

The Big Ten IPE Academic Alliance: A Regional Approach to Developing Interprofessional Education and Practice

By

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(Revised Draft)

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Abstract

Interprofessional practice and education (IPE) efforts has greatly increased in the past few years, primarily through the leadership of several national and international organizations. These organizations have sponsored forums for information exchange and best practices, which has significantly influenced the development of programs across various educational institutions and practice environments. Several regional groups have emerged, organized around a common purpose and geographic proximity, to share ideas and implement new IPE programs across the cooperating organizations. This article describes the history and growth of one of the newer regional groups, the Big Ten IPE Academic Alliance. Included in this discussion is how the group was created, its governing structure and the various results of its efforts. The intent is to provide expanded guidance how to develop regional groups that are effective vehicles for the successful implementation of IPE within educational and health settings.

Background

Educational strategies to develop interprofessional practice and education (referred to as the “new IPE” or IPE¹) have increased rapidly in the past few years, promoted by groups such as the World Health Organization (WHO)², the Institute of Medicine (IOM)³ and the National Academies of Practice (NAP)⁴. Several important organizations have been created to focus on these efforts: the Interprofessional Education Collaborative (IPEC)⁵, the National Center for Interprofessional Practice and Education¹, and the American Interprofessional Health Collaborative (AIHC)⁶.

Discussions regarding how to achieve the IPE goals take place at national meetings such as the annual NEXUS Summit¹ and international meetings such as Collaborating Across Borders⁷ and All Together Better Health⁸. These discussions spurred the growth of regional IPE groups designed to meet more local needs (in this case, the term “regional” is defined as a geographic area with similar characteristics such as location, activity, or administrative structure). Four prominent regional groups are the Midwest Interprofessional Practice, Education, and Research Center (MIPERC),⁹⁻¹⁰ the Northeastern/Central Pennsylvania Interprofessional Education Coalition (NECPA),¹¹ the Route 90 Collaborative,¹² and the Yakima Valley Interprofessional Practice & Education Collaborative.¹³ The purpose of this paper is to describe a new regional arrangement, with unique qualities, formally known as the Big Ten IPE Academic Alliance (referred in this paper as the “IPE Alliance”).

The Big Ten Academic Alliance

The Big Ten IPE Academic Alliance is a subgroup of the larger Big Ten Academic Alliance (previously known as the Committee on Institutional Cooperation). It is the academic counterpart to the Big Ten Athletic Conference and formed in 1958 by its presidents¹⁴. Currently, this group consists of 14 institutions led by their provosts. According to data published in 2016, the 14 institutions have about 600,000 students enrolled, including more than 110,000 graduate students. They employ almost 50,000 faculty and generate nearly \$10 billion dollars in research expenditures. Most of the universities are highly ranked by international and national ranking systems. They are all large institutions (ranging from 22,000 to 60,000 students on their main campuses), have both large graduate, professional, and undergraduate programs (about 70% undergraduate) and are geographically contiguous (representing the Great Lakes, Great Plains, and Mid-East regions of the United States)¹⁵.

The Big Ten Academic Alliance works together in a number of formal collaborative efforts, such as an Academic Leadership Program for faculty, collective resource sharing among libraries, technology collaboration, and a Student Summer Research Opportunities Program¹⁴. Informal peer groups who self-organize are also encouraged. Although they do not officially represent the Alliance, they are useful information-sharing groups. Examples are the Cancer Research Centers, Colleges of Pharmacy, and the Schools of Nursing¹⁴.

Creation of the IPE Subgroup

Discussion of creating a Big Ten IPE Academic Alliance subgroup began at the Collaborating across Borders (CAB V) conference in Roanoke, Virginia during the fall of 2015¹⁶. It was apparent that most universities were approaching IPE implementation with variable success, especially when operating alone. Fortunately, a number of representatives from several of the Big Ten Schools were present, including two former Deans of Pharmacy who had been members of the Big Ten Academic Alliance Pharmacy subgroup. Several of the representatives were also members of MIPERC or NECPA. These experiences generated some discussions about the possibility of creating a new regional IPE group among the Big Ten schools. This new regional group would complement the current ones by utilizing an existing, long time, large-scale inter-university network.

