American Interprofessional Health Collaborative:

Historical Roots and Organizational Beginnings

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Introduction

The American Interprofessional Health Collaborative (AIHC) is rooted in the rich history of interprofessional and interdisciplinary health professions collaboration in the United States, dating to the mid-20th century.[1] Several of the individuals who have been involved in shepherding the AIHC organizational formation have professional histories anchored in the interprofessional education (IPE) and care (IPC) movements from the 1970s. This early history is important in the mission and vision of the AIHC as it develops.

AIHC Historical Roots

In the early 1970s, based upon the premise that the interdisciplinary team represented the future of health care[2], programs were created in university-based academic health centers in the United States to promote new models of education and clinical care. Throughout the 1970s, faculty members and health professionals from a number of these academic health centers interacted at various meetings focused on cross-professional practice and education. Following

[1] Baldwin, D.C. Jr., (1996). Some historical notes on interdisciplinary and interprofessional education and practice in health care in the USA. *Journal of Interprofessional Care, 1996; 10(2): 173-187.*

[2] Institute of Medicine. (1972). Educating for the Health Team. Washington, DC: National Academy of Sciences.

two initial primary care targeted conferences beginning in the mid-1970s[3] and continuing until 2003, a national "steering" group of volunteers who were not affiliated with any one IP organization implemented the annual Interdisciplinary Health Care Team Conference (IHCTC). This conference served as an important forum for educators, clinicians, and researchers to share their scholarship and experiences across various national interprofessional programs and institutionally-based interprofessional educational and clinical activities.[4] Proceedings of these conferences, which were distributed to conference participants up through the 17th conference in 1995, document these early IPE efforts. However, with the awareness of the *Journal of Interprofessional Care,* fostered by the presence of a United Kingdom (UK) delegation at the IHCTC meeting in Pittsburgh in 1995, conference attendees were encouraged to submit their scholarly work to the Journal, and un-copyrighted publication of the conference proceedings ceased.

Although early IPE efforts focused on primary care and access to care for the underserved lost momentum when funding became scarce, other efforts focused on IPE in the United States emerged in a number of federal- and foundation-funded national projects and were represented at the IHCTCs. An example of such an effort that became linked with the annual IHCTC is the Veterans Administration Interdisciplinary Team Training Program in Geriatrics, which was implemented at 12 Veterans Affairs hospital sites between 1979 and 1983. This

[3] Baldwin, D.C, Jr. & Rowley, B.D. (Eds). Interdisciplinary Health Team Training. (1976/1982). Reno, Nevada: University of Nevada-Reno, School of Medicine. Republished in 1982 by the Center for Interdisciplinary Education in Allied Health, College of Allied Health Professions, University of Kentucky, and Baldwin, D.C.Jr, Rowley, B.D. & Williams, V.H. (Eds). (1980). Interdisciplinary Health Care Teams in Teaching and Practice. Reno, Nevada: New Health Perspectives, Inc. & University of Nevada, Reno School of Medicine.

[4] Baldwin, D.C. Jr., (1996). Some historical notes on interdisciplinary and interprofessional education and practice in health care in the USA. *Journal of Interprofessional Care, 1996; 10(2): 173-187.*

program held its annual meeting with the VA Central Office Director and the 12 team trainers just prior to the IHCTC; and this group was very active in the IHCTC.

During the 1990s, faculty who participated in academic health center focused IPE programs also met at the annual Congress of Health Professions Education and Group on Multi-Professional Education (GOMPE) meetings sponsored by the Association of Academic Health Centers (AAHC). The AAHC served as an important dissemination vehicle for scholarship as the publisher of conference proceedings, occasional papers, and books focused on many aspects of interdisciplinary and interprofessional education, with particular interest in the role of academic health centers.[5]

Although practically all U.S.- based IPE activities starting in the 1970s generally were elective, the United States was identified internationally as a leader in IPE programming and scholarship. For example, a systematic review of the interprofessional education research literature undertaken by a British Joint Evaluation Team (JET) revealed 54% of the "higher quality" studies evaluating the outcomes of IPE internationally were undertaken in the United States.[6] The next largest group – 33%- were from the United Kingdom, where the *Journal of Interprofessional Care* was established in 1986. The Center for the Advancement of Interprofessional Education[7] led IPE efforts in the UK following its creation in 1987.

