Training Interprofessional Teams for Patient-Centered Primary care

William Warning, Crozer-Keystone Family Medicine Residency

Terry Keene, UCSF, San Francisco VA Medical Center

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PATIENT-CENTERED PRIMARY CARE:
AT THE HEART OF VALUE AND QUALITY

Patient-Centered Primary Care COLLABORATIVE

PCPCC Stakeholder Centers

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

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Patient-Centered
Primary Care
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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

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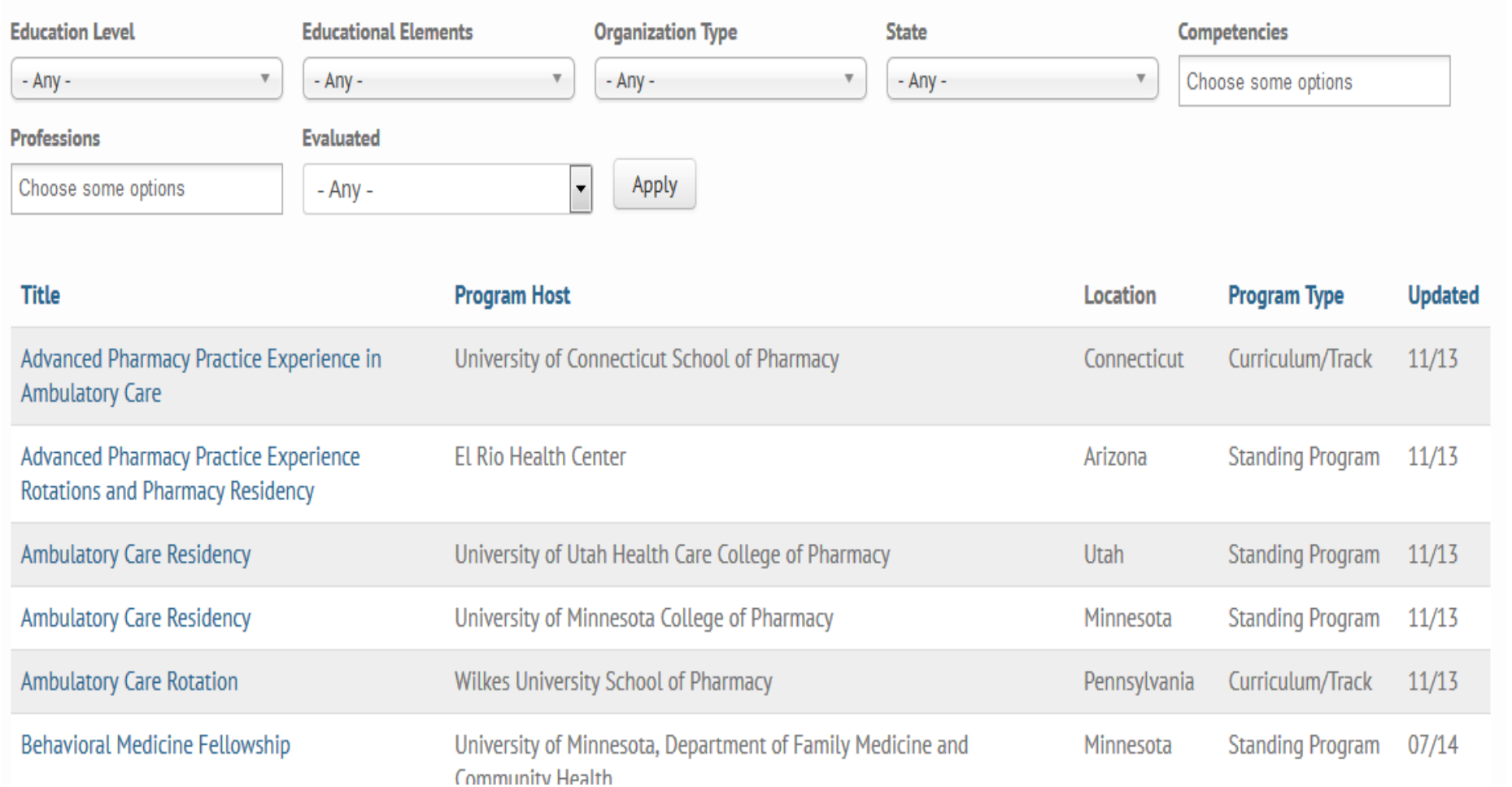
Patient-Centered Primary Care Training Database:
Features 130+ searchable programs



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

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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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PATIENT-CENTERED PRIMARY CARE:
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EdPACT
EDUCATION IN PATIENT ALIGNED CARE TEAMS

Center of Excellence in Primary Care Education

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

UCSF

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

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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

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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

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Educational Domains of EdPACT
Key Components of PACT

1. Interprofessional Collaboration
2. Patient-Centered Communication & Shared Decision-Making
3. Sustained Relationships
4. Performance Improvement

