AHC Deans Retreat Summary
Interprofessional Education
October 3, 2006

A. Definitions/Outcomes:

1. The definition was adopted from the United Kingdom Center for the Advancement of Interprofessional Education, as follows:

IPE occurs when two or more health professions learn with and about each other across the spectrum of their education to improve collaboration, practice and the quality of patient-centered care.

2. The outcomes of IPE are for students to:
   - i. **Know about** the roles of other health professionals
   - ii. Be able to **work with** other health professionals in the context of a team where each member has a clearly defined role
   - iii. Learn how to **apply disciplinary strengths** of health professionals for their highest and best value in health promotion and prevention and in care delivery.

B. Forces Driving this Change:

1. Need to improve the quality and safety of health care
2. Need to have more efficient care delivery with decreased cost and improved value
3. The market place and consumers are demanding it
4. Students desire it
5. Interdisciplinary education and research activities are part of University strategic repositioning.
6. Accrediting bodies are moving in this direction in their definition of competencies and capabilities
7. Teaming is a learned behavior and needs a planned approach in a learning environment
8. New models of care delivery will help forecast workforce needs
9. We need to prove the value of how we are educating health professionals

C. Priority Areas for the Center for Interprofessional Education to Begin With:

1. Common Ground IPE

   - i. Leadership and teambuilding learning initiative
   - ii. Principles of quality improvement and patient safety using such tools as evidence, informatics, root cause analysis, etc.

iii. Baseline health informatics
iv. Health policy and society, including global health, health diversity, public health, health economics, societal health, etc.
v. Care systems, including supply lines, care integration, government regulation, managed care, networks, insurance, etc.

2. New Models of Care Delivery:

   i. Develop an outcomes and performance-based system that evaluates the competencies and assesses capabilities as demonstrated in practice to demonstrate the value-added of IPE
   ii. Develop models for chronic care, e.g. obesity, diabetes, care of the elderly/aging
   iii. Inpatient critical care
   iv. Health promotion, prevention and maintenance

3. Considerations for IPE courses and experiences

   i. Consider the impact and value of experiences in different settings, e.g. urban vs rural, inner city vs suberbs
   ii. Consider the appropriate timing of the IPE experience in the learning timeline of health professionals, i.e., offer the right experience and the right time, in the right place
   iii. Consider the impact of diverse populations and cultural competencies on the experience
   iv. Focus on the space between the individual health professional expertise, while maximizing the use of the core of each health professional
   v. Consider how a competency is learned and reinforced throughout the continuum of a health professional's learning experience

D. Our Commitments

1. We will develop a joint statement of the importance of IPE and demonstrate our commitment to it.
   i. We will deliver this statement to the faculty and staff of each of our schools and the AHC, as often as necessary
   ii. We will set expectations for the Associate Deans about their involvement/role in IPE
   iii. We will "walk the talk" and lead by example, e.g. joint compacts, best practice sharing, joint initiatives, and learn more about each other
   iv. We will help communicate the change in culture through joint celebrations of professionalism, etc.
   v. We will advocate within each of our schools and earn the support of our curriculum committees

vi. We will create room in our educational schedules for IPE. IPE offerings will be mandatory parts of our degrees. While on-line experiences will be part of each offering, we will provide the time necessary for direct contact activities.
vii. We will build outcome assessments that demonstrate the value-added by IPE. We need to develop the tools and measure the baseline ASAP
viii. We will work to solve administrative challenges that IPE will create, including those that arise on branch campuses
ix. We will recognize and celebrate current IPE successes

2. We will make commitments to faculty participating in IPE:

   i. We will provide faculty development for IPE
   ii. We will find ways to reward and recognize faculty for IPE
   iii. We will protect time for IPE contributors, i.e. reallocate faculty time/salary for participation in IPE initiatives, projects, courses, experiences, etc.
   iv. We will include an IPE component in the 7:12 statements

E. High-level Timeline

1. Develop joint leadership statement by the end of November 2006
2. Begin communicating the joint leadership statement in December 2006
3. Launch the joint statement/commitment in the State of AHC in January 2007
4. Feature in next Pictures of Health, including picture of all the AHC Deans