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Integrating IPE into an Academic Health Sciences Center: A Bottom-Up and Top-Down Approach

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There is nothing more difficult to take in hand, more perilous to conduct, or more uncertain in its success, than to take the lead in the introduction of a new order of things. – Niccolo Machiavelli

The words of Niccolo Machiavelli, writing in *The Prince* in the 16th Century, aptly describe the challenge to institutions embarking on the development of interprofessional education programs. Education of health professionals has evolved over the years to a level of sophistication and complexity, guided by pedagogy and accreditation standards; therefore, educators are hesitant to give up tried and trusted methods. The concept of entrusting profession-defining skills into the hands of a colleague from another profession is quite often frightening and unsettling. As Machiavelli noted, "...the innovator has for enemies all those who have done well under the old conditions, and lukewarm defenders in those who may do well under the new" (Machiavelli, as translated by Marriott, 1908).

Introducing Interprofessional Education (IPE) requires a level of agreement on expected outcomes as well as a commitment throughout the Academic Health Sciences Center (AHSC) to a team approach to learning and care delivery. The purpose of IPE goes beyond the opportunities for educational experiences where students from two or more professions learn with, from, and about each other to educating our students so they can work effectively in collaborative teams and provide quality care to patients, their families, and their communities. If this understanding of the reason for and the outcomes of IPE are shared throughout an institution, IPE begins to drive the mission and ultimately the passion of all involved.

It has been the experience at East Tennessee State University (ETSU) that commitment from faculty in each of our colleges is as important as the commitment of the administrative leadership. However, our experience bears out that neither group alone can successfully integrate IPE into the curriculum. Just as IPE teaches teamwork, it requires teamwork to become a reality. This article describes the journey that ETSU began in the early 1990s. It will describe how our focus and process has matured and expanded even as new leadership and new faculty joined the institution. We have been successful because our faculty and students embrace IPE and our deans and university leaders view themselves as facilitators who help to make it happen. We like to say, "IPE is in our DNA." Even so, we cannot discount the hours of work and coordination it takes to make an IPE program successful and a way of doing business.

Internal and External Factors that Facilitated Change

Kurt Lewin describes the process of change as occurring in three stages – Unfreezing, Change, and Refreezing (Lewin, 1951). In the early 1990s, ETSU was undergoing organizational changes that unfroze the status quo and set up a dynamic that could embrace change and develop a culture supportive of interprofessional education. The Division of Health Sciences was formed in 1989 when the College of Medicine, College of Nursing, and College of Public and Allied Health were placed under the leadership of the Dean of Medicine who was also given the title of Vice President for Health Affairs. The College of Medicine was a little over ten years old at that time having been established to provide physicians for rural, primary care in Tennessee. The medical school joined a long established College of Nursing with undergraduate and graduate programs, and a College of Public and Allied Health that included health education, environmental health, and the traditional allied health programs. Before this time, the College of Medicine enjoyed separate, professional school status and the other colleges were under the leadership of the Vice President for Academic Affairs. The process of creating the new Division

of Health Sciences required the university to develop processes and procedures removing health schools from the existing academic structure and placing them into a separate unit reporting directly to the President.

As this new administrative unit was seeking its own identity, the W.K. Kellogg Foundation issued an RFP for funding for a community partnership grant. The requirements of the grant were to develop community-based, interprofessional programs for medicine, nursing, and other health disciplines. Following a year of competitive review, the ETSU Division of Health Sciences was among the final seven institutions selected for funding. The unique part of this selection process was the opportunity for the deans of the existing three health science colleges at the time to participate in Kellogg-funded conferences across the United States for a year prior to being selected for the grant. These conferences provided time for the leadership of the Division of Health Sciences to bond as a leadership team on both a personal and a professional level. It provided time for formal and informal philosophical and professional discussions through which the three deans made a commitment to each other to make the program successful. So, early in the process of forming a new administrative unit, the deans were united with a singular purpose of supporting interprofessional education. After the grant was awarded, these deans met weekly to create the administrative policies and structure to begin implementation of the program. While the deans were united in purpose, their biggest challenge was to bring on board the faculty of their colleges to implement the curriculum change necessary for success. At the time, the approach was purely “top down.” Faculty had not been involved in the year of bonding; they were not up-to-date on the literature; nor were they particularly interested in ceding their authority for the education of students in their respective disciplines to faculty in other colleges. Thus, strong and influential leadership was needed to make interprofessional education possible.