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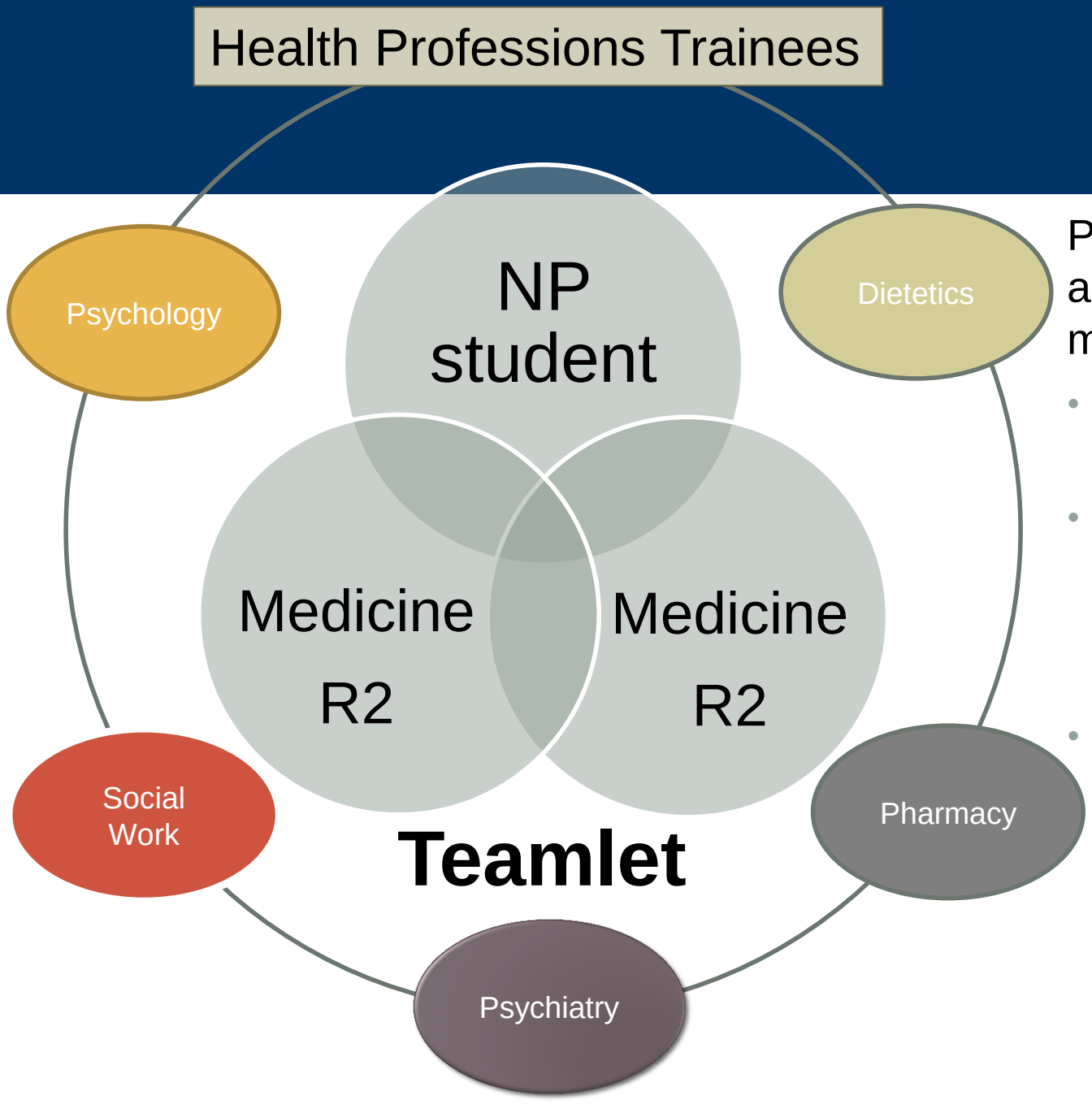
EDUCATION IN PATIENT ALIGNED CARE TEAMS

Structure



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

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EDUCATION IN PATIENT ALIGNED CARE TEAMS

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**

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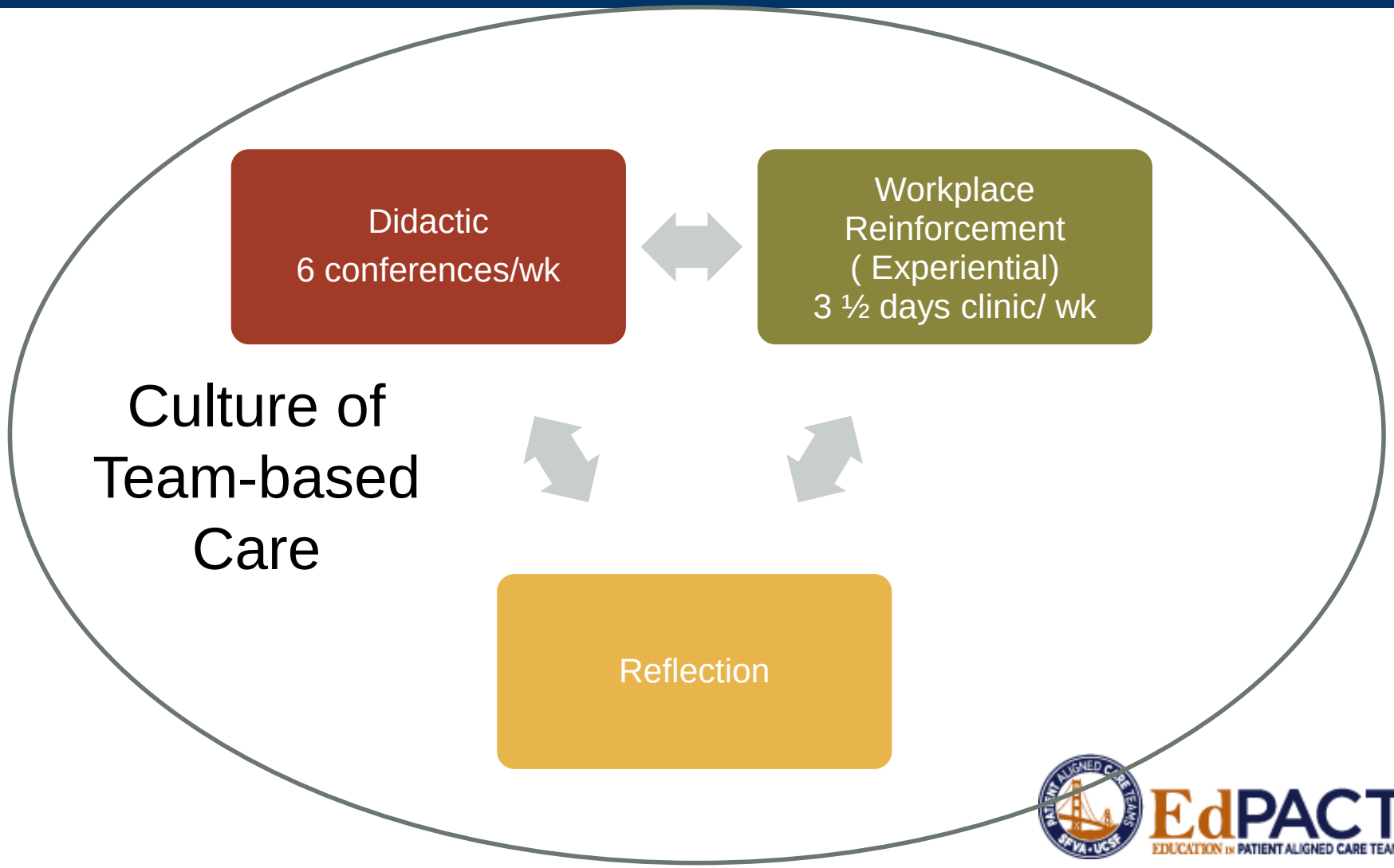
Curricular Framework



