Training Interprofessional Teams for Patient-Centered Primary care

William Warning, Crozer-Keystone Family Medicine Residency
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About the Task Forces & Special Interest Groups

The Patient-Centered Primary Care Collaborative (PCPCC) serves as a convener for several groups that focus on emerging issues across the primary care and patient-centered medical home sector. These groups include: Task Forces, dedicated to specific projects and time-sensitive deliverables; and Special Interest Groups (SIG), which are open to general members, are led by an Advisory Team of content experts, and provide ongoing informal networking and educational opportunities around a specific topic. Each of these groups works collaboratively with the PCPCC’s Stakeholder Centers to identify and inform their work and priorities.

Education & Training Task Force
The Education & Training Task Force was created in 2012 in order 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. Since its inception, the task force has:

- Compiled a list of workforce competencies to help prepare health care professionals across disciplines and skill levels for practicing effectively in medical home practices or health systems.
- Surveyed over 100 training programs across the country on best practices and fundamental competencies of collaborative patient-centered care
- Built an online searchable database of innovative residency and health professional training programs to be launched in October of 2013
- Organized and analyzed database submissions in order to identify programs to feature in future publications
Call for Submissions: Innovative Residency & Health Professional Training Programs

Dear Colleagues:

We are delighted to announce the official launch of a major PCPCC initiative led by the Education & Training Task Force: 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.

We encourage you to **submit profiles** that will identify existing training models and best practices, and represent a range of communities, institutions, geographic locations, and patient populations. The programs should emphasize learning opportunities and skills development in fundamental competencies of collaborative patient-centered care, including:

- **Interdisciplinary team-based care** built around patients’ specific health needs, including primary care providers, nurses, behavioral health specialists, social workers, etc.

- **Enhanced access and communication** using new strategies in scheduling, technology, and patient engagement

- **Cultural, socioeconomic, and linguistic competencies** that enhance patient, caregiver, and family relationships

- **Care coordination** across the larger health system or “medical neighborhood”

- **Advanced reporting and data analysis** through the use of health information technology

- **Population health management**, particularly for high-risk populations
Patient-Centered Primary Care Training Database: 
*Features 130+ searchable programs*

<table>
<thead>
<tr>
<th>Title</th>
<th>Program Host</th>
<th>Location</th>
<th>Program Type</th>
<th>Updated</th>
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<tbody>
<tr>
<td>Advanced Pharmacy Practice Experience in Ambulatory Care</td>
<td>University of Connecticut School of Pharmacy</td>
<td>Connecticut</td>
<td>Curriculum/Track</td>
<td>11/13</td>
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<tr>
<td>Advanced Pharmacy Practice Experience Rotations and Pharmacy Residency</td>
<td>El Rio Health Center</td>
<td>Arizona</td>
<td>Standing Program</td>
<td>11/13</td>
</tr>
<tr>
<td>Ambulatory Care Residency</td>
<td>University of Utah Health Care College of Pharmacy</td>
<td>Utah</td>
<td>Standing Program</td>
<td>11/13</td>
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<tr>
<td>Ambulatory Care Residency</td>
<td>University of Minnesota College of Pharmacy</td>
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<td>Standing Program</td>
<td>11/13</td>
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<tr>
<td>Ambulatory Care Rotation</td>
<td>Wilkes University School of Pharmacy</td>
<td>Pennsylvania</td>
<td>Curriculum/Track</td>
<td>11/13</td>
</tr>
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<td>Behavioral Medicine Fellowship</td>
<td>University of Minnesota, Department of Family Medicine and Community Health</td>
<td>Minnesota</td>
<td>Standing Program</td>
<td>07/14</td>
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Source: [www.pcpcc.org/training](http://www.pcpcc.org/training)
Forthcoming Publication: 7 Exemplary Programs

Multi-professional reviewers analyzed self-reported data and identified innovative programs focused on interprofessional education (IPE) training with PCMH learning competencies. Sponsoring organizations selected programs & set overall direction for the publication: AAFP, APA, CSWE, FASHP, NASW, National Center for IPE. To be released on December 11, 2014.

