other. The intent is to ensure that students develop a requisite set of interprofessional competencies that will enable them to function more effectively in the healthcare delivery and biomedical research environments. Participation in two activities is required for all MUSC students: 1) a semester-long IP course, “Transforming Health Care for the Future,” for first-year students, lays the foundations for students to understand the complexities of the healthcare system and the role of interprofessional collaboration to improve the system, and 2) the campus-wide annual Interprofessional (IP) Day that establishes a culture of collaborative teamwork and improved patient care and safety. Both activities involve MUSC faculty members and AHEC faculty and staff. Other elective IP courses are available to students, including service-learning experiences in the community, a global health course, overseas medical missions, a course on cultural competency and health, and a public health, urban and academic health center-based IPE programs.
health issues seminar series. Additional on-campus initiatives focus on fostering IP student engagement and activities designed to prepare students for team-based practice.

Extracurricular Domain
The extracurricular domain complements and enhances the academic environment by building upon existing extracurricular MUSC activities to enhance the opportunities for students to work and interact across the different health professions. The following are examples of successful, ongoing extracurricular IP activities.

The Student Interprofessional Education (IPE) Fellowship encourages interprofessional engagement among students and faculty and demonstrates to employers and residency directors that the student has acquired knowledge and skills necessary to be an effective leader in interprofessional collaboration. It consists of a variety of structured and self-directed learning activities. Students must apply for the fellowship and complete program requirements before the fellowship designation is noted on the academic transcript.

The Student Interprofessional Society (SIPS) is a campus-wide student group dedicated to promoting the concept of interprofessional education. Membership is open to all students.

The Presidential Scholars program is intended to enrich the academic environment of the university and allow meaningful interprofessional interaction on a broad range of issues that transcend discipline and professional boundaries. The scholars program is a two-semester experience for approximately 40 selected IP students, joined by selected faculty scholars from each college. The program explores complex social, political, and human issues of broad interest to healthcare professionals and biomedical researchers in a format that maximizes student participation and interaction.

AHEC and Collaborative Learning Experiences
South Carolina AHEC Program Office staff members, who have faculty appointments at MUSC, have a seat at the table for three of the C3 steering committees. Faculty with strong AHEC affiliations are also involved with IP clinical rotations and preceptor development on campus and in affiliated university practices. Our regional AHEC Center Directors and Community-Based Student Education (CBSE) Coordinators also participate in several on-campus activities and IP experiential planning sessions. Many of the IP activities that were developed by MUSC faculty have been pilot tested and extended into the community by the four regional South Carolina AHEC centers. For more than 20 years, the South Carolina AHEC has been involved in transferring classroom lessons to community practice.

Current Community-Based IPE Experiences
The South Carolina AHEC provides community-based IP training opportunities for health professions students. During these training experiences, students are exposed to the concepts of IP team care and population health. The South Carolina AHEC provides students with the opportunity to participate in the Interprofessional Service Learning Project (ISLP) and the Rural Interprofessional Student Experience (RISE).

The ISLP provides for year-round experiences and seeks to incorporate an IPE experience into community-based rotations for groups of students in selected geographic areas. ISLP rotations focus on issues that have public health implications. In 2007, ISLP began partnering with the MUSC Junior Doctors of Health (JDOH) Program, which is an interprofessional program working with underserved youth. Activities encourage healthy habits and pursuit of careers in health care or biomedical research. The JDOH program extends to the high school level the goal of building an academic pipeline and helping students develop leadership skills. Students placed in an ISLP site participate in didactic and clinical educational experiences. Public health educational content is incorporated into the rotation, including community-responsive health improvement projects. To date, almost 300 IP students have participated in JDOH projects across the state.

Funded by the U.S. Department of Health and Human Services, the Rural Interprofessional Student Experience (RISE) was developed by the MUSC Division of Physician Assistant (PA) Studies in 2010. RISE provides PA students with an intensive two-week opportunity that helps them transition from the classroom to the clinical phase of their education by providing an introduction to the front-line healthcare delivery system, exposure to rural and medically underserved communities, and IP experiences across the state. South Carolina AHEC’s videoconferencing network allows students on community rotations to participate in discussions with faculty on the MUSC campus. The students also have the opportunity to interact with clinician role models in rural practices before the end of their RISE experience. Fifty-five percent of the students in the first PA class to participate in RISE (n=63) work in primary care, 56% are in Health Professional Shortage Areas (HPSAs), and 44% are in Medically Underserved Areas (MUAs), with 26% practicing in rural areas. This compares with the national averages as reported by the American Academy of Physician Assistants of 35% in primary care and 16% in rural areas.

Lessons Learned
Health care is changing in significant ways, and the next generation of clinicians needs to be prepared for these changes. Interprofessional practice, quality improvement, and population health are becoming increasingly important. The accreditation standards for many health professions training programs now include requirements for IP collaboration and education (www.aptrweb.org/?page=crosswalk). Students need to have the opportunity early in their training to work in settings where the health care of the future is being delivered.
An AHEC’s Role in Moving Interprofessional Education from the Classroom into the Community

A seat at the table is important:
It is important for AHECs’ voices to be present whenever IP activities and planning meetings are occurring within the academic arena. An AHEC representative is able to represent the needs of the community it serves. An AHEC representative can advocate for the academic experiential coordinators to work closely with practices and support efforts to develop IP models of healthcare delivery outside of the academic medical center. And, by being present during discussions regarding grant and funding opportunities, the AHEC representative can discover areas where collaborations with the AHEC centers can add strength to the proposal.

A learning environment suitable for IPE development is essential:
It is essential for the faculty members from different disciplines to embrace and support IPE. Based on the patient-centered medical home concept, the goal is to provide students with the opportunity to model the desired IP behaviors. For students participating in IP activities such as JDOH or IP Day, it makes sense to have at least three student and faculty disciplines involved. However, if the student is being immersed in an IP experiential setting, then it does not require students from other professions to be involved as in the RISE program.

Students should participate in an overview or short-term IPE activity and be provided multiple opportunities for elective experiences. Ideally, practice-based immersion experiences will become more readily available as IP collaborative practice is embraced by healthcare professionals.

Establish and encourage creative partnerships:
The South Carolina AHEC’s involvement with its host academic medical center has facilitated the introduction of innovative educational approaches that originated from pioneering efforts at MUSC beginning in the late 1980s. The AHEC faculty and staff have been involved in university and national committees that have had an IP focus. The South Carolina AHEC faculty members initiated and currently coordinate IPE meetings that focus on collaborative approaches to community-based education. Regional AHEC Center Directors also serve on academic health center IPE committees and are charged with developing robust IPE activities for CBSE students.

Supplementary funding will be needed:
Most of the IPE activities described in this article have been initiated with grant funding. Until interprofessional clinical teams become standard in the delivery of health care, IPE opportunities will need to be developed and supported. AHEC centers should be proactive and look for sources of funding to cultivate IP initiatives, including foundations and the Health Resources and Services Administration (HRSA). Actively partner with academic health centers that are seeking funding to develop their IP curriculum. The infrastructure and insight provided by an AHEC can contribute greatly to an academic health center’s IPE proposal and participation in funded IPE activities could serve as an additional funding source for AHEC programs and centers.

Conclusion
In light of the trend toward interprofessional education and collaborative practice, it is important that AHECs encourage and facilitate IPE experiences as much as possible. The following are areas where AHECs can support the creation of stronger community-based IPE experiences: 1) Identifying and supporting excellent clinical sites for students that are recognized patient-centered medical homes, 2) Building and sustaining relationships with clinical practices that serve as premier learning laboratories for students, 3) Maintaining an ongoing relationship with IP teams working in precepting practices so they remain aware of the critical role they play in educating students about interprofessional collaborative care, 4) Partnering to provide incentives and rewards for clinical practices that will encourage their participation as model teaching sites, and 5) Working with academic centers to create faculty development continuing education programs that advance IP practice and education.

