



Interprofessional Education: An ADFM-sponsored webinar

September 22, 2014

12:00-1:30pm Central/1:00-2:30pm Eastern

Co-hosted by:

ADFM Healthcare Delivery Transformation Committee

ADFM Education Transformation Committee

Moderator/Discussant:

Denise Rodgers, MD, Vice Chancellor for Interprofessional Programs at
Rutgers Biomedical and Health Sciences

Case Presenters:

Christine Arenson, MD and Christine Jerpbak, MD
Sidney Kimmel Medical College, Thomas Jefferson University

Brian Prestwich, MD
Keck School of Medicine of University of Southern California

Dan Mickool, MS, R.Ph
University of New England

Carolyn Rutledge, PhD, FNP-BC
Old Dominion University

Webinar Format

- 12:00-12:10 Introduction & overview (Denise)
- 12:10-12:50 Case presentations – each presenter will describe their IPE project, following the templates provided in advance
- 12:10-12:20 Case 1: Chris and Chris at Sidney Kimmel/Jefferson
 - 12:20-12:30 Case 2: Brian at USC
 - 12:30-12:40 Case 3: Dan at UNE
 - 12:40-12:50 Case 4: Carolyn at ODU
- 12:50-1:15 Questions and discussion (led by Denise)
- 1:15-1:30 Reflection and concrete next steps (Denise)

AUDIENCE POLL

Case 1: Sidney Kimmel Medical College

(Chris Arenson & Chris Jerpbak)

- Formal IPE began 2007 – Jefferson Center for InterProfessional Education
- Health Mentors Program – 2 year longitudinal patient-centered team curriculum at entry to 6 health professions programs
- Clinical Skills – TeamSTEPPS, simulated discharge planning
- Clinical – Team rounds, Geriatric Assessment, Falls Risk Assessment, Family Medicine Student IPE Clinic

Jefferson HMP Program Overview

- Began in Fall 2007
- Student teams: 3-5 students, 3-4 professions
- Partnered with a Health Mentor: an adult volunteer who has one or more chronic conditions or disabilities
- Teams complete four curriculum-based modules over 2 years

Family Medicine Student IPE Clinic

- MD, NP, PharmD, PT, OT, and Couple & Family Therapy students and faculty
- Complex patients with multi-morbidity, frequently elderly with caregiver and/or mental health issues
- Student teams evaluated patients and created plans of care
- Excellent experience, highly rated by faculty, students, and patients
- We are struggling to find a sustainable financial model that supports faculty from all disciplines and optimal timing within the practice and curriculum

<p><i>Number and types (medical/nursing/pharmacy/other) of students or residents who participate in the IPE activities and in which year of training</i></p>	<p>FY14 1,427 Students (MD, RN, NP, PharmD, PT, OT, Couple & Family Therapy, Rad Science, Biomedical Science) All years of training</p>
<p><i>Number and types of experiences offered during the past academic year and planned for the 14-15 academic year.</i></p>	<p>Wide variety of classroom, service learning, clinical simulation and clinical experiences</p>
<p><i>Are the experiences elective or required?</i></p>	<p>Both</p>
<p><i>If elective, what percentages of students from the various disciplines participate in at least one IPE learning experience (by school)? Are you considering developing required IPE curricula?</i></p>	<p>100% of students participate in at least 1 IPE experience in their professional program curricula</p>

Challenges/lessons learned

- ***Stakeholder buy-in*** – KEY – at the most senior levels (President, Dean), faculty leaders, faculty champions, and student levels. For us, having Health Mentors (patients) voice support has also been key
- ***Curriculum development*** – Curriculum needs to be developed by a team of faculty (and ideally students) from the outset – retrofitting usually does not work
- ***Venues*** – Clinical simulation and clinical venues most highly valued by students
- ***Financing*** – IPE is not cheap; accreditation requirements are strengthening support from schools but we need to develop sustainable strategies for maintaining effective IPE – faculty volunteerism will only go so far for so long

Challenges/lessons learned, cont'd

- ***Relationship Management*** – Steering Committee, Jefferson IPE Curriculum Committee, IPE Retreats, Student Liaison Groups, Student-run Newsletter
- ***Defining roles and responsibilities of learners and teachers*** – clear, carefully vetted course documents reviewed by faculty and students
- ***Interface with regulatory bodies*** – IPE is a real strength at program accreditation visits
- ***Evaluation*** – We have an Evaluation and Research Committee and have generated over 60 publications

Case 2: Keck School of Medicine

The University of Southern California (USC)

(Brian Prestwich, MD)



Case 2: Keck School of Medicine

The University of Southern California (USC)

Brian Prestwich, MD

- Initial pilot located within a **FQHC Teaching Center, Family Medicine Residency clinic.**
- Team-Based Care models for care for:
 - **Perinatal Mental Health** (Pre-conception through year of 1 of child's life).
 - **Children 0-5** and their families.
 - **Seniors and Disabled Adults.**
- Translated to pilot within **Family Medicine** faculty practice at Keck School of Medicine, Academic Medical Center (AMC) practice model.

