Connecting Academic Programs and Clinical Practice Together to Inform System Improvement

2019 ASAHP Summit

May 31, 2019
Saint Louis University
St. Louis, Missouri

ASAHP ASSOCIATION OF SCHOOLS OF ALLIED HEALTH PROFESSIONS

Kindred Healthcare
Kindred Hospitals
Kindred at Home
Kindred Hospital Rehabilitation Services
RehabCare

SAINT LOUIS UNIVERSITY
DOISY COLLEGE OF HEALTH SCIENCES

2019 ASAHP SUMMIT

This Summit was a collaboration between the Association of Schools of Allied health Professions (ASAHP), Saint Louis University, and Kindred Healthcare bringing multiple stakeholders together to discuss important factors in the connection between academia and industry with the goal of reviewing recommendations put forth by ASAHP's Clinical Education Task Force and co-creating strategies that can make practical improvement to enhance health professions education and improve the health of persons, communities and the population.

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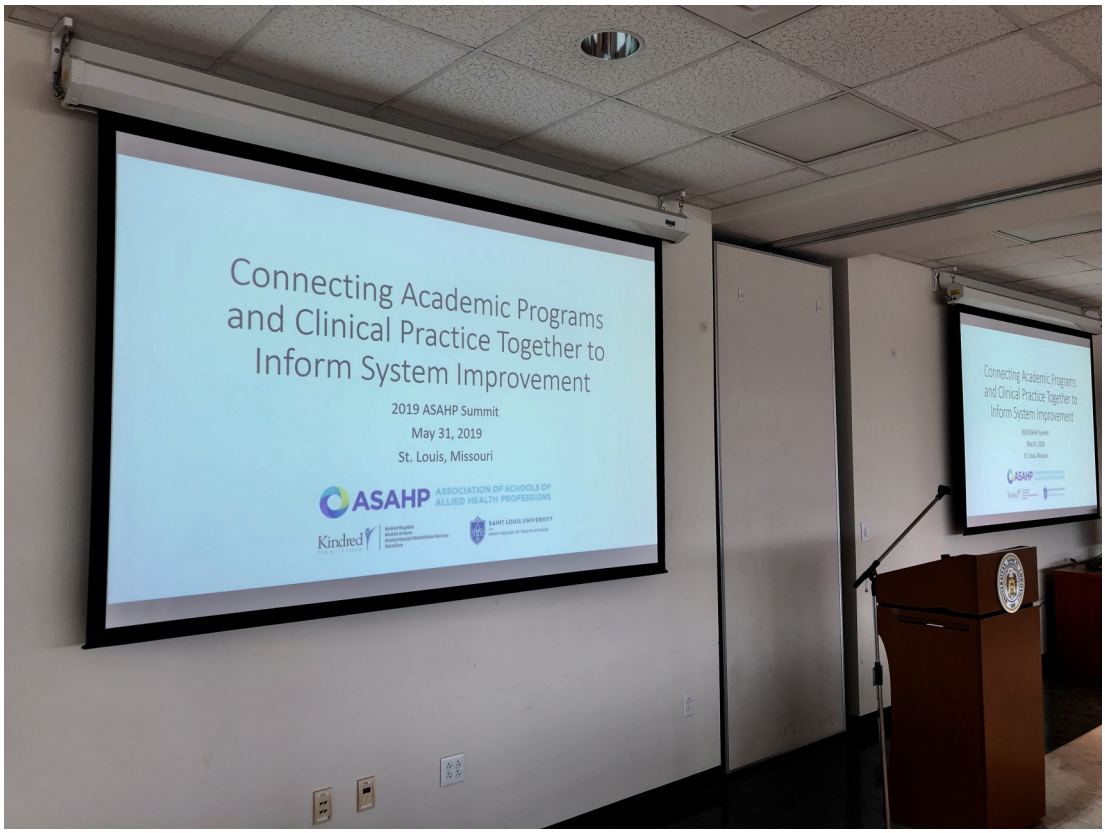


PROJECT OVERVIEW

The Association of Schools of Allied Health Professions hosted its 2nd Annual ASAHP Summit on Friday, May 31, 2019 at Saint Louis University in St. Louis, Missouri. The theme of this year's Summit, co-hosted by Kindred Healthcare and Saint Louis University's Doisy College of Health Sciences, was "Connecting Academic Programs and Clinical Practice Together to Inform System Improvement". It was a collaboration between ASAHP's Professional Education Committee and Clinical Education Task Force (CETF).

The ASAHP Clinical Education Task Force (CETF) conducts ongoing literature review and research for ASAHP, on behalf of deans and other stakeholders, to improve and strengthen the value of health science clinical education programs to ensure safe, quality, cost effective care.

The practice models, interdisciplinary team functions, intersecting competencies, economies, and settings of contemporary healthcare are all in flux, demanding the need to reconsider health professions clinical education. ASAHP and Allied Health (AH) deans, collectively and individually, must determine the priorities and strategies to embrace in advancing the future of AH education.

CETF has published and submitted for review papers that offer broad considerations and practical recommendations aligned to vitalize clinical education and spark dialogue. In this way, CETF affords guidance toward less stressful and more efficient learning systems, while providing value to all stakeholders in educational and healthcare arenas.