The Big Ten participants at the CAB meeting agreed to contact other conference institutions to ascertain their interest. An immediate challenge was how to identify the appropriate representatives. The first step was to contact the directors of the few formal IPE programs (which typically had their own website). Only a few existed. Additional individuals were identified through general contact lists previously developed by MIPERC, the National Center for Interprofessional Education and Practice, or through a research project that surveyed universities about their IPE activities. This multifaceted approach was successful in identifying the appropriate representatives from each institution. Table 1 (the first table in Appendix A) lists the various institutions involved in the IPE Alliance.

Health science educational programs at the Big Ten universities are numerous, representing about 20 different disciplines. Most of the universities have at least eight on their campuses. The most common disciplines (existing at a minimum of nine of the universities) are dentistry, dietetics/nutrition, medicine, nursing, pharmacy, physical therapy, public health, and social work. At least 50,000 health science students could be potentially involved in IPE activities across the 14 universities.

Organization

Based on the members' experience with other regional groups, it was decided that the best forum for interaction was monthly one-hour telephone conferences and a yearly day-long, face-to-face meeting, held concurrently with the Nexus Summit sponsored by the National Center for Interprofessional Practice and Education¹. A two-year rotating member leadership team consisting of a chair and a chair-elect (the current chair would rotate in a "past chair" position once his or her one-year term is finished) lead the meetings. The leadership team is responsible for setting meeting times; planning the agenda; continuously monitoring the iterative evolution of core topics; recording and distributing minutes; and coordinating information sharing. The first monthly meeting was held April 28, 2016. The first annual meeting was held in August 2016. A typical monthly meeting agenda is shown in Appendix B.

Mission Statement

One of the group's first initiatives was to establish a mission statement, described below:

"The Big Ten IPE Academic Alliance aims to facilitate sustainable interprofessional practice and education through multi-institutional collaboration, innovation, scholarship, and resource-sharing that leads to improved education, better care, added value and healthier communities."

This mission statement is similar to those of other regional groups,⁹⁻¹³ all of which focus on interprofessional collaboration and innovation across various universities. The main difference is the IPE Alliance collaboration is much larger and more diverse.

Results of the Collaborative Effort

The membership reviewed the efforts and accomplishments of other regional groups⁹⁻¹³ in order to complement or build on their efforts. They primarily focused on the following activities.

Developing a data repository. One unique approach was to develop a repository of comparative data describing the nature, scope, and depth of IPE implementation across the Big Ten institutions. The effort is still in progress. When fully functional, the data repository will enable easily accessible cross-institutional sharing in areas of common metrics, such as faculty and student involvement, curriculum use, and resources dedicated to IPE. Besides quantitative data, the repository includes narratives about topics such as faculty development, curriculum design, and assessment. Although still in the developmental stage, the existing data have allowed IPE Alliance members to use the information in developing strategic proposals for their own universities. For example, several representatives have used the data to outline the staffing and structural needs for their institution to expand their universities' IPE goals.

Comparing organizational structure and strategic planning efforts. The Universities used different approaches, as noted in Table 2 (the second table in Appendix A). The approach used is dependent on the age of the initiative and the commitment of the university leadership. The sharing of the IPE structures at each university has resulted in changes at many. For example, members of universities without a formal leadership structure have advocated for one; in some cases they have already succeeded. Another example is the success of some members in increasing the budget allocation to IPE at their universities based on information from their better-funded peers.

