Progress & Promise: Profiles in Interprofessional Health Training to Deliver Patient-Centered Primary Care

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Chief Executive Officer, PCPCC

December 11, 2014

Patient-Centered Primary Care COLLABORATIVE

AGENDA

3:03-3:08pm ET – Introductions & Housekeeping

3:08 – 3:25pm – Presenter 1: Marci Nielsen

- Development of Report & Training Database
- 7 Champion Programs
- Lessons Learned

3:25 – 3:45pm – Presenter 2: Barbara Brandt

- National Center for IPE
- Defining the "Nexus"
- Lessons Learned & Recommendations

3:45-3:58pm – Q&A with Audience

3:58-4:00pm – Closing Remarks

Co-Sponsors / Reviewers

CSWE
Council on Social Work Education

American Psychological Association

American Academy of Family Physicians
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National Center for Interprofessional Practice and Education

FASHP
Federation of Associations of Schools of the Health Professions

NASW
National Association of Social Workers

AAMC
Tomorrow's Doctors, Tomorrow's Cures®

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- **PCPCC Education & Training:** Co-Chairs Bill Warning & Cynthia Belar; Task Force Members
- **Database Submission Reviewers:** Cynthia Belar, Amy Dawson, Susan Day, Melissa Gillooly, Margaret Tomecki, Manisha Verma
- **Writers:** Stephen Pelletier & Christa Cerra
- **Editor & Design:** Jennifer Salopek & Elizabeth Jones
- **Project Lead:** Tara Hacker

Defining the Medical Home

The medical home is an *approach* to primary care that is:

Person-Centered
Supports patients and families in managing decisions and care plans

Comprehensive
Whole-person care provided by a team

Coordinated
Care is organized across the 'medical neighborhood'

Committed to Quality and Safety
Maximizes use of health IT, decision support and other tools

Accessible
Care is delivered with short waiting times, 24/7 access and extended in-person hours

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Interprofessional Education – Recent Years

2009: Interprofessional Education Collaborative (IPEC) Formed by AACN, AACOM, AACP, AAMC, ADEA, ASPH

2010: WHO Released Framework for Action on Interprofessional Education and Collaborative Practice

2011: IPEC Releases Report on Core Competencies for Interprofessional Collaborative Practice

2011: PCPCC's Education & Training Task Force Formed

2012: PCPCC's Task Force Develops 16 Training Competencies & National Survey

2013: PCPCC's Patient-Centered Primary Care Training Database Launched

2014: PCPCC Releases Report on 7 Profiles of Interprofessional Training for Primary Care

