Click on links within this document to access related resource materials

Author/Editor: Laural Traylor, MSW
The Veterans Health Administration (VHA) in collaboration with the nation’s academic institutions conducts education and training programs to enhance the quality of care provided for Veteran patients and provide health professionals to the nation. (Title 38 U.S.C. Section 7302)
Veterans Health Administration

- conducts the largest health professions training effort in the U.S training almost 121,000 trainees in AY17/18

- collaborates with the majority of accredited medical schools

- partners with >1800 colleges/universities to support 40 clinical health professions.

VA Office of Academic Affiliations Statistics 2018
It is no longer enough for health workers to be professional. In the current global climate, health workers also need to be interprofessional. By working collaboratively, health workers can positively address current health challenges, strengthening the health system and improving health outcomes.
The trainees in our clinical environments, are learning while ‘doing’ under supervision. To do that well requires that we design their education experiences to integrate with our design for the patient’s clinical experiences.

When we properly design these clinical learning environments, we will achieve benefits for patients, trainees, staff, and see added value to our systems.

Stuart Gilman, MD, MPH
(L-R – Malcolm Cox, MD; Robert Jesse MD; Stuart Gilman, MD)
VA Office of Academic Affiliations
Director, Advanced Fellowships and Professional Development,
Director, CoEPCE Coordinating Center

OAA Interprofessional Education Executive Briefings
For patients, being taken care of in a model that has nursing, psychology, social work, medicine, with the goal not only to maintain, but to improve and to bring someone to the level of health care that is best for that particular person is an opportunity that is unprecedented in medical care.

Robert Bonomo, MD,
Chief of Medical Service, Cleveland VAMC
Professor of Medicine, Pharmacology, Molecular Biology and Microbiology,
Case Western Reserve University

Cleveland VA Medical Center CoEPCE
Key Stakeholders Interview
I see patients independently, but after every patient, I discuss it with my physician or nurse practitioner preceptor, we flush things out...it helps to synthesize everything and better develop your diagnostic decision making, your assessment skills, and your treatment skills.

Ali Heilman, NP
VHA, Nurse Practitioner, Colorado Outpatient Clinic.
(Former CoEPCE Nurse Practitioner Resident/Trainee)

Cleveland VA Medical Center CoEPCE
Key Stakeholder Interview
We (the CoEPCE) have really embedded ourselves in the clinic. Now the staff are also teachers in the clinic. We have LVN’s saying “don’t worry, I will teach them (the trainees/other staff) how to huddle”.

We have been funded by our medical center to continue this work as it is so critically important.

Rebecca Shunk, MD
VA San Francisco Designated Education Officer and CoEPCE Co-Director, CoEPCE, San Francisco
Professor of Medicine, University of California San Francisco

Was That A Double Double Animal Style?
We tackle hard things usually, and we treat each other with respect, and we have been together long enough to have trust so we can do that.

Scott Smith, MD CoEPCE Coordinating Center
Professor of Medicine, University of Washington
Physician Consultant (retired) CoEPCE Implementation Kit Consultant
and former Co-Director Boise CoEPCE
In the past we trained everybody individually in their professional silos. Nurses trained nurses and doctors trained doctors, and so forth and so on, but this new model is so exciting because we're all involved.
The vision is to create the clinical learning environments necessary to produce the high-functioning individuals and teams needed to assure beneficial patient care outcomes as well as professional and personal satisfaction within the care team.

Kathleen Klink, M.D., FAAFP
Chief, Health Professions Education VA Office of Academic Affiliations

Transforming primary care clinical learning environments to optimize education, outcomes, and satisfaction
We get the opportunity to really know the patients, really manage the patients, put in a treatment plan, see it be enacted, see the results, because we bring the patients back. We see them in a couple of weeks....in a month. We check labs; and results. We call patients at home; we follow up. My colleagues not in this program don’t have that opportunity to do this.

Jason Tuckerman, MD, VA Cleveland
Prior Physician Resident
VA Cleveland Centers of Excellence in Primary Care Education
I report off to a nurse practitioner or a doctor, I tell them everything that’s going on, I give them my plan for the patient, they like my plan, sometimes they don’t like my plan, but either way we come up with the perfect plan for the patient....and I feel confident that we’re doing the right things for the patient.

Aubrey Argyle, NP, Former NP Resident
Boise VA Centers of Excellence in Primary Care Education
Given their dynamic and intricate nature, Clinical Learning Environments can have a considerable time lag between the discovery of challenges, the implementation of systems changes to address these challenges, and the demonstration of results.
I’ve found that one of the most challenging yet rewarding experiences has been changing the culture.