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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

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Huddle

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Collaborative Conferences

- PACT ICU
- Diabetes Board
- Collaborative Case Conference
- Mental Health and Primary Care Conference

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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)

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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

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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

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Thank You

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Questions?

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Team Development Results: Years 1 & 2

Fall
(Aug/Sept)

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

Spring
(Mar/Apr)

Yr 1 - Trainee Teams: 59.4

Yr 2 - Trainee Teams: 62.2

Yr 1 - Trainee Teams: 64.6

Yr2 - Trainee Teams: 70.3

www.peacehealth.org/about-peacehealth/medical-professionals/eugene-springfield-cottage-grove/team-measure/Pages/Default.aspx

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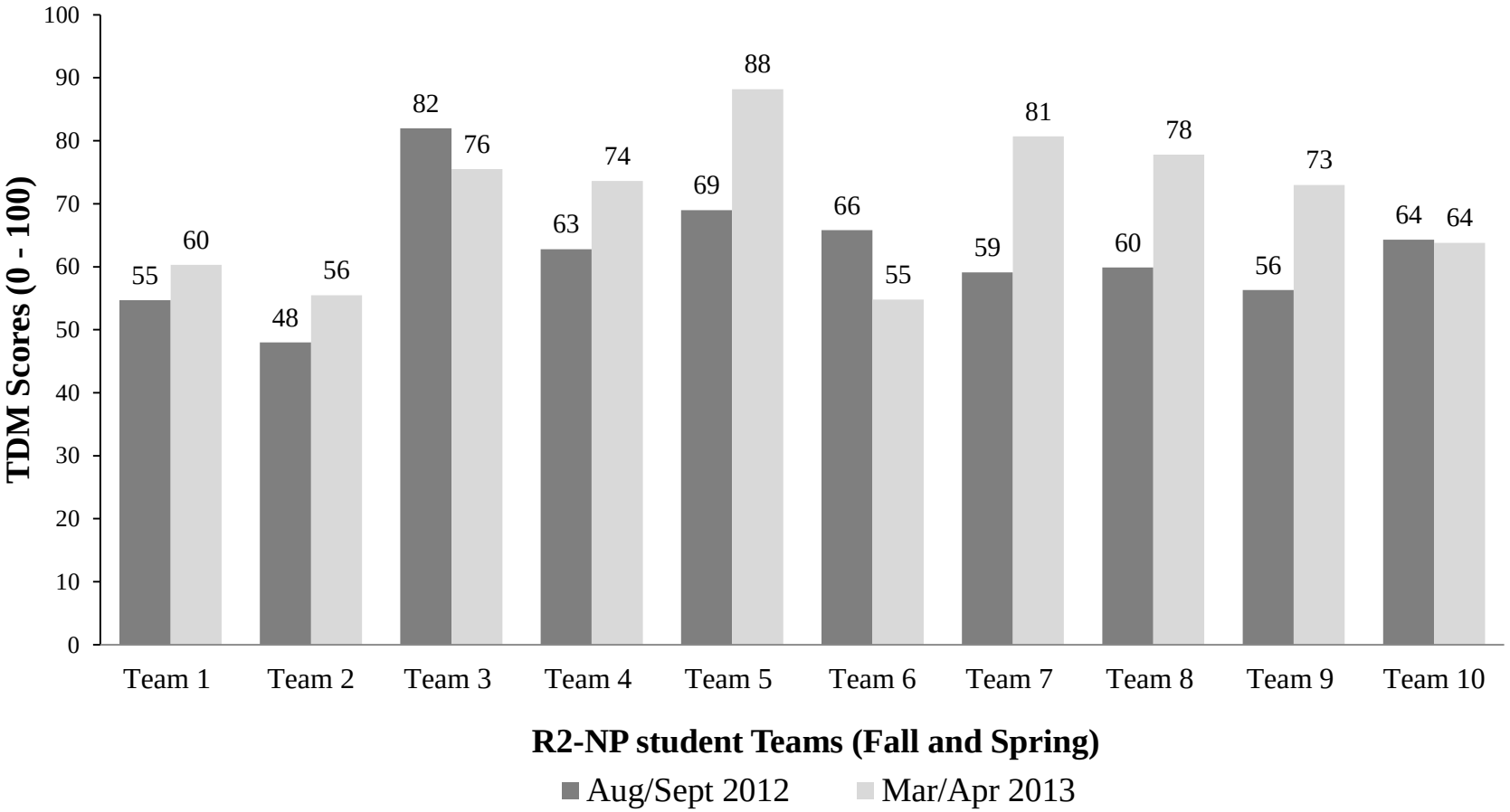
Team Development Scores by Team

Fall 2012 to Spring 2013



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Highlights from the National PACT Evaluation

Kari Nelson, MD MSHS
Associate Director, PACT Coordinating Center
Investigator, Northwest Center of Excellence, HSR&D