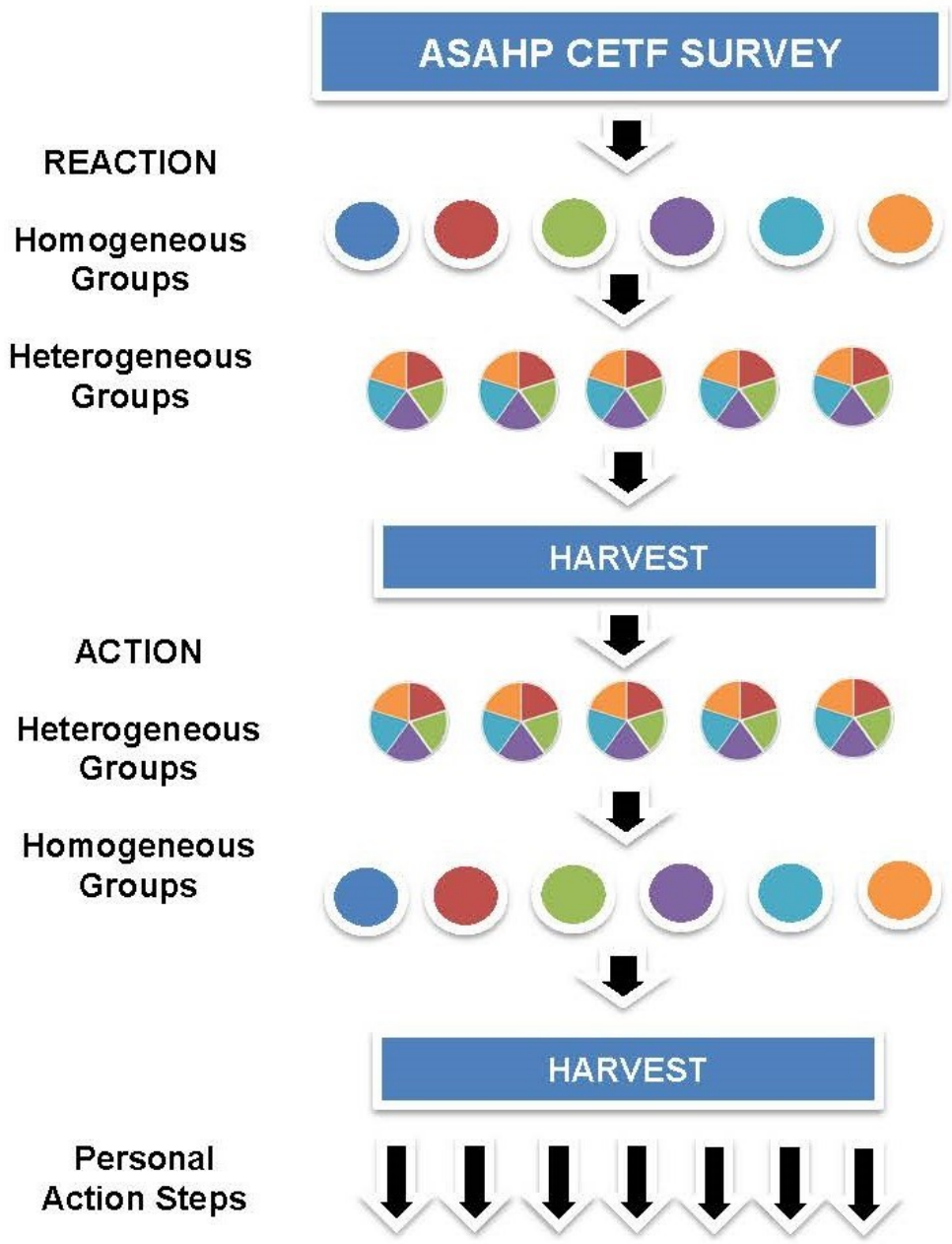
In 2018 the ASAHP CETF presented a report "Clinical Education in Transition: Recommendations and Strategies from the Clinical Education Task Force of the Association of Schools of Allied Health Professions" which made 5 recommendations on the future of clinical education for academic institutions and the health care industry:

1. *Establish strategic partnerships between academic programs and healthcare organizations*
2. *Build Interprofessional Practice (IPP) into pre-clinical curriculum and CE assessments*
3. *Incorporate healthcare technology in allied health education*
4. *Articulate IPCP principles and benefits to leaders in healthcare systems, higher education, accreditation commissions, professional organizations, and government*
5. *Conduct and disseminate CE research and scholarly activity*

The Summit brought multiple stakeholders together in a convenient venue to discuss important factors in the connection between academia and the healthcare industry. Using the framework of the CETF's 5 recommendations for improving clinical education, this project was designed to create specific strategies to enhance health professions education and improve the health of persons, communities and the population.

In preparation for the Summit, the academic and healthcare industry professionals completed an electronic survey on perceived importance, personal interest and engagement with 5 ASAHP CETF Recommendations.

Demographic factors such as professional role and profession/discipline were also collected in the survey. Survey participants then had the opportunity to participate in a face-to-face Summit. 349 persons responded to the survey. 25 of the respondents chose to participate in the Summit.



The Summit began with a foundational presentation that provided background in Interprofessional Education and Collaborative Practice as well as the ASAHP CETF Recommendations. In that presentation, the aggregated data from the pre-Summit survey was shared with the participants. After lunch, facilitated breakout sessions began, first grouped by professional role (academic administrator, healthcare administrator, clinical education coordinator, clinic director, academic faculty, and clinician/preceptor).

These homogeneous groups reacted to role-specific data from the pre-Summit survey. The participants were then put in heterogenous groups mixing individuals from different roles.

These new groups continued to react to the summit survey results.

Then a large group harvest session was conducted reviewing feedback from the breakout groups. After a short break, the heterogenous groups re-convened to determine strategies for action moving forward.

Participants then returned to their original homogenous groups to make recommendations for action by professional role. Then the large group came together for a final harvest session to discuss strategies and action steps for ways to work collaboratively to improve clinical education.

The Summit concluded with an individual reflection session where participants committed to at least one tangible action in their work moving forward.

Finally, many of the participants kept the day of fellowship and learning going at Busch Stadium where they sat together watching the St. Louis Cardinals play the Chicago Cubs.

Overall, the 2019 ASAHP Summit provided a great opportunity for dialogue and action between representative from academia and the healthcare industry. It is hoped that this method can be replicated in other regional settings to enhance collaboration with the ultimate objective of improving health outcomes.

Some Rules of Engagement (also on your table)

- Bring your experiences and expertise, AND
- Be open to new ideas, ways of working.
- "Presume the good" and suspend judgment.
- Step up and step back.
- Be aware of power, silence, dominance.

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PRE-SUMMIT SURVEY

- Professionals from academia and the healthcare industry were asked to complete an electronic survey on perceived importance, personal interest and engagement with the 5 ASAHP Clinical Education Task Force (CETF) recommendations.
- Demographic factors such as professional role and profession/discipline were also included in the survey.
- 349 persons responded to the survey/322 surveys were included in the survey data, 25 surveys had incomplete data and were excluded.

Demographics—Professional Role

Role	%	Count
Academic Program Faculty	33.9%	109
Clinical Education Coordinator (ie. CEC, CCE)	11.5%	37
Academic Administration (ie. Chair, Dean,VP)	13.4%	43
Clinician/Preceptor (ie. Staff RN, PT)	18.9%	61
Clinical Director (ie. CCO, DOT)	6.2%	20
Healthcare Administrator (ie. CEO, CFO, VP, COO)	5.9%	19
Other	10.3%	33
Total	100%	322

Demographics—Profession

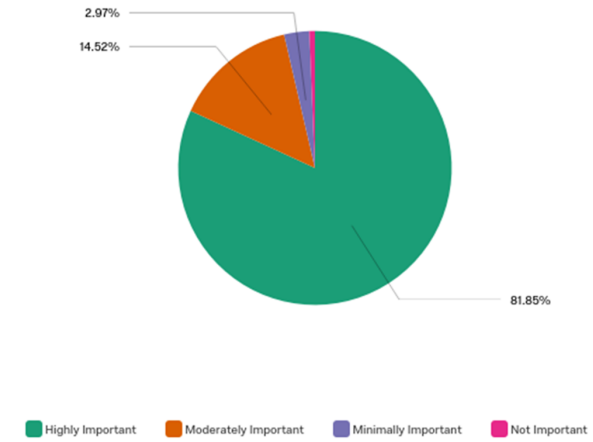
Profession/Discipline	%	Count
Athletic Training	7.53%	33
Audiology	0.68%	3
Dentistry	0.46%	2
Dental Hygiene	0.91%	4
Emergency Medicine	2.51%	11
Exercise Physiology/Kinesiology	3.20%	14
Health Care Administration	5.71%	25
Health Information Management	3.20%	14
Medical Laboratory Science	2.28%	10
Magnetic Resonance Imaging	0.00%	0
Medicine	5.71%	25
Nursing	7.08%	31
Nutrition and Dietetics	2.97%	13