- **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**: I3 Population Health Collaborative (NC, SC, VA)
- **University of Texas at Austin**, School of Social Work
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Center of Excellence in Primary Care Education

Co-Directed by:
Rebecca Shunk, MD
Terry Keene, DNP, ARNP
PACT

• Team-based patient-centered model of care
  • 1200 patients per team
  • Teamlet- Primary Care Provider, Registered Nurse, Licensed Vocational Nurse and Clerical Associate

• Practice Changes
  • Population Management
  • Panel Management
  • Pre-visit planning
  • Huddles
  • Shared Medical Appointments/Group Clinics
  • Walk-in appointments
  • Telephone appointments
  • Secure Messaging
  • Health Coaching
Centers of Excellence (COE)

• Criteria:
  • Transformative, generalizable, sustainable, and interprofessional primary care training
  • Must include MD & NP trainees

• COE awards:
  • Up to $1 M/yr x 5 years, exclusive of any new trainee positions

• 5 COEs
  • Cleveland, San Francisco, West Haven, Boise, and Seattle
Mission of EdPACT

To develop and implement an inspirational model of patient-centered, interprofessional education that will advance primary care within and beyond the VA

Joint effort with:

- UCSF School of Nursing
- UCSF School of Medicine
- Office of Medical Education
Educational Domains of EdPACT

Key Components of PACT

1. Interprofessional Collaboration
2. Patient-Centered Communication & Shared Decision-Making
3. Sustained Relationships
4. Performance Improvement
Primary care training in a team-based, PCMH model

- Practice partnership model
- Each trainee has his/her own panel and cross-covers partners’ patients
- Interprofessional trainees support multiple trainee teamlets

Health Professions Trainees

NP student

Teamlet

Medicine R2

Medicine R2

Dietetics

Pharmacy

Psychiatry

Social Work

Psychology
Educational Domains of EdPACT

1. **Interprofessional Collaboration**: care is team based, efficient and coordinated; trainees practice collaboratively

2. **Patient-Centered Communication & Shared Decision-Making**

3. **Sustained Relationships**

4. **Performance Improvement**
Curricular Framework

Didactic
6 conferences/wk

Workplace Reinforcement (Experiential)
3 ½ days clinic/wk

Culture of Team-based Care

Reflection
Curricular Content: Interprofessional Collaboration

Didactics
Interactive small group seminars:
  Huddling
  Team Members Roles
  Handoff communication
  Feedback
  Conflict Resolution
  Debriefing

Workplace reinforcement:
  Huddling
  Huddle Coaches
  Preceptors reinforce skills and provide feedback during huddles
  Teams engage in formative assessment processes

Reflection
Half-day retreat:
  Team building
  Opportunities to reflect
  Identifying similarities and differences
Collaborative Conferences

- PACT ICU
- Diabetes Board
- Collaborative Case Conference
- Mental Health and Primary Care Conference
Outcomes: Trainee Reflections

• The huddle is such an awesome opportunity to really connect with different team members and figure out what’s important to them and make a game plan for handling the tougher patients and distributing work in a way that gets stuff done and everyone feels like they have help. (R2, 2012-13)

• Watching how we built the team… and seeing how it actually improved patient care - that was inspiring for our future in primary care … It was really cool to see. (R2, 2011-12)

• On a personal level, to get to know people a little bit and feel like you have a relationship. It makes you feel better about coming to clinic and being part of a community that’s taking care of people. (NP student, 2012-13)
Faculty and Staff Participants

- Longitudinal MD & NP preceptors
  - UCSF NP Faculty- 2
  - SFVA NP Faculty- 9
  - MD Faculty -15 plus
- Chief Residents in Ambulatory Care and QI
- Clinical psychology faculty & fellows
- Experts in communication, teamwork, performance improvement
- Additional health professionals– podiatry, social work, pharmacy, nutrition
Curricular Content
Sustained Relationships: Faculty

**Didactics**
- Basic Training
  - National TeamSTEPPS Program
  - PACT training
  - TEACH and Motivational Interviewing
- UCSF SOM OME and SON
  - Faculty Development Courses
  - Small Group Facilitation

**Workplace reinforcement:**
- Interprofessional Preceptors
  - Reinforce skills/ give feedback during precepting
- Feedback on teaching sessions
- Academy of Medical Educators TIPTOP

