



JOINT ACCREDITATION™
INTERPROFESSIONAL CONTINUING EDUCATION

By the Team for the Team:

*Evolving Interprofessional Continuing Education™
for Optimal Patient Care*

Report from the 2016
Joint Accreditation Leadership Summit



The Accreditation Council for
Continuing Medical Education (ACCME®)

The Accreditation Council for
Pharmacy Education (ACPE)

The American Nurses Credentialing
Center (ANCC)



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INTRODUCTION

On April 20, 2016, the Accreditation Council for Continuing Medical Education (ACCME®), the Accreditation Council for Pharmacy Education (ACPE), and the American Nurses Credentialing Center (ANCC) convened a Leadership Summit for Jointly Accredited Providers at the ACCME's offices in Chicago.

The goal of the summit was to offer an opportunity for jointly accredited providers—as leaders in the continuing healthcare education community—to work collaboratively to identify organizational models that are effective in promoting and improving interprofessional collaborative practice (IPCP) through interprofessional continuing education (IPCE) and to share success stories that demonstrate the impact of their educational efforts.

**The Leadership Summit and this
report were supported (in part) by the
Josiah Macy Jr. Foundation.**

Leadership Summit Participants

Participants included leadership from the three accreditors and from 28 organizations that have received joint accreditation or were in the process of seeking joint accreditation. Multiple types of healthcare organizations were represented including hospitals/health systems, medical schools, specialty societies, medical education companies, and a government agency. (See table 1.)

Modeling IPCE and Effective Pedagogy

The Leadership Summit was structured to demonstrate IPCE in action. The accreditors collaborated to plan and present content. The summit was designed to stimulate collaboration among participants and accreditors. Participants representing multiple professions worked in small groups and shared stories, best practices, challenges, and strategies to overcome challenges. Following breakouts, participants came together to summarize their discussions, identify

common themes, and achieve consensus about future goals.

Welcoming the participants, Graham McMahon, MD, MMSc, President and CEO, ACCME, said, “We want to create a community of practice, where you can openly share and reflect on the real issues that affect your ability to grow and thrive. As much as we want to be visionary, we also need to be pragmatic. We want this to be a safe space for you to learn and grow. As accreditors, we are here to help. We really believe in this — and want to do everything we can to create the way forward.”

In his opening remarks, Peter H. Vlasses, PharmD, DSc (Hon), BCPS, FCCP, Executive Director, ACPE, pointed out that the summit was designed as an IPCE activity in itself. “We are here to learn about, from, and with each other. You can share and teach us what we need to do better as accreditors when working with you going forward.”



We are proud of our community of jointly accredited providers. You are in the vanguard of IPCE. Our responsibility as accreditors is to support your work, to give you the foundation to build high-quality IPCE and the freedom to innovate, so that you can continue to advance healthcare education by the team, for the team — to achieve our common goal of improving patient care.



— Kate Regnier, MA, MBA, Executive Vice President, ACCME

Part 1:

Identifying Effective IPCE Organizational Models



To create, sustain, and advance IPCE programs, educators need to demonstrate their commitment and leadership. Participants discussed the challenges they've faced and the organizational models that help ensure the success of IPCE programs. Cynthia Grimes, CCMEP, CME Director, WebMD/Medscape (left), and Kelly Hecklinger, MA, Director of Professional Education, Society of Gynecologic Oncology (right), share the lessons they've learned about bringing together multiple professions to deliver team-based education.

During this part of the summit, participants discussed organizational models that help to create and sustain a thriving IPCE program, including staffing, reporting, and funding structures.

Joint Accreditation does not require a specific organizational structure; jointly accredited providers can implement the structure that best fits their organization. Participants identified a variety of different frameworks that included flat, centralized, and decentralized structures, as would be expected given the range of organizational types. These structures demonstrate that IPCE programs are themselves a model of IPCP: Multiple departments and

professions work together to deliver team-based continuing education. Participants explained that they create interprofessional structures versus silos.

Examples of IPCE Program Staffing Structures

As part of their pre-work, participants completed a survey about their staffing, funding, and reporting structures. The cases below are examples of survey responses about staffing structures.

CASE EXAMPLES

Interprofessional leadership team: “Our Interprofessional Continuing Education Program is administered by an interprofessional leadership team representing the Schools of Medicine and Public Health, Nursing, and Pharmacy. Each school appoints an administrative and clinical lead to serve on the leadership team. Each school provides staff to support the joint accreditation program.” *-UW-Madison Interprofessional Continuing Education Partnership*

The patient is part of the team: “Within our IPCE Program, the Manager of Accreditation and Compliance reports to the Director of Patient and Provider Education. The Director of Patient and Provider Education plays a pivotal role in integrating patient involvement from beginning to end, throughout the planning and implementation process, as well as within outcomes and QI with an emphasis on interprofessional education.” *-PRIME Education*

Spanning the educational continuum: “The Chief Academic Officer (CAO) oversees the Health System’s Division of Academic Affairs, which includes undergraduate medical education (UME), graduate medical education (GME), and the Center for Continuing Professional Development (CPD), as well as training programs for several other health professions (physician assistants, nurse practitioners, etc.). The CAO reports directly to the Health System President and CEO.” *-Geisinger Health System*

Participants were asked, “Who does the IPCE unit report to at your organization?” The answers illustrate the importance of positioning IPCE programs at a leadership level within the organization or institution.

- President/CEO
- Vice President for Academic Affairs
- Executive Vice President of Human Resources and Organizational Effectiveness
- Academic Deans
- Chief Nursing Officer, Patient Safety Officer, and Senior Vice President
- Branch Chief, Office of Quality Management
- Director of Medical Education

Funding of IPCE Programs

Most participants reported their programs were funded by multiple sources including:

- Registration fees
- Exhibitor fees
- Commercial support
- Fees charged to internal departments for educational services
- Government funding
- Private funding
- Allocations from parent organization/institution

CASE EXAMPLE

This example of a multi-funded program shows the potential of **public/private partnerships** to support IPCE: “We are a unique public-private partnership that formed through a cooperative agreement with the United States Department of Health and Human Services, Health Resources and Services Administration. We are also funded in part by the Josiah Macy Jr. Foundation, the Robert Wood Johnson Foundation, the Gordon and Betty Moore Foundation, The John A. Hartford Foundation, and the University of Minnesota. While initial funding to support the IPCE program was funded through this partnership, the goal is for the IPCE program to become self-sufficient over time through its interprofessional continuing education offerings.”

