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Initial Efforts to Manage IPE during the COVID-19 Pandemic: Reports from the Big Ten Academic Alliance

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Abstract

Purpose: The COVID-19 pandemic required higher education institutions to quickly transition to a virtual platform. This was challenging for those involved in interprofessional education (IPE), given the goal that students from two or more professions learn about, from, and with one another. The Big Ten IPE Alliance is a subgroup of the larger Big Ten Academic Alliance. The purpose of this paper is to share the collective experiences of multiple large, research intensive universities in addressing the challenge of implementing IPE programs under the conditions established by the COVID-19 pandemic. **Methods:** To better understand how the Big Ten schools dealt with the transition to virtual learning for didactic and clinical IPE given the COVID-19 pandemic, a subset of representatives from the Big Ten IPE Alliance met to discuss best practices for virtual learning in the IPE realm. Each participating university completed an electronic 14 question survey related to their IPE curriculum during the COVID-19 pandemic from March 2020 thru August 2020 and the responses were analyzed. **Results:** Four categories were identified as needing to be addressed to develop and implement successful interprofessional didactic and clinical experiences. The categories identified included content/assessment, virtual technologies, faculty and facilitators, and learners. **Conclusions/Recommendations:** Consider including authentic and innovative mechanisms to deliver IPE experiences that meet the learning needs and accreditation requirements. Interinstitutional collaborations such as within the Big Ten IPE Alliance can be beneficial in assessing current and future best practices in IPE.

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Initial Efforts to Manage IPE during the COVID-19 Pandemic: Reports from the Big Ten IPE Academic Alliance

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ABSTRACT

Purpose: The COVID-19 pandemic required higher education institutions to quickly transition to a virtual platform. This was challenging for those involved in interprofessional education (IPE), given the goal that students from two or more professions learn about, from, and with one another. The Big Ten IPE Alliance is a subgroup of the larger Big Ten Academic Alliance. The purpose of this paper is to share the collective experiences of multiple large, research intensive universities in addressing the challenge of implementing IPE programs under the conditions established by the COVID-19 pandemic. **Methods:** To better understand how the Big Ten schools dealt with the transition to virtual learning for didactic and clinical IPE given the COVID-19 pandemic, a subset of representatives from the Big Ten IPE Alliance met to discuss best practices for virtual learning in the IPE realm. Each participating university completed an electronic 14 question survey related to their IPE curriculum during the COVID-19 pandemic from March 2020 thru August 2020 and the responses were analyzed. **Results:** Four categories were identified as needing to be addressed to develop and implement successful interprofessional didactic and clinical experiences. The categories identified included content/assessment, virtual technologies, faculty and facilitators, and learners. **Conclusions/Recommendations:** Consider including authentic and innovative mechanisms to deliver IPE experiences that meet the learning needs and accreditation requirements. Interinstitutional collaborations such as within the Big Ten IPE Alliance can be beneficial in assessing current and future best practices in IPE.

Keywords: inter-institutional, IPE, BIG 10, collaboration, covid-19

INTRODUCTION

The Big Ten IPE Academic Alliance began in 2015 as a subgroup of the larger Big Ten Academic Alliance.¹ Currently, the larger group consists of 14 institutions and is led by their provosts. The health science programs at Big Ten Universities represent over 20 different disciplines, with potentially 50,000 health science students involved in IPE activities across the 14 universities.¹

Since the COVID-19 global pandemic in early March 2020, serious disruption in higher education along with other aspects of our social order worldwide has occurred.² Many institutions transitioned face-to-face (F2F) education to online learning environments. Many institutions followed the restrictions on personal contact and social distancing which necessitated unique approaches to educating students.³ Virtual IPE offered remotely can be an effective approach for interprofessional education.⁴ However, given the goal that students from two or more professions should learn about, from, and with one another,² transitioning to a virtual platform in a short period of time was uniquely challenging. The uncertainty created by the pandemic makes it clear that we are in the process of developing a new normal in health professions education.

The purpose of this paper is to share the collective experiences of multiple large, research-intensive universities by addressing the challenge of implementing IPE programs under the conditions established by the COVID-19 pandemic. The specific aims are to compare and contrast interprofessional learning opportunities utilized among the Big Ten IPE Academic Alliance institutions to deliver virtual interprofessional didactic, simulation, and clinical experiences in the wake of COVID-19. And, as a result, will provide recommendations on best practices moving forward based on successful virtual IPE curriculum models used as well as improvements from lessons learned.