Lisa Bell, EdD, Past Program Manager

Cleveland VA Medical Center CoEPCE
Key Stakeholder Interview
Work in the Centers of Excellence in Primary Care Education is associated with intriguing clinical outcomes

Anaïs Tuepker, PhD
Corresponding Principal Investigator, VA Health Services Research and Development
VA Portland Healthcare System

Quality Research Enhancement Initiative (QUERI Partnered Evaluation Center)
FACT Sheet on the CoEPCE
In general, medical residents are going back to an environment at their affiliates, in which they assume the culture of the top dog, it is just part of the culture.

Physicians, in general are perfectly happy with teams, as long as they are leading the team, and that’s the problem....

That is the 800 pound gorilla in the room.

Malcolm Cox, MD
Past Chief Academic Affiliations, Department of Veterans Affairs
Adjunct Professor of Medicine, University of Pennsylvania

Trainee Panel: Centers of Excellence in Primary Care Education
Trainees in the CoEPCE
One of the things we know is that our students think that, I’m the learner; I’m just coming in to get the knowledge from you. But they don’t realize that they come in with a new, fresh set of eyes and they actually could change practice.

Kameka Brown, MS, MBA, PhD, FNP
Past NP Co-Director, Seattle Center of Excellence in Primary Care Education

VA Seattle Medical Center CoEPCE
Key Stakeholder Interview
NP’s graduate are prepared to provide very competent care, but at the cost of a really high burnout rate... working until 8pm is not a good selling point.
To have a sustainable job in doing this work, I need my colleagues in social work, I need my colleagues in pharmacy and health psychology and I need to know how to use them to better serve the Veteran.
I have learned (with my team) I can have good quality of life and provide good care.

Karlyn Nieland, NP
Prior NP Resident, West Haven VA CoEPCE
Trainee Panel: Centers of Excellence in Primary Care Education
Trainees iAPACT Meeting
One of the biggest concepts I will take away from this entire experience is the idea of psychological safety. As a clinician, it is important to feel that your input matters and having the confidence to voice your opinion or share knowledge with your healthcare team.

Lieutenant Ashley L. Adams, PharmD, MS, BCACP
Former PGY2 Pharmacy Trainee
Houston VA CoEPCE
Training health professionals together in teams, but actually including elements in training, like leadership training, facilitation training, conflict management training all the skills were assumed that we knew after we graduated, now we're actually training trainees how to be effective in those areas.

Rebecca Brienza, MD, MPH
Co-Director, VA Center of Excellence in Primary Care Education
Assistant Professor of Medicine Yale University School of Medicine

VA West Haven Medical Center CoEPCE
Key Stakeholder Interviews
Through diligent and continued work in this area, it is possible that new clinicians will enter an era where interprofessional learning and collaborative practice will be engrained and accepted as an essential part of high-quality patient care.

The role of national stakeholders – today and in the future – in optimizing conversations, practices and structures that will enhance interprofessional learning in the context of patient care.
The biggest mission, the main mission, of the CoEPCE nationally, and our specific mission was this focus on the skills needed for practice during training and to try to break down these silos of education and to bring groups of trainees together.
The ability to ensure good health and well-being requires collaboration across multiple dimensions. The absolute beauty and elegance of the VA health care delivery system is that we don't just deliver health care. It's a broad base of social services that we know are important to engender good health and well-being. We're also expanding them out into the social services world, which becomes really important as we try and move more and more of the care out of the clinic, out of the hospital, and back into the space where people live and work and love and sleep.
This is all really is an immersion experience, and I believe that the best learning and the most meaningful and valuable learning happens through doing whatever you are trying to teach!

Bridget O’Brien, PhD
Evaluation Lead San Francisco CoEPCE
Associate Professor, Department of Medicine, University of Southern California San Francisco
Though most of these initiatives took six months or less to design and implement initial versions, sites put a great deal of effort into development and improvement of complex curricula over time that integrate formal instruction, workplace learning and reflection.

Stuart Gilman, MD and Laural Traylor, MSW (editors)
Right off the bat we chat about the patients that will be seen today, any sort of outstanding issues that we're expecting, or any sort of opportunities for team work that will necessarily come up during the day.

Anna Strewler, MS, AGNP-BC
Co-Director (and past Nurse Practitioner Post-Masters Resident)
CoEPCE San Francisco
Assistant Clinical Professor University of California, San Francisco
Helping care teams develop systematic ways of approaching the very common things and each of these are strengths that the other ones don’t necessarily have or you only have in random, isolated groups.

So, ultimately we’ve got to find a way to pool that knowledge base, and I think this is the first step to do that.