-National Center for Interprofessional Practice and Education

Advancing IPCE: *Commitment and Courage*

To create, sustain, and advance IPCE programs, educators need to demonstrate their commitment and courage, participants said. They shared recommendations for ensuring the success of IPCE programs based on their experience.

Structure that fits: Ask yourself—should your structure be from the bottom up, or the top down, or a combination? Determine what will work best for your program/organization. One organization hired an administrator for the new IPCE program. Others used existing staff to manage the program.

Phased-in approach: Don't try to rapidly change the infrastructure. A phased-in, organic approach to change will be less threatening. Remember that IPCE is an evolution, not an event.

From accidental to intentional learning: Start by identifying the circumstances in which professions are “accidentally” coming together to learn. How and why does that

happen? Determine how to apply those circumstances to creating intentional interprofessional learning environments.

Pilot projects: Use pilots to try new approaches and push the program forward. Include sunset rules: if you try a project and it doesn't work, have a mechanism in place for stopping it.

Create integrated work groups: Faculty advisory groups, committees, and workgroups create a structure for participation in IPCE programs across organizations and departments. Participating in the workgroup is an opportunity for interested staff and volunteers to advance their careers.

“

Most of the emphasis in interprofessional education is on the degree or preservice level. People spend about eight years at that level — and then 40 years in practice. We are not going to change the healthcare system unless professionals in practice learn from, about, and with each other and foster that learning in the students coming up behind them. It is very important work that you're doing and it's very important that you document the benefits and outcomes of your work as jointly accredited providers.”

— Peter H. Vlasses, PharmD, DSc (Hon), BCPS, FCCP, Executive Director, ACPE

Focus on the entire patient

experience: Patients are part of the IPCE team. Ask yourself: how is the structure helping patients? What professions affect patient outcomes? Remember the purpose and value of the program is to support the patient. Consider including the patient as planner, teacher, and learner in your IPCE. Think about including education for patients.

Collaboration, collaboration,

collaboration: It sounds simple, but teamwork takes a fundamental, ongoing commitment to the principles of interprofessional collaborative practice. The secret to collaboration is to actually collaborate.

Be a model: If we want healthcare teams to practice collaboratively, we have to model interprofessional collaborative practice as educators, participants said. We have to be leaders.

Share your passion. More than a program, IPCE is a philosophy. You have to be a true believer, keep on living it, preaching it. For some organizations, a sentinel event motivates initial discussions about the importance of IPCP—but for an IPCE program to succeed, it needs the ongoing commitment of the program leaders. Infuse your enthusiasm into the program.

Improvements for IPCE Programs

Participants shared the strategies they've used to implement improvements as their programs mature.

- **A Bigger Tent:** Expand to include additional professions, such as social workers, dentists, physical therapists, occupational therapists, and others. Consider including any/all professions that are involved in identifying the performance gaps and patient outcomes that the education is addressing. With IPCE, all voices are heard, all needs are heard, all gaps identified.
- **Beyond branding:** Changing the name of the program can reinforce your commitment to IPCE. Changing the word “oncologists” to “oncology” in the program name sent a message that the program was welcoming to multiple professions, said one participant.
- **Relationship maintenance:** Don't take the interprofessional relationships that you've created for granted. Maintaining relationships with individuals who work in silos takes effort. Meeting regularly can help.

- **New voices:** Bring in new volunteers and staff to create and maintain momentum.
- **Standardize education:** When possible, develop standardized activities that can be disseminated across an institution, or a regional or national platform.
- **Evolve the business model:** Organizations may need to evolve their business models to accommodate the growing diversity of learners. For example, an association may need to expand membership to more professions. Marketing and outreach strategies need to adapt to connect effectively with multiple groups; for example, marketing to social workers and dentists requires different approaches.

Challenges

- **Growing pains:** The success of the program creates challenges as well as benefits. Increased demand and the involvement of more professions can create capacity issues. More staff may be needed to manage the successful, sustainable growth of the IPCE program.
- **Institutional policies as barriers:** Some institutions have policies that, for example, require CE

activities to include a certain percentage of faculty from one profession. Those kind of constraints can preclude educators from addressing the gaps that have been identified and designing an activity that best meets learners' needs.

- **Lack of recognition:** Since IPCE is relatively new, there is low awareness among institutional leadership and other stakeholders about the value and benefits. While commitment to IPCE programs is sometimes built from the bottom up, it is more difficult to develop and expand IPCE programs without the buy-in of leadership.

Communicating with Leadership

Participants identified strategies for communicating the value of their work to their leadership. Sell your product, advised participants. You are the voice of IPCE.

- Be clear and explicit about your mission or charge, about what you do and why.
- Show that you are a true believer. IPCE is about more than following accreditation rules and making it easier for learners from different professions to meet licensing and other requirements.

- Explain to leadership how you identify and address gaps and needs across the organization, and that IPCE enables you to recognize new gaps and opportunities for process improvements. When we work in silos, we don't know what we don't know, said participants. Coming together as an interprofessional group, we really start to understand our commonalities and work together.
- Demonstrate the value of alignment in streamlining processes and education efforts. IPCE can conserve time and resources.
- Describe the value of IPCE in improving patient care.
- Communicate with a single voice to leadership. Demonstrate that the professions are not competing for resources — the IPCE program identifies common goals and supports alignment, trust, and cooperation among the professions.
- Explain that IPCE is critical to advancing alignment across the continuum of medical education. There is much emphasis now on pre-professional interprofessional education. As students move into the professional sphere,

they need to continue along the trajectory. Continuing education leaders have a responsibility to provide emerging generations of professionals with an educational home that advances IPCP.