<p><i>Number and types (medical/nursing/pharmacy/other) of students or residents who participate in the IPE activities and in which year of training</i></p>	<p>FAMILY MEDICINE PRACTICES- <u>FQHC</u>: MS1-4, PA 1-2, Pharm D 1-2, OT 1-2, SW 2.</p> <p><u>Faculty Practice AMC</u>: MS3-4, PA 2-3, Pharm D 3-4, OT 2, PT faculty, SW faculty, Dietary faculty.</p>
<p><i>Number and types of experiences offered during the past academic year and planned for the 14-15 academic year.</i></p>	<p><u>FQHC</u>: Weekly 40 weeks at 1 FQHC site 2012-2014, Weekly 48 weeks at 2 FQHC sites 2014-2015.</p> <p><u>AMC</u>: Daily 5 days/week 48 weeks 2013-2014, relocation to community-based non-FQHC site 2014-2015.</p>
<p><i>Are the experiences elective or required?</i></p>	<p><u>FQHC</u>: Elective. Selective process to participate.</p> <p><u>AMC</u>: Clerkship rotations. Students choose to rotate at this clinical site.</p>
<p><i>If elective, what percentages of students from the various disciplines participate in at least one IPE learning experience (by school)? Are you considering developing required IPE curricula?</i></p>	<p>50% of students have at least 1 experience, many have a longitudinal experience.</p> <p>Faculty IPE Committee and Faculty IPE Expert Committee actively promoting required curriculum.</p>

Challenges/lessons learned

- **Stakeholder buy-in:** Crucial. Begins with interprofessional student commitment (students as “change agents”), highest level administration from each respective school, faculty “champions,” host clinic administration (preferably clinicians as well).
- **Curriculum development:** Faculty training (University of Toronto, Center for IPE). Emphasis on experiential learning. Formal curriculum development will follow, too many logistical barriers to delay implementation of an experiential opportunity for the students that begins day 1 of their graduate program.
- **Venues:** Working clinics are preferred. Family Medicine is optimal to provide experience across the life-cycle and create a culture of “Family-Centered Care.”
- **Financing:** Our FQHC model was supported by a HRSA grant that covered cost of 1 Family Medicine and 1 PA faculty. However, FQHC “cost-based reimbursement” (CBR) makes this a financially sustainable model, as in FQHC-based residency training clinics. CBR also supports an interprofessional staffing model.

The AMC pilot required 8 hours/week of dedicated time for 1 Pharm D faculty.*

***Sustainable within a team-based staffing model environment, easily justified in emerging value-based payment markets and expanding integrated care networks (including AMC-based networks).**

Challenges/lessons learned, cont'd

- ***Relationship Management:***
 - ***FQHC-*** Strong endorsement from Deans, structured faculty supervision of student leadership, peer-defined selective process for student participation.
 - ***AMC-*** Formal approval from CEO, Director of Primary Care, Chair of FM (Med Dir participant), Clinical Directors. Monthly IPE/IPC meetings of directors and lead clinicians.
- ***Defining roles and responsibilities of learners and teachers:***
 - ***FQHC-*** Student developed, faculty endorsed role definitions/care pathways for clinic visits. Formative learning by faculty and students.
 - ***AMC-*** Student roles defined by Clerkship, clinical roles formative, faculty roles formative.
- ***Interface with regulatory bodies:***
 - ***FQHC-*** Affiliation agreements between each school and FQHC. Monthly SRC agenda item in clinic operations meetings. Activity recognized by schools as formal component of respective curriculum activities. HRSA site visit resulted in formal recognition by HRSA and invitation to discuss model on HRSA sponsored national webinar.
 - ***AMC-*** All care provided by interprofessional teams meets compliance for student/supervision, billing, and care guidelines to drive QI and optimal performance on PQRS measures.