While international efforts progressed, new national initiatives in the United States were refocusing and expanding the commitment to interdisciplinary, interprofessional and team-based collaboration, practice, research and education. "Traditional" IP areas had crossed multiple

[5] See, for example, Holmes, D. E. (1997). Interdisciplinary Education as a Prelude to Interdisciplinary Practice. Washington, DC: Association of Academic Health Centers and Holmes, D.E. & Osterweis, M. (Eds.). (1999). Catalysts in Interdisciplinary Education. Washington, DC: Association of Academic Health Centers.

[6] Barr, H. et al. (2005). Effective Interprofessional Education: Argument, Assumption & Evidence. Oxford, UK: Blackwell.

[7] See http://www.caipe.org.uk/.

philosophies and programs, including rehabilitation, mental health, geriatrics, primary care, rural health, access to care in the community health center and other federal movements, prevention, critical care, and hospice and palliative care. Beginning in 1999, the Institute of Medicine (IOM) published three seminal publications focused on health care quality and patient safety and the relationship of these to health professions education in the United States. *To Err is Human* (2000), [8] *Crossing the Quality Chasm* (2001),[9] and *Health Professions Education: A Bridge to Quality* (2003),[10] provided significant impetus to a new approach and urgency to rethinking interprofessional relationships, systems-thinking, and team-based care. The Institute for Healthcare Improvement (IHI) created a nationally focused collaborative to stimulate new thinking about restructuring health professions education across professions related to patient safety and quality[11] simultaneously with practice initiatives to improve safety and quality. Such efforts have shifted the previous conversations about IPE focused largely in the community, where they remained on the margin, to core issues for hospitals, health systems, and universities and generated a new wave of training and research efforts targeted at the teamwork dimensions of patient safety.

Integrating Initial U.S. IPE Efforts with International Efforts

Although U.S. patient safety and quality issues in the clinical arena have led the way to a new awareness of the importance of interprofessional teamwork in practice, not only nationally

[8] Institute of Medicine. (2000). To Err is Human: Building a Safer Health System. Washington, DC: National Academies Press.

[9] Institute of Medicine. (2001). Crossing the Quality Chasm. Washington, DC: National Academies Press.

[10] Institute of Medicine. (2003). Health Professions Education: A Bridge to Quality. Washington, DC: National Academies Press.

[11] See http://www.ihi.org/NR/rdonlyres/4F1C5D8C-4667-4996-AC3A-39324DAF7DDE/0/ProfessionalDevelopment.pdf Accessed April 13, 2010.

but internationally as well, U.S. leadership in interprofessional education has been surpassed as more organized and better funded efforts internationally have rapidly gained strength. Two important initiatives from a U.S. perspective are 1) the launch of the international All Together Better Health (ATBH) IPE conferences in 1997 and 2) the creation of the Canadian Interprofessional Health Collaborative (CIHC)[12] in 2005, as an outgrowth of massive funding for IPE and IP practice undertaken by Health Canada following publication of key national health reports.

The first ATBH Conference was held in 1997 in London, UK. Subsequent conferences have been held in Vancouver in 2004, in London in 2006, in Stockholm in 2008, and in Sydney in 2010. The American IHCTC steering committee scheduled their annual meeting to be integrated into the 1997 ATBH Conference in London. This event grew out of planning with the delegation from the UK who attended the annual IHCTC in Pittsburgh in 1995.

Concurrent with IPE developments in Canada, the ATBH conferences moved forward, with the second one held in Vancouver at the University of British Columbia in 2004. The IHCTC in the U.S. had come to an end in 2003, after two years of partnering with the National Academies of Practice annual meeting. U.S. IHCTC leaders were eager to support the development of the international meetings.