- When new leadership joins the organization, such as a new director of nursing, take the opportunity to educate them about the IPCE program.
- Show the financial benefit. IPCE programs may be viewed as cost centers rather than revenue generators. However, IPCE activities that improve patient outcomes can result in cost savings for an institution. In addition, they have value as a risk mitigation strategy. Rather than focusing on the cost of education, ask leadership to consider the cost of withholding an educational intervention. Investment in education that improves processes for safety and quality can prevent a lawsuit. It's important to do the right thing every time — not just to prevent mistakes. Education can support that strategic approach.

IPCE Works! What the Evidence Shows

Summit participants presented the outcomes of their own work and discussed the importance of continuing to build a body of research about the effect of IPCE on team performance and patient outcomes.

There is a growing body of evidence supporting the relationship between participation in IPCE and improvements in healthcare professionals' knowledge, attitudes, competence, and performance.^{1, 2} There is also evidence that patient and/or system outcomes are positively impacted.² While the preponderance of evidence has evaluated relationships between healthcare professional students participating in interprofessional education and outcomes, a 2016 systematic review published by Reeves and colleagues reveals a significant increase in studies evaluating the relationship between post-licensure/post-certifying healthcare professionals' participation in IPCE and outcomes, from 2007 (29%; 6 of 21 studies) to 2016 (39%; 18 of 46 studies).² The outcomes of interprofessional education/IPCE were predominantly positive. Studies generally reported more than one outcome. Studies involving practicing healthcare professionals were more often linked to levels 3, 4a, or 4b. Results from the studies included:

- **Level 1: Reaction.** Valued and supported the interprofessional education experience; were satisfied with involvement; found the experience enjoyable and/or rewarding
- **Level 2a: Modification of attitudes/perceptions.** Positive attitude maintained over time; some studies reported positive attitudes initially, growing more negative over time
- **Level 2b: Acquisition of knowledge/skills.** Self-reported improvements in knowledge

and skills; two studies validated change in skills by additional assessment

- **Level 3: Behavioral change.** Self-reported change in behavior; two studies validated change in behavior by additional assessment (ED teamwork and breaking bad news)
- **Level 4a: Change in organizational practice.** Improvements in service delivery (illness prevention, patient screening, safety practices)
- **Level 4b: Benefit to patients/clients.** Improvements in mortality rates, reduced clinical errors and patient length of stay; improvements in patient clinical status (BP and cholesterol levels)

Outcomes achieved by jointly accredited providers reflect those published in the systematic review by Reeves and colleagues.² Jointly accredited providers have demonstrated:

Learner outcomes such as self-reported increases in understanding the role of the healthcare team in patient management, ability to collaborate more effectively with members from other professions, and improvements in team-based clinical and interprofessional skills.

Improvements in patient clinical outcomes such as average patient length of stay, number of infants on ventilators, maternal complication rates, and overall maternal health.

Team performance clinical outcomes such as improvements in application of guidelines and evidence into practice, and identifying the most appropriate treatment interventions for patients.

Improvements in team performance non-clinical outcomes

such as communication skills, respect between professions, leadership and teamwork skills, and confidence in decision-making.

Improvements in jointly accredited providers' own ability to teach and learn in teams.³

Support from leadership: Summit participants emphasized that support from leadership is critical to the success of IPCE programs. Research supports that view, with studies showing that organizational support in providing access to resources such as time, space, and finances, is one of the factors critical to both the development and successful sustainability of interprofessional education.²

Support from regulatory bodies: Summit participants noted that the Joint Accreditation program helps to support their efforts and discussed the importance of creating alignment with other healthcare regulatory bodies. Research shows that support from regulatory bodies serves to drive the development of interprofessional education. The motivation to develop IPE is linked to either top down approaches, such as government policies, professional regulations, or bottom-up approaches, such as local interprofessional education champions and organizational support. A mixture of those two drivers is particularly effective in motivating the implementation of interprofessional education.²

1. Hammick, M., Freeth, D., Koppel, I., Reeves, S., & Barr, H. (2007). A best evidence systematic review of interprofessional education: BEME Guide no. 9. *Medical Teacher*, 29, 735-751.

2. Reeves, S., Fletcher, S., Barr, H., Birch, I., Boet, S., Davies, N., McFadyen, A., Rivera, J., & Kitto, S.C. (2016). A BEME systematic review of the effects of interprofessional education: BEME Guide No. 39. *Medical Teacher*, 38(7), 656-68.

3. 2017 (in process) Chappell, K.B., Regnier, K., & Travlos, D. (2017). Interprofessional Continuing Education. In P.D. Dickerson (Ed.). *Core Curriculum for Nursing Professional Development*, 5th Edition (Chapter 6). Chicago, IL: Association for Nursing Professional Development.

Part 2:

IPCE Examples from Practice



Using case examples from their own programs, participants described strategies for planning and implementing team-based education designed to achieve improvements in team performance and patient care. Harjit Sull-Garewal, JD, CME Compliance, Contemporary Forums (left), and P. James Ruiter, MD, Medical Director, Salus Global Corporation (right), discuss best practices for IPCE.

Prior to the summit, participants submitted case examples of their IPCE initiatives, describing the practice gaps, change objectives, and outcomes of the activities, and the IP teams who were involved.

During this part of the summit, participants gave brief overviews of their examples, followed by Q&A and discussion. Through this process, key themes emerged about opportunities, challenges, and best practices. (See page 28 for more case examples.)

Pedagogical Approaches

IPCE providers employ a variety of different pedagogical approaches to deliver education, including online, face-to-face, and multimodal formats. Approaches included role-playing with simulated/standardized patients, case studies, study groups, and hands-on computer labs. Simulation centers were described as being especially helpful for teams, offering professionals and students the opportunity to learn together in a safe environment that mimics the practice environment.