Case Study: USC Student-Run Clinic



****NOTE: case study available for download on the ADFM resources site***



Case 3: University of New England

(Dan Mickool)

- Formal IPE training provided to students and faculty
- The university houses an “IPE Center” with faculty and staff as dedicated resource.
- Annual IPE Clinical case workshop required by all health disciplines on campus DO, PharmD, MSW, DMD, OT,PT, Nursing, and PA. Round tables with a clinical case facilitated for communication and participation.
- Smaller monthly IPE events (voluntary attendance with cases) ((food provided!!))

Intro continued

- IPE integrated into several practice sites and growing in participation.
- 2012 UNE partnered with Maine General to begin a concentrated pilot with Family Medicine.
- DO and Pharmacist precept pharmacy and medical students together. “IPE Team”
- This “team” sees patients in the clinic and identifies patients at risk for misadventures and sees those patients in the home one day per week. Great interventions have been made!

Some highlights

- A pre and post rotation survey to students showed an improvement in attitude about the power of collaboration of the team in the areas of communication, respect, and more effective patient interventions. 60 students since inception.
- The IPE team of students share their experiences of collaboration and clinical interventions with the hospital team of residents, medical students and other providers.
- Interventions are tracked and shared with the health system administration since these are shared patients. Utilization has decreased and compliance has increased. Errors have been averted.
- Students have several reflective exercises and journal entries shared indicate attitudinal changes as well as inward changes about the positive effects of teamwork. “ I now value the role of X”

<p><i>Number and types (medical/nursing/pharmacy/other) of students or residents who participate in the IPE activities and in which year of training</i></p>	<p>Annual Clinical Symposium (reqd) Monthly IPE cases (elective) Practice sites developing IPE activities Participation varies by discipline. All health professions on campus participate to some degree</p>
<p><i>Number and types of experiences offered during the past academic year and planned for the 14-15 academic year.</i></p>	<p>1 required campus activity and 9 elective opportunities for students to learn. Activities vary off campus based on the practice site</p>
<p><i>Are the experiences elective or required?</i></p>	<p>Mix of each</p>
<p><i>If elective, what percentages of students from the various disciplines participate in at least one IPE learning experience (by school)? Are you considering developing required IPE curricula?</i></p>	<p>Pharmacy and Medical education are changing to have required elements of IPE. Changes are now in progress. The other health disciplines are also in process of change</p>

Challenges/lessons learned

- ***Stakeholder buy-in*** - This was a key feature as the health system was convinced they were already doing this and IPE activities were re-dundant and not needed. After much convincing we were able to demonstrate some outcomes of why this model was different and more effective in the long run.
- ***Curriculum development*** - Minor changes were made to the curriculum to include a new orientation with “getting to know you” exercises, shared presentations through the rotation, reflective exercises, and defining of roles and the addition of a home visit program
- ***Venues*** - Family Medicine Clinic and Maine General Health.
- ***Financing*** - Faculty pharmacist position was funded. The clinic allocated 8hrs/wk of DO time for home visits which are billed to offset cost.

Challenges/lessons learned, cont'd

- ***Relationship Management*** - Some students have not welcomed this style of learning but by the end of rotation saw benefit. Initial work of clarification of roles and responsibilities helped overcome this.
- ***Defining roles and responsibilities of learners and teachers*** - Roles and responsibilities are covered in the orientation process. Students are given an opportunity to “play-act” their patient encounters with each other to be prepared for the real thing. A script is provided as a start point.
- ***Interface with regulatory bodies*** - Now a requirement for accreditation in medical education. The health system is now reporting results to TJC.

Case 4: Old Dominion

(Carolyn Rutledge)

- IPE began in 2012 with a \$1 million HRSA grant
- Funded 2014-2017 with \$1.2 million HRSA grant
- Is led by the School of Nursing at Old Dominion University
- Focus is on:
 - Providing care to rural and underserved populations
 - Using technologies such as Telehealth to connect healthcare professions to each other at a distance
 - Managing patients with Multiple Chronic Conditions (MCC)

ODU Program Overview

- *Didactics*
 - *Health promotion*
 - *Geriatrics*
 - *Leadership*
- *Educational Modules*
 - *Ethics*
 - *IPE*
 - *MCC*
- *Interprofessional leadership workshop*
 - *Disc Profile*
 - *Emotional Intelligence*
 - *“Escape the Fire”*
 - *Interprofessional teams with instigator*

ODU Program Overview

- Standardized Patient Encounters
 - IP group visit
 - Telehealth visit with home health technology
 - MCC – Stroke patient with family caregiver and home health nurse
- Technology driven interprofessional projects
 - Website
 - App Development
- Will be adding Service Learning