METHODS

To better understand how the Big Ten schools dealt with the transition from F2F to virtual learning for non-clinical (foundational/introductory and simulations) and clinical (clerkship/clinical/community/professional practice with patients/clients/populations) IPE given the COVID-19 pandemic, a subset of representatives from the Big Ten IPE Academic Alliance developed a collaborative working group around this topic.

Participants

Fourteen universities representing the Big Ten IPE Academic Alliance were invited via email to participate in this study. Prior to the pandemic, each university had at least 5 years of experience with IPE with varied experience using e-learning as a platform for required IPE activities.

Research Design and Procedures

Data was collected electronically. Each participating university completed 14 questions and one open-ended free text box to share additional insights related to their IPE curriculum during the COVID-19 pandemic from March 2020 thru August 2020 (Appendix).

The group used a multiple-case design⁵ and used a two-phased data collection process over a 3-month period of time that (a) began with each participant sharing their university's IPE experiences during the beginning of the pandemic and (b) subsequently, the group jointly reviewed and discussed the answers that each other had provided. In multiple-case design studies, several descriptive cases are created using multiple methods of data collection. In this study, completion of the original questionnaire and the subsequent joint discussion informed the creation of a descriptive case for each of the participating universities. The two members independently reviewed the data and then worked together to identify categories pertaining to curriculum delivery and best practices. These results were validated through review by the other xxx members of the group until there was consensus on the final categories. Themes pertaining to curriculum delivery and best practices that emerged from the data were vetted and agreed upon by all members of the working group.

RESULTS

Nine of the Big Ten universities participated in this study, and five did not respond to multiple requests for information. Explanation for choosing to participate or not was not sought. Four categories pertaining to curriculum delivery surfaced as critical components of virtual IPE and IPC experiences (summarized in Table 1).

Similar Content, Different Pedagogical Delivery and Assessment Requirements

Although content did not differ substantially between virtual and F2F IPE, the sudden shift to online delivery required changes to the curriculum design framework incorporating pedagogical principles that made online learning effective for students. This involved creatively engaging students in online environments and enabling social learning connections with peers including tactics such as: assigned pre-session interactions and partnerships across professions; use of team-based learning pedagogies to facilitate completion of pre-work readings and accountability to the team; mid-session "buddies" to empower learners' contributions and to

create psychologically safe spaces; assignment of team-specific roles; and post-session peer feedback. Online learning also created some challenges with assessment. To ensure students' engagement and learning, many universities used reflection as one approach in the online environment. Due to the number of submitted reflections and the limited IPE faculty/facilitators, in some cases there were not enough faculty to review/grade self-reflections and assignments in a timely manner. Also, some universities raised concerns whether the IPE assessment tools used for in-person sessions would still be useful in the virtual learning environment, yet the rapid conversion to virtual experiences prohibited the development of new, validated assessment instruments and approaches appropriate for virtual learning. One participant stated, "Intentional IPE and competency development, particularly at the immersion level, is challenging with asynchronous interactions."

Table 1. Early Challenges & Opportunities in Transitioning from F2F to Virtual IPE

Category	Summary
Content, Delivery, and Assessment	<p>Content</p> <ul style="list-style-type: none"> ● Comparable content/objectives when delivered F2F or by remote mechanisms. ● Incorporated new pedagogies to engage learners online <p>Assessment</p> <ul style="list-style-type: none"> ● Required different modalities (completing online versus on paper) ● Virtual curricular delivery was often more time consuming for students and facilitators since materials require conversion to engaging, online delivery platforms
Virtual Technology	<ul style="list-style-type: none"> ● Multiple virtual platforms available - consistency a challenge ● Privacy and security settings in virtual environment must be addressed ● Opportunity to engage additional disciplines within student teams since geographic co-localization is not necessary ● Virtual requires increased human and technological resources to create engaging learning activities and support those with technological challenges
Faculty, Facilitators, and Standardized Patients	<ul style="list-style-type: none"> ● Increased time commitment and/or need for support staff to convert materials to online platforms ● Varying levels of comfort with technology and/or teaching or acting virtually
Learner Empowerment	<ul style="list-style-type: none"> ● Increased student empowerment by allowing more flexibility and space for equal engagement ● Increased student autonomy and responsibility with pre-work and accountability to team in e-learning environments