PCPCC's Education & Training Task Force

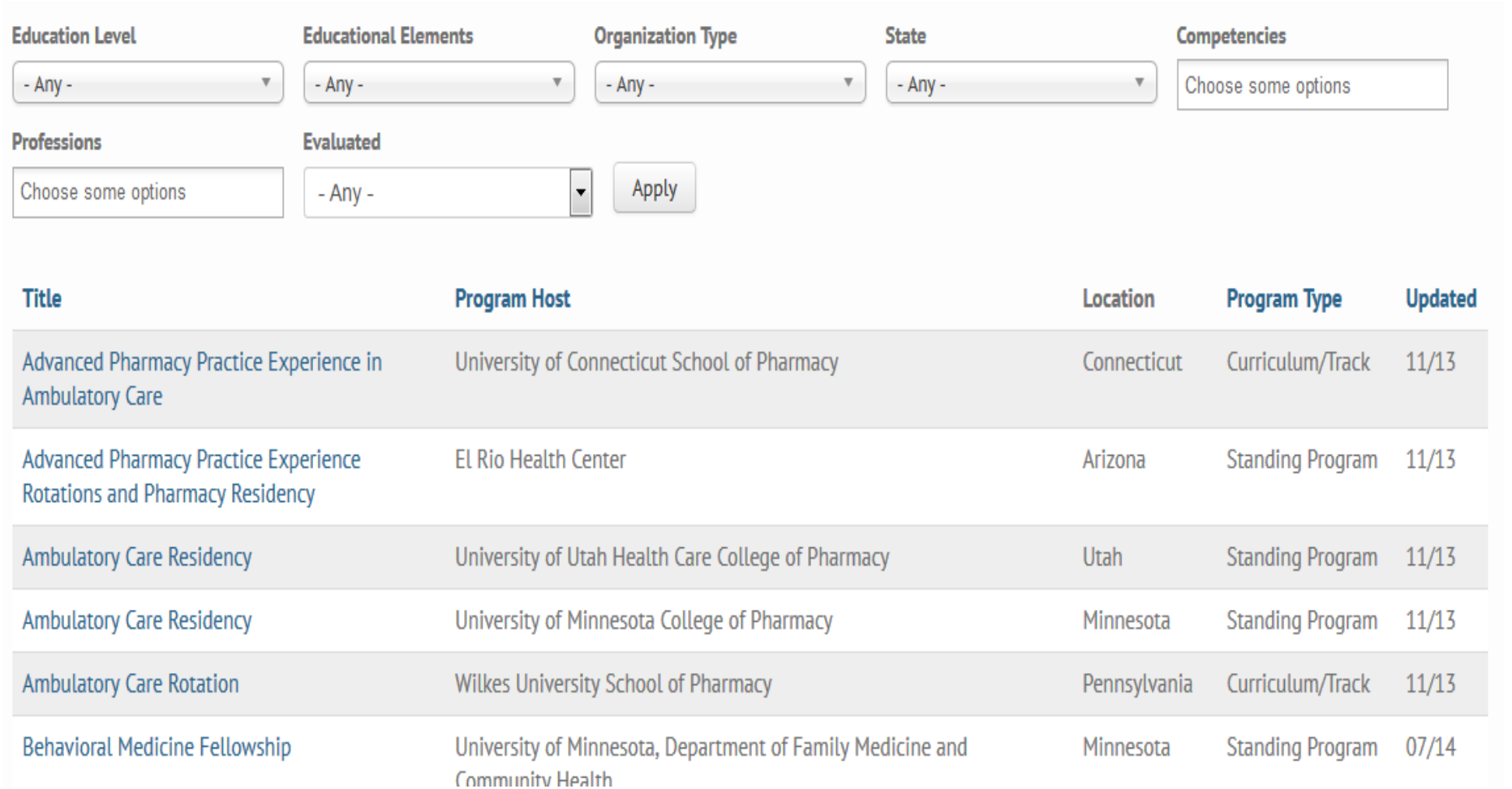
Purpose & Background

- Created in 2012 to build a rich collection of primary care residency and health professional training programs that incorporate advanced practices in primary care and the patient-centered medical home.

Activities

- Compiled a list of **workforce competencies** to help prepare professionals across disciplines and skill levels for practicing effectively the PCMH.
- **Surveyed 100+ training programs** across the country (Spring 2013) on best practices and competencies of collaborative patient-centered primary care.
- In December 2013, **launched an online searchable database** of innovative residency and health professional training programs. Regularly updated with new programs (130+ programs currently).
- In December 2014, released a **publication on interprofessional training for team-based primary care** featuring 7 program case studies.

Patient-Centered Primary Care Training Database:
Features 130+ searchable programs



Title	Program Host	Location	Program Type	Updated
Advanced Pharmacy Practice Experience in Ambulatory Care	University of Connecticut School of Pharmacy	Connecticut	Curriculum/Track	11/13
Advanced Pharmacy Practice Experience Rotations and Pharmacy Residency	El Rio Health Center	Arizona	Standing Program	11/13
Ambulatory Care Residency	University of Utah Health Care College of Pharmacy	Utah	Standing Program	11/13
Ambulatory Care Residency	University of Minnesota College of Pharmacy	Minnesota	Standing Program	11/13
Ambulatory Care Rotation	Wilkes University School of Pharmacy	Pennsylvania	Curriculum/Track	11/13
Behavioral Medicine Fellowship	University of Minnesota, Department of Family Medicine and Community Health	Minnesota	Standing Program	07/14