Chris Vanderwarker, MD
Medical Director Primary Care
Centers of Excellence in Primary Care Education
Assistant Director of Medicine, University of Washington

VA Seattle Medical Center CoEPCE
Key Stakeholder Interviews
I was really pushed; I was challenged because I had two faculty members that were always there to support me. I saw patients who were much more complex than I ever saw as a student, and I was able to because of the support I received from the team. In addition to that, I also got training in facilitation, motivational interviewing, and patient-centered care.

Elena Speroff DNP-NP-C, WHNP-BC, Boise CoEPCE NP Associate Director and Former West Haven CoEPCE Trainee
Being able to express complementary expertise, you (the IP team member) are looking at something through a different lens than other professions do. Being able to do this confidently and freely is really the essence of quality patient care and patient safety. This is not trivial in team development.

Malcolm Cox, MD
Past Chief Academic Affiliations, Department of Veterans Affairs
Adjunct Professor of Medicine, University of Pennsylvania
If we are to think about a redesign of educational elements we need to frame that within the context of the clinical system redesign.

Malcolm Cox, MD
Past Chief Academic Affiliations, Department of Veterans Affairs
Adjunct Professor of Medicine, University of Pennsylvania

Patient-Centered Model for Continuous Improvement in Clinical Education and Practice  VA: Cox, M. (2012)
If we are to have a stable, socially based, efficient, and safe health system, it will be necessary for all of us, as health care workers, policymakers and educators, to implement interprofessional learning and collaboration at all levels of our healthcare system.

Scott Reeves, PhD, MSc, PGGCE, BSc
Past Editor in Chief, Journal of Interprofessional Care
Founding Director, Center of Innovation and Inteprofessional Education and Professor of Social and Behavioral Sciences and Professor of Medicine, UCSF
Senior Scientist, Wilson Centre for Research in Education and Professor of Psychiatry, University of Toronto

Interprofessional Health System Collaboration for a Health System in Crisis
We can only take students so far to prepare for the future if they enter traditional, hierarchical practices...

Students and residents, rightly so, question whether classroom-only team problem-based learning, simulations, or activities represent authentic care experienced every day by health professionals and their patients.

Barbara Brandt, PhD, EDM
Associate Vice President and Director
National Center for Interprofessional Practice and Education/NEXUS
Professor, Department of Pharmaceutical Care & Health System

While there is a lot of talk about teamwork, there is very little rigorous teaching of the skill necessary to produce and sustain highly functioning healthcare teams...

The huddle coach makes sure that all team member voices are heard, including the clerk, nurse practitioner, a student, a pharmacist and that the team communication skills are reinforced. Team members now find value in huddles, especially in how huddles assist in care coordination and planning. Once huddle communication is established, huddle coaches move to more advanced roles.
For the psychology trainees, is that they’re kind of in the soup with all these other trainees; they’re all trainees. There’s something leveling about that. So, even though it’s medical residents, it’s nurse practitioner students, it’s the nursing students, etcetera, they’re all in it together; they’re all figuring out this model together.

Adam Brotman, PsyD
Staff psychologist Former AD Psychology, Boise CoEPCE
Large-scale systems transformation of education and clinical care is a complex undertaking that requires dedicated work of national leadership and policymakers, clinical and academic leadership, faculty, clinical staff and the trainees themselves.

Nancy Harada, PhD, PT, Lead Author
Evaluation Manager
Physical Therapy
Professor, UCLA David Geffen School of Medicine

VA OAA National Coordinating Center - Interprofessional transformation of clinical education: The first six years of the Veterans Affairs Centers of Excellence in Primary Care Education
We need to have a much closer link with our educators and our delivery system so education and delivery are really intertwined. Education is informed by the needs of the patients in the delivery system, and the delivery system is built intentionally to accommodate and support education. Learning how to work in a team, is a fundamental skill that all physicians and other health professionals should have and we should intentionally teach how to lead a team and how to follow a team.

George Thibault, MD
Recipient, Abraham Flexner Award for Distinguished Service to Medical Education
Past President of the Josiah Macy Jr. Foundation

Dr. George Thibault, Gold Board Member, Receives AAMC’s Most Prestigious Honor
Before long...we will look back and say, can you believe that we actually had to have a program to teach people to do that?...and now it's just part of something that we do.

Chris Ruser MD
Chief of Primary Care, VA Connecticut Healthcare System
Associate Professor of Medicine, Cornell University Medical College
Just because you are a good clinician doesn’t mean you are a good teacher or preceptor. Clinician educators need to learn how to develop curriculum and be a teacher.