The South Carolina AHEC has been able to forge alliances with faculty members in academic health centers, with rural preceptors, and with technology specialists to keep IPE in the forefront of most new endeavors. Leveraging academic and community partnerships has allowed the South Carolina AHEC to develop an infrastructure for moving students from academic-based IPE activities into IP practice settings. In our experience, the South Carolina AHEC’s involvement and available resources make a significant contribution to the creation and implementation of IPE experiences for health professions students throughout our state.

REFERENCES


Medical University of South Carolina Creating Collaborative Care (C3) [http://academicdepartments.musc.edu/c3/]
The Interprofessional Team Seminar: A Curriculum Designed for Medical Students

Fred Rottnek, MD, MAHCM; Kelly M. Everard, PhD; and David Pole, MPH

Individual patient care and navigation of the healthcare system today is complex. There are multiple healthcare professionals involved in the care of patients who contribute aspects of specialized care, yet the overall experience is often fragmented and lacks coordination (Young & Cosgrove, 2012). The combined aspects of complexity and lack of coordination also contribute to the high cost of health care in the U.S. and the lack of quality patient outcomes. Interprofessional patient-centered collaborative practice is envisioned to provide more effective and efficient care and is seen as a mechanism for improving patient outcomes. (King, Shaw, Orchard, & Miller, 2010; Baker, Egan–Lee, Martimianakis, & Reeves, 2011). The notion of interprofessional education (IPE) and interprofessional collaborative practice (IPCP) is not novel (Lavin, Ruebling, Banks, Block, Counte, Furman, Miller, Resse, Vielmann, & Holt, 2001), but the integration and practice of effective programs for IPE and IPCP are not yet integrated on a system-wide level (Pecukonis, Doyle, & Bliss, 2008).

The 2001 Institute of Medicine (IOM) report, Crossing the Quality Chasm, described the condition of the healthcare system as failing to provide the health care needed by all the people of our country and concluded that the system needed a complete redesign (Institute of Medicine, 2001). One recommendation to address the problem was that patient care should be provided by interprofessional teams. The 2003 IOM report, Health Professions Education: A Bridge to Quality, explicitly called for all health professionals to be trained to deliver care as a member of an interprofessional team (IOM, 2003). Since that time, educators have been trying to determine the best way to provide IPE to prepare students for IPCP. IPE refers to occasions when students from two or more health professions learn about each other, with each other, and from each other to improve collaboration and quality of care (Centre for the Advancement of Interprofessional Education, 2002; IOM, 2010). IPCP refers to healthcare practice in which there is collaborative, interdependent use of shared expertise directed toward a unified purpose of delivering optimal patient care (Interprofessional Education Collaborative Expert Panel, 2011).

Many academic health programs across the United States have been developing and implementing IPE programs. The Journal of Allied Health highlighted 10 such programs in the fall of 2010 (Interprofessional Education and Care, 2010). There are many different types of programs that are described as providing IPE, and the health professions participating vary by institution, including programs for students from nursing, midwifery, occupational therapy, physical therapy, and nutrition and dietetics programs (Williams, Brown, McCo, Boyle, Palermo, Molloy, McKenna, Scholes, French, & McCall, 2011); dental, health administration, occupational therapy, pharmacy, physician assistant, physical therapy, and psychology programs (Buhler, Farrell, Fuentes, Scott, Shaffer, & Von, 2011) nursing and medicine (Brashers, Peterson, Tallmann, & Schmitt, 2012); and medical laboratory science, respiratory therapy, and diagnostic cytology and genetic technology programs (Bandali, Craig, & Ziv, 2012). Few programs include medical students. According to a recent survey of internal medicine clerkship directors, most agree that IPE should be included in the clerkship. However, very few have implemented IPE (Liston, Fischer, Way, Torre, & Papp, 2011). The major barriers to implementing IPE were scheduling alignment and time availability in the existing curriculum.

Health professions education programs know that creating lasting cultural change requires effective didactic and experiential training opportunities in the formative years of the health professionals’ education (Gilbert, 2005). Likewise, there have been proposals to revise the process and methods of continuing education programs for practicing health professionals to improve the translation of new information into practice and improve life-long
learning (Macy Foundation Report, 2011). The Journal of Interprofessional Care published a supplement in May of 2005 focusing on IPE and the challenges of implementing IPE into medical education. Barriers to developing meaningful interprofessional educational experiences can be structural: training schedules differ by professions in time, location, duration of training and integration of theory and practice; logistics of space and facilities for students from multiple programs; and readiness of the health professions programs to have the IPE be an integrated component of their professional program versus a stand-alone separate unit. Additionally, challenges include varying levels of faculty knowledge and skill level at implementing IPE, ability to facilitate small-group discussion, and confidence in working with students from different professions. Even if students can come together to learn, they encounter cultural barriers between health professions training programs that need to be addressed. The educational goals of each health profession program also differ in accord with their accreditation and licensing body and how they want to address and integrate IPE.

The 2003 IOM report on health professions education acknowledged that an important factor in redesigning the broken healthcare system was the need to address practitioners being required to function as members of interprofessional teams while still being trained in silos, separated from other professions, and not being trained in team-based skills (IOM, 2003). This goal of interprofessional education and the new competencies for interprofessional collaborative practice that were issued in 2011 were designed to prepare health professionals to effectively work together to build a safer and better patient-centered healthcare system (Schmitt, Blue, Aschenbrener, & Viggiano, 2011).

In this paper the unique St. Louis University (SLU) Interprofessional Team Seminar (IPTS) that was developed and implemented to include medical students is described. IPTS has just completed its fourth academic cycle. In addition to describing the program, lessons learned and revisions that have been implemented over the years to overcome challenges and respond to student and faculty feedback are discussed.

History of Interprofessional Education at SLU

In 2006, SLU embedded five IPE courses into its baccalaureate–entry health professions programs at the School of Nursing and the Doisy College of Health Sciences (Lavin et al., 2001). The IPE curriculum included large-group and small-group activities and addressed the following topics: Introduction to IPE and Teamwork, Healthcare Systems and Health Promotion, Evidence-Based Practice, Applied Interprofessional Ethical Decision-Making, and a Community-Based IPE Team Practicum (Royeen, Jensen, Chapman, & Ciccone, 2010). By 2009, approximately 1,500 students enrolled in the health professions programs were engaged in the SLU-IPE curriculum, including students from athletic training (60), clinical laboratory science and investigative medicine (89), cytotechnology (8), nuclear medicine technology (37), nursing (613), nutrition and dietetics (102), occupational therapy (117), physical therapy (425), and radiation therapy (38) programs.

At the same time IPE was being introduced into the health sciences curriculum, attempts were made to introduce IPE to medical students at SLU. The SLU Area Health Education Center (AHEC) Program Office sponsored the development and implementation of an elective in 2003 on the interprofessional care of medically underserved populations that included students from medicine, nursing, physical therapy, social work, and public health programs. First-year medical students participated in this elective, which was offered in the evening because there was no time during the day when all health professions students could meet. The small number of medical students who did participate often engaged further in underserved communities and were open to collaborating with other professions to meet the community's needs. This elective course continued through the 2006–2007 academic year.