Profession/Discipline	%	Count
Nuclear Medicine Technology	0.91%	4
Occupational Therapy	10.27%	45
Pharmacy	1.60%	7
Physical Therapy	10.73%	47
Physician Assistant	6.62%	29
Psychology	1.14%	5
Public Health	2.51%	11
Radiation Therapy	1.14%	5
Radiology	2.51%	11
Social Work	1.60%	7
Speech-Language Pathology	8.68%	38
Not Applicable	1.14%	5
Other:	8.90%	39
Total	100%	438

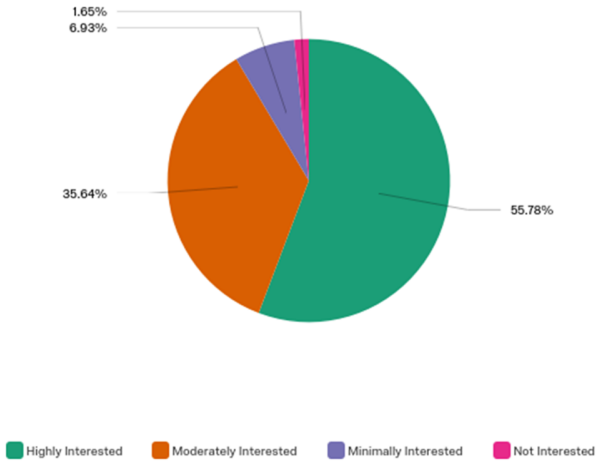
ASAHP CETF SURVEY DATA

Recommendation #1:
Develop meaningful strategic partnerships between academic and healthcare organizations to prioritize evolving needs for current and future healthcare.

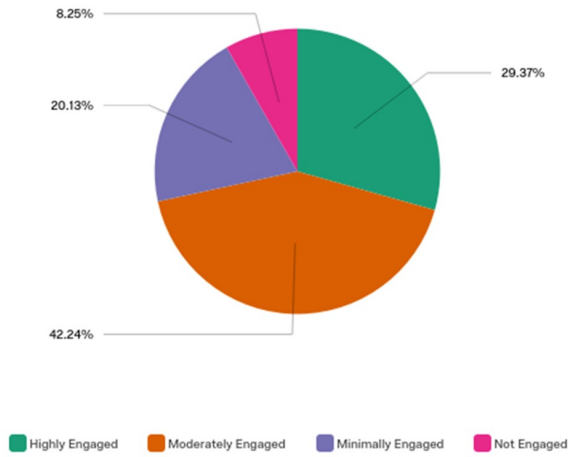
Level of priority/importance of this recommendation:



My personal level of interest in this recommendation:



Engagement in this area in my current role:



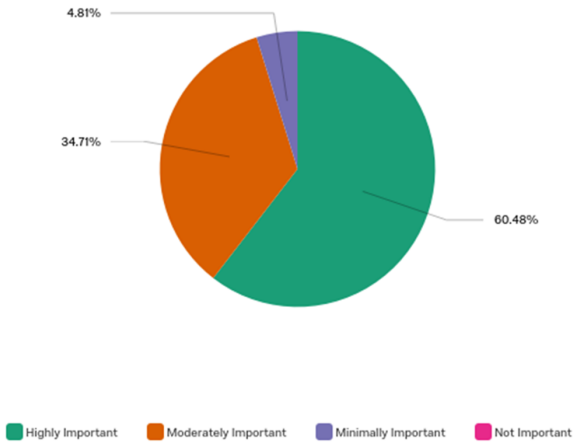
Comments:

- Healthcare is changing faster than schools can educate on the changes. New graduates coming out have different expectations than the regulations, placing more education and stress on employers to bridge the gap.
- High interest due to the need for succession planning. A larger number of our staff will be retiring in the next five years and we need to ensure that there are skilled and highly capable persons able to fill these positions.
- It is critical that students not only have the necessary academic preparation but the "soft skills" to be able to meet the needs of the work force.
- It is imperative that schools of health professions partner with health systems. When health systems are involved with the training of health professions students, not only does it potentially reduce their recruitment costs, but it also can model optimal team practice, improve population health, and help systems successfully navigate the challenges of value-based reimbursement models. For the schools, such partnerships are essential to securing sufficient and reliable training opportunities.
- Healthcare evolves very rapidly; when a gap exists between education and health entities, it results in poorer performance by both entities.
- All need to be aware of what each other can do and then work together for better healthcare.

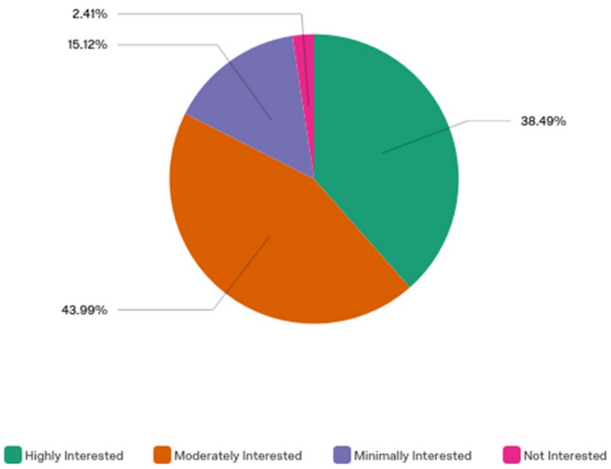
ASAHP CETF SURVEY DATA

Recommendation #2:
Adapt pre-clinical curriculum and clinical education assessments to meet contemporary needs for efficient and effective interprofessional collaborative practice (IPCP).

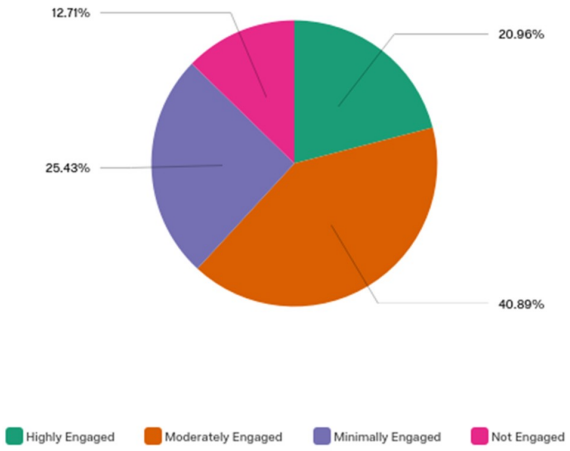
Level of priority/importance of this recommendation:



My personal level of interest in this recommendation:



Engagement in this area in my current role:



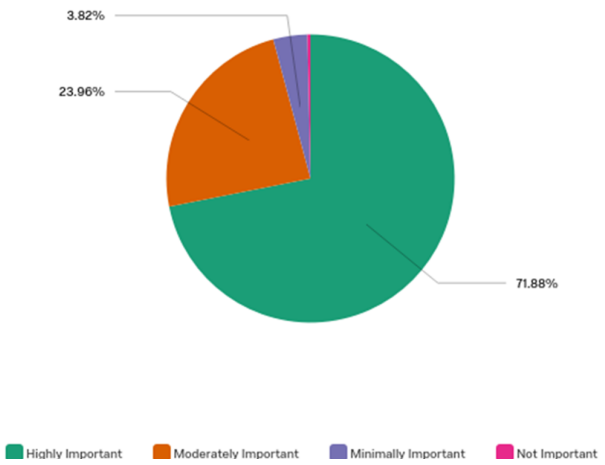
Comments:

- I find the more prepared the students are before they do their clinical placement, the more they can take advantage of clinical opportunities and interprofessional collaboration in their placements.
- I see opportunities in teaching the students how to be part of the interdisciplinary team, not just focused on their individual area of study.
- Students need to have adequate knowledge base prior to starting clinical experiences with "live" patients, especially in this day and age when Medicare is questioning use and billing practices of students in the clinic.
- While some academic programs have insight into the planning for IPCP, many only want this to check an accreditation box - not fully invested.
- Interprofessional interaction is more challenging at some clinical sites than others due to availability of various healthcare provider types—could be challenging to implement universally.
- We will always educate based on best practice, evidence based medicine. We could be preparing students to be "system ready" healthcare providers with very little effort on the part of the system. We must agree to help facilitate communication with and encourage their providers to precept students.

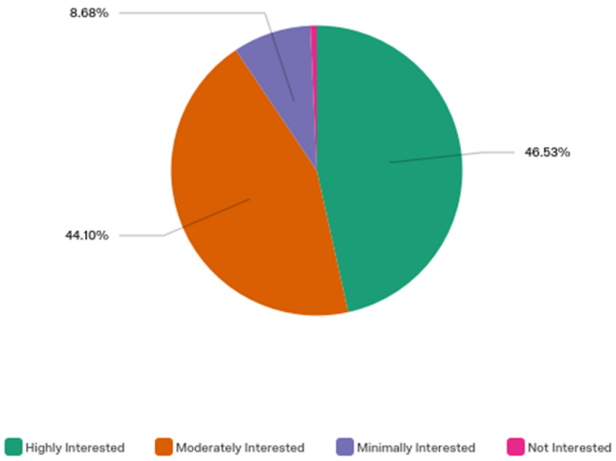
ASAHP CETF SURVEY DATA

Recommendation #3:
Incorporate effective use of healthcare technology into health professions education and practice.

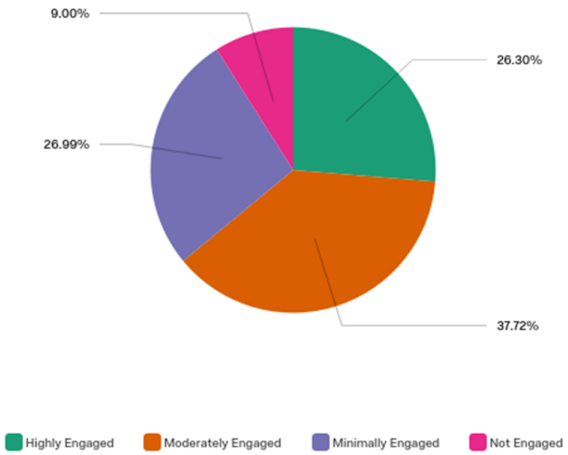
Level of priority/importance of this recommendation:



My personal level of interest in this recommendation:



Engagement in this area in my current role:



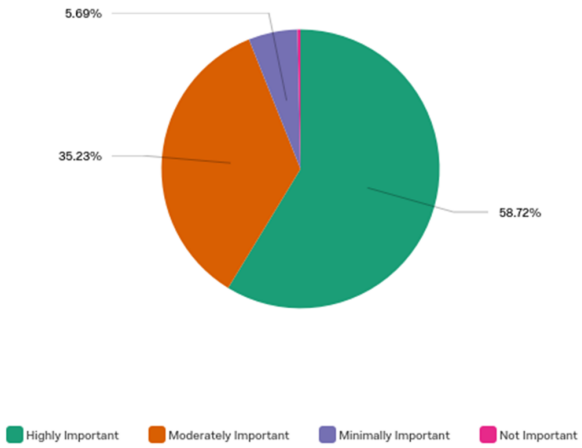
Comments:

- Technology is not going anywhere and should happen later in education, otherwise students may have learned something obsolete by the time they are graduated.
- Students need to be knowledgeable of the latest technology and its impact on health care, especially how different systems interact.
- Important and open to collaborations on how to best use technology to accomplish IPL goals and improve IPP outcomes, but not my area of interest or expertise.
- The technology needs to decrease workload, not make more tedious and cumbersome. Needs to not take away from clinical interaction with the patient.
- The extent to which students are trained in all aspects of health care technology, from EMRs to telehealth to medical devices, will determine their level of comfort and competency post-graduation and will influence the degree to which they adopt these technologies into their practice.
- The expense of technology hinders allied health education programs. We cannot afford to purchase and so rely on clinical experiences.
- Younger students have good technology skills. They lack communication skills.

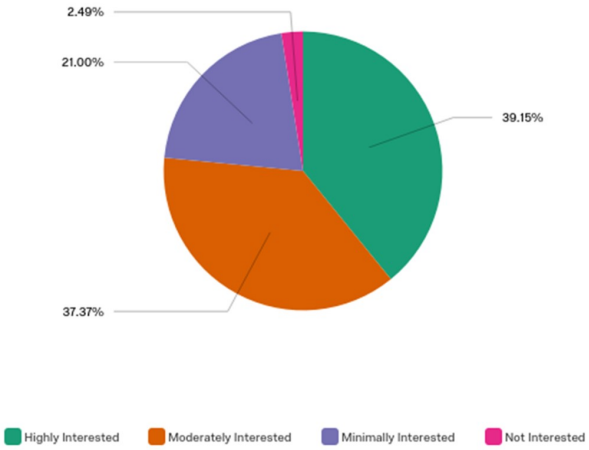
ASAHP CETF SURVEY DATA

Recommendation #4:
Advocate within and among healthcare systems, higher education leadership, accreditation and professional organizations, and governmental agencies to foster and support IPCP and effective

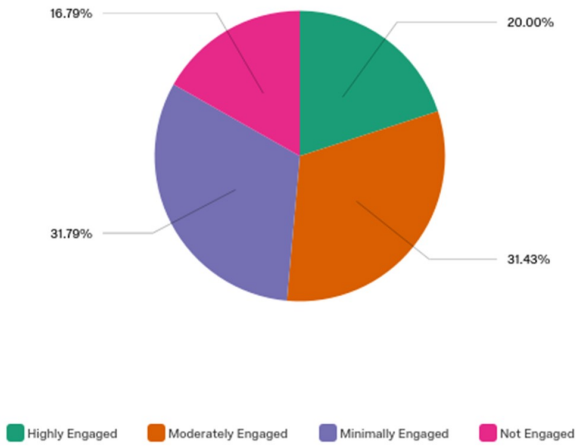
Level of priority/importance of this recommendation:



My personal level of interest in this recommendation:



Engagement in this area in my current role:



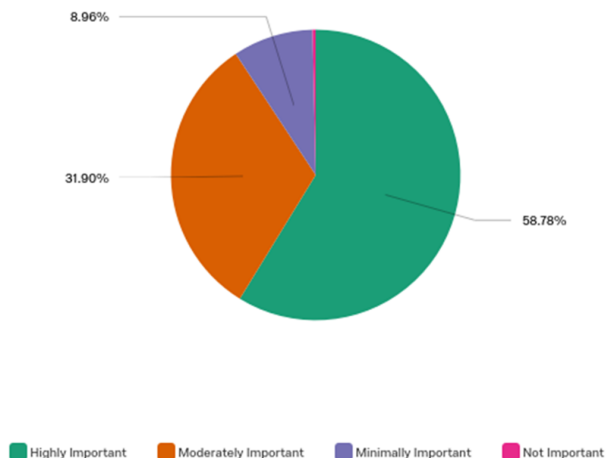
Comments:

- Allied health professions should get together and advocate with each other to push forward better policies that improve healthcare delivery and access.
- Integrating the various silo'd organizations is essential to developing prepared leaders in the field. The more collaboration and consistency the better for everyone.
- It may be necessary to investigate or engage in discussion to determine what cross-discipline referrals are not happening due to lack of awareness of IPP value and teamwork vs. no mechanisms for reimbursement for the care referrals or only available to those with full insurance.
- We must be more active in the legislative arena - in order to improve practice laws and ensure that we can practice at the top of our training.
- This is important but we need physician buy-in for this to occur. Allied health professionals saying it should be so is not enough. AAMC has to say it is important. We need to work with the AAMC.
- This type of advocacy must occur first to convince the healthcare system that it is not only good for the patient but is also cost effective. If it is only good for the patient, the current cheaper model may continue to be "good enough" and nothing will change.

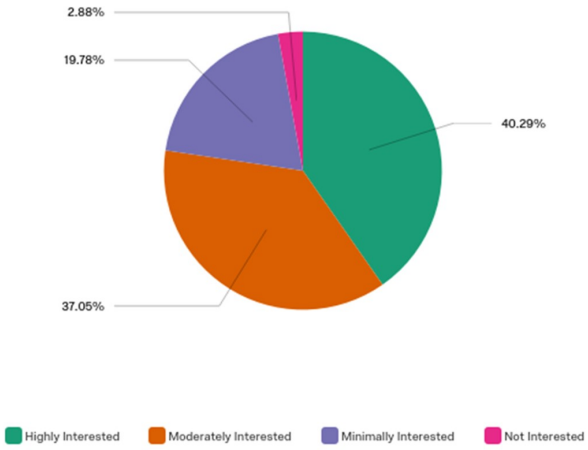
ASAHP CETF SURVEY DATA

Recommendation #5:
Drive excellence in clinical education through promotion of research and scholarly activity.

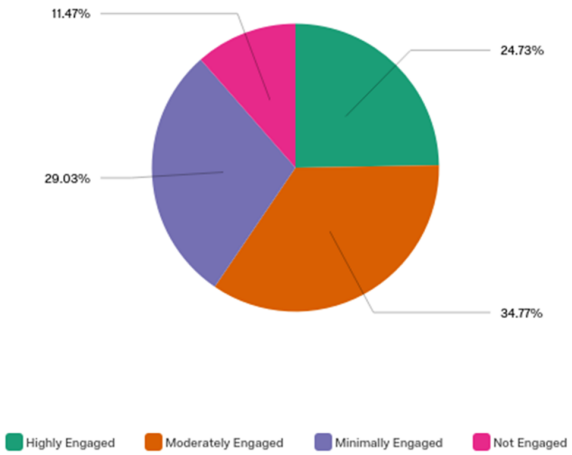
Level of priority/importance of this recommendation:



My personal level of interest in this recommendation:



Engagement in this area in my current role:



Comments:

- New graduates seem to be very well educated on research but lack creativity and critical thinking skills that need to be utilized in patient care.
- Research and evidence-based medicine are great, but what is lost in today's world is the art of medicine or nursing. Students need to be taught to pay attention to the patient and treat them as a human not just charge on the computer and use evidence-based medicine research.
- I agree that there needs to be an expansion of the concept of research to include educational and clinical outcomes to determine best practices and application to unique settings.
- Research and evidence based practice is vitally important, but researchers need to find a way to make this applicable to clinical practice. Research is often trying so hard to control the variables in a study that the outcome becomes narrowly focused and makes it difficult to apply the finding to the broader population.
- Research to develop IPCP models across the spectrum of clinical conditions and healthcare practitioners that can be tested in small or large healthcare systems is key to success.
- Research and scholarly endeavors set us apart from those who merely practice. We must engage in higher order investigations to advance our respective professions.

ASAHP SUMMIT

Methodology

Facilitators at each table discussion and in large group "harvest" sessions recorded statements by the subjects in a structured format electronically on encrypted shared drive. No identifiers were recorded at any time. Retrospective data analysis was approved as exempt by the Saint Louis University Institutional Review Board.

Part 1: Reaction

Purpose:
Uncover reactions to CETF recommendations and to the survey results

Part 2: Action

Purpose:
Generate ideas for strategies and actions to advance recommendations and IPCP to improve patient care

Round 1

Skim the survey results for your role. Then share . . .

1. What do you notice? What stands out? What surprises you?
2. Why do you think the results look the way they do?
3. How do you think the results might differ for other roles?
4. What did you think about the five CETF recommendations?
5. What, if anything, is missing from the recommendations?

Round 2

Briefly, re-introduce yourself to your table mates if needed.

1. What did you think of the five CETF recommendations?
2. In what ways do the recommendations reflect your own experience and understanding of the needs in preparing professionals for IPCP?
3. Share your impressions of your own role's survey results. The aggregated results presented earlier. What do you think the results are telling us as a collective?

Harvesting: Reaction

Table report-out: Top 2 items for each round

Reactions? Anything missing?

What else would you like to share about the recommendations?
The survey results?

Round 3

Considering the recommendations, survey results, and discussions . . .

1. What **could** be done, as a collective, to respond to / enact these recommendations? *(blue sky thinking)*
2. What **should** be done? *(don't worry yet about who'll do it)*
3. Looking at the **should-do** list, who/what areas "should" or "could" work on those things?

Round 4

Considering the recommendations, survey results, and discussions . . .

1. What **could** we do from our positions / roles? *(blue sky thinking)*
2. What **should** we do from our positions / roles?
3. What do we think is needed from other positions / roles?

