



AMERICAN
SPEECH-LANGUAGE-
HEARING
ASSOCIATION

Ad Hoc Committee on Interprofessional Education

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Final Report

Interprofessional Education (IPE)

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The ASHA Ad Hoc Committee on Interprofessional Education (IPE) was created in the spring of 2013 by the ASHA Board of Directors with the following charge:

Resolved, That an ad hoc committee be established and charged to develop specific actions that address education and core competencies of interprofessional education related to reimbursement models for students and members.

The membership of this committee included: Bob Burkard (chair), Kenn Apel, Diane Jette, Nancy Lewis, Robert Moore, Judy Page, Betty Rambur, Robert Turner, Neil Shepard (Board of Directors liaison), Lemmie McNeilly (ASHA chief staff officer for speech-language pathology), Janet Brown (ASHA ex officio), Ellen Fagan and Loretta Nunez (ASHA staff consultants).

The Process

Through the summer and early fall of 2013, the committee convened via conference call to discuss a number of specific IPE publications to educate and calibrate all committee members on the current role of IPE in the training of health care providers.

The majority of committee members attended a face-to-face meeting at the National Office October 12–13, 2013. The first day of the meeting included some brief presentations in the morning, followed by a series of breakout sessions where small groups of attendees discussed a specific question and reported back to the group as a whole. The reports were followed by a group discussion. Late in the day, a subgroup of meeting attendees met to distill the discussions into a list of action items.

The five discussion topics were as follows:

Discussion Topic 1:

What are the concepts and strategies that ASHA could recommend to academic programs and to those professionals outside of academic programs for developing IPE and interprofessional practice (IPP) in the context of health care economics?

➤ Three separate subtopics:

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|--|---------|
| a. Educating the Educators: | Group 1 |
| b. Educating Students: | Group 2 |
| c. Educating Practicing Professionals: | Group 3 |

Discussion Topic 2:

How can ASHA develop and foster connections with other organizations to promote IPE and IPP with regard to health care economics? What would be a logical sequence of steps?

- All three groups discuss the same topic.

Discussion Topic 3:

Is assessment of all five core competencies of IPE—listed below—necessary and sufficient to describe the efficacy of IPE in increasing the value of health care?

1. Provide patient-centered care
2. Work in interdisciplinary teams
3. Employ evidence-based practice
4. Apply quality improvement
5. Utilize informatics

- All three groups discuss the same topic.

Discussion Topic 4:

How can one measure value in health care of IPE and IPP, in general, and specifically for (a) prevention, (b) diagnostic services, and (c) rehabilitative services?

- Three separate subtopics:
 - a. Prevention: Group 1
 - b. Diagnostic Services: Group 2
 - c. Rehabilitative Services: Group 3

Discussion Topic 5:

How can certification/accreditation/licensure bodies be used to promote IPE? Which of these bodies should be approached? What recommendations should be made to these bodies?

- Three separate subtopics:
 - a. Certification Bodies: Group 1
 - b. Accreditation Bodies: Group 2
 - c. Licensure Bodies: Group 3

On October 13, the committee convened to discuss the draft list of tentative action items and to engage in a consensus process to accept or reject each item. If 8 or more of the 10 members approved an action item, it was accepted; if 3 or fewer members accepted the item, it was rejected; if between 4 and 7 accepted the item, it was again discussed and another vote was taken. If on the second vote either 8 or more or 3 or fewer accepted the motion, the item was finally accepted or rejected and removed.

Those items accepted by the group went through one additional vote to determine whether the item was of high or low priority. Three outcomes were available: **High Priority** (8/10 or greater), or **Low Priority** (3/10 or fewer), or “**No Consensus**” (4–7/10).

Discussion and Recommendations

The committee reiterated the importance of IPE/IPP as it relates to changes in the health care economic environment and the role of IPE leading to IPP, demonstrating the increase in value of services provided to clients/patients. ASHA’s commitment to IPE/IPP should continue to be advanced through the recommendations that follow.

The wording of the charge to the ad hoc committee, which specifically includes the term *reimbursement models*, was considered to be too limiting; we expanded the charge so that we could incorporate in our conference call discussions the broader area of health care economics and practice models. Thus, in the following discussion and recommendations, this portion of the charge is more broadly considered to reflect the coming changes in practice, as well as reimbursement, in response to the Patient Protection and Affordable Care Act.