Curriculum. Developing innovative curricula that can be shared across various disciplines, schools, and universities is a key focus among all groups⁹⁻¹³. The IPE Alliance uses the same approach but on a larger scale, with future plans to take advantage of the Big Ten Academic Alliance's formal commitment to shared educational experiences. This commitment is illustrated by a program called CourseShare that allows Big Ten students to register for designated "shared" courses at the same time and in the same manner as regular courses. It is typically used for less popular offerings at each university (such as certain language courses) in order to consolidate resources. Grades and credits are reported on the student's home university transcript. There are no additional fees associated with shared courses, making them even more attractive to students. Faculty and department contacts at the institutions are responsible for initiating and approving the shared course. Over 130 different less commonly taught languages (LCTLs) have been shared using CourseShare including Swahili, Thai, Vietnamese, and Islamic and Korean Studies.¹⁷

Not surprisingly, the current IPE curricular efforts vary by university as noted in Table 3 (the third table in Appendix A). There are also significant similarities. For example, members have begun joint discussion regarding the planning and implementation of foundational experiences for the IPE Alliance students. This includes discussion among several universities on sharing an online introductory course on IPE. Another discussion is the development of inter-university assessment of student IPE progress, an approach used previously by the Big Ten Alliance Pharmacy Subgroup¹⁸.

Faculty engagement and development. All the regional groups have been involved in the professional development and engagement of their faculty. Their efforts range from workgroups, conferences, workshops, written guidelines, and small grant programs⁹⁻¹³. Several of the IPE Alliance members have tried similar approaches as noted in Table 4 (the fourth table in Appendix A) with a goal of sharing efforts in the future. The IPE Alliance is also extending beyond the other regional groups in examining the incentive and barriers to faculty involvement in IPE that a common across the institutions.

Impact

As with the other regional groups,⁹⁻¹³ establishment of a Big Ten IPE Academic Alliance gives practitioners and educators from diverse institutional backgrounds an opportunity to promote development, evaluation, and dissemination of best practices by sharing ideas and eventually resources. By connecting across institutions and working together, to assist the needs of all, IPE Alliance members benefit from engagement with like-minded institutions and individuals to solve issues that will advance health education and delivery. Moving beyond one's own institution, to consider what is occurring at peer institutions, can be a powerful force to move the IPE field along quicker and result in greater accomplishments than could be achieved alone. The structure of the IPE Alliance is similar to that of other successful

regional groups in several ways, including: limiting membership to a small number of institutions, with designated representative from each institution, and having all major costs (travel, meeting, communication, project-related) assumed by member institutions¹⁹⁻²⁰.

Although the IPE Alliance is relatively new, this collaborative impact is already beginning to occur. Members are sharing administrative strategies to facilitate the effective implementation of IPE at their institutions, instituting plans to share data, comparing organizational strategies, co-developing similar curricular offerings, and exchanging ideas for developing a faculty workforce skilled and motivated to teach and practice IPE. Some of these efforts are common to other regional groups,⁹⁻¹³ but have the added advantage of an existing, long-standing inter-university leadership structure that can facilitate the necessary shared changes needed to develop sustainable IPE programs.

The external impact has been limited so far, which is not surprising given the relative newness of the group. The IPE Alliance has had several conversations with representatives of the Health Professions Accreditation Collaborative (HPAC) regarding joint plans to develop best practices for implementing IPE activities across disciplines. The conversations have focused on identifying the IPE accreditation issues that each university is likely to confront (e.g., inconsistent interpretation from the various accrediting bodies, the lack of guidelines for the overall university response, minimal acceptable contacts with other disciplines) and sharing those concerns with HPAC as they formulate their IPE requirement. Members are also working together in preparing presentations and papers that jointly address key issues in the implementation of IPE, such as promotion and tenure incentives, implementation of innovative curricula, and faculty development programs.

Key Features for Success

The Big Ten IPE Academic Alliance is a successful and productive regional group that is promoting IPE sustainability and growth across 14 large, complex, research-intensive academic institutions. Based on the group's activities since its creation in 2016 and the experiences of other regional groups⁹⁻¹³, several characteristics stand out as necessary and generalizable to others who desire to create similar initiatives.