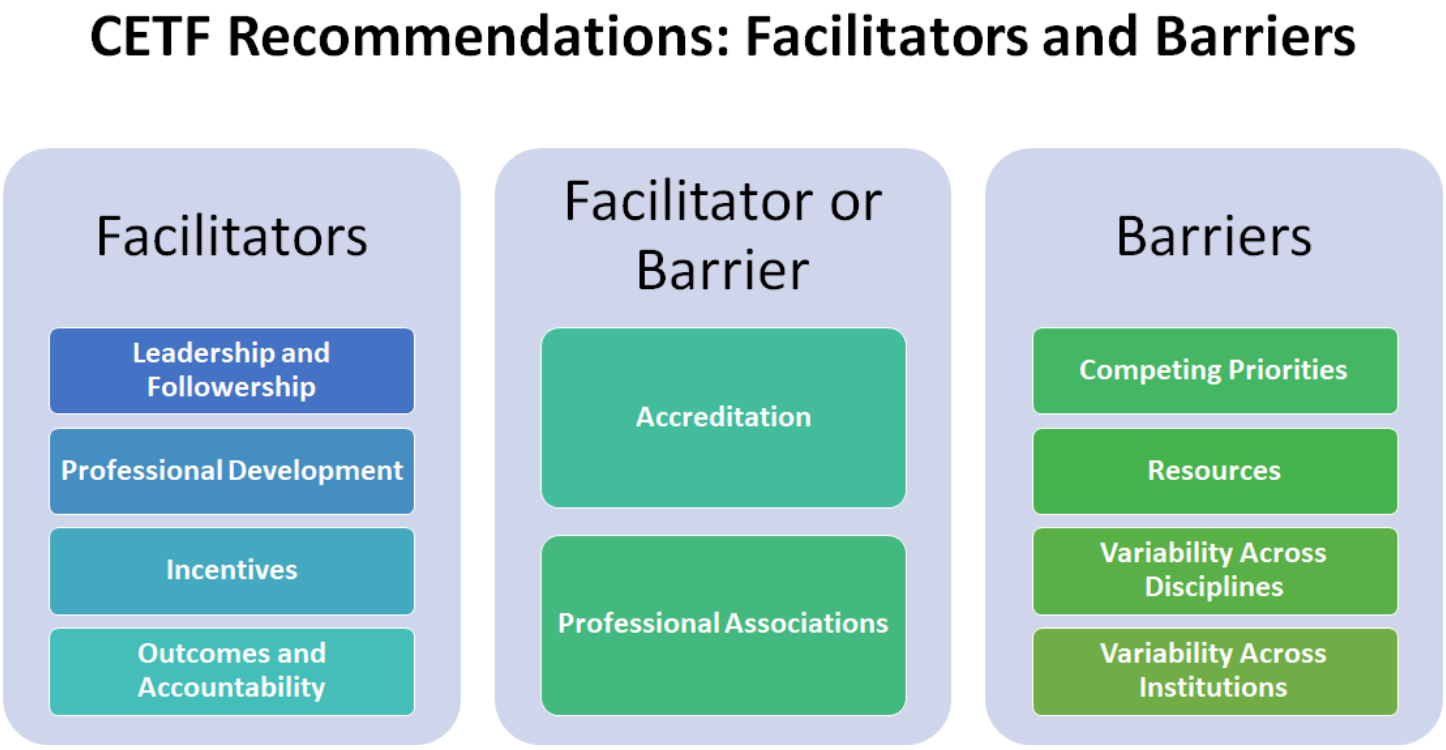
Harvesting: Action

Table report-out

1. **Re: "could dos":** which ideas from the tables generated the most excitement/energy in your discussions? Why?
2. **Re: "should dos":** which ideas seem most **pressing**? Why?
3. **Meta question**: in your discussions, what have you learned/discovered today that you didn't know before? What ideas were new to you?

DATA ANALYSIS

These key themes and recommendations were collated based upon the many statements from the Summit harvest discussions and pre-summit survey responses. Statements shared during harvest discussions and responses to open-ended items on the pre-summit survey were analyzed and categorized based on the potential facilitation of or opposition of the five recommendations of the ASAHP Clinical Education Task Force (CETF). Specifically, respondents commented on the following areas.



OVERALL RECOMMENDATIONS

- Identify and cultivate leaders at all levels who will serve as champions and supporters for the CETF recommendations.
- Ensure that institutional and individual incentives align with and promote achievement of each recommendation.
- Develop and implement strong and varied professional development offerings that address the needs of all stakeholders.
- Institute a robust program of assessment to evaluate outcomes and institute improvements related to the CETF recommendations.
- Leverage the support of accrediting bodies and professional organizations to move the work forward.

FACILITATORS FOR IMPLEMENTATION

LEADERSHIP and FOLLOWERSHIP

In order to move the ASAHP Clinical Education Task Force recommendations forward, Summit participants were clear that strong **administrative leadership and support** was a critical factor. Clinical and academic leaders were identified as essential for creating environments in which these recommendations were an important part of each institution's strategic mission and vision. These leaders are also in a position to allocate resources and create structures and incentives that support this work. In addition, Summit participants and pre-survey respondents overwhelming noted that for initiatives such as IPE and IPCP, identifying individuals who could serve as **champions** was a key ingredient for successful implementation. Advocacy at the administrative and faculty/provider levels is crucial for the effective, efficient implementation of IPE/IPCP. Respondents further recommended that the champion be allocated dedicated time and function as a liaison to facilitate relationships, policies, and procedures. Finally, participants highlighted the need for **commitment** or "buy-in" from all stakeholders for full implementation of IPE and IPCP, Stakeholders from academic and industry settings and across all disciplines should be involved in discussions in simultaneous fashion in order to build interdisciplinary relationships and fully integrate IPE and IPCP. Physician commitment to this work was highlighted as particularly important. The efficacy and value of IPE and IPCP should be demonstrated through ongoing research and should prove to be a valuable tool for motivating administrative leadership's continued commitment.

PROFESSIONAL DEVELOPMENT

Respondents indicated significant need for the development and wide dissemination of continuing education events for faculty and clinicians, specifically citing concern for implementation knowledge for IPE and IPCP. In addition, participants suggested that professional development needs extended to technology and keeping both faculty and clinicians up-to-date with current practice and advances in the other group's environment (e.g. faculty engagement with clinical practice and clinician knowledge of research advances). These educational opportunities may be more effective and efficient with shared resources, such as academic curricula, clinical service delivery models, webinars, conferences, and partnerships.

INCENTIVES

The implementation of incentives for academic faculty and industry partner providers was identified as an important way to drive engagement for all stakeholders. Specific incentives discussed during Summit harvest sessions included financial compensation, paid time off, resources to support conference attendance, and decreased productivity expectations to meet the demand of student supervision. Shared resources could also be an important incentive, such as having university resources available to industry partners, and industry resources available to the university academic program. Financial, educational, and employment benefits could be shared to create mutually beneficial incentives for IPE and IPCP implementation. Respondents also suggested that the academic-industry partnership could provide an efficient and effective means of dissemination of best practice information.