Canadian-American Partnerships and the Inaugural Collaborating Across Borders (CAB) Conference

An effort to reach across borders for a Canadian-American IPE meeting in Toronto, Canada in 2005 resulted in few American attendees, but was definitely a signal event for IPE in Canada, with many new Canadian IPE grants announced at the conference. U.S. participants attending the 2005 Toronto IPE meeting were committed to finding a sponsor/venue in the U.S.

[12] See http://www.cihc.ca/library/handle/10296/1 Accessed on April 13, 2010.

to host an expanded Canada-U.S. IPE conference. Explorations were undertaken with a U.S. national organization that had provided recent support for IP educators. With a change in leadership, these explorations terminated a few weeks before the ATBH conference in London in May, 2006. An impromptu lunch meeting to reconsider sponsorship and a venue for a Canadian-American meeting sparked interest from Barbara Brandt, a seasoned IPE leader who was attending the Conference from the University of Minnesota, an academic health center with a long history of IPE. This led to the inaugural CAB Conference in the Fall of 2007, jointly planned by IPE leaders in the U.S. and Canada, with a local organizing committee based at the University of Minnesota.

Beginning in November 2006, John Gilbert, leader of the Canadian Interprofessional Health Collaborative (CIHC), and Barbara Brandt co-chaired the planning for Collaborating Across Borders: An American-Canadian Dialogue on Interprofessional Health Education (CAB I) held in Minneapolis on October 26 – 28, 2007. Madeline Schmitt significantly contributed as the program consultant and was instrumental in identifying many programs, organizations and individuals with an interest in IPE. Throughout 2007, significant CAB I planning efforts focused on identifying individuals who represented the various strands of IPE. At the time, unlike the new CIHC, which represented an integrative "one stop" contact as a focused, open, and free membership organization, individuals in the U.S. working in IPE crossed many professional practice and education institutions and membership associations and had no way to network with each other about their ongoing work. As the net was cast more widely to attract interest in conference planning and participation, 50 individuals representing 20 universities and 6 professional organizations eventually were involved in the creation of CAB I. An average of 16 individuals participated in frequent planning conference calls throughout the year.

In an effort to support the sharing and networking functions of the conference, the planning group decided that the framework for the CAB format would move beyond "talking head" experts to create "dialogue" between American and Canadian participants to focus on perspectives on a single topic in one of four tracks: New Models of Care, Cutting Edge Innovations in Curriculum & Instruction, Transformation/Change/Leadership, and Addressing Barriers Through Policy Development. Program planners decided not to be responsible for publishing conference proceedings as in past efforts, but rather to commit their energies to creating venues that would facilitate a continuing conversation about IPE beyond the conference. From the beginning, John Gilbert identified that knowledge about IPE was emerging rapidly and efforts to share conference experiences should focus on quick dissemination in addition to traditionally slower forms of individual journal publications. Conference materials are archived on the University of Minnesota Academic Health Center website[13], and other online and Internet platforms have evolved to support information-sharing among colleagues working in IPE.[14]

The cross-border sharing and networking goals informed the planning committee's processes and the development of the conference content. During the spring 2007, conference organizers distributed a request for session proposals to be peer-reviewed by one American and one Canadian. In May, 127 proposals (71 from Canada, 55 from the United States, 1 from the United Kingdom) were received. Qualitatively, the nature of the proposals varied, reflecting the difference in recent levels of commitment to IPE in the two countries. Canada's single payer health system, funded IPE projects, and the CIHC as the single interprofessional collaboration and education organization contrasted with the health care and education system fragmentation

[13] See http://www.biomed.lib.umn.edu/conference/index.php/IPE/IPE/ Accessed April 14, 2010.
[14] See for example, http://www.atpm.org/prof_dev/interprofessional_ed.html Accessed April 15, 2010; http://www.ihi.org/IHI/Programs/IHIOpenSchool/?TabId=1 Accessed April 15, 2010; and http://teamstepps.ahrq.gov/ Accessed April 15, 2010

in the United States. For example, Canadian proposals described developing higher education / health systems networks, comprehensive curriculum mapping with IP competencies across institutions, and many data-rich evaluation studies with sophisticated designs. Only Canadians submitted collaborative practice proposals (16). By contrast, the United States proposals focused on single events, days, courses or focused programs, demonstrating a lack of a comprehensive vision, even at an institutional level.