In 2007-2008, the dean for curriculum at the SLU School of Medicine (SOM) felt it was important for all medical students to address topics of disparities, barriers to care, cross-cultural care, and working with other health professionals. Six modules were added to the first-year "doctoring course" called Patient, Physician, and Society (PPS-1). Students from multiple health professions attended lectures together and the course encouraged small-group discussion with different health professions students during the didactic sessions. There was a panel discussion with faculty from multiple health professions on their roles in a complex patient case, and a few separate small groups where students from multiple professions worked through cases addressing barriers to access based upon insurance status and understanding a little more about the roles of different health professions in the care of a complex patient case. There were mixed and poor reviews from medical students regarding these sessions. Upon reflection, the course directors realized that the session design did not meet the definition of IPE, which requires students learning about, with, and from each other regarding improvements to patient care. In this course, students from multiple professions were hearing a lecture at the same time but had limited interaction and no explicit learning objectives about IPE or collaborative practice.

Due to the challenges of trying to effectively address IPE with all the different health professions schedules, the dean for curriculum asked the AHEC and IPE program faculty to revise and take leadership of the course for the following academic year. The dean also suggested that medical students may be more receptive to the IPE concepts once they enter the clinical stage of their training and were working with other professions in a clinical setting. The importance of interprofessional care did not resonate with medical students during their preclinical years and there was no context or
other reference in the medical school curriculum to support 
IPE integration.

The new AHEC course directors assembled an 
interprofessional faculty to assist with the curriculum 
planning. They started with the premise that in order to 
develop a true IPE learning experience, faculty from the 
different professions must be engaged in the development 
and teaching of the material. They also decided as a planning 
team with the SOM dean for curriculum that the course 
would better serve the medical students if it was moved to 
their third year, as the different health professions students 
in the course would be in a similar place in their training and 
hopefully have clinical experiences with other professions 
that would support the application of IPE. The initial 
IPE/PPS-1 course was designed with sessions focused on 
access, disparities, barriers, cultural competency, and health 
literacy. During this curriculum revision, the focus of the 
sessions was changed to 
patient care and outcomes, 
with IPE themes embedded 
into patient cases, to be more 
immediately relevant to the 
medical students. In terms of 
the structure, the time 
spent in lecture and large-
group activities was reduced 
and instead small-group 
discussions and interactions 
facilitated by faculty members 
of all the professions involved 
was emphasized.

During the revision of this 
course for the 2008-2009 
academic year, the course 
directors drew upon lessons 
learned from the other IPE 
programs at SLU that had 
been implemented at the baccalaureate-entry level since 
2006. The new course that was implemented at the medical 
school in 2008-2009 was designed as an Interprofessional 
Team Seminar (IPTS) at the post-baccalaureate/professional 
training level. Designed with the medical student in mind, 
the IPTS course would eventually bring together over 600 
students from seven professions who were engaged in the 
clinical training phase of their programs in medicine, nursing, 
physician assistant (PA), social work, physical therapy (PT), 
occupational therapy (OT), and pharmacy. The remainder of 
this article chronicles the development of IPTS over the last 
four years along with lessons learned, initial evaluations, and 
future directions.

IPTS Year One: The Pilot (2008-2009) 
In the pilot year, IPTS was introduced as an elective for 
third-year medical students who met once a month for seven 
months (September to March), with each session lasting two 
hours. As an incentive for participation, medical students 
received one week of fourth-year elective credit. To minimize 
the disruptions that can occur when students leave clinic 
early, the seminars were scheduled on the same day that all 
third-year medical students returned to campus for their 
Basic Science Clinical Correlation Conferences. In 2008- 
2009 logistics were only able to be coordinated for students 
in the medicine, nursing, and physical therapy programs, but 
the course development team included representatives from 
medicine, nursing, PT, OT, PA, and social work. The initial 
IPTS course had 160 students from the three professions who 
were divided into 15 groups. Faculty from each profession 
and members of the planning team facilitated these groups.

The course directors developed the IPTS as a two-semester 
curriculum with four sessions in the fall and three in the 
spring semester that introduced IPE and had students work 
through complex patient cases. The first session started with 
a large-group session on teamwork and communication 
followed by small-group sessions where the students 
introduced themselves, their health professions’ scope of 
practice, and their reasons for choosing their professions. For 
the remaining three sessions in the fall, a case-based format 
was used. Each session had a two-part format where 
students were grouped by health profession and huddled 
to address the theme related to 
a patient’s care (e.g., creating a 
treatment plan, breaking 
bad news to a patient and 
family, identifying barriers to a 
patient’s health maintenance). 
Each group presented from 
their own perspective, and 
then all groups convened as 
an “interprofessional team” to address the issue through 
negotiation of priorities and patient perspective.

In the second semester, emphasis was shifted to 
interprofessional teamwork and common issues affecting 
outcomes in interprofessional care. Small-group exercises 
included a session with a standardized patient, a simulated 
office visit, and a discussion of working with challenging 
patients in clinical settings. Embedded within the clinical 
cases were issues of race and bias, low health literacy, 
negotiating the agenda of a patient visit, and investing in a 
patient relationship. Throughout the year, students were 
given assignments to recap each session and to prepare for 
the next session that included journal articles related to the 
embedded themes in the case, IPE, and online modules from 
the TeamSTEPPS training on interprofessional teamwork 
(Agency for Healthcare Research and Quality [AHRQ], 
2012).
Since the IPTS teaching format and the IPE learning objectives were new for many of the faculty facilitators, a 30-minute faculty development session was planned to be held prior to each seminar. During these faculty development sessions the content of the day, the case, and the didactic techniques useful for that session were outlined and reviewed. Facilitators were encouraged to share their own clinical experiences while leading the discussions. The faculty development sessions were also used to discuss progress with each small group, challenges and issues, and techniques that faculty found to be most effective.

Due to the nature of the pilot course, several forms of feedback were utilized including end-of-course evaluations from students and facilitators, informal conversations with students and faculty following each session, and a facilitator’s post-course discussion. Enrollment in the 2008-2009 IPTS pilot included 30 medical students, 69 physical therapy students, and 67 accelerated bachelor of nursing students.

Lessons Learned from Year One
Positive student feedback indicated that the course was on the right track. Medical students rated all the seven sessions individually between 4.2 – 4.7 (on a 5-point scale where 1 was “unacceptable” and 5 “excellent”). Other evaluation measures indicated that medical students increased their understanding of other professions’ scope of practice (4.1) and increased their ability to identify other professions they want on their care team depending upon patient needs (4.4). Evaluation measures with lower ratings included the value of readings and assignments relating to small-group discussions (3.2) and the development of skills that were valuable to future practice (3.7). All of these items were rated on a 1 to 5 scale where 1 was “strongly disagree” and 5 “strongly agree.” The faculty facilitators provided much feedback over the course of the year about opportunity for discussion and discovery within the small-group sessions. As trust developed within the groups, students discussed each other’s unique and shared experiences in training such as hospital politics, challenges learning under disparaging instructors, and the cost of education. Medical students in particular discussed the lack of opportunities to process patient care experiences, the burden of debt and its influence on specialty choice, the sacrifice of personal and family goals due to professional pressures and responsibilities, and the challenges of taking on increasing levels of responsibility in the course of training. Finally, the discussion unexpectedly uncovered more aspects of professional socialization, professional stereotyping, and professional silo practice that occur in the various health professions programs. Nursing students perceiving that physicians feel they know everything; medical students perceiving that if pharmacy students were that smart why didn’t they become physicians; PT students frustrated by requiring “doctors’ orders” and the physician having no training or experience (not knowing what they are prescribing) in musculoskeletal evaluation and treatment.

Suggestions for improvement for the next year included assigning additional reading from the non-medical professions, adding students from other health professions (particularly OT, PA, and social work) in the groups, and creating more explicit teaching suggestions and guidelines for the facilitators for certain sessions. Finally, due to comments from students that the take-away message was “we all have to get along better,” the course directors realized that they needed a stronger framing tool for IPE and IPCP, which was to improve interprofessional collaboration and communication in order to improve patient safety and outcomes.