IPCE providers paired learners to work on self-directed projects, modeled and implemented interprofessional rounding, brought in coaches to offer ongoing support, created online community forums for reviewers and planners to facilitate interprofessional collaboration, and developed train the trainer initiatives to prepare faculty and clinicians to lead and promote interprofessional collaborative practice and education. Education was viewed as a process, not an event, with learners involved in long-term projects. Many of the initiatives are ongoing and delivered across institutions and systems.

Accreditors encouraged IPCE providers to continue to be innovative and to move beyond traditional definitions of activity formats. Technology was seen as an opportunity to support innovation; providers can, for example, use virtual patients.

CASE EXAMPLE

Integrating education into existing processes supports learner retention and change. As a follow-up to an activity teaching emergency department (ED) clinicians how to collaborate with maternity staff to manage imminent birth, **Salus Global** partnered with multiple departments on emergency drills so ED clinicians had the opportunity to train with the maternity staff as a team and practice the imminent birth skills they gained during the education. Additional resources support clinicians' ability to engage in IPCP and reinforce the relevance of the education. The MORE^{OB} Core Team provided maternity staff with maps of the emergency department and the location of their OB/GYN cart in that department.

Teams: *A Broader Definition*

Participants described the importance of keeping an open mind about the range of professionals to include in educational initiatives. In addition to allopathic and osteopathic physicians, pharmacists, nurses, and nurse practitioners representing multiple professions, IPCE education included planners, faculty, and learners representing the following professions/individuals:

- Administrators
- Attorneys
- Audiologists
- Behavioral health professionals
- C-suite administrators
- Case managers
- Chaplains/church leaders
- Community health workers
- Dietitians
- Genetics counselors
- Health educators
- Law enforcement/justice system professionals
- Mental health counselors
- Midwives
- Nutritionists
- Patients
- Physician assistants
- Physical therapists
- Physiologists
- Psychologists
- Public health professionals
- Quality improvement/patient safety experts
- Researchers
- Social workers
- Substance abuse counselors
- Support services, such as housekeeping

- Technicians from various professions
- Victim-witness specialists

Participants described how the range of target audiences expanded during the process of developing activities. When planning an

educational intervention, it's important to think about all the professionals who impact the gap the activity is designed to address. One of the benefits of bringing in more professions is that new needs are identified.

CASE EXAMPLES

When implementing an initiative aimed at eliminating healthcare disparities and inequalities, **Cine-Med, Inc.** initially focused only on physicians and nurses, but as the activities progressed, the target audience widened to include social workers, first responders, and others.

The Schwartz Center Rounds, an IPCE forum to discuss compassionate care, offered by **Centra**, generated high interest, drawing not only nurses, physicians, chaplains, and social workers, but also the nutrition services team — individuals who did not need to fulfill CE requirements, but who joined because of their commitment to patient-centered care.

A Patient Safety and Quality Improvement Strategies Conference, produced by **Geisinger Health System**, was targeted to meet the needs of any healthcare professional or other clinical support personnel who comes into contact with patients during any patient encounter.

During an initiative on improving care transitions for patients with acute coronary syndrome, **Creative Educational Concepts** found that case managers did not have the resources they needed to educate patients, and community pharmacists might not have access to the medication that the patients were prescribed. Through the IPCE activities, adherence issues for patients were identified, and in response, Creative Educational Concepts developed a new adherence initiative.

Patient-Centered IPCE

Participants emphasized the importance of including patients as planners, faculty, and learners. Evaluations show that patient involvement in IPCE motivates powerful and lasting change.

CASE EXAMPLE

Faculty can help to facilitate patient involvement; for example, **WebMD/Medscape** worked with faculty to identify patients who were willing to participate in video vignettes for an activity designed to teach clinicians how to work with cancer patients as partners in their own care. Patient education can be a useful adjunct to IPCE activities; for this activity, Medscape produced a downloadable patient education resource.

Addressing Cross-Professional Issues

IPCE providers are in a position to lead efforts to promote improvement in cross-professional competencies, such as change management, leadership, communication skills, professionalism, cultural competency, healthcare disparities, compassionate care, faculty development, and how to teach and learn in teams. When addressing issues of cultural

competency, look for organizations or structures that include community health workers, advised participants. They can help integrate with patients and may be one of the greatest, untapped resources and strategies for success.

Graham McMahon, MD, MMSc, President and CEO, ACCME, offered his perspective as an endocrinologist. “My experience with cross-professional issues is there are often blind spots in our community,” he said. “Most of our community are able to focus on endocrine diseases, but very few of them seem to be able to focus on communications or self-reflection or values. This is a real opportunity for CE professionals to say, we can take care of your specialty area of interest, but we also can address the cross-cutting blind spots such as cultural care, compassionate values. The opportunity is not just to address the blind spot but to bring the team together and share the values around those issues.”

CASE EXAMPLES

Duke University Health System created an initiative to promote respectful communication between team members and improve their ability to work together collaboratively. Early career nurses and physicians working in the same units were paired and directed to choose a project. As part of their work together, they developed presentations about their projects. The collaborations were so successful that observers were unable to tell the difference between the nurses and physicians in the presentations; both professions took equal ownership of the projects and presentations. By focusing on process — collaboration and communications — rather than content, and allowing the learners to choose a clinical care area of interest to them, educators ensured that the activity was relevant and meaningful.

Baystate Health, Inc. launched a Culture of Safety initiative to improve patient safety by overcoming hierarchical structures, empowering all team members to “stop the line,” and improving communications and teamwork. The institution-wide, ongoing initiative includes coaches who help teach learners how to huddle and to consistently practice the principles of fair and respectful communication. Following the initial activity, coaches work with the learners on an ongoing basis, to help them maintain the use of huddles and other process changes to support better teamwork.