As a result of observations about these content differences, the University of Minnesota planning group redesigned the framework to promote dialogue, based upon types of proposals that were received. The expanded program sessions included: Cutting-Edge Innovations in Curriculum and Instruction, 21st Century Technology-Enhanced IPE, IPE Through the Eyes of Students, Transformation /Change/Leadership, Addressing Barriers Through Policy Development, Faculty/Teaching Skills Development, and New Models of Care.

The October 26-27, 2007 conference in Minneapolis was attended by over 350 participants and was well received and evaluated. A conference highlight was recognition of DeWitt C. "Bud" Baldwin M.D. for his long-standing support and scholarship in the area of interprofessional education and collaborative practice. Madeline Schmitt edited a supplement of the *Journal of Interprofessional Care* containing a selection of Dr. Baldwin's papers, which arrived in time for initial distribution at the conference.[15]

On a scale of 1 (low) – 5 (high), participants who completed evaluation forms rated the conference as follows: Conference met my expectations: 4.32; Examples to implement IPE: 4.61; Research evidence & lessons learned: 4.47; Practical applications: 4.19. The question

[15] Schmitt, Madeline H. (Ed.) DeWitt C. Baldwin, Jr. M.D.: An Interprofessional Celebration. *Journal of Interprofessional Care, 2007. 21 (S1).*.

focused on setting a future agenda was evaluated lower, at 3.74. Participants expressed an interest in continuing the dialogue into the future and were interested in a second conference.

The Emergence of the AIHC

Following the inaugural CAB I conference at the University of Minnesota, individuals who had been involved in IPE in the United States throughout the earlier years, working with a new generation of IPE leaders, recognized that it was an opportune time to revitalize IPE through a national organizational umbrella that tied the emerging interprofessional education emphasis on patient safety and quality with past IP efforts. CAB I conference planners and interested participants continued to meet on a regular basis by phone hosted by the University of Minnesota and facilitated by Gwen Halaas. John Gilbert joined the calls representing the CIHC to share their experience. Invited by Amy Blue, the group agreed to convene a one day meeting in January 2009 at the Medical University of South Carolina, in Charleston to further formalize their efforts and establish initial organizational goals. A key outcome of the Charleston meeting was to name the developing organization the American Interprofessional Health Collaborative to reflect a "sister" organization to the CIHC. Led by Gwen Halaas, this group worked together to articulate the purpose of the Collaborative and the value it would bring to the IPE national and international discussions. As health professionals and educators deeply committed to the further development of interprofessional education in order to improve health and health care, we recognized a need for leadership to integrate proliferating, but isolated, IPE efforts in response to clinical practice needs in the United States. This led to the mission statement: "Working to transform healthcare by building effective collaborative education, care and research." A values statement was also written:

As a Collaborative we value:

- Inclusion of all stakeholders in transforming health care
- Using an evidence-based approach
- Providing open access to information and resources

Initial organizational aims included:

- Gathering and exchanging information about current programs in interprofessional education, including success, barriers and opportunities;
- Building capacity by sharing evidence of effective interprofessional education and collaborative practice and developing more sites for training;
- Partnering with other national and international organizations;
- Advocating for necessary change in accreditation, licensure, and reimbursement to support interprofessional education and collaboration;
- Sharing effective interprofessional education resources;
- Developing a database of research outcomes and programs or projects; and
- Partnering with others to support an agenda for needed research.

In addition to the mission, values and aims, a logic model was developed as a framework for the future efforts of the collaborative with three components identified: *Building the Collaborative*, *Identifying and Sharing Best Practices*, and *Knowledge Exchange*. Activities, inputs and short-and medium-term outputs were identified for each component. The long-term output mirrors the mission to "transform healthcare by building effective interprofessional collaborative education, care and research."