The needed leadership was exerted by the then Vice President for Health Affairs, who was also the Dean of Medicine. At an off-campus retreat, a group of faculty with interest in participating, along with the three deans, met to discuss ways to overcome obstacles to implementing the grant. The external facilitators were individuals with negotiation experience at the highest levels of the U.S. government. Early in the retreat, the group realized that those mediation skills would be used to the full extent possible during the discussions that followed. It was easy to identify the obstacles – schedules, accreditation requirements, essential skills and knowledge for each profession, fear of change and loss of autonomy – but much more difficult to identify solutions or ways forward. At one point in the discussion, the nursing faculty stood up and walked out of the room close to tears, the medical faculty tightened into a unified cluster, and the public health faculty wondered what all the “fuss” was about as they already used a multi-disciplinary approach to addressing issues of population health. Instead of capitulating to the emotions in the room, the Vice President simply said, “We have accepted this grant, we have made a commitment, and we will find a way to make this venture work.”

From that time forward, it was clear that IPE was not an alternate choice; it was an essential element of the mission of the health sciences programs. The funding from the Kellogg grant provided an administrative infrastructure and funding for an Executive Director skilled in interpersonal and community relations. The funding also allowed for teams of faculty to work together by buying out teaching time, paying for travel to the two community sites, and providing opportunities for faculty development and scholarship. The impact of the external

stimulus provided by the Kellogg grant should not be underestimated. As a university, we had made commitments, accepted funding, and had an obligation to be successful. We also had the resources and the determination of the senior leadership of the three colleges to take the necessary steps and spend the necessary funds within their units to make it happen. If we consider these events using Lewin's model, the formation of the Division of Health Sciences unfroze the organization, change was inserted with the Kellogg grant and the colleges in the health sciences refroze with an approach focused on interprofessional education that has grown and matured over the intervening twenty-five years.

Being part of a larger national effort to bring disciplines together to improve the health of communities was reinforcing of purpose. The five universities from across the country that were the initial awardees of the Kellogg Community Partnership grants provided support and reinforcement to each other through yearly meetings where programs and progress were compared. This nationwide distribution developed pockets of activity across the country, which added momentum and a sense of urgency to our work. Perhaps most importantly to ETSU, the young Division of Health Sciences had a niche consistent with its mission and was a unifying force for three colleges, which had not previously worked closely together.

As time passed and the Kellogg grant ended, each of the three colleges identified ways to sustain the interprofessional effort. The program hours and requirements were trimmed, but the university's commitment to its partner communities and to the interprofessional mission continued. As the early leaders of IPE at ETSU moved on to other jobs, and new deans and department chairs were hired, the original interprofessional program continued with the Executive Director as the primary champion. The program still had a cadre of dedicated faculty who worked together through the Interdisciplinary Curriculum Committee. Students still enrolled and learned together as teams placed in rural communities. IPE continued to be vital to the mission of the health programs, but the passion was beginning to wane.

New leadership had emerged in the Academic Health Sciences Center since the initiation of the Kellogg program. None of the original deans or senior leadership was in place except the Executive Director of the Community Partnerships program. There was a new vice president and five new deans as the AHSC had grown to five colleges from three when the Gatton College of Pharmacy was formed in 2005 and the College of Public and Allied Health split into two colleges in 2007 creating the College of Public Health and the College of Clinical and Rehabilitative Health Sciences. These new colleges joined the College of Nursing and the Quillen College of Medicine in the AHSC. The new leadership did not feel that the program was growing nor did they feel ownership of the interprofessional curriculum. It was time for renewal and revitalization of IPE at ETSU.

Using Planning Retreats to Confirm Leadership Commitment

At an AHSC planning retreat in June 2010, the AHSC Deans began a series of discussions that continued throughout their regular meetings during fall semester about how to assure that all students graduating from a health professions program at ETSU would have a common set of knowledge, skills, and values gained from IPE. The ultimate goal of the deans was to produce graduates who could work as members of collaborative care teams. While passion for IPE was expressed and a list of current activities ongoing in the AHSC was documented, the time set aside in regular meetings was insufficient for long-term planning.