Many issues and concerns were raised during discussion of the first day’s five topics. Although ASHA members have been involved in interdisciplinary research, training, and practice (e.g., Leadership Education in Neurodevelopmental and Related Disabilities [LEND]), the recent focus on interprofessional education to increase value in health care delivery has primarily involved the disciplines of medicine, nursing, pharmacy, and public health. Although a number of ASHA members, volunteer leaders, and National Office staff have emerging expertise in the area of IPE/IPP, we need to immediately begin educating the academic arm of our professions so that they can begin educating and training other educators, practicing professionals, and future practitioners in IPE/IPP. There may be push back from many of our academic members in terms of spending both the time to learn about IPE and including this in their course work. Our professional course work requirements are already quite demanding, and spending the time to instruct IPE will be viewed as taking time away from more substantive (i.e., more discipline-specific) topics. Thus, it is important to make it clear that much of the inclusion of IPE/IPP, which involves new ideas and methods of education, will (at least initially) be infused into the curriculum. Similarly, there may be concern among practicing clinicians about having to learn and implement an entirely new skill set in order to engage in IPP.

During our discussion, it became clear that there is relatively sparse information concerning the efficacy of IPE in demonstrating value in professional practice. This limited information base represents a barrier to fully embracing IPE, but is also an opportunity for education research. We will need to develop tools for assessing competence in IPE (or surrogate measures, such as the interprofessional education collaborative [IPEC] core competencies). We will need to create metrics to quantify the cost and quality of health care in order to demonstrate the value in health care. It is only through such analyses that we can demonstrate the efficacy of IPE in driving down health care costs.

Much of the discussion focused on collaboration, including the question of which professionals we will partner with for IPE/IPP. There is concern about being included as equal partners in the health care IPE initiatives created by medicine, nursing, pharmacy, and public health. IPE is also required in educational settings. We discussed a three-pronged approach to pursuing IPE collaboration—with all health care providers, with a small set of health care providers (e.g., OT, PT, social work), and with those in primary and secondary education settings (e.g., OT, PT, teachers, and special educators, etc.).

There was concern about the role of our professions in IPP. As we reframe our professions and evidence is obtained that demonstrates the value of IPP, we should be in a better position to define our roles in the provision of post-fee-for-service health care reimbursement models.

One of our challenges in working in an interdisciplinary format, both in the health system as well as in educational settings, involves the logistics and strategic steps to accomplish the concept of IPE leading to IPP. One suggestion from the committee was the use of systems engineering (logistic model engineering) as a means for establishing a framework of logical steps to accomplish the goals embedded in the establishment of IPE leading to IPP.

We offer, in this report, a new vision of the roles of speech-language pathologists (SLPs) and audiologists in health care delivery. While retaining our profession-specific identities, we need to blend knowledge and practice with professionals from other disciplines. As experts in hearing and balance, oral and written language, swallowing, and health literacy, we can play a central role by working with other professionals to prevent disease/disorders, reduce medical errors, promote patient safety, and improve population health.

Recommendations From Face-to-Face Meeting

- I. Recommend the BOD endorse the IPEC Core Competencies for Interprofessional Collaborative Practice included in the domains of Values/Ethics for Interprofessional Practice, Roles/Responsibilities for Collaborative Practice; Interprofessional Communication; Interprofessional Teamwork and Team-Based Care. **Consensus–HIGH Priority**

TOPIC 1: Educating students, faculty, practitioners about IPE/IPP and its value

- II. Develop an education initiative to educate stakeholders (students, faculty, practitioners). **Consensus–HIGH Priority**
 - A. Recommend ASHA, Council of Academic Programs in Communication Sciences and Disorders (CAPCSD), Special Interest Groups (SIGs) 10 (Higher Education) and 11 (Administration and Supervision) collaborate to promote infusion of IPE across professional program curricula (e.g., ASHA Academy) such as:
 - Offering an IPE course taught by faculty from different professions to students from all disciplines
 - Promotion of IPE in clinical practica
 - Promotion of faculty development (i.e., academic and clinical faculty, externship supervisors)
 - Develop online resources that define and illustrate IPE/IPP and the role of core competencies and link IPE/IPP to changes in health care
- III. Create a list of change leaders who can be speakers/writers on IPE and IPP. **Consensus–HIGH Priority**
- IV. Create a PR campaign to promote awareness of and value of IPE/IPP. **Consensus–HIGH Priority**
 - A. Educate other professions and the public about our professions' expertise in:
 - oral and written communication
 - health literacy
- V. Encourage ASHA Continuing Education to expand offerings in IPE/IPP. **Consensus–HIGH Priority**
 - A. Encourage CE providers to include or push IPE/IPP
 - B. Develop in-house IPE/IPP activities