The faculty development sessions themselves proved an invaluable and enjoyable aspect of the course. Not only were the course directors and the facilitators able to work as an interprofessional team in developing the course, many expressed that it was their only opportunity to work together interprofessionally and that such work resonated strongly with their ideal vision of clinical practice. Also, the sessions provided facilitators with the skills and confidence they needed to lead groups of students from different health professions and with specific IPE learning outcomes.

IPTS Year Two (2009-2010)
In year two, the IPTS continued as an elective for medical students (30), and included students from nursing (68), occupational therapy (70), physical therapy (70), physician assistant (31), and social work (7) programs. Year two also included a pilot group of 30 students from the St. Louis College of Pharmacy (an independent institution unaffiliated with SLU) for a total of 306 students. Planning meetings were held with instructors from each health profession to make the objectives and outcomes for each seminar more explicit, and recruitment of facilitators was expanded to all seven professions so students were split into 22 groups representing at least five of the professions. Based on evaluations from year one the following revisions were made: decreased the number of sessions to six; dropped the expectations for the on-line discussion; created more specific objectives for the 30-minute faculty development sessions to focus discussions on skills building for facilitators (e.g., working effectively with standardized patients); increased the use of standardized patients; and made the explicit purpose of IPTS to improve patient safety and outcomes. The first session began with a patient testimonial from a TeamSTEPPS representative regarding errors and adverse outcomes leading to the permanent disability of her son and the death of her husband and the clear message that the adverse outcomes were not one person’s fault, but that any one person could have stopped the cascade of terrible events.

Lessons Learned from Year Two
Course evaluations from the medical students remained generally positive. Students thought the faculty was well prepared for the sessions and overall rated the value of the course highly (4.5 and 4.1 respectively on a 5-point scale where 1 was “unacceptable” and 5 was “excellent”).
As expected, year three was a challenge and the lessons learned were plentiful. Not surprisingly, the greatest challenge came from medical and pharmacy students who were now required to take IPTS.

Comments were similar to the previous year. Ratings were high for understanding of other professions' scope of practice and allowing for an open discussion of patient care and topics without the fear of being chastised or judged. The students also clearly understood that the issue was patient safety and clinical outcomes, which was an improvement over the previous year where students thought they were supposed to learn to get along. The students identified areas to address for future course development. Some students from the OT, PA, and pharmacy programs were not able to describe their professions' unique scope of practice as well as others or in a manner that expanded understanding for other professions. Students also commented that they needed more clear expectations of the goal behaviors as a result of IPTS.

In addition to changes in content, the logistics of the course were improved. Changes included scheduling that better suited all programs and facilitator guides that included outlines for resources to provide additional information to help guide the discussion. IPTS for medical students was a stand-alone course that had goals and objectives outside of those for their clerkships. The other six professions, however, integrated IPTS as required seminars within an existing course and revised course learning objectives to include IPTS. This difference has proven to be a significant one that influenced the outcomes and student perceptions of how IPE is integrated into their preparation and formation as future practitioners.

**IPTS Year Three: A Pivotal Year (2010-2011)**

The dean of the SOM requested that the IPTS become a required course for all third-year medical students at SLU, expressing both a commitment to IPE at SLU and a response to the positive student and faculty feedback. At this time the dean was also appointed the SLU Vice President for Health Sciences. He convened a standing meeting with the deans from all the health professional schools to discuss IPE and how to advance SLU in the leadership and practice of both IPE and collaborative clinical practice. Likewise, the dean of the St. Louis College of Pharmacy made IPTS required for all fifth-year pharmacy students. While this commitment to IPE and IPTS was a significant vote of confidence for the course, it also created challenges. IPTS expanded to include over 600 students from seven professions, requiring a doubling of faculty facilitators to accommodate the increase from 22 to 44 small groups and utilizing classrooms across the entire health sciences campus. Small-group session dynamics would also shift with a larger portion of the groups comprised of medical and pharmacy students. The recruitment of medical school and other faculty was expanded and the search was opened to include community practitioners. The increase in the number of small groups also required the expansion of faculty development and small-group facilitation skills training for facilitators. Faculty members from each profession were asked to review the cases and propose additions or revisions to the patient problems or care plan that would engage their students; they made only minor adjustments to the cases. Faculty were recruited from each health profession based on the proportion of their students participating in the IPTS to share the teaching responsibilities equitably across the professions. A lack of physical space for this increased number of small groups resulted in the division of the course into A and B sessions in consecutive weeks with each session running twice with a different set of 300 students and 22 faculty facilitators. Each small group had students from four or five health professions.

**Lessons Learned from Year Three**

As expected, year three was a challenge and the lessons learned were plentiful. Not surprisingly, the greatest challenge came from medical and pharmacy students who were now required to take IPTS. Course evaluations from the medical students reflected this and the overall value of the course was rated by them at 2.5 on the 5-point scale. However, the same kind of resistance was seen from the other health professions students when IPE was first required in the SLU baccalaureate entry programs. The prior experience of the IPE program faculty realizing that the negative student comments were normal was valuable. The comments would diminish over time as the cohorts who experience IPE as an embedded part of the curriculum learning objectives progress through their academic and clinical training. The hope was that the experience with the medical and pharmacy students would be similar.

Another observation made during this transition was that not all students were at the same level in their clinical training. Some students had more clinical experience than others and, as a result, they had differing skills for contributing to the discussion or answering clinical questions. Students with more clinical experience found this difference frustrating, which reinforced their perception that IPE was of little help to them. The imbalance of professions in the small groups, now with five medical students and five pharmacy students in a group of 15 students, made it possible for some
students to fade into the background or others to dominate the discussion. The faculty development sessions continued to be held prior to each session and were valuable for the health professionals to share ideas. They learned to be better facilitators and how to represent the roles of the different professions to draw students into the discussion.

**IPTS: Year Four (2011-2012)**

In 2011, the Interprofessional Education Collaborative (IPEC) issued Core Competencies for Interprofessional Collaborative Practice (Interprofessional Education Collaborative Expert Panel, 2011). During the end-of-course facilitator evaluation session for 2010-2011, the course directors identified 13 core competencies from the four domains that related explicitly to the learning objectives of the IPTS. The IPEC competencies enabled the discussion to move from reacting to student evaluations and feedback to discussing how the learning activities could be adjusted to better achieve the competencies. It was found that the concepts were included in the structure of the course, but student feedback indicated that faculty was not being as effective at using the cases to accomplish the learning objectives. The faculty also indicated that they, too, sometimes lost focus on how the sessions were different or what the focus point of the session was and they felt like they were duplicating previous session key messages.

In year four of IPTS, faculty focused even more explicitly on safety and patient clinical outcomes as the product of IPE. They utilized the Teach Back and Situation Background Assessment Recommendation (SBAR) techniques from the AHRQ toolbox (2010) as part of the seminars and students practiced using them either with the standardized patient or with each other. The specific activities students did outside of class were eliminated and instead they were asked to bring in cases from their own clinical experience to discuss with the group. By this time, facilitators had had valuable experience with these students and offered to provide training and feedback for new facilitators. A new session was introduced at the end of the year with cases based on real lawsuits, readmissions, deaths, and injuries that resulted from poor communication among healthcare teams.

**Lessons Learned from Year Four**

As was hoped, year four demonstrated a cultural change among the medical students regarding IPTS. The students realized the course was now part of their expected third-year experience. Evaluations became more positive and comments became more meaningful and useful. A new 4-point scale was used for the evaluation for year four of the IPTS. Course evaluations from the medical students reflected this and they rated the overall quality of the course as 2.8 on a 4-point scale where 1 was unacceptable and 4 was excellent. In order to compare the rating from year three to year four, the rating from year four was multiplied by 1.25 to create an equivalent rating on a 5-point scale. The scaled rating is 3.5, which indicates an improvement in the overall quality of the course from year three (2.5) to year four.