Virtual Technology as Enabler and Barrier

Many facilitators, students, and standardized patients had not previously engaged in virtual learning. Consequently, there were a wide range of comfort levels using technology, and where this comfort level was low, there was a steep learning curve. Additionally, numerous virtual technology platforms were available. "One major challenge for us is going to be training the facilitators on the platform" was stated by a participant. Universities often supported one or two specific platforms, and for those using unsupported platforms, this led to frustration among students and/or faculty. Furthermore, each platform had its own unique set of features, such as the availability of breakout rooms, polling, annotation, shared screens, white boards, etc. for students to work in interprofessional groups. While such features allowed for increased collaboration opportunities in the remote learning environment, becoming familiar with these more complex features, in addition to learning about the general functionalities, was time consuming. Different resources such as cameras, microphones, and other instructional design staff were needed to support faculty in the virtual world. "IT technical support for each of our 5 simultaneous synchronized sessions will be needed," was stated by a participant.

In the clinical IPE setting, new privacy and security requirements arose that were not present or necessary in the F2F environment. For example, health-system specific HIPAA-compliant versions of virtual platforms were necessary to conduct virtual patient visits, as were new methods of distributing and collecting patient-specific information and tracking/monitoring students' clearances. In addition, scheduling virtual visits and gaining external access to patient charts were challenging.

One new opportunity that became available with virtual patient care visits was the ability to add new or additional disciplines to the care team that would not have otherwise been able to participate. One institution was able to engage students from disciplines outside of the university to complement the already existing team, allowing more participants to be involved than would have normally been possible in a small examination room. Another new opportunity that became available during virtual clinical encounters was to have a staff person manage breakout rooms for pre-briefing "huddles" in advance of seeing patients for information sharing purposes and post-encounter "huddles" during which students developed joint care plans before formally "presenting" the patient to faculty. There was consensus from participating institutions that virtual patient care visits may have eventually been instituted as a form of practice, but curricular changes brought about by COVID-19 accelerated implementation of this model of care which will benefit programs going forward.

Faculty/Facilitators/Standardized Patients are Challenged

Faculty reported that virtual delivery of IPE activities was more time-consuming as compared to F2F IPE. This was due to many reasons, including time needed to convert F2F activities to virtual platforms using curricular design processes and pedagogies that encourage student engagement, additional time for revising/updating assessment tools, and debriefing groups of students using online platforms, etc. One participant stated, "Our goal was to make faculty preparation and participation as easy and convenient as possible for faculty. During this stressful time, we did not want them to feel that this work added to their burdens." Additionally, some faculty were inexperienced with virtual teaching, which led to discomfort using the technologies that were available and increased the probability of less-effective experiences for students. As such, IPE faculty development for faculty, facilitators, and standardized patients was expanded to include effective methodologies for virtual instruction.

Learner Empowerment

Virtual environments often empowered students who would otherwise have been quiet, shy, and passive during in-person activities, to have a greater voice in discussions. In the virtual environment, students often demonstrate more autonomy and took on additional responsibilities when working in teams (e.g., serving in special roles for their online team such as a Qualtrics manager, a Technology manager, a Timekeeper, etc.). By necessity, many teams set up their own meeting times to work on projects, rather than being scheduled for in-person activities. Particularly during times of heightened social distancing restrictions where students had limited classroom interactions with their peers, some interprofessional online groups continued to meet and engage with each other for months after the IPE event because they "felt like they made new friends" as a result of their IPE team experiences; in pre-COVID times, when students participated regularly in classroom and social activities with their peers, they may have been less inclined to develop lasting friendships with students outside of their own profession. "In addition, we aimed to always be available for support – even nights and weekends, to answer their questions, walk them through step by step one on one in some cases, and to do so with kindness and with a collaborative spirit – we were all in this together with the same goal – to help provide a valuable experience for our learners," stated one participant.