**Reflective Practice:**
- American Academy for Communication in Healthcare
- Team Retreats
- Monthly Curricular Meetings
Thank You
Questions?
# Team Development Results: Years 1 & 2

<table>
<thead>
<tr>
<th>STAGE</th>
<th>SCORE</th>
<th>COMPONENTS</th>
<th>SOLIDIFICATION</th>
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<tbody>
<tr>
<td>Pre-team</td>
<td>0-36</td>
<td>None to Building</td>
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<tr>
<td>1</td>
<td>1-46</td>
<td>Cohesiveness</td>
<td>In Place</td>
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<tr>
<td>2</td>
<td>47-54</td>
<td>Communication</td>
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<tr>
<td>3</td>
<td>55-57</td>
<td>Role Clarity</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>58-63</td>
<td>Goals-means Clarity</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>64-69</td>
<td>Cohesiveness</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>70-77</td>
<td>Communication</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>78-80</td>
<td>Role Clarity</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>81-86</td>
<td>Goals-means Clarity</td>
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<tr>
<td>Fully Developed</td>
<td>87-100</td>
<td>Everything</td>
<td>Firmly In Place</td>
</tr>
</tbody>
</table>

**Fall (Aug/Sept)**

- Yr 1 - Trainee Teams: 59.4
- Yr 2 - Trainee Teams: 62.2

**Spring (Mar/Apr)**

- Yr 1 - Trainee Teams: 64.6
- Yr 2 - Trainee Teams: 70.3

Team Development Scores by Team
Fall 2012 to Spring 2013

R2-NP student Teams (Fall and Spring)

- Team 1
  - Aug/Sept 2012: 55
  - Mar/Apr 2013: 60
- Team 2
  - Aug/Sept 2012: 48
  - Mar/Apr 2013: 56
- Team 3
  - Aug/Sept 2012: 82
  - Mar/Apr 2013: 76
- Team 4
  - Aug/Sept 2012: 63
  - Mar/Apr 2013: 74
- Team 5
  - Aug/Sept 2012: 66
  - Mar/Apr 2013: 88
- Team 6
  - Aug/Sept 2012: 66
  - Mar/Apr 2013: 55
- Team 7
  - Aug/Sept 2012: 81
  - Mar/Apr 2013: 78
- Team 8
  - Aug/Sept 2012: 60
  - Mar/Apr 2013: 73
- Team 9
  - Aug/Sept 2012: 56
  - Mar/Apr 2013: 64
- Team 10
  - Aug/Sept 2012: 64
  - Mar/Apr 2013: 64
• Modest overall effect of PACT on health care utilization & costs
  • Decrease ACSC hospitalizations & specialty mental health visits; increased primary care visits
  • Potential costs avoided from April 2010- FY2012 $600M; modest negative short term ROI
• Provider and staff burnout rates are high
  • Volume of clinical reminders reported as greatest barrier to delivering optimal patient-centered care
  • Teamlet huddles reported as greatest facilitator to PACT implementation
• Implementation can be measured using administrative, provider and patient level data at the national level
  • Higher levels of implementation associated with higher patient satisfaction, lower provider burnout, and decrease in ACSC hospitalizations
Results: Hospitalizations for Ambulatory Care Sensitive Conditions (ACSC), Veterans age <65

Predicted ACSC hospitalizations if PACT=0

Observed hospitalizations for ACSCs

Hospitalizations avoided -4.2%
Changes in process of care pre- and post-PACT
Patient Access and Utilization Quarterly Trends

Large increases in phone care visits

Rosland, Nelson in press AJMC

PACT starts
Changes in process of care pre- and post-PACT

Steady increase in access and continuity

Large increase in post-hospital follow up

Smaller increase in secure message enrollment and utilization

Trends in Patient Access, Continuity of Care & Care Management

- % Patients seen w/in 7 days of desired date
- % of PCP visits w/ Assigned PCP
- % Requests for Same-Day Appt Accommodated
- % Patients Contacted w/in 2 days of D/C from VHA Hosp
- % Patients Enrolled in Enhanced Personal Health Record
- % Patients using Secure Messaging
- % Patients Using Telehealth Monitoring

Rosland, Nelson in press AJMC
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I³ Population Health Collaborative
Training Interdisciplinary Teams