A focus group with third-year medical students resulted in some very concrete suggestions for improving the course and making it more relevant for their training experiences. They suggested using chart notes from all health professions rather than interviewing standardized patients and increasing the number of patients discussed. Students also wanted sessions where they learned conversation skills to broach uncomfortable topics like poor care resulting from bias or ignorance of IPE principles. These suggestions will be implemented in the course for the next academic year.

**Future Directions for IPTS: Year Five and Beyond**

The Interprofessional Team Seminar remains a work in progress. Faculty are confident that they have a successful curriculum that has the support of the institution, is sustainable, and can effectively teach the concepts and values in IPE that lead to IPCP. The next steps include creating an evaluation to measure outcomes; introducing IPE earlier into the medical school curriculum; increasing student exposure to interprofessional practice; developing a universal resource for course directors, faculty course advisors, facilitators and students; and introducing other health professions at SLU into the mix.

**Conclusion**

Until medical students are effectively integrated into the IPE experience, IPE will not attain its goals. The SLU course, the IPTS, is one means of creating value for IPE in the minds of medical students. While the process has taken years of planning and implementation, outcomes are demonstrating that medical students are seeing the importance of IPE, particularly in its goal of IPCP and its emphasis on increased patient safety and better clinical outcomes. The lessons SLU has learned the hard way can be adapted so that others can build effective IPE programs.

**Creating an IPE Course with the Medical Student in Mind: The SLU Model**

1. Assess the institutional and cultural barriers, your starting point
2. Identify administrative support in the SOM, a champion in Curricular Affairs, and faculty who advocate IPCP
3. Build on successful programs if IPE is established somewhere on your campus
4. Build on working relationships with faculty and administrators from other curricular projects
5. Use patient case studies to embed IPE principles and values
6. Emphasize student work in small interprofessional groups, facilitated by faculty and community preceptors, preferably with IPE experience
7. Engage in IPE faculty development, addressing small-group facilitator skills and reviewing strategies that work best in your culture
The Interprofessional Team Seminar: A Curriculum Designed for Medical Students

8. Emphasize course and class objectives clearly and repeatedly: The ultimate goal of IPE is THE DEVELOPMENT OF Interprofessional Collaborative practices that increase patient safety and result in better patient outcomes.

9. The IPTS equation: Clinical Skills x Teamwork Skills = Improved Patient Clinical Outcomes and Increased Safety

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In South Dakota, Interprofessional Student Experiences are Key to Bolstering Rural Care

Cheri Buffington; and Sandra Stockholm, MPA

Rural South Dakota sets the stage for a lesson in defining community. Access to a four-week, interprofessional experience in a rural community has demonstrated that health professions students gain a greater understanding of their roles and the roles of the other healthcare team members around them. This positive experience is one factor that leads them into rural healthcare careers.

In small towns, coordinated care is not a new concept; it has been the practice since the day the town doctor hired a nurse to assist, since the hospital opened, and since lab, radiology, housekeeping, and admitting staff worked side-by-side in one building. Interprofessional care has expanded through technology by bringing outside providers right into the hospital setting.

The two primary objectives of the Rural Experiences for Health Professions Students (REHPS) Summer Experience Program at the Yankton, South Dakota Rural Area Health Education Center (YRAHEC) are to increase the number of health professions students who have had a positive experience in a rural South Dakota setting and to promote interprofessional learning. Both objectives work toward a goal of increasing the number of practicing professionals in rural South Dakota. After completing its third year in 2013, the REHPS Summer Experience program now has graduates returning to rural areas to begin their careers.

"I was afraid that following an MD as a PharmD student may not help me a lot, but it’s taught me a lot about collaborative medicine," wrote Alyssa Osborn, a 2012 REHPS participant in Redfield, SD. Osborn has accepted employment as a clinical pharmacist in Redfield upon graduation in 2014.

Another Perspective Enriches the Experience
After hearing positive reports from participating communities in year one (2011) of the program, it became clear the students benefited greatly from the interprofessional experience. Students from multiple disciplines learned from each other, and having preceptors outside of their chosen field gave them the ability to discuss various options for treatment in a comfortable atmosphere. The interprofessional aspect of REHPS enhanced communication and understanding of each other's role.

The YRAHEC REHPS program finished its third year in 2013 and marked the end of its Health Resources and Services Administration grant award. Program staff members are searching for funding to keep healthcare students connected to rural South Dakota and this unique interprofessional opportunity. Additional grant dollars could expand the number of disciplines served. In 2014, 12 communities will host 24 participants.

Since 2010, 36 health professions students attending South Dakota State University (SDSU) and the University of South Dakota (USD) have been paired at “Best Practice Model” sites across the state. These communities specifically request and welcome students from different health professions disciplines. A host of preceptors including physicians, dentists, pharmacists, physician assistants, laboratory technicians, physical therapists, and long-term care providers interact with the two students, providing a framework for the continuum of care. In a short time, the students realize that...
rural healthcare professionals take the lead in many roles both in the facility and in the community.

“The REHPS program reinforced to me the importance of small-town medicine,” said Tia Haines, a 2012 REHPS participant. “Rural medical clinics are the foundation for routine wellness and medical care, and I am honored to be able to contribute to the well being of rural South Dakotans.” A USD School of Health Sciences graduate, Haines, a certified physician assistant, now works at the Avera Geddes, South Dakota and Avera Platte, South Dakota medical clinics. During her REHPS experience, Haines mentioned that she was able to experience aspects of medicine that she would normally not experience during her regular physician assistant rotations.

She is not alone in that sentiment. The Best Practice Model sites bring REHPS participants to a variety of situations regularly experienced in a rural healthcare facility. Early on in the REHPS program, students identified three main preconceived notions of rural health care: lack of technology, distance from major populated areas, and the feeling of being “out by yourself.” One determinant of success identified for the REHPS program was to provide students with a positive experience, which included exposure to a variety of healthcare situations, especially those they do not encounter during their course of study.

REHPS participants expressed that their summer rural experience was unlike anything their classmates experienced in urban areas. As a result, the REHPS students reported that it opened their eyes to the many opportunities in rural primary care.

“From atrial fibrillation to head trauma, the afternoon was packed with ER (emergency room) patients. It was amazing to see how all the X-ray technicians, medical assistants, nurses, and doctors worked together to treat each patient. I got to look at X-rays, labs, and medication sheets to determine what each patient had going on,” Amber Zemlicka wrote during her 2013 REHPS experience. Zemlicka is a pharmacy student at SDSU in Brookings. In the course of traditional training, she would not have been a participant in the review of labs and X-rays.

At the conclusion of her experience in Custer, SD, Zemlicka wrote: “It is really interesting when you see something begin in the clinic, a culture created in the lab, and end with the patient receiving a prescription in the pharmacy. … By participating in this program, I feel like I have had a better hands-on experience in all aspects of health care.”

Blending the Interprofessional Mix of REHPS Participants
The REHPS Summer Experience Program helps place health professions students from South Dakota universities with preceptors established in rural or frontier areas of the state. Medical and physician assistant students from USD in Vermillion, SD and pharmacy and doctor of nursing practice students from SDSU in Brookings, SD make up the interprofessional mix of participants. The program has expanded from three sites in 2011, to six in 2012, and to nine in 2013. To apply for the REHPS Summer Experience, students submit a resume, letter of recommendation from a current professor, and an essay. A selection committee scores the applications. Committee members consider applicants’ healthcare and volunteer experience, goals, life experiences, and attitude toward pursuing a rural healthcare career. Applicants detail how participating in REHPS would further their goals. The committee assigns students from different disciplines for each Best Practice Model site. The REHPS program manager coordinates the experiences by working closely with universities, facilities, communities, and students. After securing facilities to host students, the program manager meets with all participating health professions disciplines to encourage participation and to stress the interprofessional opportunity provided by the program. The program manager ensures that facilities and communities are able to provide housing, meals, and community involvement opportunities for the participants. The program provides a unique recruiting tool for rural communities, where residents work hard to sell their towns as places to live and work.

