

Interprofessional Education: “Thinking and Acting Differently:” PCMH Workforce Development Models

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Over several decades, interprofessional education and collaborative, team-based practice (IPECP) have experienced peaks and lows of interest with shifting national health care issues. While some teams—such as geriatric, rehabilitation, renal, surgical, and transplantation—survived over the years, team-based primary care has not been the norm. The same is the case historically for interprofessional education in universities and colleges. Since the mid-2000s, a number of forces, including quality, cost, access, safety, and policy, are giving “lift” to the Patient-Centered Medical Home (PCMH) movement to redesign primary care. These same forces are also fueling new interest in interprofessional education as a viable approach to developing team-based competencies. Both movements present innovative strategies to redesign the processes of care *and* health professions education together to become more efficient, effective, and outcome-focused.

Interprofessional education

“occurs when students from two or more professions learn about, from, and with each other to enable effective collaboration and improve health outcomes (World Health Organization, 2010).”

The National Center for Interprofessional Practice and Education (<https://nexusipe.org>), a public–private partnership based at the University of Minnesota, was created as a national coordinating center for IPECP. The National Center approaches its work to take advantage of national efforts to realign clinical practice redesign with new models of interprofessional education. Partnering with the Patient-Centered Primary Care Collaborative to interview the identified exemplar PCMHs profiled in this report presented us with the opportunity to showcase new workforce development strategies in what we call the “Nexus.”

The Nexus is defined as *clinical practices in transforming systems that partner with health professions education programs to think and act differently because they support continuous professional development while educating the next generation of health professionals*. PCMHs provide excellent environments to role model patient partnerships for students and residents. In the National Center, we are discovering the characteristics of these emerging workforce development models in clinical practice. These settings are working to actively:

- integrate clinical practice and education in new ways₂
- partner with patients, families, and communities₂

- 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 aspect of the partnership.

We at the National Center are encouraged that all identified sites for this publication demonstrated a commitment to an educational mission. To us, this confirms that innovative workforce development strategies incorporating students and residents synergize well with transforming clinical practices. During the interviews, three sites particularly illustrated elements of the “Nexus:” the University of Oklahoma’s Family Medicine Center, the San Francisco VA Medical Center, and New Mexico State’s Counseling Psychology PhD program. These sites are “thinking and acting differently” in compelling ways:

Sharing a vision. These three sites demonstrated a shared vision and extraordinary commitment between the PCMH and their partner health professions education programs. They are able to articulate a common purpose and effective strategies to address significant barriers. For example, Eve Adams, PhD and Daubney Harper, PhD of NMSU draw attention to the importance of understanding and meeting each partner’s needs and perspectives. They explain that bridging cultures to create a new one requires a significant amount of face-to-face time, often unpaid, in order to build relationships, trust, and a working appreciation for one another.

The patient-centered curriculum. Curriculum development for team-based, interprofessional practice is challenging. To do so, Mark Britton, PharmD of the University of Oklahoma Family Medicine Center, firmly believes in the importance of starting with the patient in mind, rather than the needs of an academic program or the clinical practice. Therefore, being a PCMH helps in designing a relevant educational program. “Identify the needs of the patient within the system, create and implement services and educational activities to address the needs, and *then* incorporate the learner,” he suggests.

Terry Keene, DNP-FNP, comments that to hear and respond to the patient voice, the San Francisco VA uses a shared-decision making model in which students are trained to identify the needs and wants of the patient, and then provide the patient with choices based on their needs. Keene comments that when using such a model, interprofessional trainees learn to respect the wishes of the patient. “They learn to ask open-ended questions and partner with the patient in order to understand their station and situation in life, and how that impacts their care,” remarks her colleague Rebecca Shunk, MD.

Innovation for culture change. The integration of students and patients into the PCMH teams in these sites is creating innovative strategies for individual and team growth. We observed that these sites demonstrated a commitment to a fundamental shift in culture away from traditional, hierarchical models toward more level and innovative approaches

as crucial to the transformative process. To support development, sites are gravitating toward engaging in new ways of understanding the roles and responsibilities of all team members. For example, at the University of Oklahoma Family Medicine Center, students learn to maintain weekly journal entries focused on daily instances of the benefits and challenges of working in teams. Entries are then reviewed anonymously and collectively by the learner–clinician/faculty interprofessional team at the end of each week. As a result, Britton comments that individuals “begin discovering that they do not have to know all of the answers, and that they can rely on other team members for help when needed.”

Site champions for innovation are also essential drivers to making the shift in culture. Adams and Harper note the importance of having key individuals onsite who are interested in the process. Harper places emphasis on individual willingness to develop relationships. “Building something greater than just your silo goes a long way,” they suggest. Shunk remarks that champions forge a very active process, continually reinforcing the model of working in teams and providing support by demonstrating collaborative practice with student learners as well as other colleagues.

Sites are also discovering that a shift in culture may not always require making big changes. Shunk comments that because physicians at the San Francisco VA have traditionally had “more of the power in the whole thing,” Shunk and Keene relocated morning interprofessional huddles from the physician clinic room into the nurse practitioner clinic room. “This simple move, in which the NP is sitting at his or her computer and the resident is sitting on the bed and not in the power chair, helped to flatten the hierarchy piece,” remarked Shunk.

Spontaneous team leaders. The patient-centered curriculum promotes a focus on the unique needs and experiences of each patient. New Mexico and Oklahoma reported that the more students are trained in communication and conflict resolution, the easier it becomes to listen and respond to actual patient needs. In this model, team leaders—no matter which profession or whether clinician or learner—emerge spontaneously based on the individual needs of the patient. Team members naturally master new skills.

Benefits of the Nexus to the PCMH. Clear benefits to the practice site are also emerging. Shunk and Keene note that when students and residents are meaningfully embedded into the PCMH, the whole site benefits. “Students bring fresh ideas and ask tough questions” related to collaborative practice, Britton believes. He notes that the new models of interprofessional education keeps providers and support staff honest and expansive in their thinking as they begin to appreciate their own limitations, and start realizing that they need others in order to deliver more efficient and effective patient care.

Benefits of the Nexus to students and residents. Harper comments that students intentionally trained in team-based care settings appear to be more “collaboration-ready” and marketable. Therefore, they are more likely to be fully utilized in rural New Mexico where patients have limited access to care. Students are also completing their rotations with a higher degree of confidence after experiencing a rotation in team-based care.

Harper remarks that students are better able to articulate their worth within a team, and have less anxiety about participating in patient-centered, collaborative practice. Oklahoma also finds that during face-to-face interactions on a regular basis, students become more confident when provided with the opportunity to openly discuss how to address barriers to collaboration.

We are inspired by these sites because they are demonstrating new interprofessional education models in exemplary PCMHs. While they have specific ecologies and cultures, they share characteristics that can be transportable and scalable to other practices. We have much to learn from them. The National Center looks forward to showcasing how these sites are developing beneficial Nexus relationships to advance patient-centered primary care workforce development by “thinking and acting differently.”

Resources

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