Outcomes Data: *Overcoming Barriers*

The case examples show that IPCE results in improvements in knowledge, competence, and patient care in clinical and nonclinical areas. However, participants reported challenges in obtaining post-activity outcomes data from learners. While many learners may fill out a survey immediately after an activity and make a commitment to change, the response rate dramatically decreases for follow-up surveys. Organizations that do not provide direct clinical

care face obstacles in accessing health and practice data and in observing changes in performance or patient care. Participants discussed strategies for overcoming these barriers.

Focus on survey responders. Instead of becoming discouraged by low response rates, focus on the people who do respond. Bring them together in a focus group to gather more qualitative data.

Create ongoing relationships with learners. Inform learners prior to the activity that the education is a process, not an event, and that you expect their ongoing participation in follow-up evaluations to assess the impact of the education. Frame the surveys as part of the activity – not as a separate endeavor. Let them know that you will provide coaching throughout the process to support their improvement and to optimize the effect of the education.

Form partnerships. Rather than collecting your own data, partner with a healthcare delivery institution that can share practice data with you, enabling you to identify outcomes.

Set reasonable goals. Determine a minimum, reasonable outcome for your activity. For a conference about child abuse, the University of Wisconsin-Madison Interprofessional Continuing Education Partnership decided not to specifically expect behavior change; rather, a reasonable outcome would be motivating attendees to think about their own biases.

Know that small changes matter. If even one healthcare professional achieves and maintains an improvement as a result of an IPCE activity, it may not be a significant enough outcome to publish in a study, but it will be quite significant for that healthcare professional's patients.

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This is a real opportunity for CE professionals to say, we can take care of your specialty area of interest, but we also can address the cross-cutting blind spots such as cultural care and compassionate values. The opportunity is not just to address the blind spot but to bring the team together and share the values around those issues.

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—Graham McMahon, MD, MMSc, President and CEO, ACCME

About Joint Accreditation for Interprofessional Continuing Education

Medicine, Pharmacy, and Nursing — Advancing Healthcare Education by the Team for the Team

Launched in 2009, Joint Accreditation for Interprofessional Continuing Education is a collaboration of the Accreditation Council for Continuing Medical Education (ACCME®), the Accreditation Council for Pharmacy Education (ACPE), and the American Nurses Credentialing Center (ANCC).

Joint Accreditation promotes interprofessional continuing education (IPCE) specifically designed to improve interprofessional collaborative practice in healthcare delivery. A leading model for interprofessional collaborative practice, Joint Accreditation establishes the standards for education providers to deliver continuing education planned by the healthcare team for the healthcare team.

This innovation promotes interprofessional education that leads to improved healthcare delivery and better patient outcomes. Joint Accreditation enables providers to achieve distinction from three leading healthcare continuing education accreditors; increase operational efficiency, saving time, money, and resources; provide continuing education for physicians, pharmacists, or nurses separately or together; and improve collaboration and reduce hierarchies among healthcare professions.

Jointly accredited continuing education providers must meet rigorous standards for educational quality and independence—including the ACCME Standards for Commercial Support: Standards to Ensure Independence in CME ActivitiesSM. With Joint Accreditation for interprofessional continuing education, the ACCME, the ACPE, and the ANCC seek to assure the public that healthcare teams receive education that is designed to be independent, free from commercial bias, based on valid content, and effective in improving the quality and safety of care delivered by the team.

For more information, visit www.jointaccreditation.org.

Part 3:

Promoting the Value of Joint Accreditation and IPCE



Participants identified approaches for communicating the value and benefits of Joint Accreditation and IPCE to stakeholders. Jennifer Kertz, MPP, Deputy Director, National Center for Interprofessional Practice and Education (NCIPLE), describes the value of her organization's Train the Trainer Interprofessional Faculty Development Training Program, designed to build a cadre of faculty who can lead interprofessional education across the learning continuum from classroom to practice.

Participants worked in small groups to answer the question: *What is important for stakeholders to know about Joint Accreditation for Interprofessional Continuing Education?*

Joint Accreditation is not synonymous with interprofessional education. Joint accreditation is awarded by the accreditors in medicine, nursing, and pharmacy — but jointly accredited providers offer activities for a wide range of professions beyond those three. The accrediting bodies are working to include other accreditors within the Joint Accreditation framework, but in the meantime, there are no barriers restricting the target audiences for activities offered by jointly accredited providers. In addition, jointly accredited providers are not limited to offering IPCE. They recognize that some education is more appropriate for a single profession and that uni-professional education is valuable.

Joint Accreditation has the same credibility as accreditation in medicine, nursing, or pharmacy. Joint Accreditation means the provider has been recognized by not only one, but three, well-established accrediting bodies. Jointly accredited providers are held to a high set of standards that embody the values and principles of all three accrediting bodies.

Joint Accreditation supports staff recruitment and retention. Human resource departments can use an institution's status as a jointly accredited provider to attract and retain staff, and can employ IPCE as a performance improvement tool. Research shows that high-performing organizations across all sectors have high-performing teams, and that training is an essential component to reducing turnover and burnout, and improving morale, productivity, and the quality of services.

Jointly accredited providers understand and know their audiences. Educators understand their learners' practice environments, locations, and barriers, and design IPCE to effectively address those real-world challenges.

Joint Accreditation creates a safe space where all learners — including patients — have a voice. Engagement is ongoing and does not end with a single educational activity.

Non-clinical skills are essential skills. IPCE is an appropriate, effective venue to teach the essential skills of

professionalism, communications, and teamwork. These skills cannot be taught as effectively to single professions: teaching nurses alone will not address issues with physicians, for example.

IPCE is of the team, by the team, for the team. IPCE does not just mean bringing multiple professions together for an activity. It means educating the professions together as a team, so that learners understand their roles and goals related to patient care.

Focus on quality, not quantity. Joint Accreditation reduces redundancies and creates efficiencies, enabling educators to focus their attention on creating high-quality, strategic team interventions, rather than multiple, similar activities for multiple professions.

Jointly accredited providers are strategic partners. With their multi-professional scope and expertise, IPCE units function as strategic partners, driving major initiatives across institutions and systems.