A Rural Environment Naturally Encourages Interprofessionalism
South Dakota is a rural and frontier state in which geography plays a huge role in the accessibility of quality and affordable health care. Many times people travel in excess of 100 miles to seek medical care. Access to primary care is a serious problem due, in part, to travel distances and supply and demand factors associated with the healthcare workforce. For example, there are significant distances between healthcare services in rural areas and tertiary care providers in the two largest cities, which are located at opposite ends of the
In South Dakota, Interprofessional Student Experiences are Key to Bolstering Rural Care

Tia Haines participated in REHPS at Winner, SD in 2012. Tia, a certified physician assistant, now works at Avera Geddes and Avera Platte Medical Clinics. Her REHPS partner in Winner was Justin Cunningham, a college of pharmacy student from South Dakota State University.

state. This challenges access to care for an array of medical conditions and requires team approaches to care.

“The Avera eConsult is just one of the several ‘e’ services that the Platte Health Center has,” Erin Rasmussen, a medical student from the USD Sanford School of Medicine, said during her 2013 REHPS experience. “These services connect Platte with physicians and other healthcare professionals and resources in Sioux Falls, showing how technology is allowing rural areas to enhance their care and services with additional and expanded help. It is quite an advanced technology that adds another set of eyes and additional health provider review for the patients presenting with various health issues at that facility. It also allows patients to avoid having to travel to Sioux Falls for some of their appointments.”

Rural Areas Need Providers
Although South Dakota’s rural areas are defined as medically underserved, students are quick to see the quality and progress being made in the program’s Best Practice Model sites; so much so, many picture their professional careers centered on attending to the medical needs of rural people in the near future. Many REHPS participants are still completing their education, and six students returned to REHPS sites for further rotations. Five prior participants are now practicing in rural or underserved areas. These are encouraging developments, because healthcare professionals (such as primary care physicians, physician assistants, nurse practitioners, and pharmacists), are in short supply in rural South Dakota. This soon will become even more significant, as nearly half of these professionals across the state are older than age 45, according to the 2013 Workforce Report from the South Dakota Department of Health. According to the report, 56 of the state’s 66 counties are complete or partial shortage areas for primary medical health care, while 58 counties contain a medically underserved area or community.

The state’s universities also are working to address these shortages. They are active collaborators with the REHPS program. The USD Sanford School of Medicine and Health Sciences Program, along with SDSU’s School of Pharmacy and School of Nursing, support the involvement of their students in REHPS.

Another REHPS Interprofessional Opportunity
The Summer Experience Program is one component of REHPS. Another element prepares healthcare professionals and students for mass casualty/natural disaster situations.

In two years of conducting Disaster Training Day, REHPS and its collaborators have trained 712 students in Core Disaster Life Support (CDLS). Nine South Dakotans received National Disaster Life Support training, including a former REHPS participant. Disaster Training Day also is an interprofessional experience, as it brings together physician, physician assistant, nursing, occupational therapy, physical therapy, clinical lab science, social work, dental hygiene, pharmacy, and advanced practice nursing students. Increasing the number of trained personnel who can manage a disaster event is important to rural medicine in South Dakota, as the nearest regional or tertiary hospital may be up to 200 miles away.

Close-Knit Professional and Rural Communities Promote Optimum Care
The interprofessional experiences gained through the REHPS Program and YRAHEC spark an awareness of rural area needs and a willingness to serve these communities where providers are in touch with technology and their patients. Participants report through journals and surveys that the interprofessional feature of the program helps make it a positive experience.

By participating in the REHPS Summer Experience, health professions students come to understand the rural culture. This helps erase negative perceptions of practicing in rural areas.

Experiencing the various roles of healthcare providers in a rural setting also brings career clarity to students. In 2013 at Sisseton, SD, Ashley Benda, an SDSU pharmacy student, joined Elizabeth Hoffman, a USD Sanford School of Medicine student. Benda said the REHPS experience gave her a greater sense of her role in health care.

“Sometimes you have to take the time to understand what others do before realizing where you fit into everything,” Benda said, “and I’m so grateful that I have the opportunity to complete this experience so closely with a student from another profession.”
Interprofessional Education in a Rural AHEC Region: Multiple Institutions and Multiple Professions Collaborating for Shared Success

Jeff Hartz, MEd

Introduction
Interprofessional education (IPE) “occurs when students from two or more professions learn about, from, and with each other to enable effective collaboration and improve health outcomes” (World Health Organization [WHO], 2010, p. 7). IPE represents a multi-profession, collaborative approach to learning that lays the foundation for health professions students to become future members of interprofessional collaborative healthcare teams, where healthcare providers from different professional backgrounds work together to “deliver the highest quality of care” and “engage any individual whose skills can help achieve local health goals” (WHO, 2010, p. 7). At the highest levels of national and international healthcare conversations, groups such as the WHO, the Institute of Medicine, and the Josiah Macy Jr. Foundation are studying the effectiveness of IPE models and offering sets of IPE standards and policy suggestions. This article looks at how these high-level IPE conversations translate into practical actions at a group of health science degree programs housed across multiple colleges in a rural Midwestern region.

The Changing Conversation on IPE
IPE is now broadly recognized as one of the keys to “safe, high quality, accessible, patient-centered care” (Interprofessional Education Collaborative [IPEC], 2011, p. i) and is seen as an innovative strategy with an important role to play in mitigating the health workforce crisis on both a national and global level (WHO, 2010, p. 7). In recent years the conversation has shifted from whether to do IPE to understanding how to do it well. The goal now is to identify strategies to maximize the learning value of IPE activities and to integrate IPE effectively into a wide range of health professions education programs.

Evidence of this shift can be found in the Association of American Medical Colleges’ (AAMC) Medical School Graduation Questionnaire, where the number of students responding “yes” to a question on whether they participated in required activities involving learning with students from other health professions has trended upward from 65.6% in 2011 to 68.8% in 2012 to 73.4% in 2013 (p. 40). Nearly three out of four medical students in the U.S. are now participating in interprofessional education as a part of their medical school curriculum, and many major health science universities are implementing institution-wide IPE programs across multiple professional curricula.

Overcoming IPE Barriers in a Rural Area
Widespread recognition of the value of IPE does not automatically break down all barriers to developing IPE opportunities for students, however. The IPEC report on Core Competencies for Interprofessional Collaborative Practice identified a lack of institutional collaborators as a key challenge to the implementation of IPE Core Competencies (p. 34), and this issue is particularly significant in rural areas where health professions training often occurs not at a central health sciences university or medical school campus but rather on multiple campuses of different institutions, each with one or two health professional programs distributed widely across the region.

In 2012, five different educational institutions serving as home to eight different health professions degree programs in central and southeastern Indiana sought to overcome this barrier by working in collaboration with the East Indiana Area Health Education Center (EIAHEC) to plan a multi-institution/multi-discipline educational event to introduce students to IPE.