Clear vision of purpose. The presence of other regional groups helped in establishing the purpose of the IPE Alliance, especially the Mission Statement⁹⁻¹³. The creation of the IPE Alliance also benefited from the experiences that the initial leadership brought to the group. Two of these individuals were former deans of Big Ten Colleges of Pharmacy and participants in a similar alliance for pharmacy schools. Others were part of regional groups such as MIPERC or NECPA. This experience participating in regional groups created a workable structure relatively quickly and allowed the IPE Alliance members to address key common issues almost immediately.

Common mission and geographic proximity. Similarity of purpose and geographic proximity are important features of regional groups⁹⁻¹³. The Big Ten IPE Academic Alliance has the added advantage of a long history of working together on multiple academic issues¹⁴.

Forum for formal/informal interaction among members. Monthly meetings and an annual face-to-face meeting create many opportunities for members to share ideas, advance consensus topics, and provide feedback to one another, similar to other regional groups⁹⁻¹³. The IPE Alliance extends this interaction by encouraging members to post questions in a shared forum and the creation of a common data repository.

Members have a clear responsibility. A unique feature of the IPE Alliance is that the member universities selected their IPE Alliance members to serve in this regional subgroup. Thus, the commitment to share is from the university, not the individual. The key criterion for selection was having some level of responsibility for IPE activities at the university level. Members could have formally titled positions (e.g., Associate Dean, Vice-Chancellor, Director) and oversee large programs or they could have designated informal responsibilities in smaller initiatives. Most report directly to key administrators (e.g., Chancellor/Vice-Chancellor of health or clinical affairs; Provosts, Health Science Deans Council). All

members are responsible for representing their respective institutions and encouraging its participation in various alliance projects. Although others from the member institutions can participate, there is only one IPE Alliance representative per university.

Relatively small number of Universities involved. Group size is a key distinguishing factor between national and regional IPE groups. Regional groups size vary from five (Route 90 Collaborative and Yakima Valley Interprofessional Practice & Education Collaborative) to 25 (MIPERC)⁹⁻¹³. The IPE Alliance has 14 members, which is a manageable size and comparable to NECPA¹¹. The key is to choose a number that is small enough for efficient sharing of information yet large enough to have sufficient diversity of input.

Forming a Regional Group: Lessons Learned

The important factors in forming regional groups are compatibility and willingness to develop a sustainable entity⁹⁻¹³. Compatibility facilitates the sharing of ideas and the creation of common solutions. For the IPE Alliance, the long history of Big Ten universities working together enhance commonality.

Willingness to develop a sustainable entity requires commitment from the members to meet regularly and assume some responsibility for implementing the regional group's within their institutions. The University administration should officially designate their representatives in order for the members to be effective and accountable. Single representatives seem to ensure more accountability. Other participants can be added later as part of more narrowly focused subgroups. For example, MIPERC includes a set of "champion subgroups" that focus on professional development, curricular development, and clinical simulations, respectively¹⁰.

Individuals who are interested in starting regional groups should first learn if their university is already part of an academic sharing group. Some athletic conferences are similar to the Big Ten in that they have parallel academic arrangements. This arrangement is beneficial because a formal network of cooperation and information sharing already exists. If a conference network does not exist, an alternative may be a regional or statewide connection. This is the most common regional approach currently used, as indicated by MIPERC (mostly Michigan and the surrounding states)¹⁰⁻¹¹, NECPA (NE/Central Pennsylvania)¹¹, the Route 90 Collaborative (upstate New York)¹² and the Yakima Valley Interprofessional Practice & Education Collaborative (Washington state)¹³.

Forming a regional IPE group should be a thoughtful undertaking and strategically planned. Successful initiatives are most likely when academic institutions share many commonalities and have membership from engaged individuals who are willing to lead and participate. Ultimately, thoughtfully formed regional interprofessional groups may hold the key to the national and international goals of improved patient experience and health outcomes.