<p><i>Number and types (medical/nursing/pharmacy/other) of students or residents who participate in the IPE activities and in which year of training</i></p>	<p>2012-1014 Nurse Practitioners (40), Clinical Nurse Specialists (8), Doctor of Nursing Practice (40), 2nd year Physical Therapists (45), MS & PhD Clinical Counselors (22), and MS Dental Hygienists (12)</p> <p>2014 added MS Speech Therapy (30) and 4th year medical students (144)</p>
<p><i>Number and types of experiences offered during the past academic year and planned for the 14-15 academic year.</i></p>	<p>3 semester long didactic courses 1 daylong workshop 1 day of standardized patient encounters 3 interprofessional technology focused projects 4 modules On-going service learning activities</p>
<p><i>Are the experiences elective or required?</i></p>	<p>Some are required and some elective depending on profession</p>
<p><i>If elective, what percentages of students from the various disciplines participate in at least one IPE learning experience (by school)? Are you considering developing required IPE curricula?</i></p>	<p>100% of Nurse Practitioners, Clinical Nurse Specialists, Physical Therapists, Speech Therapists, DNPs, and medical students 33% of Dental hygienists and clinical counselors</p>

Challenges/lessons learned

- ***Stakeholder buy-in***
 - Senior levels at ODU (Dean of each College, Chair of each School)
 - Senior level at EVMS (Leader of Predoctoral education)
 - Faculty leaders, faculty champions, and student levels
- ***Curriculum development***
 - Faculty learn much about other professions as they work collaboratively to develop curriculum
 - Curriculum must be developed and taught jointly
 - All professions must have an equal say
 - Meeting the requirements of various programs can be challenging and requires creativity
- ***Venues*** – Students become most engaged when faced with clinical simulation and practical experiences. Using technology such as telehealth can enhance the ability of students to collaborate.
- ***Financing*** – The two HRSA grants have been invaluable in allowing for the development of the IPE programs and standardized patient (SP) encounters.
 - Students lab fees can be used to subsidize the SP experiences.
 - As programs are developed, they can become ongoing parts of the existing curriculum.
 - Having various professions share the cost and responsibility of various courses and experiences can decrease the burden on a single profession.

Challenges/lessons learned, cont'd

- ***Relationship Management*** – Monthly meetings of the IPE committee, Collaboration with consultants, Leadership workshop, IPE College retreats (IPE has become a central theme in the College of Health Science at ODU)
- ***Defining roles and responsibilities of learners and teachers***
 - Following the IPEC domains
 - Allowing the faculty member with the greatest expertise in each area take the lead
 - Dividing up responsibilities equally
 - Clear expectations tied to each IPE experience
- ***Interface with regulatory bodies*** – IPE is being identified by the regulatory bodies as a need/requirement in many of the health professions
- ***Evaluation*** – Programs and experiences are evaluated using both quantitative and qualitative measure.
 - Changes in interprofessional attitudes, beliefs, and performance are evaluated using standardized measures
 - Performance on projects and with standardized patients is evaluated by faculty and SPs
 - Both self and peer evaluations are used
 - We have been actively involved in publications, presentations, pre-conferences, student research, and funded research grants

Questions and Discussion

- What feedback (if any) have the presenters received in their IPE innovations from regulatory bodies such as LCME or ACGME?
- How has IPE evolved beyond the “usual suspects” in your site for who is teaching (usual being FM, IM, peds)? How much has your institution been able to show there is a broad-based need for IPE?
- What is the “right” mix of students (as perceived by the presenters)? For example, is it better to teach second year medical students with first year nurse practitioner students and second year pharmacy students? Does it matter?
- What type of faculty development do you have in place specific to IPE?

Resources

- The Interprofessional Education Collaborative
<https://ipecollaborative.org/>
- The National Center for Interprofessional Practice and Education
<https://nexusipe.org/>
- Exploring Interprofessional Education in the Family Medicine Clerkship: A CERA Study
<https://www.stfm.org/Portals/49/Documents/FMPDF/FamilyMedicineVol46Issue6Everard419.pdf>
- The Four Pillars for Primary Care Physician Workforce Reform: A Blueprint for Future Activity
<http://www.annfammed.org/content/12/1/83.full.pdf>

(NOTE: all available on the ADFM website at:)

Please complete our brief evaluation!

<https://catalyst.uw.edu/webq/survey/akharris/246386>