<table>
<thead>
<tr>
<th>Institution</th>
<th>Programs Participating in IPE Day</th>
<th>Student Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Butler University</td>
<td>Pharmacy (Pharm D)</td>
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</tr>
<tr>
<td></td>
<td>MS Physician Assistant</td>
<td>2</td>
</tr>
<tr>
<td>Indiana University - Purdue University Columbus</td>
<td>MA Mental Health Counseling</td>
<td>11</td>
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<tr>
<td></td>
<td>BSN Nursing</td>
<td>19</td>
</tr>
<tr>
<td>Ivy Tech Columbus</td>
<td>AS Paramedic Science</td>
<td>11</td>
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<tr>
<td></td>
<td>AS Medical Assisting</td>
<td>11</td>
</tr>
<tr>
<td>Ivy Tech Madison</td>
<td>ASN Nursing</td>
<td>34</td>
</tr>
<tr>
<td>King’s Daughter’s Health School of Radiologic</td>
<td>Radiologic Technologist</td>
<td>12</td>
</tr>
</tbody>
</table>

Fig. 1. Institutions and Disciplines Participating in IPE Day

Jeff Hartz, MEd, is Outreach Coordinator at East Indiana AHEC.
Interprofessional Education in a Rural AHEC Region: Multiple Institutions and Multiple Professions
Collaborating for Shared Success

Faculty from IUPUC; Butler University; Ivy Tech Community College campuses in Columbus and Madison, Indiana; and the King’s Daughters’ Health School of Radiologic Technology in Madison, Indiana as well as EIAHEC’s Center Director, worked throughout 2012 to develop a regional IPE Day which would serve approximately 100 students drawn from a 50-mile radius around the event site in Columbus, IN. This group of students would include AS students in paramedic science, medical assisting, nursing, and radiologic technology; BS students in nursing, and graduate students from pharmacy, physician assistant, and mental health counseling programs.

Event planning did not begin with a selection process or discussion of criteria for which institutions and programs would get to participate. Rather, it was understood that faculty and leadership at this diverse set of programs all had an important commitment in common—each of them wanted students in his or her program to have access to innovative, educational resources, even if this meant stepping beyond typical institutional boundaries and collaborating with new partners. Thus, the design of the IPE event was shaped in part by a desire to develop an inclusive, effective learning opportunity relevant to all students from this wide variety of health professional paths.

Instructors from the involved programs used the IPEC Core Competencies for Interprofessional Collaborative Practice to develop activities that would serve as an introduction to IPE for the graduate and undergraduate-level student participants. Because of the logistics involved in coordinating the schedules of eight programs across five campuses, the team chose a one-day model with all students traveling to a central location in Columbus, Indiana on March 6, 2013.

Participant Background
As would be expected of a multi-campus, multi-profession group of learners drawn from a rural region, there was much diversity in terms of age, background, and experience amongst the participants. Approximately 40% of the participants were adult learners (defined as over age 25). More than half of the participants were from a rural background, which is significant from an AHEC perspective, as EIAHEC is interested in preparing students likely to ultimately practice in its largely rural region. Approximately half of the participants were from a disadvantaged background, again significant from an AHEC perspective, in terms of preparing students likely to practice with underserved populations.

Finally, while there were many graduate-level health professions student participants (which is not uncommon at health science university-based IPE programs), approximately half of the participants were drawn from associate’s degree-level health professions programs. This included professions such as medical assisting, paramedic science, and radiologic technology that are not frequently included in IPE events (Association of American Medical Colleges [AAMC], p. 41 and WHO, p. 16) but nonetheless have significant roles to play on a healthcare team. Michael Siegel, PhD, Dean of the School of Health Sciences at Ivy Tech Columbus, noted the importance of including these students, stating that “by the nature of their curricular experiences, community college allied health students rarely have the opportunity to participate in activities outside of their professional training.”
Interprofessional Education in a Rural AHEC Region: Multiple Institutions and Multiple Professions
Collaborating for Shared Success

IPE Day
A snowy beginning to the morning of March 6, 2013 did not stop students, some of whom had significant commutes to the site, from arriving at the Columbus Learning Center. Learning activities began when students were divided into 13 interprofessional teams.

First, the students completed two IPE-focused icebreaker activities to introduce themselves to each other and provide an opportunity to learn about their professional roles and contributions to the healthcare team. One of the learning objectives for this event was for students to identify similarities and differences within and between their professions, so these icebreakers fostered dialogue about elements unique to a specific profession or shared amongst several professions. Larry Lynn, MD, Assistant Professor in the Butler University Physician Assistant program, told students, “If you don’t understand the function of everyone on a healthcare team, you can’t fully utilize their skills. Patient care is not optimal if you don’t understand everyone’s role on the team.”

Next, the 13 interprofessional teams worked through a three-part unfolding case study. The case was designed to engage students in understanding the variety of healthcare team roles as they assessed a patient and developed a collaborative plan of care. After teams worked through the case, they presented their care plans and discussed the process of developing those plans. A particular emphasis was placed on identifying issues raised by specific health professions students that were surprises to team members from other health professions disciplines. Participants were also encouraged to note which students of specific professions emerged as leaders in various facets of patient care planning.

Outcomes and Next Steps
Participants completed an anonymous evaluation of the IPE learning activities that included a program/profession identifier question and both Likert-scale and open-ended questions about the IPE learning experience. They also completed a standard EIAHEC evaluation form which included personal identifier information and questions about how the IPE activity impacted their preparation to work with other professionals as well as how it impacted their future practice plans.

Participant reflections indicate that this event was successful in helping students think through the similarities and differences in their professional roles. Evaluation comments were frequent and along the lines of: “We had more skills in common than we realized,” and “We are all working toward the same goal—safe patient care!” Significantly, 86% of participants completing evaluations said they “agreed” or “strongly agreed” that they felt more prepared to engage other health professionals in shared problem-solving.

Because of this initial success, the institutions involved plan to hold a similar multi-institution/multi-discipline IPE event in the spring of 2014 to introduce a new group of students to IPE. They also plan to go beyond this introductory level by developing interprofessional simulation opportunities that will again engage students from multiple institutions and multiple disciplines throughout the EIAHEC region.

Tamara Hall, MSN, RN, Assistant Professor of Nursing at Ivy Tech Community College’s Madison, Indiana campus, said that during the initial conversations about a joint IPE event, she thought she was getting into something that would be a tremendous amount of work to plan. She was “impressed with how well things came together over many conference calls,” since individual instructors were at sites as far as two hours away from each other.

Conclusions and Implications for AHECs
The Health Resources and Services Administration (HRSA) goals for AHEC are to “enhance access to care through academic-community partnerships” and “to promote Interprofessional Education to improve quality of care” (2013), and that is exactly the role that EIAHEC played in developing this IPE Day.

Faculty from the educational institutions involved were the drivers of curriculum development for this event, while it was the EIAHEC that facilitated the relationships and fostered the collaboration necessary to make this IPE event happen.

Participant reflections indicate that this event was successful in helping students think through the similarities and differences in their professional roles.
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Each institution involved had previously partnered with EIAHEC on other projects, so there was a pre-existing sense of trust and of shared regional goals that allowed the various institutions to feel confident in partnering with one another.

AHECs can play a critical role nationwide to eliminate barriers to IPE by bringing together the expertise of faculty in health professions programs across a region in an environment based not on competition for students or for funding but on collaboration to reach shared regional goals. AHECS frequently partner with multiple community and educational institutions in a region for a variety of programmatic aims, from health careers pipeline programs for high school students to veterans’ mental health awareness initiatives for primary care providers. The relationship-building and history of successful collaboration among community partners that happens through AHEC programs can be a catalyst for IPE opportunities that require collaboration and buy-in from multiple education partners across a region.

In reflecting on this successful IPE Day, Rebecca Bartlett Ellis, PhD, RN, Assistant Professor at the Indiana University School of Nursing (which includes IUPUC) said this example of a successful regional IPE event proves that “distance between educational settings does not need to be a barrier in the delivery of Interprofessional Education.” AHECs have an important role to play in bridging both physical and philosophical distances that may be barriers to IPE in a region, because collaborative IPE events bring partners together with an understanding that the teaching and learning that go on in health professions programs in a region are ultimately connected to improved patient care in that same region.