OUTCOMES and ACCOUNTABILITY

Accountability was identified consistently as crucial for IPE and IPCP success across organizations. Respondents suggested IPEC core competencies-based assessments for both students and clinicians in order to facilitate improved outcomes and develop accountability measures for academic and industry practice settings.

BARRIERS TO IMPLEMENTATION

COMPETING PRIORITIES

Respondents acknowledged that one barrier to implementation of the CETF recommendations related to competing priorities in the workplace. Specifically, respondents recommended that productivity expectations should be balanced with clinical education of students, wherein productivity goals should be adjusted to account for clinical supervision activities. Respondents noted that competing priorities, such as financial productivity and student clinical education, can make it hard to be engaged in IPE and IPCP implementation. Similarly, it was suggested that research and scholarly activity was less of a priority for those in clinical practice where the emphasis was on productivity related to patient care.

LIMITED RESOURCES

Summit participants recommended that release **time** be provided to faculty and clinicians to develop relationships and curricula. Committed time to IPE and IPCP, the development of strategic academic and industry partnerships, and research and scholarship can only begin with some level of interest by administration, faculty, and providers, and is facilitated when workload responsibilities are shifted to include these activities directly. Some respondents indicated that faculty and clinician providers “lack time” to engage in work related to the CETF recommendations and that individuals may perceive that some of these activities are not part of their role. In addition, institutional (university & practice) commitment to providing adequate **financial resources** is crucial, although the exact source of funding is unclear. Respondents suggested funding should come from academia, clinical practice partners, grants, and even through governmental support. However, respondents recommended sharing the financial responsibility of IPE and IPCP implementation through shared training experiences. Students and clinicians can be trained together as clinical education experiences for the student clinicians and continuing education opportunities for the providers.

VARIABILITY ACROSS DISCIPLINES

Survey responses and harvest discussions revealed an acknowledgement of the need to respect different levels of training as appropriate for each discipline. This variability can create challenges when structuring strategic partnerships as what works for one discipline may not work for another. Respondents also acknowledged the opportunity presented by both IPE and IPCP to advocate for different professions as well as increase visibility of lesser known professions. Differing supervisory requirements across disciplines may contribute to difficulty with implementation of IPE and IPCP, particularly as these requirements relate to accreditation and certification standards. Finally, respondents questioned whether certain disciplines were appropriate for inclusion in IPE and IPCP activities.

VARIABILITY ACROSS INSTITUTIONS

Similar to variability across disciplines, respondents acknowledged the need to identify the unique strengths and weaknesses across academic and clinical institutions, which could include size, resources, technology access, and community size. This variability can create challenges for instituting CETF recommendations related to strategic partnerships, technology, research and IPCP. Respondents recognized that healthcare settings in rural areas may have fewer academic institutions with whom to partner and may experience higher provider turn-over rates leading to difficulty implementing and maintaining IPCP. Respondents also discussed variability in the amount of time required to adopt and apply IPE and IPCP principles in the academic and industry settings.

FACILITATORS FOR OR BARRIERS TO IMPLEMENTATION

ACCREDITATION

Several statements from respondents acknowledged the important role that accreditation can plan in furthering all of the CETF recommendations. For example, including IPE in academic program accreditation standards ensures that this important component is addressed in the curriculum. Additionally, respondents expressed concern over somewhat limiting accreditation and certification standards, wherein licensed professionals across disciplines are generally excluded from supervising student clinical experiences in preparation to meet professional certification requirements.

PROFESSIONAL ASSOCIATIONS

Respondents also placed strong emphasis on the role of professional associations to emphasize the benefits of IPE and IPCP for increasing healthcare outcomes. Further, respondents recommended champions at the national level to assist in the development of practice guidelines, academic program accreditation standards, and professional certification standards. Respondents specifically recommended professional associations should provide professional development opportunities, advocacy at the legislative level, and facilitation of discussions across disciplines as well as academic and clinical practice partners.

ROLE OF TECHNOLOGY

The Summit discussion of CETF recommendation #3 related to technology extended beyond facilitators or barriers. Respondents strongly suggested that access and training for technology are imperative for IPE and IPCP, and specifically important to connect IPE and IPCP. However, conflicting messages were provided by Summit participants and in the pre-summit survey regarding training specific to technology use. In the pre-summit survey, respondents indicated that technology should be incorporated in all aspects of the educational program, and suggested that technology training should happen later in the student's academic career so that technology is still relevant when the student enters professional clinical practice. In the Summit harvest discussions, however, respondents warned against placing emphasis on technology in the academic setting because of the ever-changing and variety of equipment in clinical use. Training in the clinical practice setting may be more practical than in the academic setting. Respondents acknowledged that technology is highly variable across academic and practice institutions, as well as the impact of rapidly changing technology potentially leading to decreased face-to-face time with patients and reduced productivity during periods of learning new equipment and technology.

PERSONAL ACTION ITEMS

Participants were asked to identify an action item that they would do upon leaving the Summit.

Part 3: Reflection

Purpose:
Create space for individual reflection and spark action

Write your one thing on a sticky note.

Place it on the wall.

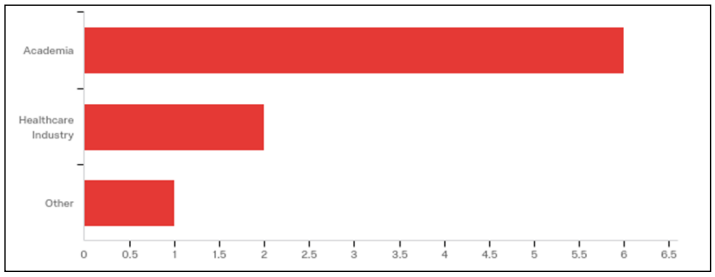
PHOTO CREDIT: Dooley, Kevin. Reflection. No changes made. Flickr. CC BY

- Make connections with people outside my organization and learn how I can help make their job/ experience better
- Lead Innovative change in the curriculum - not be afraid of change
- Discuss outcomes and key integration with Provost
- Discuss outcomes and key integration with Dean of SOM
- Invite (industry) to (campus) to provide new perspective
- Be more inclusive in projects and activities
- Continue to push for institutional/industry partnerships
- Continue initiative to build out faculty development tracks: IPE facilitator, IPE preceptor, IPCP clinical champion
- Change communication strategies
- Educate myself on IPE
- Offer shadowing for students
- Be more mindful of IPE goals during development and implementation of education plans
- Keep IPE/IPP top of mind in interaction with students, faculty and clinicians
- Continue the conversation with my colleagues
- Recommend full site clinicals for entire program span for students clinical experience
- Look into how we can involve medical directors in CE
- Support and educate staff on the importance of IPE
- Connect with students when they rotate on our floor
- Become more involved in this professional organization
- IPE in didactic value added roles in Clinical Year
- Leverage my role as a middle-woman between schools and clinic to start the conversation on bridging the gap between IPE and IPP. Make the positive change for the current students we host annually in our facilities nationwide. Partner better with our academic partners to educate/ collaborate their students on IPP. ie bring the clinic to school to demonstrate IPP.
- Incorporate multiple mini-interviews in admissions process with interviewers from many disciplines including consumers
- State Hospital Association meets in the fall. It is an opportunity to work with industry partners regarding what they need, what we need, what students need and what does the marketplace need. I will be attending the conference and will take to quality board.
- Reconnect with (University) regarding Exercise Science students (my facility)
- Advocate for more funding to promote IPE activities both in clinical practice and academic settings