Source: www.pcpcc.org/training

PCPCC's New Report on Interprofessional Training

Download at www.pcpcc.org

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Seven Champion Programs

- **Harbor-UCLA Family Medicine**: Transforming Primary Care & Faculty Development Fellowship
- **New Mexico State University**: Counseling Psychology PhD Program
- **Northwestern McGaw Family Medicine Residency**: Teaching Health Center
- **San Francisco VA Medical Center**: Center of Excellence in Primary Care Education
- **University of Oklahoma**: College of Pharmacy
- **University of South Carolina School of Medicine**: I^3 Population Health Collaborative (NC, SC, VA)
- **University of Texas at Austin**: School of Social Work

Team-Based Primary Care Training Competencies

Developed in 2011 by PCPCC's Education & Training Task Force

Patient-Centered Care Competencies

- Advocacy for patient-centered integrated care
- Cultural sensitivity & competence in culturally appropriate practice
- Development of effective, caring relationships with patients
- Patient-centered care planning, including collaborative decision-making & patient self-management

Coordinated Care Competencies

- Care coordination for comprehensive care of patient & family in the community
- Health information technology, including e-communications with patients & other providers
- Interprofessionalism & interdisciplinary team collaboration
- Team leadership

Comprehensive Care Competencies

- Assessment of biopsychosocial needs across the lifespan
- Population-based approaches to health care delivery
- Risk identification

Accessible Care Competencies

- Promotion of appropriate access to care (e.g., group appointments, open scheduling)

Care Quality & Safety Competencies

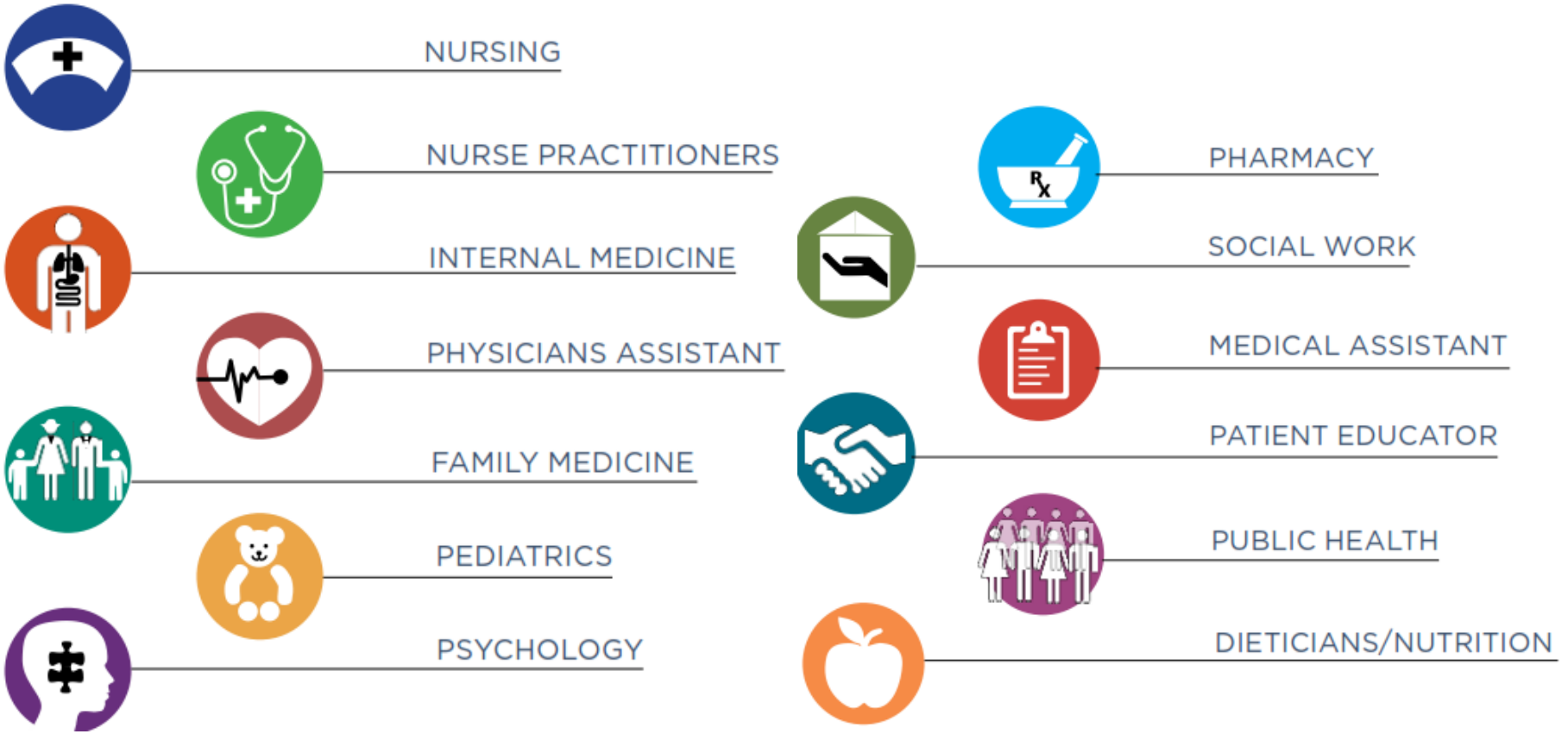
- Assessment of patient outcomes
- Business models for patient-centered integrated care
- Evidence-based practice
- Quality improvement methods, including assessment of patient-experience for use in practice-based improvement efforts