In order to give this topic the commitment and focused planning that was needed, a two-day planning retreat was scheduled in January 2011. The first day of the retreat included the AHSC Deans and their academic associate deans, who were responsible for curriculum oversight. The objective for this day was to reach consensus on the deans' definition of IPE followed by establishment of five to six learning objectives. On the second day, the deans invited additional individuals, such as department chairs and faculty who would be instrumental to the implementation of an IPE curriculum to join the discussion. A transition event that included a reception, dinner, and a motivational guest speaker was scheduled for the evening of the first day to bring all participants together and set the tone for the day two discussions. The speaker for that event was David Reagan, MD, PhD, Medical Director of the James H. Quillen Veterans Affairs Medical Center, our partner Veterans Administration hospital, and he emphasized the importance of teams and collaboration in health care delivery. Dr. Reagan provided concrete examples from his experience of why teaching students to be active team members is critical to their future as health care collaborators. He demonstrated how a team approach allows his major health system to confront issues of access, quality, patient satisfaction, and efficiency. The collected leadership of the AHSC left the event that evening with these words provided by the speaker: "Teams out-achieve individual efforts, and there are too few health science professional graduates now prepared to work in teams."

This retreat, now viewed as a seminal event in our IPE journey, honored the legacy of the community partnership program while reaching agreement that moving forward, there was a need for a pedagogically based approach that would include identified groups of students. The first day achieved the level of commitment and enthusiasm for taking our interprofessional education programming to the next level. With this "buy-in" by the senior leadership of the AHSC, the task for day two was to begin making this vision a reality.

The second day of the retreat, which included the expanded group of selected department chairs, faculty and two of the doctoral-level public health students who had been influential in planning the retreat, focused on a more detailed discussion of how to move from concept to implementation of broad-based interprofessional experiences. Earlier in the year, the deans had reviewed the accreditation criteria and literature from each profession that advocated interprofessional education. A retreat in the summer of 2010 brought focus to the volume of literature advocating interprofessional education that was appearing in academic journals, government reports, and health care reform recommendations. The AHSC leadership was particularly in sync with recommendations from an international conference reported in *The Lancet*, which provided insight from professional experts worldwide who cited their belief that interprofessional approaches are more efficient, effective and equitable in meeting personal and population health needs (Frenk, et al., 2010). The Summer Retreat had also begun the discussion of overcoming the impediments of scheduling, already overloaded curricula, and cognitive learning level of the students. The work of moving from concept to implementation, therefore, was less daunting with some preliminary focus on a program structure that could be value added (outside of the regular curriculum for each college) and focused clearly on specific learning outcomes common to every graduate/professional student. This proposed program structure provided a framework for small group discussions throughout the afternoon of Day 2. When the participants were able to explore together in their small groups how activities could be developed outside of the curriculum with a defined pedagogy, they were able to develop examples of learning activities to populate a program matrix. As the participants left the retreat, there was a

collective belief that together we could accomplish our goals within a set of prescribed parameters.

While a lot of work and consensus building had occurred from Summer 2010 to the January 2011 retreat, the combined impact of a group coming together to advance an agreed upon goal was significantly enhanced by the two days of focus on common definitions, core values, and expected outcomes. The outcome of our retreat was consensus among the faculty and AHSC leaders who were present to move to the next level of commitment to Interprofessional Education. The group agreed on some very important curriculum components and actions to guide implementation, but the curriculum plan and strategies were yet to be fully developed.

This is the point in our process that we moved from the “top down” approach to the grassroots or “bottom up” process.

Expanding Faculty Involvement

With a common definition, core values, and a curriculum matrix in place, the AHSC leadership next focused on developing an Interprofessional Education Curriculum Committee (IPEC) that would be responsible for developing learning experiences to populate the curriculum matrix. It was readily agreed that the associate deans for academics in each college should be on the committee in addition to one to two faculty/student representatives from each college. The Associate Dean for Academic Affairs for the Gatton College of Pharmacy was appointed to chair the committee. The committee’s charge was to take the components developed at the January Retreat, along with best practices from the literature, to develop an Interprofessional Education Pilot Project that would include students from the graduate and professional programs in all five colleges of the Academic Health Sciences Center. This pilot is described in detail in another article in this supplement and it put into action the theoretical constructs of the ETSU IPE vision. The IPEC was given a clear charge and met periodically with the AHSC Deans during the year before initiating the Interprofessional Education Pilot (IPEP). Deans had the opportunity to provide feedback to the plan as it was being developed, and the committee had confidence that they were creating a pilot consistent with the vision for IPE at ETSU. As the Deans were able to give their endorsement to the pilot as it was being developed, in turn, they were able to clear some barriers to implementation when they arose within their colleges. The process was iterative in nature, roles were clear, and authority was given to the IPEC along with the responsibility of curriculum design.