Joint Accreditation drives innovation. The Joint Accreditation Criteria reflect the values of the CE community and are designed as a framework for creating relevant, practice-based, independent education. Within this framework, jointly accredited providers are empowered — and encouraged — to create innovative education that inspires teams to improve their collaborative practice and patient care.

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Only positives come out of interprofessional education. We are an extension of — not a replacement for — CE for individual professions. We are not a different system — as postgraduate educators, we are continuing the loop from undergraduate and graduate education.”

—Dimitra V. Travlos, PharmD, Assistant Executive Director, and Director,
CPE Provider Accreditation, ACPE

Key Recommendations

Participants in the 2016 Joint Accreditation Leadership Summit identified eight key recommendations for creating and sustaining a successful IPCE program.

1. Develop buy-in from leadership.

Communicate clearly and explicitly the mission of your IPCE program and its value in addressing gaps across the organization and identifying areas for improvement. Show how your IPCE program identifies common goals and supports alignment, trust, and cooperation among the professions. Explain that investing in education yields results — improvements in quality and safety processes can reduce costs for your institution and improve patient care.

2. Support your organization's strategic mission.

With its multi-professional scope and expertise, your program can be a strategic partner in major initiatives across your institution, system, and community. Align your mission with your leadership's strategic goals and identify ways to contribute to initiatives focused on both clinical and nonclinical areas, such as quality and safety, professionalism, team communications, and process improvements.

3. Build your IPCE team and model best practices.

Create a program structure that models best practices for interprofessional collaborative practice. Keep an open mind and inclusive attitude, and expand your team as your program grows. Consider including any/all professions and support personnel who are involved in the performance gaps and patient outcomes that your education is addressing. With IPCE, all voices are heard.

4. Involve patients. Patients are an integral part of the IPCE team.

Consider including patients as planners, teachers, and learners. Always maintain a focus on the ultimate goal of IPCE — improving patient care.

5. Implement a phased-in approach.

Remember that you don't need to create rapid change or implement all aspects of the program at once. A phased-in, organic approach to building an IPCE program is more likely to generate support and sustain growth and success.

6. Focus on quality.

Focus on creating high-quality, strategic team interventions. Employ a diversity of pedagogical approaches to deliver education. Use technology to support innovation. Remember that education is a process, not an event; create ongoing projects and sustain longitudinal relationships with learners.

7. Measure outcomes.

Identify outcomes that are reasonable and achievable for your IPCE activities. Outcomes measurement enables you not only to improve your own program, but also to contribute to building a body of research that demonstrates the effectiveness of IPCE in improving team performance and patient care.

8. Communicate the value of IPCE.

Be an IPCE champion. Educate your leadership and stakeholders about the contributions of IPCE to improving healthcare delivery, team performance, and patient care.

Part 4:

Future Directions



Building on the day's discussions, participants identified future goals for IPCE and Joint Accreditation, and reflected on how they can work together to support the advancement of team-based continuing education. Sterling North, MPH, Director of Continuing Professional Development for Geisinger Health System, led a discussion about how jointly accredited programs have evolved and the opportunities open to the IPCE community.

In the closing session, participants reflected on the day's discussions and identified goals for the future of Joint Accreditation and IPCE.

Alignment across professions and the continuum: Accreditors and IPCE providers need to continue to create alignment across the professions and educational continuum. The goal of alignment is to expand the diversity of educational opportunities that promote IPCP. IPCE is an extension — not a replacement — of postgraduate education for individual professions. Joint Accreditation serves to continue the interprofessional education many students are now receiving in undergraduate and graduate environments, and offers an educational home where team members can learn with, from, and about each other.

Communities of practice: Building on the work of the summit, jointly accredited providers need to generate a repository of best practices and curricula, and, when appropriate, join together to create education solutions that meet a common need and can be shared and distributed.

Evidence and outcomes: The IPCE community needs to demonstrate how and why programs are effective through conducting and publishing

outcome studies and research. While it is challenging to establish a causal relationship between an educational intervention for a single profession and improved patient outcomes, it is easier to attribute outcomes to team performance, since care is delivered in teams. However, it is still difficult to produce significant data about IPCE outcomes. It's important for jointly accredited providers to begin building a body of research, even starting with small steps, such as publishing an article about how an intervention worked (or didn't work). Demonstrating the value of IPCE will be the most effective argument for increased recognition, staffing, and funding.

Share the stories: In addition to producing data, IPCE providers need to continue to share the stories of their successes and challenges, as they did at the summit. Examples of IPCE in practice need to be disseminated across the continuum of healthcare education and throughout the healthcare community.

Promoting the value of Joint

Accreditation: The community of jointly accredited providers needs to conduct an awareness campaign to educate stakeholders about the meaning and value of Joint Accreditation. Just as healthcare stakeholders understand and recognize the value of Joint Commission accreditation and the ANCC's Magnet Recognition Program®, they need to understand the contributions of Joint Accreditation in improving healthcare

delivery and patient care. In addition to healthcare systems and institutions, stakeholders include patient advocacy groups, payers, regulators, legislators, government agencies, foundations, and organizations focused on community, public and population health.

“

We thank you for the work you are doing every day to make a difference. We want to work with you, and convene a community of practice to sustain, stimulate, and nurture you so that you can continue to do your awesome work. I encourage you to convey your enthusiasm to your CEOs, health system leaders, and other stakeholders, and to demonstrate your capacity to be a strategic partner and to leverage the power of education to improve team-based care for the patients we serve.”