ASAHP SUMMIT FEEDBACK

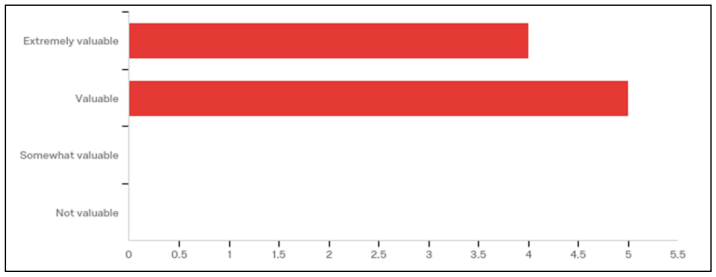
After the Summit. participants were sent a feedback survey via Qualtrics. No personal identifiers were collected.

You are primarily employed in which sector:



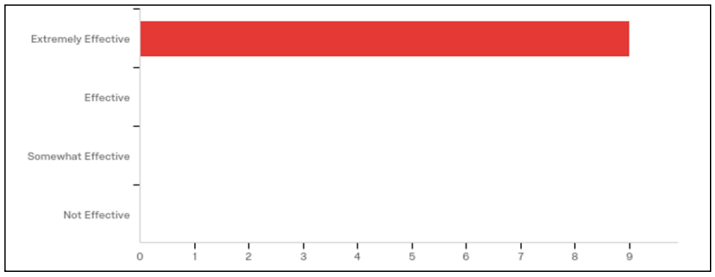
Academia	66.67%	6
Healthcare Industry	22.22%	2
Other	11.11%	1
Total	100%	9

How valuable was attending this summit for you?



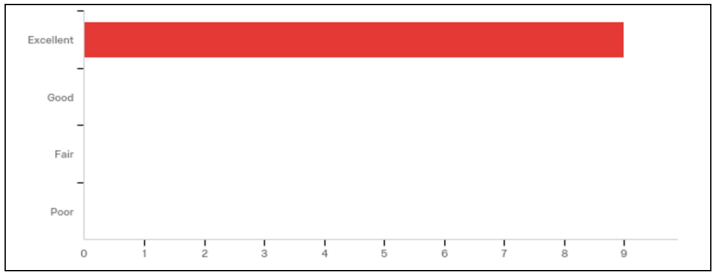
Extremely valuable	44.44%	4
Valuable	55.56%	5
Somewhat valuable	0.00%	0
Not valuable	0.00%	0
Total	100%	9

How effective was the facilitation of the interactive discussions?



Extremely Effective	100.00%	9
Effective	0.00%	0
Somewhat Effective	0.00%	0
Not Effective	0.00%	0
Total	100%	9

Overall, how would you rate the summit?



Excellent	100.00%	9
Good	0.00%	0
Fair	0.00%	0
Poor	0.00%	0
Total	100%	9

How would you rate the:

	Opening Presentation		Interactive Discussions	
Excellent	44.44%	4	88.89%	8
Good	44.44%	4	11.11%	1
Fair	0.00%	0	0.00%	0
Poor	0.00%	0	0.00%	0
Did not attend this portion of Summit	11.11%	1	0.00%	0
Total	100%	9	100%	9

ASAHP SUMMIT FEEDBACK

What did you learn from attending the summit?

It is important for both academic and healthcare to stay in touch with and collaborate with each other for optimum results

We all face similar challenges in developing IPE and in extending these experiences into our clinical learning environments. It was great sharing with others and discussing ways to improve IPEP for our area. Accreditation ideas shared were very helpful.

I enjoyed speaking to Deans and program heads about how they would like to see IPE handled by programmatic accreditors.

We have common goals; we sometimes just need to collaborate more on how to reach them

Opportunities to include more healthcare systems students in IPE (HMP, HIM, MPH, Health Policy)

Different perspectives on what is working, what needs development and ideas on how to move forward

It was a great, collaborative environment. I learned something from everyone who was there, and many were from specialties I'd never really have the opportunity to learn from.

Interesting way to collaborate.

Thoughts about the programs and clinical experiences across a wider base.

How do you see yourself applying what you learned in your future practice?

I will take an active approach to ensure our healthcare workers have educational opportunities like this

Working closer with our clinical partners and sharing accreditation needs with them for their input for achieving these. Also, new ways to communicate with others involved with IPEP will be helpful as we move forward with our work.

I will be working with our committee and board in a more informed and educated way.

I would like to share the information learned with the rest of my colleagues in my department.

Advocate to integrate more healthcare systems students in IPE experiences; prioritize creating sustainable faculty development for facilitators, preceptors, and clinicians.

Utilize the example provided of facilitated inquiry and action process; I look forward to reviewing the initial data discussed in the first session to better utilize in advocating for expanded IPE/IPCP; using notes on action items from the discussion groups to bring back to the IPE team at my university to stimulate added discussion

Broadening my view of IPP/IPE; purposefully putting it into curriculum and clinical education; trying to engage physicians in the process as well

I plan to contact the interesting people I met for reciprocal tasks in our work.

Doing what I can at my institutions to further the cause and make the programs and experiences as beneficial as possible.

What else would you like to share about the experience of attending the summit?

The summit was organized and each participant felt valued and heard.

Thank you so much for organizing this! It was great to meet others and talk about our concerns and needs in a "safe" environment. Let's have a follow up!

Structured time for discussion was key to moving conversations along and feeling productive. The facilitator was exceptional at making conversation meaningful, keeping us on task, and respecting our time.

Thank you, great job, enjoyed networking aspect as well

It would be a good idea, at the start, to have some "agreed-upon" definitions so you know when people say, for example, "industry", that they are all meaning the same thing and understanding one another.

It was a great experience. I hope to participate in next years summit.

Great event!

ASAHP SUMMIT WORK GROUP

The ASAHP Summit Work Group represented both the ASAHP Interprofessional Subcommittee and the Clinical Education Task Force:

Facilitator:
- Debra Rudder Lohe (Saint Louis University)

Summit Team:
- Carol Beckel (Saint Louis University)
- Anthony Breitbach (Saint Louis University)
- Andrew Butler (University of Alabama-Birmingham)
- Laura Dailey (Kindred Healthcare)
- Kathrin Eliot (University of Oklahoma Health Sciences Center)
- Annie Roden (Kindred Healthcare)
- Barbara Wallace (Kindred Healthcare)

Research Team:
- Elizabeth Adams (University of South Alabama)
- Lisa Dutton (St. Catherine University)