As the associate deans and faculty worked to create the pilot curriculum, opportunities were found for the Vice President and others to speak with faculty throughout the AHSC about the IPE initiative. The discussion of IPE became central to any public gathering of students and faculty and it grew as a “brand” or a “niche” for our programs. Entering students understood that by choosing the Academic Health Sciences at ETSU they were obtaining a “value-added” education preparing them to be members of collaborative health care teams when they graduated. The importance of collaborative care to quality patient outcomes was stressed in formal and informal ways. Existing interprofessional courses, such as the Health Communication course required for all Medicine and Pharmacy students, were key to providing students and their faculty opportunities to learn team concepts before the beginning of the IPEP. The existing courses in community-based research were also continued as an established curricular approach to interdisciplinary learning opportunities for students. A challenge to the IPEC continues to be

how to retain the best of what has been done, while developing a new approach to interprofessional education.

Faculty involved in establishing the pilot IPE program wanted to approach this process using national benchmarks, but also want to develop a set of assessment and evaluation tools to validate the outcomes. This evaluation process added a level of credibility to the pilot, but also provided a mechanism to test effectiveness of various methods being used. Underlying this emphasis on assessment was a belief we were truly doing work that could be replicated and we needed the evidence to share this work with others. This scholarly approach to the pilot was very persuasive to our high achieving faculty who wanted to be part of the experiment in education of our students.

Students were excited about being on the cutting edge of IPE nationally. Led by a senior pharmacy student, an interdisciplinary group of students created a student organization supporting interprofessional education at the student level. This organization called the “Association of Interprofessional Healthcare Students” or “AIHS” brought extensive visibility to IPE and reinforced the faculty’s resolve to develop and implement a program that would provide essential foundations for working in health care teams. The students planned programs and activities to promote understanding of the roles and role responsibilities for different members of the health care team. Their energy and enthusiasm were contagious. AHSC dedicated its second annual report to the activities of IPE and featured activities from an AIHS meeting on the cover.

In the period of less than two years, it was evident to students, faculty, and the AHSC deans that IPE is a hallmark of our educational programs. We used slogans like, “IPE – it’s in our DNA” to describe our central to our vision this approach to education was for our health profession programs. We built on areas of strength and communication among the health professions deans to articulate a common vision, and we were able to translate that vision to dedicated faculty who were excited about collaborative practice and eager to facilitate interprofessional learning among their peers and students.

Further, financial support was identified to provide release time for the Chair of the Interprofessional Education Committee (later changed to Interprofessional Education and Research Committee – IPERC – to reflect the important role of interprofessional research). Two Graduate Assistants were funded to support the chairs and to assist with data collection and activities of the committee. In the past year, a faculty fellowship program has been established to provide dedicated time for one or more faculty members to work with and expand the capacity of the IPERC Chair. Funds to support interprofessional faculty and student grants have also been designated. It is anticipated that in time oversight of the IPERC efforts will become more formally integrated into the governance structure by identifying an Associate Vice President responsible for interprofessional education and research. As we transition from the IPE pilot to full implementation (including all graduate students and eventually all undergraduate students), it will be increasingly important to have the governance and support infrastructure in place to: 1) coordinate student activities, 2) work with colleges to assure curriculum integration, and 3) provide the faculty development and support necessary to maintain momentum.

Reflections on Progress to Date

An Academic Health Sciences Center is comprised of a large number of individuals coming together with a variety of backgrounds, educational dogma, and professional ideals. Bringing this group of professionals together in concert to achieve a common goal was critical for the advancement of IPE at ETSU. The value and role of each person had to be respected. Deans needed ownership of the vision as much as the faculty needed ownership of the curriculum. Students also had to recognize the value of these experiences to their educational portfolio. The serendipity of the students creating their own professional association added more impact than faculty could have generated on their own. The challenge has been finding student leadership who can sustain the passion of the founders.

The momentum continues and the passion is still alive for faculty and administration. However, neither passion nor momentum are self-sustaining. It is important to realize that reinforcing the culture is a critical function of the senior leadership of the AHSC. The fact the pilot program has evolved, faculty members have participated in a national workshop, bonds have been created and other support systems are developing continues to stimulate interest and commitment. It is now time to build incentives into the promotion and tenure system to make interprofessional work part of the expectations of the faculty role. Likewise, identifying ways to make interprofessional work “hard-wired” into the curricula of each professional school will secure IPE as integral to student success in our programs. Additional strengthening of the infrastructure and financial support will also be critical to sustaining this initiative.

There is still much work to do. Having established a culture of planning and working together, it is natural to move into a strategic planning mode where interprofessional education and research will be integral to our future. Development of our five-year strategic plan for interprofessional education and research is in process. We can only hope that through systematic and committed focus, we will be successful in putting into place ...”a new order of things.”

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