- 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

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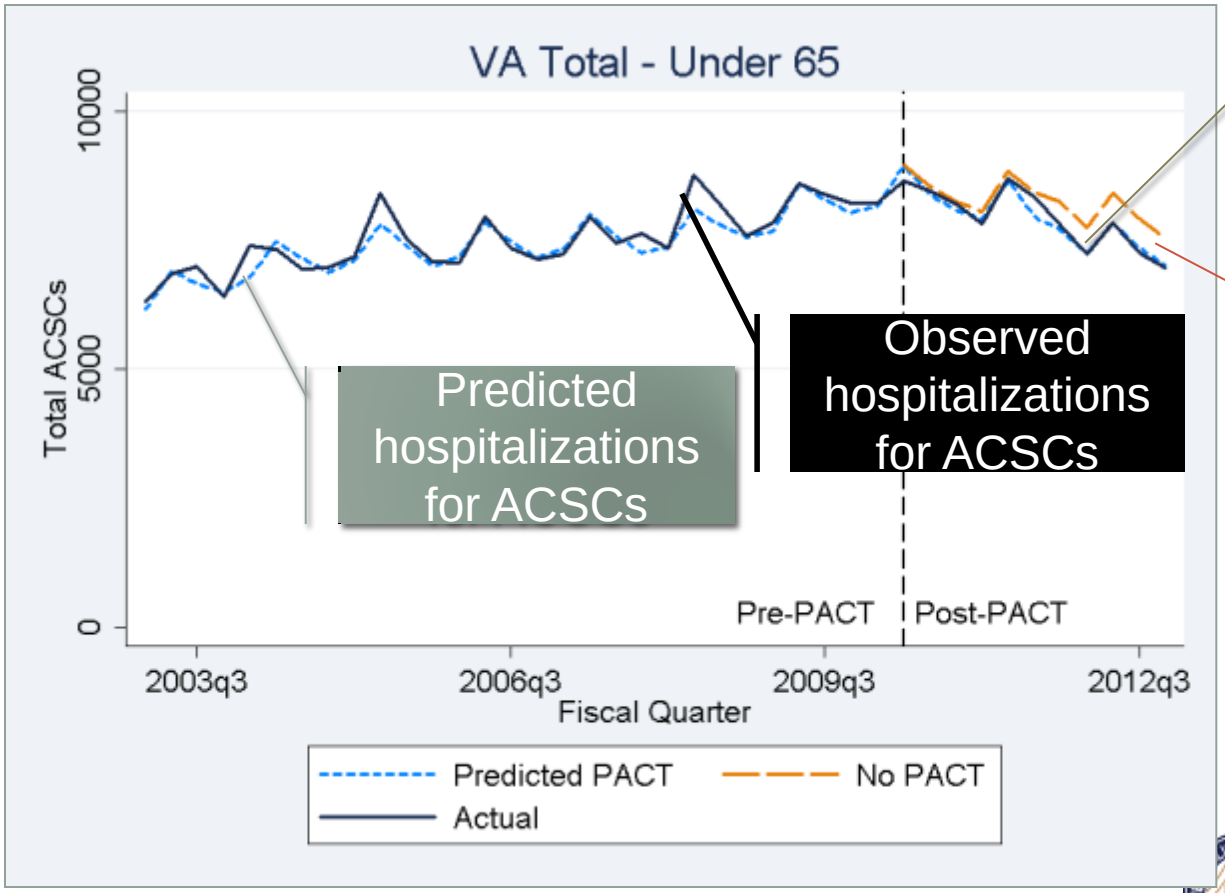
Results: Hospitalizations for Ambulatory Care Sensitive Conditions (ACSC), Veterans age <65



Predicted ACSC hospitalizations if PACT=0

Hospitalizations avoided -4.2%

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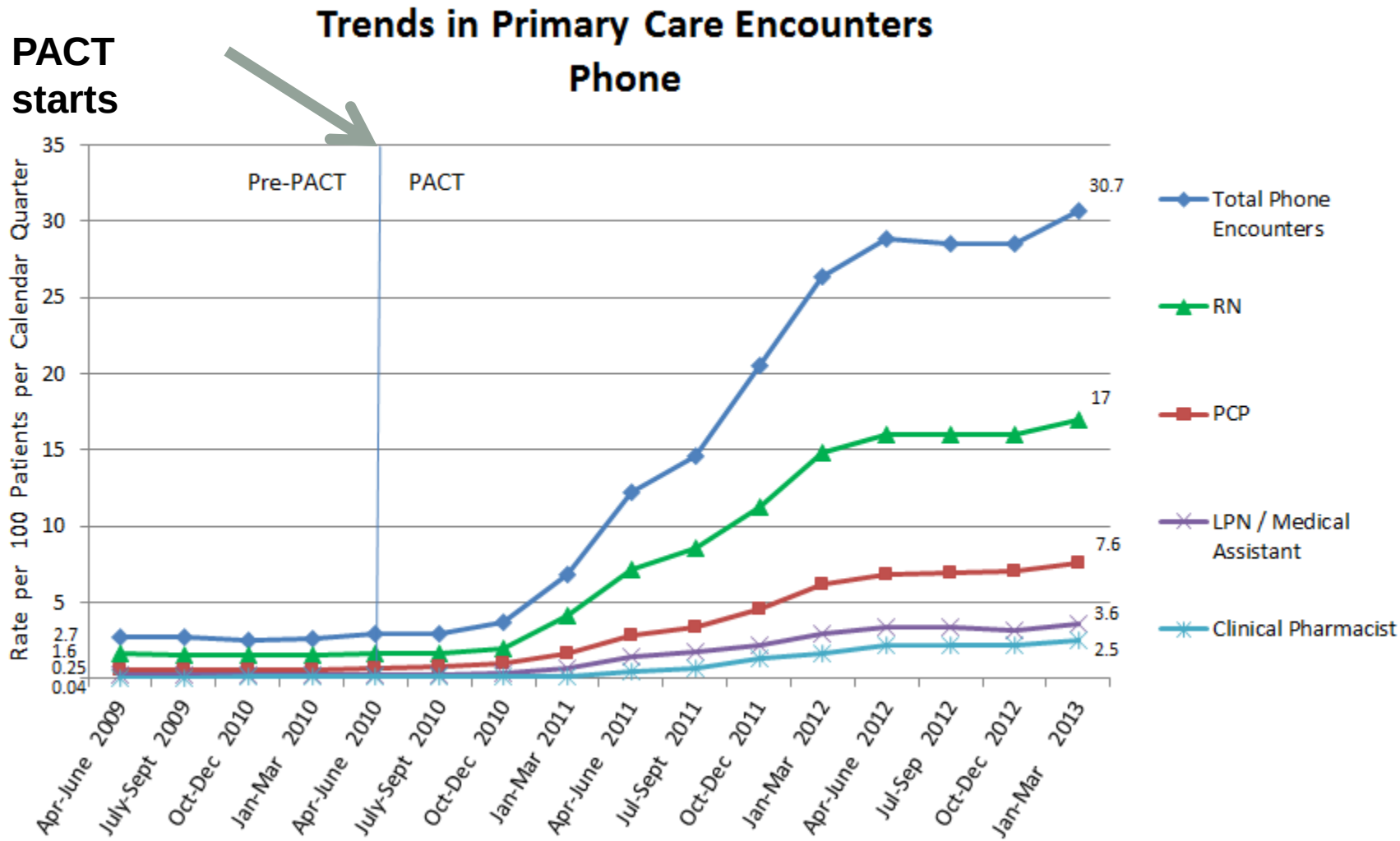
Changes in process of care pre- and post-PACT