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Appendix A

Table 1

Universities in the Big Ten IPE Academic Alliance

University name

Indiana university^a
Michigan State University
Northwestern University
Penn State University College of Medicine
Purdue university^a
Rutgers, The State University of New Jersey
The Ohio State University
University of Illinois at Chicago^a
University of Iowa
University of Maryland-Baltimore^a
University of Michigan
University of Minnesota
University of Nebraska Medical Center^a
University of Wisconsin

^aThe Academic Health Science Center (or Academic Medical Center) is located on a different campus from the main one.

Table 2

Discussion of University IPE Organizational Structure

Issue	Similarities	Dissimilarities	Comment and Action
Infrastructure	<ul style="list-style-type: none"> • Each university has a formally recognized representative. • Representatives report to some type of university leadership. 	<ul style="list-style-type: none"> • Reporting lines vary, ranging from the Provost, Vice chancellor/VP for health to a Dean of a College. • Some programs are fully funded and have extensive Centers while others have small informal groups of volunteers. • Representatives come from all disciplines; pharmacy is the most common. 	The consensus is to move toward a more formal mechanism to encourage inter-unit cooperation. Other approaches besides a Center are being evaluated (e.g. Interprofessional Council or Office).
Level of Funding	<ul style="list-style-type: none"> • Some level of funding is available. • Funding typically is from internal re-allocation of funds. 	<ul style="list-style-type: none"> • Amount varies significantly, from over \$1 million annually to a few thousand with no annual budget. 	The level of funding appears to be related to age of the initiative because some of the less funded programs are reporting budget increases as their IPE efforts increase. Members generally believe that the focus of the funding should be toward administrative support of the initiative. Teaching support should come from the units involved. Some institutions are considering more stable funding sources. One prominent possibility is student fees; another is designated tuition allocation. The members are not favoring continued support primarily by external grants.
Location	<ul style="list-style-type: none"> • Large, complex universities. • Many health disciplines (Average=8). • Affiliated with academic health/medical center. • Research Intensive. 	<ul style="list-style-type: none"> • Some members are located on the main campus; others are part of a quasi-independent academic health/medical center. 	Almost all of the units are in environments that allow significant interaction with a diverse set of health care professionals and providers. The IPE educational programs developed by each of the universities reflect this diversity.

Strategic
planning

- Commitment from university leadership.
- Commitment varies financially and by allocation of resources.
- Extensive strategic planning has occurred in only a few intuitions.

All members recognize the value of strategic plans although the approach to planning varies. Some plans are limited while others are extensive and based on organizational theory. The value of any of the plans is unproven due to the limited history of the IPE initiative at each university.

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Table 3

Discussion of Curricular Efforts at Each University

Issue	Similarities	Dissimilarities	Comment and Action
Curricular plan	<ul style="list-style-type: none"> • All have a curricular plan. • Most are based on IPEC competencies and progression. • Lacking a strong linkage to collaborative practice experiences. 	<ul style="list-style-type: none"> • The extent of the plan varies from very rudimentary (e.g., a small collection of activities/courses) to comprehensive offerings. • Some plans focus on longitudinal curricular maps for all students; others use a more “menu” driven approach. 	The lack of a comprehensive curricular plan usually reflects the age of the program. The different approaches reflect the diversity of the opportunities for interprofessional interaction. The institutions will continue to work toward a common curricular plan, which will undoubtedly include the different expectations of accreditors.
Foundational experiences	<ul style="list-style-type: none"> • All have or are contemplating a set of foundational experiences for their students. 	<ul style="list-style-type: none"> • Experiences range from organized “get together”, to online offerings of introductory modules coupled with student asynchronous interactions. 	The size and diversity of the health student body at each of the universities represents a challenge to providing meaningful, cost effective experiences. A key is the use of technology such as asynchronous discussions of online case studies or simulations coupled with synchronous class discussion in smaller groups. Several of the members are working together to create a scalable, efficient system for delivering the appropriate introductory experiences.
Assessment	<ul style="list-style-type: none"> • Focus on IPEC competencies. • Based primarily on student self-report or faculty observation. • Movement toward practice competencies. 	<ul style="list-style-type: none"> • No uniform approach regarding actual measures used. 	All universities will eventually have an assessment plan based on student reports of attitude and behavioral change. The plans vary by discipline dependent on the accreditors of that discipline, although some commonality is expected. No university has developed a comprehensive program to assess the impact of IPE efforts on specific or general health care outcomes. Assessment efforts will improve, partially due to accreditation pressures.