Michele Stanek, MHS
I³ Population Health Collaborative
University of South Carolina Department of Family & Preventive Medicine
Population Health Collaborative

- 29 Family Medicine, Internal Medicine and Pediatric residencies across SC, NC, VA and FL
- Almost all PCMH Level 3 designated teaching practices
- Over 325,000 patients, providing over 850,000 visits
- Majority served are minority patients
- 680 Residents
- 339 Faculty
- 140 staff
Improvements in teaching practices benefit:
- Patients of the practice directly
- Graduating residents’ patients
- Community practices’ patients
Regional focus
Ongoing learning community
Practice improvement & related curriculum innovations
Additional meetings & more time
Team participation
Academic arm (scholarship & curriculum)
**Chronic Illness Collaborative**

**Diabetes**
- **Process measures**
  - HbA1c testing
  - Foot exam
  - Self-management documented

- **Outcome measures**
  - HbA1c ≤ 7
  - BP ≤ 130/80; ≥ 140/90

  **All met/exceeded NCQA goals**

**CHF**
- **Process measures**
  - LVEF
  - ACEI/ARB
  - β-blocker
  - “Best practice” care

- **Outcome measure**
  - Hospitalization
  - **38% reduction in hospitalization**

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I3 Population Health Collaborative

I3 PCMH Collaborative

PCMH - NCQA Recognition
May 2009 - Nov 2010

Goals

Spread
- Topic: chronic illness → practice
- Geography: more residencies (25)
- Discipline: Peds, GIM

PCMH
- NCQA recognition
- Practice improvement
- Education

Key Outcomes

NCQA Recognition
- 22/25 programs committed to NCQA application
- All 22 achieved recognition

I^3 Population Health Collaborative

**Goals**

**Spread**
- Topic: practice → population
- Geography: additional residencies
- Discipline: Peds, GIM

IHI ‘Triple Aim’
- Improve patient experience
- Reduce cost of care
- Improve quality of care

All **at the same time**

**Key Outcomes**

- Core Measures Across the Triple Aim
- Threads/Workgroups focusing on specific improvements in each aim
Methods

Learning Sessions
• 2x per year
• Face-to-face contact
• Share clinical innovations & best practices
• Share new curriculum and training approaches
• Develop capacity for transformation
• Dedicated team time
• Plan next action period

Action Periods
• Monthly thread data collection & PDSAs
• Monthly thread webinars
  • Expert didactics
  • Data reporting
  • Experience sharing
• i³ SharePoint site
• Academic Arm: Curriculum & scholarly products
• Annual Core Measures submission
Practice is the curriculum
Approach

- Preparing future healthcare professionals as well as supporting current healthcare professionals in gaining new knowledge and skills
- Broad approach to “learners” - All Learn/All Teach
- Tactical approaches to practice change including team-based care
- Experiential learning experiences
- Focus on system/curricular changes but also need cultural changes
- Learning organization - meet needs of practice teams
Training/Curriculum

- Team-Based Care
- PCMH
- Population Health
- Quality Improvement
- Choosing Wisely®
- Chronic Illness Care
Interdisciplinary Team Training

• Form/Structure
  – Interdisciplinary team participation
    • Incentives for team involvement
    • Active mentorship of practices
  – Shared leadership at collaborative & practice-level
  – Teams required to develop and implement curricular changes
  – Redirection in course every 6-months; new strategic direction every 2-3 years
  – Learning opportunities open to all members of team
Interdisciplinary Team Training

• Function/Dynamics
  – 3 monthly webinars led by interdisciplinary practice team members
  – Learning Sessions
    • Role-based Affinity Groups
    • *Team-based Care* concurrent session track
    • Learner Sessions
    • Learning from Each Other Sessions
      – Practice Improvement
      – Educational/Curriculum
  – Participating practice innovations & best practices
  – IHI Open School chapters
Promise & Challenges of Team-Based Care Development

- Support development of new/expanded roles
  - Acquisition of new skills & experiences
  - Acceptance of new roles
  - Adaption of new capabilities/job performance metrics
- Education & training is not always enough -- Content to Culture
- Teamwork & team-based care in acute environments
- Multiple masters
- Tension between continuity with personal provider & care team
- Resources needed for team-based care
- Impact of team-based care on patient experience