— Graham McMahon, MD, MMSc, President and CEO, ACCME

Feedback from Participants

- *“I’m encouraged to communicate with company leaders more than I have in the past. I’ve relied on the staff to communicate how valuable the IPCE program is, but I think I’ll start reporting on our successes myself.”*
- *“[A new strategy is to] develop succinct talking points to be used with various groups, i.e., administration/clinical personnel, focusing on the positive outcomes for patient care — such as better coordination of care, increased quality measures, increased reporting of adverse events, improved communication strategies with patients and families.”*
- *“[A new strategy that we gained for communicating the value of IPCE] is leveraging the community we have joined as a jointly accredited provider. Together we are all stronger.”*
- *“It is inspiring to know we are leading the nation with these efforts. New strategies: focusing on the data we do have, not the data we do not have. Increasing the variety of partners, using pilots and a sunset approach.”*
- *“This summit helped me see value in utilizing the patient voice more often in CME/CE activities.”*
- *“[The biggest takeaways] were the different types of activities that fit interprofessional [education] rather than just didactic lectures.”*
- *“The case studies were very instructional in learning what others are doing — what works and what doesn’t. Also, [it was valuable] learning about the challenges faced by different organizations and ways to overcome them.”*
- *“Networking with other organizations was extremely helpful. We were able to make connections with other groups that will open up our collaborative thinking even more.”*
- *“[The most valuable part was] hearing from groups that are in the various stages of Joint Accreditation—learning from their experiences and insights, and having the time to interact.”*

What Is Interprofessional Continuing Education?

Interprofessional continuing education (IPCE) is when members from two or more professions learn with, from, and about each other to enable effective collaboration and improve health outcomes (ACCME, ACPE, ANCC, 2015).

Table 1. Leadership Summit Participants

Aurora Health Care	MedEDirect, LLC
Baystate Health	National Center for Interprofessional Practice and Education (NCIPE)
Boston Children's Hospital	National Lipid Association
CAMC Education & Research Institute	PRIME Education, Inc.
CentraHealth	Rutgers Biomedical and Health Sciences
Cine-Med, Inc.	Salus Global Corporation
Contemporary Forums	Society of Gynecologic Oncology
Continuing Education Alliance	Studer Group
Creative Educational Concepts, Inc.	University of Minnesota, Continuing Pharmacy Education
Dannemiller	University of Minnesota, School of Nursing
Department of Justice Federal Bureau of Prisons Health Services Division	UW-Madison School of Medicine and Public Health
Duke University Health System Department of Clinical Education & Professional Development	Washington University St. Louis School of Medicine
Geisinger Health System	WebMD/Medscape
Hawai'i Pacific Health	
Hospital Corporation of America (HCA Healthcare)	

IPCE in Action: Case Examples

As part of their pre-work for the summit, participants submitted case examples of IPCE activities. During the summit, participants presented their cases, led discussions about the key themes exemplified by the examples, and answered questions. Some of these examples are included in the main body of the report. Here are some of the other examples.

Organization: Boston Children's Hospital

Team: Registered nurses, health unit coordinator/nursing assistant (combined role) from inpatient unit; EKG technicians from adult unit

Practice Gap: During debrief of Supraventricular Tachycardia (SVT) case scenario, it was recognized that EKGs are not readily available in the pediatric inpatient setting.

Goal: Using a team-based simulation, the activity taught learners the proper steps in the care of children presenting with SVT, including how to access EKGs.

Outcomes: Observed changes in protocols, processes, and procedures, including the increased utilization of the hospital emergency care system and the pediatric inpatient unit's inclusion of EKG technicians as a resource.

Organization: CAMC Health Education & Research Institute

Team: Physicians, nurses, pharmacists, respiratory therapists

Practice Gap: Through QI data an increase in sepsis diagnosis and treatment was noted throughout the system. The sepsis rate had increased due to a lack of proper monitoring and the administration of antibiotics/medication pack on identification of symptoms.

Goal: Through lecture and onsite simulation exercises, the sepsis workshop was designed to change the team's response and recognition of symptoms; to improve monitoring and outcomes for the sepsis patient.

Outcomes: More efficient recognition of sepsis symptoms by the healthcare team and a decrease in the sepsis morbidity-mortality rate for our health system.

Organization: Dannemiller, Inc.

Team: Physicians, pharmacists, registered nurses, nurse practitioners, physician assistant, registered dietitian, psychologist

Practice Gap: There is a gap in the dissemination of the most modern advances in research, treatment, and best business practices for weight loss professionals. Ninety-four percent of a sample of 580 primary care physicians, endocrinologists, and cardiologists ranked obesity as an “extremely severe” or “severe” health issue however, survey data indicate that only one-third of obese patients receive an obesity diagnosis or weight-related treatment advice from their physicians.

Goal: The Obesity Treatment & Prevention Conference 2015 was designed to improve the competence and performance of healthcare professionals in managing and treating obese patients.

Outcomes: Ninety-five percent of participants said the conference increased their competence, and 96% said it would improve their performance. Participants identified changes that they intended to make, including changes in protocols, policies, procedures; and management and/or treatment of patients. Participants identified barriers to change and strategies for addressing those barriers.

Organization: Hawai'i Pacific Health

Team: Nurses, physicians, social workers, and other healthcare professionals

Practice Gap: A significant gap was identified regarding end of life care in the Hawai'i Pacific Health hospital system, including a lack of advance care planning discussions/decisions as well as low referrals to hospice care.

Goal: As part of a multiyear, multifaceted strategy, CE sessions aimed to increase end of life care discussions and decisions, and to honor patients' wishes. Sessions included role-playing with simulated patients and case studies.

Outcomes: Total number of patients with advance care planning discussions documented in the electronic medical record increased from 629 in 2011 to 5,096 in 2015. The total number of filed Provider Orders for Life Sustaining Treatment (POLST) increased from 68 in Quarter 1 of 2011 to 1,179 in Quarter 4 of 2015. Data from 2014 and 2015 shows that 94% of patients had their POLST wishes honored while receiving services in the Hawai'i Pacific Health hospital system.

Organization: MedEDirect

Team: NASA Chief Medical Officer's staff, physicians, nurses, audiologists, psychologist, physiologists, nutritionists

Practice Gap: Need for an evidence base supporting policies and practices to improve the management of humans in extreme environments

Goal: Conduct the research necessary to address the gap. Project includes study groups and hands-on computer labs. It is funded by NASA and jointly provided with the George Mason University Center for the Study of International Medical Policies and Practices.