DISCUSSION

Since most health professional accreditation agencies now require some form of IPE,⁶ sharing ideas for how different programs approached the challenge of continuing to foster competence in IPE during the COVID-19 pandemic was beneficial for the Big Ten IPE Academic Alliance. The COVID-19 pandemic required a rapid change in IPE curricula. Reflecting upon and learning from this shared experience will prepare us to better respond with purpose and intentionality when/if another pandemic occurs. The reflections of the group are detailed in Table 2 including discoveries and best practices related to content and assessments; virtual technologies; challenges for faculty, facilitators and standardized patients and learner empowerment. While the ideal methods for IPE delivery differ across professions and at different institutions, it is imperative to maintain an open and flexible mindset in terms of content, platforms, and assessments and choose those best suited for the current environment.

Positive Changes to IPE

The COVID-19 pandemic has facilitated a number of positive changes for IPE:

1. The teamwork necessary for optimal patient outcomes is unprecedented.
2. Many healthcare professionals' roles have expanded, highlighting valuable and perhaps unexpected contributions on the "front line" of the public health crisis.
3. The rapid expansion of telehealth/telemedicine will permanently alter some aspects of how healthcare is delivered. IPE can capitalize on all of these by creating learning opportunities/case scenarios that highlight both success stories of

effective teamwork as well as quality improvement activities around scenarios in which teams did not function effectively during crisis situations. IPE activities can be developed that highlight expansion of professional roles and responsibilities that occurred as a result of the pandemic and delve into concepts such as scope of practice or role overlap.

4. Virtual IPE activities can be framed to help learners prepare for the changing realities of the workforce that they will enter, and prepare them for roles in telehealth/telemedicine. This is a particularly unique opportunity for early learners and an online environment may provide them with a platform to begin developing an interprofessional social network.⁷

For many, common assumptions about the ideal delivery of IPE were challenged due to COVID-19. Previously, virtual IPE delivered in an asynchronous fashion has been successful in providing meaningful learning experiences,^{4,8-10} but much less is known about the effectiveness of IPE when it comes to virtual synchronous learning.⁹ Institutions were challenged when rapidly pivoting F2F IPE events to virtual synchronous formats.

Despite the challenges, virtual delivery of IPE has been rewarding. For example, moving to a virtual landscape has afforded new opportunities for collaboration with programs that are geographically distant. It has also provided new opportunities for learners to establish longitudinal relationships, as well as structures in which meaningful self- and group- reflections enhance the learning experience. Remote IPE clinical experiences using telehealth technologies have provided new ways of bringing patients, providers, and students together in ways that prevent infection transmission and have been used successfully to bridge education and patient care across large geographical distances; although the pandemic thrust universities into using telehealth and e-learning environments by necessity, these methods of instruction and patient care will become increasingly utilized and are here to stay.¹¹⁻¹³ Health professions students prefer telemedicine encounters with patients over simulated experiences with patient actors or electronic cases and have indicated support for their training programs to add formal education into their curricula that enable them to 'practice' telehealth.¹¹ Simultaneously, though, it has been discovered that virtual synchronous IPE is quite time and resource intensive. We discovered, as did others, that successful integration of e-learning platforms, technologies, and pedagogies is imperative to implementing effective asynchronous online IPE activities.¹⁴ No doubt, the future of IPE/IPP will include virtual learning that is both synchronous and asynchronous; therefore, it will be imperative for faculty/facilitators to be skilled in both modes of instructional delivery.

Limitations & Future Directions

One limitation to our group discussion is that we missed an opportunity to hear the student perspective. Student experiences are likely both positive and negative given such a diverse group. As with all of our IPE experiences, many vantage points exist and a need to dive deeper into the student voice will be imperative in the virtual IPE landscape. Areas for future research may include the benefits and pitfalls of effectively conducting IPE for remote synchronous delivery.

Recommendations

Table 2. Key Guidance Issues: Recommendations for IPE during the COVID-19 pandemic