At the conclusion of the Charleston retreat, it was agreed to send a letter of invitation to participants of the CAB I meeting and other subsequently identified individuals to inform them

about the developing organization. During Spring 2009, some of the AIHC initial planning group participated with Dalhousie University colleagues to plan the CAB II conference: Building Bridges Between Interprofessional Education and Practice held in Halifax, Nova Scotia in May 2009. It was determined to hold an AIHC informational meeting at CAB II for interested persons engaged in IPE work in the U.S. Amy Blue and Susan Meyer co-chaired the meeting; 40 U.S. conference participants attended. At this meeting, formal announcement of the Collaborative was made and persons interested in joining were invited to submit their names and contact information. A second meeting focused on the idea of the AIHC partnering with other U.S. national health professional education organizations to make the best use of relevant expertise in the many facets of IPE development.

The initial planning group of individuals, now formed as a steering committee for the Collaborative,[16] continued monthly conference calls focusing on next steps for the organization. Particular issues explored were: building an infrastructure to support the organization's efforts, engaging Collaborative members, sharing resources, moving the energy of the individuals in the Collaborative forward in a productive manner, and defining the scope of work. Through the auspices of the University of Minnesota, which had been providing staff support for the conference calls and other initial organizational needs, a blog-format website was created as a means to establish communication exchange amongst individuals within the Collaborative.

[16] On-site participants of the 2009 Charleston meeting included: Amy Blue and David Garr, Medical University of South Carolina; Gwen Halaas, formerly University of Minnesota and currently University of North Dakota; Madeline Schmitt, University of Rochester; Robin Harvan, formerly of University of Colorado and currently Department of Defense, John Gilbert, Canadian Interprofessional Health Collaborative. Teleconference participants include: Annette Greer, East Carolina University; Pamela Mitchell, University of Washington; Susan Meyer, University of Pittsburgh. Staff: David Howell, Medical University of South Carolina and Susan Kostka, University of Minnesota. Additional steering committee members include: Maria Clay, East Carolina University; Carolyn Giordana, Thomas Jefferson University; Kevin Lyons, Thomas Jefferson University, Brenda Zierler, University of Washington.

Momentum for organizational development grew in fall 2009, when the steering committee agreed to hold an inaugural AIHC meeting for the growing network, with a focus on issues salient to persons with leadership responsibility for IPE implementation at academic institutions. As members of the AIHC steering committee, Kevin Lyons and Carolyn Giordano, generously offered to host a small AIHC meeting as a pre-conference for the second annual Jefferson Interprofessional Education Conference in Philadelphia. Targeted pre-conference attendance was 30 participants. However, 85 people from across the U.S. and who centrally involved in IPE initiatives on their campuses attended the pre-conference. The pre-conference theme was "Institutionalizing Interprofessional Education and Practice - A Leadership Conversation" and, to organize meeting content. Four sub-themes for panel presentations were identified:

- Organizational change practices: lessons learned
- Faculty development, recruitment and retention issues
- Interprofessional education and practice: role models for learners
- Outcomes assessment

Those participating in the AIHC electronic network were invited to submit brief proposals indicating their interest to serve as a panelist for one of the themed sessions, their related experience, and an outline of areas for discussion. Goals for the panel sessions were to maximize participation, as well as geographic, institutional and professional diversity of persons engaged in IPE work at academic institutions. Twenty-two people submitted proposals. A small conference planning committee designed the agenda by matching the session topics with submitters' identified areas of expertise and experience around the pre-conference themes. In each session, panelists were asked to speak to the topic without Powerpoint technology and were

given 5 minutes each, followed by general discussion. To maximize sharing ideas and conference networking, each session was run twice to allow all conference attendees to hear all sessions.

The AIHC pre-conference was held March 11-12, 2010 in Philadelphia on the campus of the Jefferson University School of Medicine. David Garr was a keynote speaker and his talk addressed aspects of IPE national efforts, including the work of the Association of Prevention Teaching and Research, the Area Health Education Centers across the country, Health and Human Resource Administration (HRSA) programs more broadly, and current efforts to include an IPE prevention related objective in the Healthy People 2020 framework. Most of the schedule was spent in the panel sessions.