Vast Majority of 16 Competencies Met by 7 Programs

Team-Based Primary Care Competencies Trained	H-UCLA	I³PHC	NMSU	NM FMR	OU	SF VAMC	UTA
Patient-Centered Care Competencies	●	●	●	●	●	●	●
Advocacy for patient-centered integrated care	●	●	●	●	●	●	●
Cultural sensitivity & competence in culturally appropriate practice	●		●	●	●	●	●
Development of effective, caring relationships with patients	●		●	●	●	●	●
Patient-centered care planning, including collaborative decision-making & patient self-management	●	●	●	●	●	●	●
Comprehensive Care Competencies	●	●	●	●	●	●	●
Assessment of biopsychosocial needs across the lifespan			●			●	●
Population-based approaches to health care delivery	●	●	●	●	●	●	●
Risk identification		●	●	●	●	●	●
Coordinated Care Competencies	●	●	●	●	●	●	●
Care coordination for comprehensive care of patient & family in the community	●	●	●	●	●	●	●
Health information technology, including e-communications with patients & other providers	●		●	●	●	●	●
Interprofessionalism & interdisciplinary team collaboration	●	●	●	●	●	●	●
Team leadership	●	●		●	●	●	●
Accessible Care Competencies	●	●	In progress	●	●	●	●
Promotion of appropriate access to care (e.g., group appointments, open scheduling)	●	●	In progress	●	●	●	●
Care Quality & Safety Competencies	●	●	●	●	●	●	●
Assessment of patient outcomes	●	●	●	●	●	●	●
Business models for patient-centered integrated care	●				●		
Evidence-based practice	●	●	●	●	●	●	●
Quality improvement methods, including assessment of patient-experience for use in practice-based improvement efforts	●	●	In progress	●	●	●	●

Patient-Centered Primary Care COLLABORATIVE

Professions Trained by Programs



Patient-Centered Primary Care COLLABORATIVE

New Mexico State University
Counseling Psychology PhD Program







Location: Las Cruces, NM

Provider/Practice Type: Family Medicine Residency, Primary Care Facility, Health Professions Shortage Area

Patients: Predominantly Hispanic & uninsured

Program Graduates (2004-2014):

- 66 FM Residents
- Doctoral Students (65 Counseling Psychology & 13 Nursing)
- Masters Students (33 Social Work, 10 Public Health, 4 Pharmacy)

Patient-Centered Primary Care COLLABORATIVE

UT-Austin School of Social Work

Integrated Behavioral Health Scholars Program

Location: Austin, TX

Provider/Practice Type: FQHC

Patients: Adults with mental illness; chronically ill & homeless; Spanish-speaking low-income families

Program Participants (2012-2015): 19 Masters Students (Social Work)

Patient-Centered Primary Care COLLABORATIVE

University of Oklahoma College of Pharmacy

Integrating Pharmacists into the Delivery of Primary Care

Location: Oklahoma City, OK

Provider/Practice Type: Family Medical Center, Tier 3 PCMH, Primary Care Practice