Patient Access and Utilization Quarterly Trends

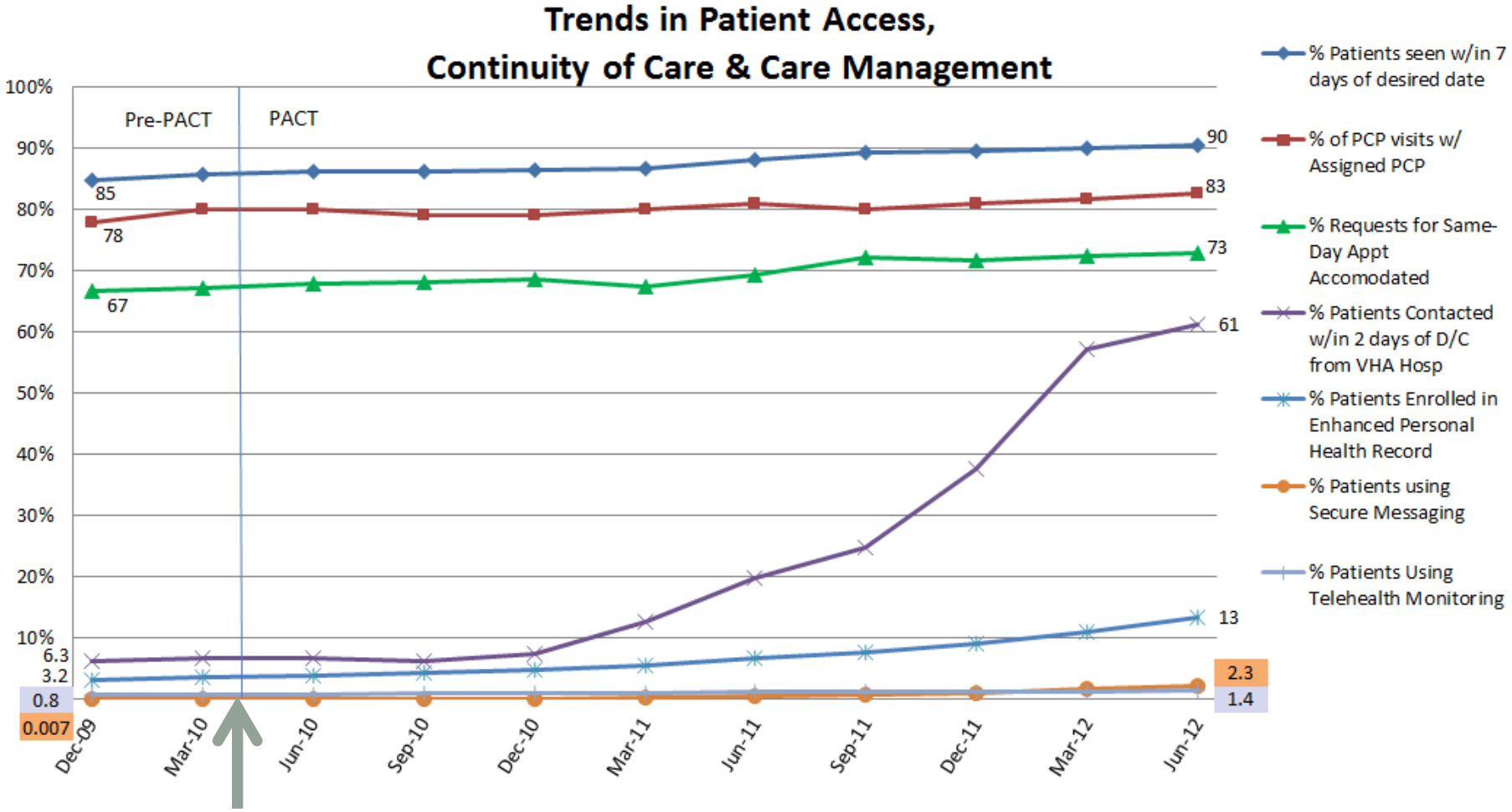


Changes in process of care pre- and post-PACT

Steady increase in access and continuity

Large increase in post-hospital follow up

Smaller increase in secure message enrollment and utilization



PACT

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Rosland, Nelson in press AJMC