The majority of the participants who provided feedback to the planners of the AIHC pre-conference meeting indicated that they were satisfied or very satisfied. On a scale of 1 (very dissatisfied) to 4 (very satisfied), satisfaction with the overall meeting was rated as 3.78. Individual sessions were also highly rated. A sample of sessions are: Top-down leadership and sustainability: 3.62; Grassroots Development of IPE: 3.49; Institutionalization of faculty recognition: 3.33; and Fostering institutionalization of an assessment plan: 3.37. Participant comments recommended future meetings on a variety of focused topics as well as expanding opportunities for online, continued discussions.

At the inaugural business meeting, attendees were informed about the planning underway for the third CAB meeting to be held in fall 2011 in Tucson, Arizona and that the organization was in the process of formalizing the structure as a non-profit membership-based organization. An electronic poster about the AIHC was presented at the All Together Better Health V meeting in Sydney, Australia to inform the international community about the establishmentof the

organization. Members of the AIHC steering committee are scheduled to meet at the University of Minnesota in May 2010 to take the next steps in formalizing the status of the AIHC organization and to continue strategic planning efforts.

Looking Toward the Future

Challenging economic times, increasing concerns about access to effective primary health care and safe, affordable health care services in all settings have created a sense of international urgency, as well as an openness to the innovation and change that interprofessional collaboration can bring. This is reflected in the World Health Organization's report *A Framework for Action on Interprofessional Education and Collaborative Practice.*[17] It is clear there is once again strong momentum for interprofessional education in the United States, as evidenced by the attention given to the need for better intra and interprofessional teamwork in the patient safety movement[18] changing professional education standards[19],[20],[21], and advocacy by national health professions education organizations[22]. These forces, coupled with policies

[17] World Health Organization. A Framework for Action on Interprofessional Education and Collaborative Practice. (2010). Geneva: World Health Organization. Available at http://www.who.int/hrh/resources/framework_action/en/index.html Access on April 13, 2010.

[18] See for example http://teamstepps.ahrq.gov/ Accessed on April 13, 2010.

[19] American Association of Colleges of Pharmacy. Annual Report of the Task Force on Interprofessional Education 2007-2008. (2008). http://www.aacp.org/governance/councilfaculties/Documents/COF_InterprofessionalEducation2008.pdf. Accessed February 3, 2010.

[20] See for example, Physician Assistant Education Association. Mission and Goals. Alexandria, VA: Physician Assistant Education Association, 2010. http://www.paeaonline.org/index.php?ht=d/sp/i/212/pid/212. Accessed on April 13, 2010.

[21] See, for example, American Association of Colleges of Nursing. The Essentials of Doctoral Education for Advanced Nursing Practice. Washington, D.C: American Association of Colleges of Nursing. October 2006. http://www.aacn.nche.edu/DNP/pdf/Essentials.pdf Accessed April 13, 2010.

[22] See for example, Association of American Medical Colleges. 2007. The Mission, Vision, and Strategic Priorities of the AAMC. Washington, DC: Association of American Medical Colleges.

and standards governing health care delivery that encourage more interprofessional models[23] as well as national health care reform efforts targeted at interprofessional practice models[24] speak to the continued need for IPE development and sharing of effective implementation strategies, model programs and outcomes assessment. The number of educational institutions committed to IPE through the development of centralized administrative structures and health professions education programs that integrate IPE is increasing, as evidenced by the roles of many AIHC participants in their home institutions, and the presentations at the first AIHC [Pre-]Conference. Through continued networking and collaboration in the AIHC, the goal is to learn together in an integrated, efficient and effective fashion to effect the health professional educational changes that foster improved practice collaboration and health care outcomes.

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[23] See, for example, NQF Safe Practice #3. http://www.qualityforum.org/Publications/2009/03/Safe_Practices_for_Better_Healthcare%E2%80%932009_Update.aspx Accessed April 15, 2010

[24] See, for example, http://www.prnewswire.com/news-releases/new-approaches-in-health-care-reform-bill-to-improve-care-of-chronically-ill-elderly-residents-of-the-region-89394452.html Accessed April 15, 2010 ; http://www.accp.com/announcements/healthreform.aspx Accessed April 15, 2010 ;