- C. Infuse IPE/IPP in Schools and Health Care Conferences
- D. Continue/expand IPE/IPP convention strand beyond 2014 (e.g., increase resources to invite speakers)
- E. Provide pre-professional and professional development on health literacy
- F. Educate ASHA members about our role in prevention at all levels, including screenings and Medicare quality measures
- G. Educate members about IPE/IPP through infusion in SIGs

VI. Consider funding IPE/IPP initiatives. *Consensus–LOW Priority*

- A. Approach ASHFoundation regarding awards for research on efficacy of IPE/IPP
- B. Existing ASHA programs and awards (e.g., MARC, AARC, SPARC) for teaching/research in IPE/IPP
- C. Innovative projects that advance IPE/IPP in the professions

TOPIC 2: Connections with other organizations

VII. Communicate with organizations we have a relationship with (e.g., state associations, state academies, regional college and university accrediting bodies, American Academy for the Accreditation of Ambulatory Surgical Facilities, American Academy of Audiology, Academy of Doctors of Audiology, American Occupational Therapy Association, American Physical Therapy Association, American Academy of Private Practice in Speech Pathology and Audiology, Association of Schools of Allied Health Professionals, National Association of Principals, National Alliance of Specialized Instructional Support Personnel, Council on Exceptional Children, The Joint Commission, National Association for Advisors in the Health Professions, National Alliance of Pupil Services Organization, National Association of Elementary School Principals, National Association of Secondary School Principals) and seek opportunities for collaboration and information sharing on IPE/IPP. *Consensus–HIGH Priority*

VIII. Partner with other professions for joint professional development on IPE/IPP (with CE credit for each profession). *Consensus–LOW Priority*

IX. Communicate with other entities to promote/educate about the value of CSD services in IPP. *Consensus–LOW Priority*

- A. Payers (insurance companies)

- B. Vendors
- C. Patient organizations
- X. Look for opportunities to include members of other organizations on relevant ASHA committees that deal with topics for which IPP is best practice.
Consensus–LOW Priority

TOPIC 3: Research agenda for IPE/IPP

- XI. Develop a research agenda to assess the effectiveness of IPE/IPP.
Consensus–HIGH Priority

TOPIC 4: Certification, accreditation, licensure

- XII. Engage the Council on Academic Accreditation (CAA) to:
Consensus–HIGH Priority
 - A. Consider including IPE didactic and clinical activity (including the IPEC domains) in the standards
 - B. Consider standards for faculty qualifications for teaching IPE/IPP
 - C. Modify practice analysis to collect data on IPP
- XIII. Engage the Council for Clinical Certification (CFCC) to consider:
Consensus–HIGH Priority
 - A. Accepting a portion of clinical practicum hours supervised by professionals outside CSD
 - B. Infusing IPE principles and competencies into the certification standards for didactic and clinical experiences
 - C. Having a “user of services” on the CFCC to promote patient-centered care
 - D. Infusing IPE/IPP content in Praxis exams (e.g., scenarios that infuse IPE/IPP)
 - E. Modifying practice analysis to collect data on IPP

XIV. Consider revising scope of practice documents to reflect IPE/IPP.

Consensus–LOW Priority

XV. Harmonize standards for IPE/IPP competencies across credentialing bodies and regulatory agencies.

Consensus–LOW Priority

XVI. Recommend communicating with National Council on State Boards of Examiners in Speech-Language Pathology and Audiology (NCSB), state departments of education certification boards, and each state licensure board (after certification and accrediting bodies) to educate them about IPE/IPP.

Consensus–LOW Priority

A. Craft model language for state licensure boards regarding IPE/IPP

B. Consider allowing specified non-CSD professionals to supervise students and CFs and support personnel