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PATIENT-CENTERED PRIMARY CARE:
AT THE HEART OF VALUE AND QUALITY

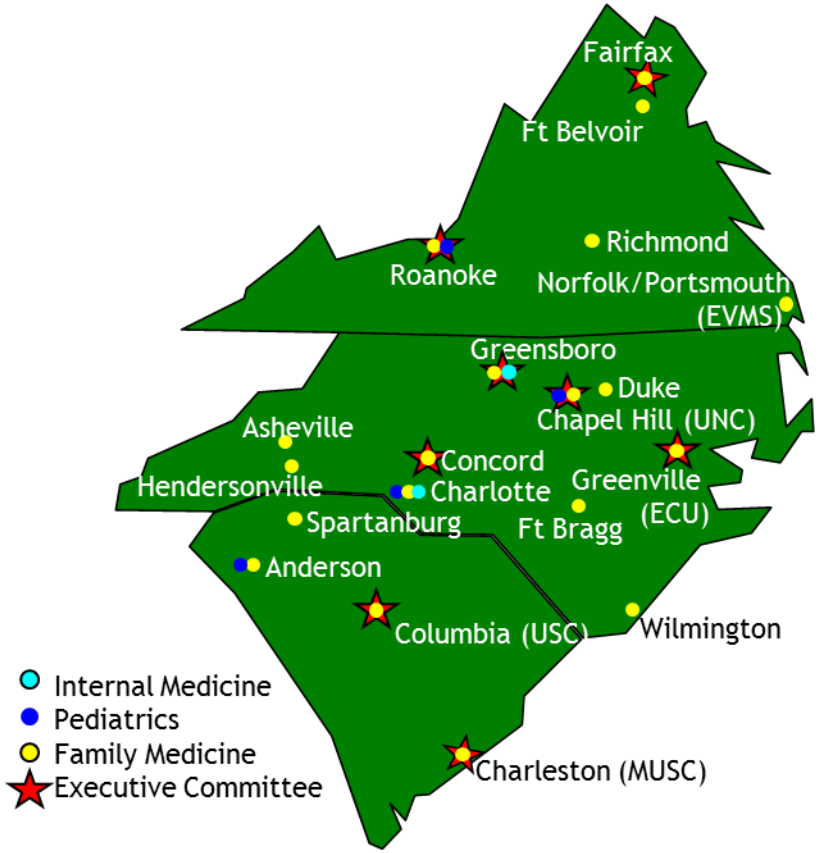
I³ Population Health Collaborative Training Interdisciplinary Teams

Michele Stanek, MHS

I³ Population Health Collaborative

University of South Carolina Department of Family & Preventive Medicine

I³ 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*

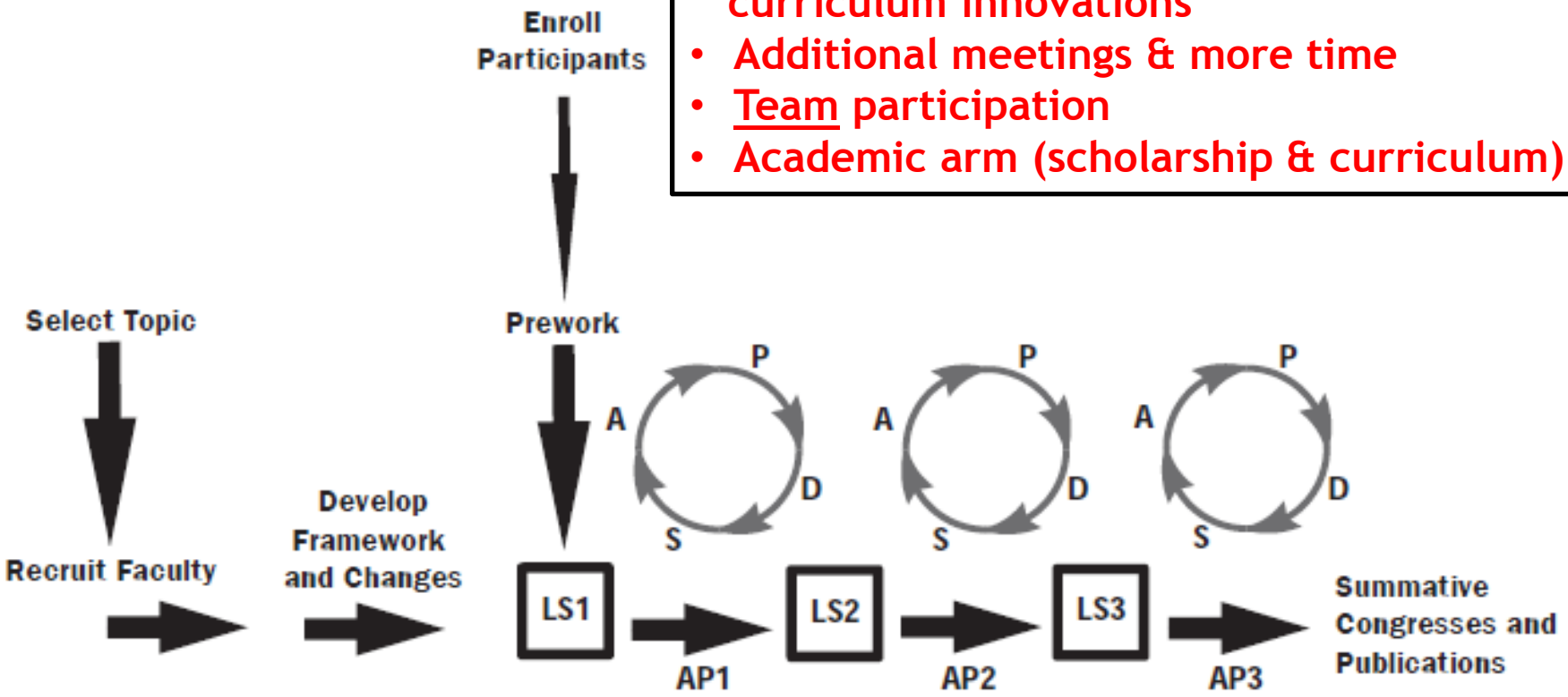
Improvements in teaching practices benefit:

- Patients of the practice directly
- Graduating residents' patients
- Community practices' patients

I³ Population Health Collaborative

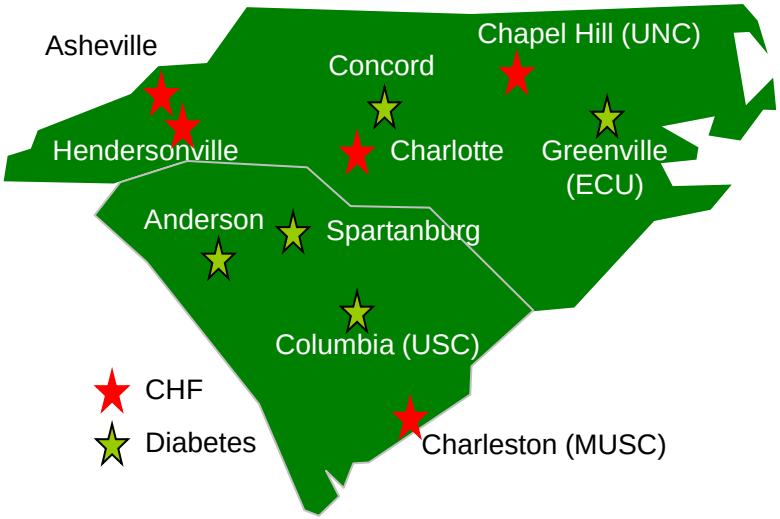
Academic

- Regional focus
- Ongoing learning community
- Practice improvement & related curriculum innovations
- Additional meetings & more time
- Team participation
- Academic arm (scholarship & curriculum)



I³ Chronic Illness Collaborative

Chronic Illness (Diabetes, CHF)
May 2006 – September 2008



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

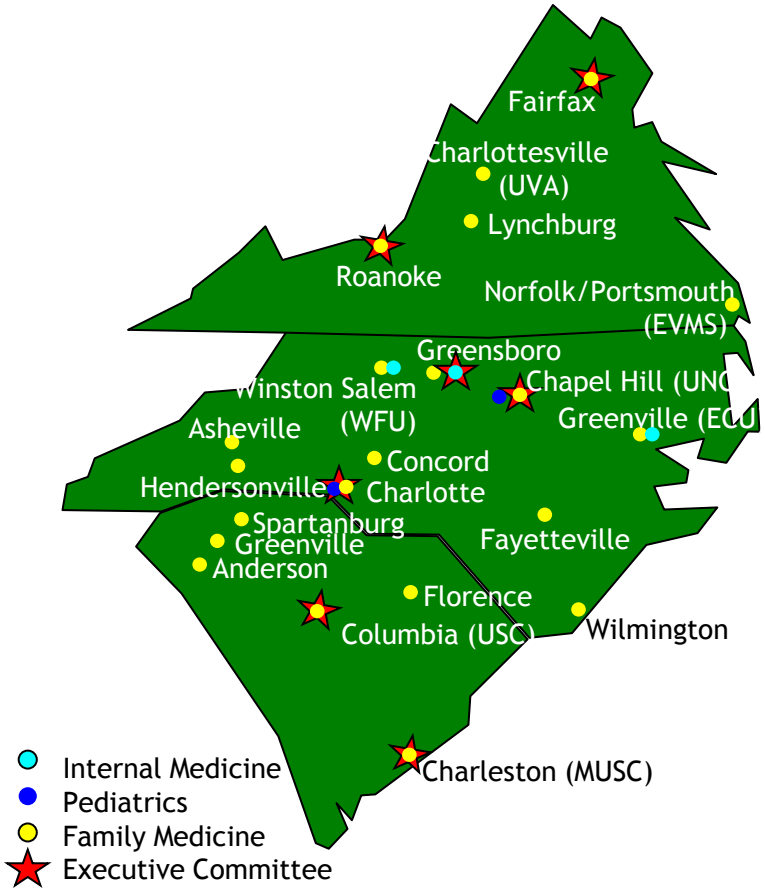
Outcome measure
- Hospitalization

38% reduction in hospitalization

Newton W, Baxley E, Reid A, et al. Improving chronic illness care in teaching practices: learnings from the I³ collaborative. *Fam Med*. 2011;43(7):495-502.