Patients: 60% Medicaid, 15% Medicare; many indigent, minority and/or foreign

Program Participants (to date): Pharmacy & Other IPE Students (75 total)

Patient-Centered Primary Care COLLABORATIVE

San Francisco VA Medical Center:
Center of Excellence in Primary Care Education

Location: San Francisco, CA

Provider/Practice Type: VA Medical Center

Patients: Veterans (all ages & socioeconomics)

Program Participants:

- Core Trainees (183 total): IM, NP, Pharmacy, Social Work, Psychology, Nutrition
- Additional Trainees (49 total): Podiatry, Optometry, Psychiatry

I³ Population Health Collaborative

North Carolina, South Carolina, Virginia

Location: NC, SC, VA (and now FL)

Provider/Practice Type: Tri-state Learning Collaborative of 27 Academic Primary Care Programs

Program Participants: Residents and faculty physicians (>1,120)

Northwestern McGaw Family Medicine Residency

Teaching Health Center: Team-Based Care Curriculum

Location: Chicago, IL

Provider/Practice Type: Teaching Health Center, FQHC

Patients: 84% Hispanic, 8% African American, 97% below 200% FPL

Program Participants: FM residents (8/yr), Social work interns (2-3/yr), Advance practicum psychology externs (1-2/yr)

Harbor-UCLA Family Medicine:

Transforming Primary Care & Faculty Development Fellowship

Location: Harbor City, CA

Provider/Practice Type: Family Health Center (ambulatory practice site)

Patients: 51% Latino, 20% African American, 46% uninsured (Southwestern LA County)

Program Participants: Fellows (3-6/yr; following graduation from a primary care residency)

Program Hallmarks of Excellence

- **Focus on Patient-Centered Care:** collaborative decision-making; patient self-management; group appointments; open scheduling; advocates for PCMH
- **Cultural Sensitivity & Community Focus:** sensitivity & culturally appropriate competencies; designed to meet patient needs specific to the community; neighborhood-based

Program Hallmarks of Excellence, cont…

- **Continuous Improvement:** trainees design and execute practice-based improvements
- **Dispersed Team Leadership:** shared leadership among teams; learning guided by various professionals
- **Integrating Behavioral Health:** role of BH professionals increasingly recognized as integral component of team care

Opportunities for Improvement

- **Insufficient Resources, Challenging Logistics:** lack of time and money; scheduling barriers across professions; staff turnover
- **Outdated Financial Models:** many grant funded; fiscal practices not updated to reflect realities of practicing in a PCMH
- **Incomplete Patient Integration:** patients not yet fully integrated into the design and administration of teams or health professions education systems
- **Technology's Promise Unfulfilled:** use of population-based data not yet routine and varies across training programs

Opportunities for Improvement, cont…

- **Lack of Standard, Meaningful Measures:** most measures of progress and success typically more anecdotal than data-driven
- **Blurry Relationship to Patient Outcomes:** don't yet have good measures for patient outcomes
- **Student Engagement:** at-times difficult to engage students on team-based care concepts due to preference for learning clinical competencies
- **Varying Potential for Scaling & Replicability:** expressed successes unique to circumstances (e.g., academic and community partners); scaling possible with right mix of resources available

Thinking and Acting Differently at the Nexus

Barbara Brandt, PhD
Director, National Center and
Associate Vice President for Education,
University of Minnesota

December 11, 2014

UNIVERSITY OF MINNESOTA

National Center for Interprofessional Practice and Education

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Topics

- The National Center involvement
- What is the “Nexus” – Interprofessional Education
- What we learned
- Recommendations

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Process

- Seven PCMHs selected by PCPCC
- National Center participated in interviews to learn:
  - Presence of interprofessional education
  - Nexus – alignment of IPE with clinical practice redesign
- What are characteristics of sites that display both, as reported in the interviews?
- Articulate themes to inform new development

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Characteristics of the Patient Centered Medical Home (PCMH)

- A team-based health care delivery model
- Continuous care to populations of patients with the goal of obtaining maximized health outcomes
- An approach to providing comprehensive primary care for children, youth and adults
- Shift care from acute to ambulatory/community settings
- Care coordination – essential, requiring additional resources
  - Health information technology
  - Appropriately trained staff to provide coordinated care
  - Workforce redesign
- Reduce costs

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Interprofessional Education (IPE)

Interprofessional education "occurs when two or more professions learn with, about, and from each other to enable effective collaboration and improve health outcomes."