REFERENCES


The National AHEC Organization supports and advances the Area Health Education Center (AHEC) Network to improve health by leading the nation in recruitment, training and retention of a diverse health workforce for underserved communities.
Developing Interprofessional Education in an AHEC Region Distant from the AHEC Medical School

Marty Schaller, MS

Northeastern Wisconsin Area Health Education Center’s (NEWAHEC) geographic region poses a challenge faced by many AHECs trying to implement interprofessional education (IPE). It is located quite far from the University of Wisconsin School of Medicine and Public Health (UWSMPH), the medical school that supports its AHEC program.

For many years NEWAHEC struggled with implementing IPE programs for students in its region. NEWAHEC convened a summit in early 2010 that was attended by its academic partners. The purpose was to discuss the current state of IPE in the region and gauge interest in developing more IPE programming. Partners from nine academic institutions attended, including two four-year state schools, three four-year private schools, and four technical schools. All offer more than one health professions discipline. Most attendees were deans. Also in attendance were staff from NEWAHEC and the Wisconsin AHEC program, and a representative from ThedaCare, a regional healthcare provider that has developed a nationally recognized collaborative care model.

There were several important outcomes from the summit. First, a recognition that very little IPE was occurring in the region. Second, a consensus was reached among attendees acknowledging the value and importance of developing and implementing more IPE opportunities within the region. Third, there was a commitment among all partners to move forward with an IPE strategic planning process for the region.

NEWAHEC facilitated the IPE planning process. The group articulated a vision for IPE in the region: Every health professions student has the opportunity to participate in an interprofessional education experience, so that students understand and respect the roles of other health professionals. The group also identified a total of 30 gaps between their future vision and the current state of IPE in the region. Gaps were organized into three categories: data/information; organizational/institutional; and perception of IPE. From these gaps, three strategic priorities were developed: 1) Increase the perceived value of IPE among key stakeholders, 2) Create and implement an inter/intra institutional IPE program that is efficient; effective, sustainable, incorporates best practices, and addresses stakeholder barriers/concerns; and 3) Develop a plan for measuring outcomes that addresses the needs and expectations of all key stakeholders.

Several key actions occurred after completing the planning process. First, the group developed a survey tool for regional faculty members to measure attitudes toward IPE and teamwork in the work setting. The survey was administered by one of the IPE work group faculty members and data was collected, analyzed, and disseminated. Second, a communications plan regarding key messages concerning IPE was drafted in an effort to communicate key IPE concepts to college administrators and other stakeholders. Third, NEWAHEC developed and delivered two “IPE101” workshops in the fall of 2011 to educate faculty of health professions training programs. Lastly, NEWAHEC developed and piloted a one-day student IPE workshop that was delivered during the winter term in January of 2012.

NEWAHEC then expanded its capacity to provide additional support for IPE through two strategic actions—hiring additional AHEC program staff, which allowed the existing program staff member to devote more time to IPE;
Developing Interprofessional Education in an AHEC Region Distant from the AHEC Medical School

NEWAHEC’s investment in IPE capacity-building has resulted in the following outcomes:

• Implemented a successful IPE collaboration between two health professions training programs
• Implemented a new IPE curriculum at one school utilizing nursing and social work students
• NEWAHEC developed and is coordinating a statewide IPE student collaborative case competition. Eight IP student teams from throughout the state competed for cash prizes. NEWAHEC’s region had eight team applications; the region with the next highest number of applications had two applications.
• Continued growth in the winter term IPE student workshop. Student participation has doubled from 18 students last year to 36 students this year.
• One partner school with 10 health professions training programs has embraced and is institutionalizing IPE. NEWAHEC has supported this organization by providing an IPE faculty workshop and faculty support for attending the Collaborating Across Borders IV conference.

Due to logistics, institutional politics, and a relatively small amount of medical student training that occurs in the region, none of the IPE activities to date have included medical students. This is gradually changing, however. In 2011 the UWSMPH implemented a training site within NEWAHEC’s region for its Wisconsin Academy of Rural Medicine (WARM) program. WARM students receive most of their third- and fourth-year training in rural communities. This new WARM site is providing increased access to medical students for regional IPE activities. NEWAHEC’s IPE activities are also getting noticed at the medical school.

Fig. 2. Students participating in the J-term IPE workshop

There will be medical student participation in the winter term workshop this year. In January of 2014, NEWAHEC’s IPE coordinator was a presenter for a breakout session on IPE teaching symposium sponsored by the UWSMPH.

Lessons Learned

1. Commitment and Collaboration are Crucial. Engaging key leaders of academic partners at the beginning of the process was crucial to gauge interest and buy-in to IPE. Once assurance was received that academic partners were committed to developing more IPE opportunities, collaboration naturally followed.

2. You Can Do IPE Without Medical Students. Out of necessity, NEWAHEC’s IPE programming initially was developed without medical students, though engagement of medical students was always a goal.

3. Persistence Pays Off. Being located distant from the medical school presents numerous challenges to engaging medical students into IPE programming. Through demonstrated successes with other disciplines, there has been slow progress with engaging medical students in IPE.

4. AHEC is the Glue. AHECs have a long history of successfully convening multiple partners to develop and deliver quality health professions student education. This project is no different. Partners were engaged and motivated to participate but lacked the resources and political neutrality that AHEC was able to provide.

There are numerous logistical and political challenges to developing student IPE opportunities in a geographic region distant from a medical school. It is not only difficult to engage medical students who train in the region but also to work through organizational and logistical problems that are inherent when trying to engage nine academic institutions located within the region. NEWAHEC began its IPE journey by collaborating first with the nine regional academic partners. The medical school has noted the successful IPE programming that NEWAHEC has been able to develop, which has opened the door to engaging their students.
Call for Articles
“Creating a Sound Mind and Body: The Role of AHEC in Creating a Diverse Behavioral Health Workforce”

Across the nation there is much concern about the state of the behavioral health workforce and about its future. Workforce problems have an impact on almost every aspect of prevention and treatment across all sectors of the diverse behavioral health field. This edition will focus on efforts to address issues related to recruiting and retaining a culturally competent behavioral health workforce, the absence of career ladders for employees, and limited access to relevant and effective training.

The Editorial Board is looking for articles that address three important topics:

1. How the Affordable Care Act is affecting the availability of mental health insurance coverage and strategies utilized by AHECs to respond to the mental health crisis in America

2. The involvement of AHECs in responding to behavioral health workforce challenges relating to such special populations as:
   - Youth mental health (e.g., Youth Mental Health First Aid Corps, etc.)
   - Seniors (e.g., are AHECs working with assisted living facilities and nursing homes to help with their workforce requirements?)
   - Veterans (e.g., what initiatives are being utilized to address behavioral health issues and access to mental health services among veterans?)
   - Primary care providers (e.g., the role of AHECs in training or retraining physicians to provide mental health services in their offices; recertification of adult nurse practitioners in psychiatric care; providing workforce training that is interprofessional in nature and connects behavioral health providers and students with primary care providers and students)
   - AHEC strategies for responding to mental health workforce challenges in rural or urban settings (e.g., collaborations with community health workers) and the special challenges identified in each of these settings

3. How AHECs are utilizing technologies such as telemedicine and telehealth to bring mental health services to underserved areas and for home monitoring of patients

Please submit drafts, photos and accompanying materials to editor@NationalAHEC.org.

Refer to the NAO website for Journal submission guidelines:

Submission Cover Sheet must be included with the article

1st Draft Article Submission is due Sept. 15, 2014. The publication will be released in the Winter of 2015.
AHEC is in the Division of Health Careers and Financial Support
The National AHEC Organization Mission
The National AHEC Organization supports and advances the AHEC Network to improve health by leading the nation in the recruitment, training and retention of a diverse health workforce for underserved communities.

The AHEC Mission
To enhance access to quality health care, particularly primary and preventive care, by improving the supply and distribution of healthcare professionals through community/academic educational partnerships.

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