Table 4

Faculty Development Activities

Curricular Issues	Similarities	Dissimilarities	Comment and Action
Faculty engagement	<ul style="list-style-type: none"> Members are dependent on a set of volunteer faculty who are “champions” for IPE. Inconsistent involvement of other faculty. 	<ul style="list-style-type: none"> Some programs have formal structures (e.g., Executive Committee, Advisory Council) to get faculty involved in administering the initiative; others do not. Funding faculty efforts for administrative or teaching efforts vary. Some universities provide administrative support but funding faculty release time to teach IPE is rare. 	The members recognize that the IPE Initiative at their universities must evolve beyond faculty volunteers or champions to become sustainable. The faculty incentive structure and better training/development need to be addressed.
Faculty incentives/rewards	<ul style="list-style-type: none"> All members recognize that there are inadequate incentives or rewards for faculty involvement in IPE activities. The faculty reward system needs to be more balanced between research productivity and educational excellence. 	<ul style="list-style-type: none"> Only a few are examining/developing strategies to create better incentive/rewards for faculty involvement. There is no consensus among the members about what incentives/rewards would be acceptable. 	The IPE Alliance members are investigating ways to encourage faculty involvement in IPE activities, although only a few have been tested or implemented. These include teaching awards; scholarship incentives; recognition of IPE as an educational innovation; and special designations of faculty involved in IPE activities or completed training programs (e.g., certification).
Faculty development programs	<ul style="list-style-type: none"> All recognized a need to develop a faculty workforce skilled in teaching IPE and to act as leaders and change agents. 	<ul style="list-style-type: none"> Some of the universities have formal faculty development programs, but most do not. 	Several pilot programs are being tested. These include an extensive leadership “fellows” program, small workshops, small grant projects, interprofessional conferences, and certification programs.

Appendix B: Example of a Monthly Meeting Agenda

Big Ten Workgroup Monthly Meeting

Thursday, April 19, 2018

12 –1 pm EST (11 – 12 pm CST)

Join from PC, Mac, Linux, iOS or Android: XXX

Or Telephone: Dial: XXX

AGENDA

1. Welcome and Roll Call
2. Nexus Summit Registration Update
3. Potential sites for Society of Teachers of Family Medicine interprofessional project
4. Survey results, T&P Practice
5. Feedback/Input, Collaborating Across Borders VII
6. April Discussion Topic: Trends in IPE Scholarship
7. Guidelines for Scholarship
8. Updates and Announcements
9. Important Dates
 - a. Big Ten IPE Annual Meeting – July 28, 2018
 - b. Nexus Summit (<https://summit.nexusipe.org/register/details>) – July 28-July 31, 2018
 - c. All Together Better Health, Auckland New Zealand (<http://www.atbhix.co.nz/>) – September 3-6, 2018
 - d. Collaborating across Borders VII - October 20-23, 2019
 - e. Jefferson Interprofessional Education Conference (https://www.jefferson.edu/university/interprofessional_education/2018-conference/overview.html) - October 26-27, 2018
 - f. **Next Big Ten IPE Meeting:** May 17, 2018 11 am CST | 12 pm EST
 - g. Others?
9. Summary and Follow up