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

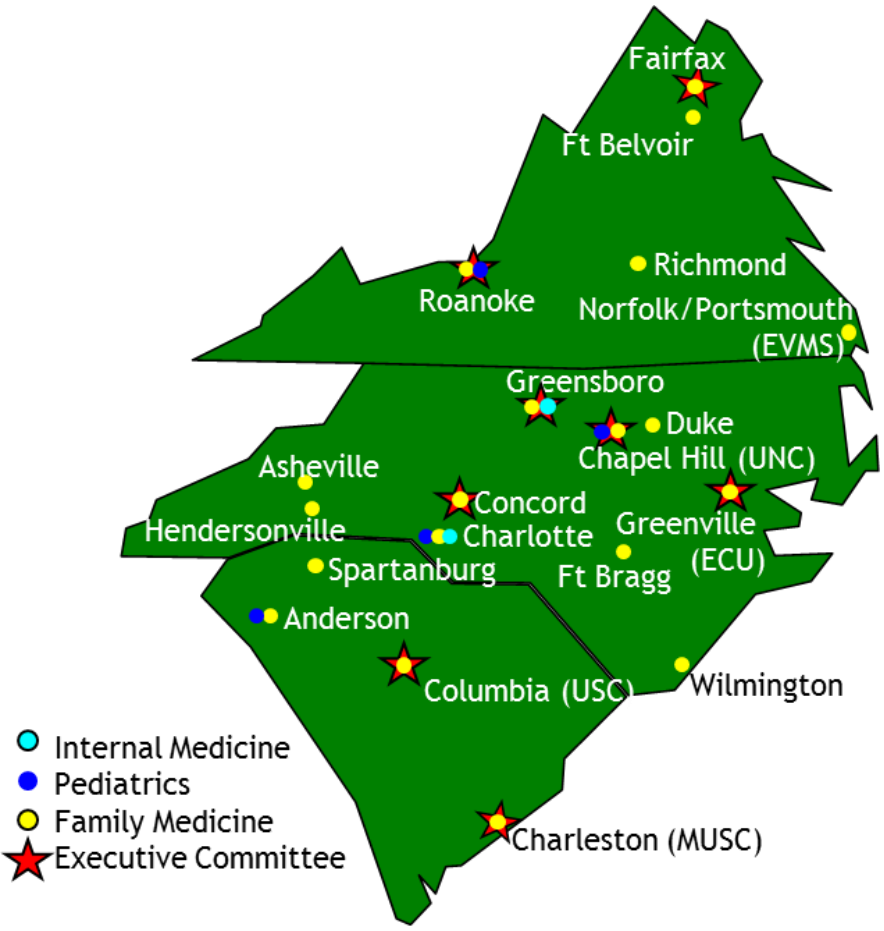
Key Outcomes

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

Reid A, Baxley E, Stanek M, Newton WP. Practice transformation in teaching settings: Lessons from the I3 PCMH Collaborative. *Family Medicine*. 2011;43(7):487-94.

I³ Population Health Collaborative

Population Health
May 2012 –Dec 2015



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

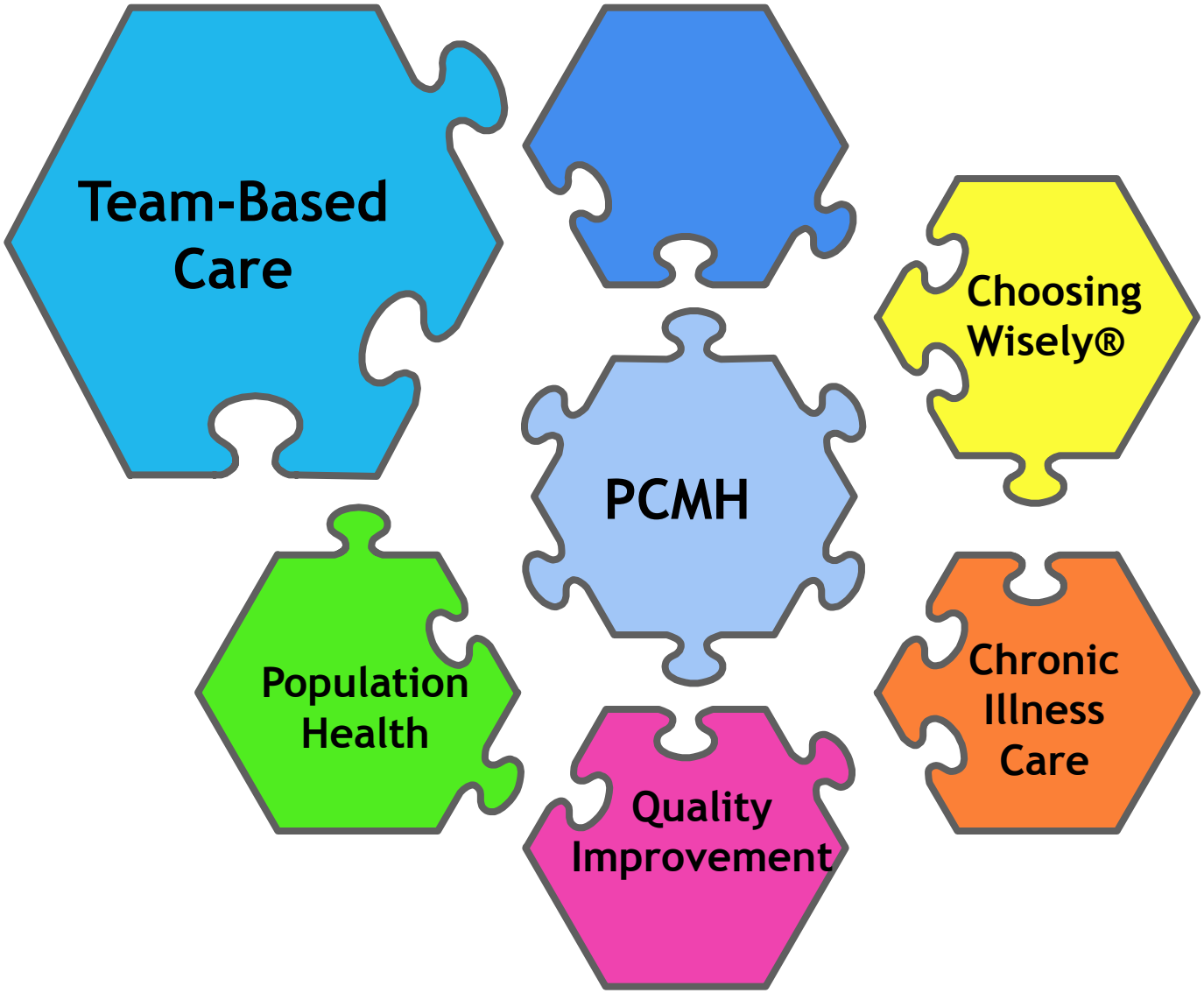
Action Periods
- Monthly thread data collection & PDSAs
- Monthly thread webinars
  - Expert didactics
  - Data reporting
  - Experience sharing
- I³ SharePoint site
- Academic Arm: Curriculum & scholarly products
- Annual Core Measures submission

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



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