Outcomes: Project is ongoing; database is in development.

Organization: National Center for Interprofessional Practice and Education, in collaboration with the University of Washington, University of Virginia, and University of Missouri

Team: Interprofessional teams of emerging leaders; January 2016 offering included physicians, nurses, pharmacists, public health professionals, social workers

Practice Gap: Several health professions' accreditation councils have added requirements for interprofessional education and IPCP for higher education institutions. Many institutions have discovered that the majority of their health professions faculty and collaborative practice clinicians are not prepared to lead this type of training.

Goal: The Train the Trainer (T3) Interprofessional Faculty Development Training Program is designed to build a cadre of faculty who can lead interprofessional education across the learning continuum from classroom to practice. The initiative includes face-to-face training, webinars, and coaching sessions.

Outcomes: The program began in January 2016 and is ongoing for 12 to 18 months. Outcomes analysis is not yet available.

Organization: National Lipid Association

Team: Physicians, nurse practitioners, nurses, pharmacists, dietitians, physician assistants

Practice Gap: Clinicians and other health-care providers need to know more about non-pharmacologic and therapeutic lifestyle changes that reduce cardiometabolic risk factors.

Goal: Discuss the role of team members in coordinating patient care to ensure optimal treatment of dyslipidemia; explain

the principles of collaborative, patient centered care in clinical lipidology settings; improve knowledge of medication options; analyze case studies in lipid management to improve treatment and prevention of cardiovascular disease

Outcomes: Not yet available; activity in the planning stage

Organization: Rutgers Biomedical and Health Sciences

Team: Behavioral health professionals, including physicians, nurses, psychologists, social workers, substance abuse counselors, and mental health counselors

Practice Gap: Patients with mental illness who smoke are unable to obtain the appropriate smoking cessation interventions due to behavioral healthcare teams' lack of ability to engage with patients, provide resources, and to provide aggressive assessment, treatment, and referrals to treatment. Effective smoking cessation efforts at mental health institutions are failing due to the lack of institutional smoke-free policies.

Goal: Provide healthcare team members with the skills and strategies to apply evidence-based treatment strategies to assist patients to quit smoking, adopt smoke-free healthcare facility policies at their agencies, and employ tools and tactics to successfully empower patients to choose a healthy tobacco-free life.

Outcomes: Data from the pre-activity and three-month post-activity surveys show improvement in team members' behavior in implementing effective tobacco cessation treatment strategies and advancing smoke-free healthcare facility policies at their workplace.

Organization: Society of Gynecologic Oncology

Team: Gynecologic oncologists, medical oncologists, radiation oncologists, obstetricians/gynecologists, fellows and residents, research scientists, nurses, nurse practitioners, physician assistants, genetic counselors, pharmacists, and others involved in the care of patients with gynecologic malignancies

Practice Gap: Regional and institutional barriers, such as access to materials, education, and training, prevent healthcare teams from translating knowledge and skill into improved patient outcomes.

Goal: This annual meeting was designed to teach team members about the latest global research in the screening,

prevention, and treatment of gynecologic cancers, and how to integrate new therapies into clinical practice in an evidence-based manner.

Outcomes: Increased usage of genetic testing; further exploration of biologic treatments; better understanding of each individuals' roles; responsibilities, and how they can improve practice and patient outcomes; better management of adverse effects; earlier integration of palliative care; more exploration of complementary treatments.

Organization: Studer Group

Team: Physicians, nurses, respiratory therapists, physical therapists, other therapists, support services, such as housekeeping, C- suite representatives such as CEO, CFO

Practice Gap: The gap between current and desired practice in the healthcare team's organizational performance

Goal: The Institute was designed to teach participants strategies and tactics for improving organizational performance, leadership skills, and employee engagement and alignment.

Outcomes: Data from 30-day follow-up surveys showed that 98% of survey participants believed they were able to implement at least three tools, techniques, or best practices learned at the Institute to improve service, clinical, or operational performance. They also identified barriers; the major barriers encountered were time management, employee/leader buy-in, and resistance to change.

Organization: Washington University St. Louis School of Medicine

Team: Physicians, nurses, administrators, physician assistants, pharmacists, QI/ Patient safety officers, other healthcare team members

Practice Gap: Lack of knowledge of the characteristics of a highly reliable organization and lack of competence to build one. Quality and patient safety not uniform among divisions or across the healthcare system.

Goal: Improve participants' understanding of how highly reliable organizations function and improve their ability to apply these principles in their own settings; improvement in patient outcomes and safety through more standardized care

Outcomes: One year follow-up surveys show interprofessional rounds were instituted or enhanced (yes: 59%), increased safety event reporting (yes: 75%), greater recognition of individuals who report (yes: 60%), more standardized hospital/unit practices (yes: 63%), and more effective communication among team members (yes: 72%).

“

ANCC is incredibly proud of our collaboration with ACCME and ACPE in creating Joint Accreditation for Interprofessional Continuing Education, the only program of its kind in the world. We have worked side-by-side, demonstrating interprofessional collaborative practice as accreditors. We too have learned from, with, and about each other through our collaborative relationship. Our partnership has benefited the CE provider community, regardless of whether those providers pursue Joint Accreditation or remain individually accredited through different accreditors. We also know, as evidenced by this report, how we have positively impacted collaborative care among healthcare professionals and patient outcomes.”

— Kathy Chappell, PhD, RN, FAAN, FNAP, Interim Chief Officer, ANCC



JOINT ACCREDITATION™
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Front cover: LCDR Sherri A. Wheeler, RN-BC, BSN, DNPc, Bureau of Prisons National Continuing Professional Medical Education Coordinator, explains that educators need to demonstrate courage and commitment to manage successful IPCE programs.

Back cover: Megan Grimm, Prime Education Accreditation and Compliance Manager