Adapted from:

The Centre for the Advancement of Interprofessional Education, UK, 1987

World Health Organization, Framework for Action on Interprofessional Education and Collaborative Practice, 2010.

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Our vision for health

- Improving quality of experience for people, families, communities and learners
- Sharing responsibility for achieving health outcomes and improving education
- Reducing cost and adding value in health care delivery and education

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Interprofessional Collaborative Practice

Interprofessional (or collaborative) care "occurs when multiple health workers and students from different professional backgrounds provide comprehensive health services by working with patients, their families, carers (caregivers), and communities to deliver the highest quality of care across settings."

Framework for Action on Interprofessional Education and Collaborative Practice, WHO 2010

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Elements of the Nexus

- Integrate clinical practice and education in new ways,
- Partner with patients, families and communities,
- Strive to achieve the Triple Aim in both health care and education (cost, quality, and populations),
- Incorporate students and residents into the interprofessional team in meaningful ways,
- Create a shared resource model to achieve goals, and
- Encourage leadership in all aspects of the partnership.

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Three Programs

University of Oklahoma, College of Pharmacy

San Francisco Veterans Affairs Medical Center

New Mexico State University, Counseling Psychology PhD Program

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Refined Definition of the Nexus

"Clinical practices in transforming systems that partner with health professions education programs

think and act differently

learning organizations that support continuous professional development

while educating the next generation of health professionals"

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Characteristics

- Sharing a vision
- The patient-centered curriculum
- Innovation for culture change
- Spontaneous team leaders
- Benefits of the Nexus to the PCMH
- Benefits of the Nexus to students and residents

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Sharing a Vision

- An extraordinary commitment to workforce development between PCMH and partner health professions education program

- Able to articulate common purpose and strategies to address significant barriers:
  - Understand and meet each partner's needs and perspectives
  - Bridge culture to create new one
  - Significant face-to-face time, often unpaid
  - Builds relationships, trust and working appreciation for one another

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The Patient-Centered Curriculum

- Start with the patient in mind: not clinical practice or health professional education program
- Being PCMH helps with relevant educational program
- Successful strategies:
  - Needs of patient, then incorporate learner
  - Shared decision-making partnership with patients
  - Explicitly role models the needs and wants of patients for all learners

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Innovation for Culture Change

Explicitly articulated:

- Essential role of site champions
- A commitment to a fundamental cultural shift away from a traditional, hierarchical model to a more innovative, team-based approach
- Critical to transformation of clinical practice
- Teaching/learning strategies to learn in practice how to function in teams
- Small changes add up

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Spontaneous Team Leaders

- Shift to patient-centered curriculum
- Role of collaboration and conflict resolution skills
- Promotes leadership no matter which profession or whether clinician, student or resident
- Naturally learning new skills in practice

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Benefits of the Nexus to the PCMH

- Benefits to the whole site, including clinicians and staff
- Students and residents bring new ideas about interprofessional education and collaborative practice
- Students asking “tough questions” about efficient and effective patient care

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Benefits of the Nexus to Students and Residents

- Intentionally trained in skills needed in practice
- More “collaboration-ready” and confident
- Marketable skills
- Prepared for practice in underserved areas
- Learn to address barriers to practice

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Practical Take Homes

Engage in dialogue with your sites and others. Explore:

- what is working
- gaps in practice
- barriers to progress

Start with the patient in mind

Strengthen the Nexus:

- identify and engage in opportunities for partnership
- design for practice and education model around principles of PCMH

Significant commitment to a shared vision that benefits all

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Join the IPECP Community

Create a profile: www.nexusipe.org

Add a resource: www.nexusipe.org/resource-exchange

Start a conversation: www.nexusipe.org/forum

Go social: www.twitter.com/nexusipe

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