Category	Key Guidance Issues: Recommendations / opportunities
Similar Content, different assessment requirement	<p>Recognize what and how the alternative delivery platform(s) may impact the content and the assessment of student learning.</p> <p>Select effective pedagogies that engage students in online learning environments</p> <p>Acknowledge that assessment may need new tools and/or modalities for data collection.</p>
Virtual Technology as enabler and barrier	<p>Technology:</p> <p>Embrace the virtual world as a way to increase the value, authenticity, and depth of self-reflections by building experiences that are longitudinal.</p> <p>Build intentional IPE bridges by helping students make linkages between the online learning environment and real-world telemedicine/telehealth clinical encounters by revamping learning outcomes to include competencies that have become the new norm (e.g., what does “professionalism” look like in online environments -- backgrounds, distractions, eating food, posture, etc.) .</p> <p>Integrate interactive platform tools as simple ways to keep students engaged throughout the encounter (e.g., CHAT and PARTICIPANT features, white boards, annotation, polling, breakout groups, deliverables, etc.)</p> <p>Acknowledge uncertainty by questioning how to move forward, do we continue to use the new virtual platforms, revert back to pre-COVID-19 ways, or embrace a combination of “old” and “new” methods?</p> <p>Develop primary and contingency plans as the new norm.</p> <p>Recognize that virtual interprofessional challenges are different than uni-professional challenges.</p> <p>Resources:</p> <p>Consider team reflections rather than individual and peer review processes for feedback.</p> <p>Dedicate one or more staff members to “manage the technology” and assist students in trouble-shooting so instructors can focus on leading the activity.</p>
Faculty/Facilitators are challenged	<p>Use virtual IPE as an opportunity to recruit new facilitators.</p> <p>Ensure that students, standardized patients and facilitators have reliable access to Wi-Fi and necessary online platforms.</p> <p>Seek help from instructional design experts at your institution.</p> <p>Invest in facilitator training and consider facilitator pairs, partnering experienced with novice individuals.</p>
Learner empowerment	<p>Create equity within learner teams.</p> <p>Consider establishing ground rules for virtual teams.</p> <p>Explore new IPE partnerships since the virtual environment eliminates geographical barriers with schools/colleges/collaborating institutions no longer needing to be geographically co-localized.</p>

CONCLUSION

The virtual IPE landscape affords institutions the opportunity to be selective in innovative and authentic learning experiences for didactic and clinical learning. It also effectively addresses the challenges of creating a common learning environment for a large, diverse set of health professional learners. Specific attention should focus on faculty development and learner empowerment as we work together to maintain high quality IPE at our institutions. Virtual IPE provides the opportunity for longitudinal relationships between learners. The authentic online environment may be preparing a practice-ready group of learners in an increasing telehealth world. More information is needed on virtual team development and assessment of virtual IPE experiences.

Disclosure Statement

The authors of this work declare no financial interest or benefit from this work.

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APPENDIX**Non-Clinical Activities: These include Foundational/Introductory and Simulation Experiences**

1. Did you have an IPE Class/Activity/Experience planned for the end of winter term or spring/summer term (March 2020-August 2020)? If yes, briefly describe. Please include the number of learners.
2. a. If yes to #1, what modifications were required for the experience (i.e. how was the activity affected by COVID-19)? Please limit to 1-2 examples.

b. If no to #1, what modifications will you have to make for fall term? Please limit to 1-2 examples.
3. What were your lessons learned from the examples in #2?
4. Was there a positive outcome or silver lining as a result of the changes made to your examples above? If yes, please explain.
5. What is your plan moving forward for delivery in the next academic year for your examples above?
6. For the examples you described, if using online delivery, how are you changing the way you assess learning outcomes?
7. For the examples you described, if using online delivery, do you anticipate any specific challenges and/or need any specific resources (e.g. technology) to successfully implement your examples in the coming academic year?

Clinical/Community/Professional Practice IPE Activities: These include real patients/clients, populations, and patient care.

1. Did you have an IPE CLINICAL/Professional Experience planned for the end of winter term or spring/summer term (March 2020-August 2020)? If yes, please describe briefly and include the number of learners. Did you move the activity to online delivery?
2. If yes to #1, what modifications were required for the experience (i.e. how was the activity affected by COVID-19)? Please limit to 1-2 examples?
3. What were your lessons learned from the examples in #2?
4. Was there a positive outcome or silver lining as a result of the changes made to your examples above? If yes, please explain.
5. What is your plan moving forward for the delivery in the next academic year for your examples above considering the challenges from COVID-19?
6. For the examples you described, if using online delivery, how are you changing the way you assess learning outcomes?
7. For the examples you described, if using online delivery, do you anticipate any specific challenges and/or need any specific resources (e.g. technology) to successfully implement your examples in the coming academic year?

Please share any comments or insights that you may have related to COVID-19 and IPE/IPP in the space below.