Kathryn Wirtz Rugen, PhD, FNP-BC, FAAN, FAANP
CoEPCE Coordinating Center, NP Consultant
Associate Professor, University of Illinois at Chicago College of Nursing

CoEPCE Nurse Practitioner Residency Program
I feel like I can go to them (the IP Team) and contact them at any time, It’s more open and I find the care is more comprehensive.

Katherine Rickert, Veteran
The challenges to bringing about transformational change in health professions education, which includes much stronger emphasis on “learning together to work together,” are real and will require creativity and commitment to overcome. However, positive changes, such as the examples described, indicate that many of the elements requiring change are “unfreezing”.

Core competencies for interprofessional collaborative practice
I definitely think it makes me a better Pharmacist. I learn a lot of items that I didn’t learn in Pharmacy school. So, there’s different aspects to disease states that aren’t necessarily taught to pharmacists, but if you can catch those in your practice and learn those, those are just added benefits of knowledge that you can take on for your years of practice.
Katherine...Having PharmDs integrated with us has to be, I mean, I can't imagine anything better. I don't know how people are in practice at my level, and not having somebody to ask those questions of every day. Really, it's amazing.

John...to know that behind the scenes when they're not here personally in the clinic, we're more than likely talking about them (Veterans) and coordinating their care and making sure that their interests are being put on the table from multiple perspectives.
Establishing an interprofessional QI curriculum allowed pharmacy residents in PGY1 and PGY2 programs to collaborate with other members of the healthcare team. Benefits include QI skills development, a greater understanding of QI initiatives at the institution, stronger relationships with other healthcare trainees and mentors, and improvements to patient care and safety and facility performance.

Amber K. Fisher, PharmD,
Past CoEPCE Director (2nd author)
(1st author Lindsey M. Hunt, PharmD (not pictured)

Primary care collaborative practice in quality improvement: Description of an interprofessional curriculum.
Organizations responsible for education should develop specific strategies and a structure to unify culture, resources, and processes to cultivate a climate that supports an optimal learning environment across the continuum of health professions education.
NP residents self-reported strengths in patient-centered care and interprofessional teamwork. They identified clinical skill acquisition as the major area for improvement. Their short- and long-term goals focused on personal and professional growth.

Elena Speroff DNP-NP-C, WHNP-BC,
Boise CoEPCE NP Associate Director and Former West Haven CoEPCE Trainee (First Author, (Primary Author, Kathy Rugen, Not Pictured)

Nurse Practitioner residents' perceptions of competency development during a year-long immersion in Veterans Affairs primary care
Protected time of clinicians and staff was necessary to identify needs, develop interprofessional workplace learning strategies and faculty, and shape the interprofessional clinical learning environment within each Center.
VA CoEPCE NP residents demonstrated (from both mentors' ratings and self-ratings) the ability to practice without supervision at program completion. These findings strongly support the need for residencies to prepare new graduate NPs for independent practice.

Evaluation of Veterans Affairs primary care nurse practitioner residency: Achievement of competencies.
The benefits of interprofessional case conferences are twofold: they provide a forum in which learners have access to content experts with clinical and systems/resource knowledge and allow participants to work together in real time with space to plan, coordinate and improve quality of care. ...They also provide opportunities for faculty and staff to be learners as well as teachers.
Our experience with a local adaptation of the SGIM TEACH curriculum suggests that it is feasible to complete a meaningful interprofessional faculty development curriculum. It appears that including multiple professions may improve not only self-reported teaching skills and confidence, but also subsequent interprofessional collaboration, co-presentation, and feedback.

First Author: William Weppner, MD, MPH, FACP
VA Boise CoEPCE Co-Director
Associate Professor of Medicine, University of Washington

Taking SGIM’s teaching educators across the continuum of health care on the road – A local, interprofessional faculty development innovation.
There is a need for IP education practices that teach health profession trainees why and how to work with one another as members of a comprehensive patient-centered care team. Augmenting didactic presentations about the roles and responsibilities with workplace learning experiences is vital.
Improving a team’s function and collaboration frequently require transcending these profession-specific discourses. Once overcome, the team can work more creatively and flexibly in partnering with patients to improve health outcomes.
Creative solutions to overcoming the barriers to providing timely, high quality care as well as a commitment to providing sufficient time and quality in Primary Care education are essential. These models will afford patients, providers, and trainees sufficient time for patient care, continuous relationships, learning, and reflection, resulting in improved satisfaction and more meaningful work.

Author, Rebecca Brienza, MD, Director, West Haven CoEPCE Assistant Professor of Medicine, Yale University

At a crossroads: The future of primary care education and practice.
To realize new models for interprofessional teaching, faculty, staff, and trainees must understand the histories, traditions, and program requirements across professions and experiment with new approaches to achieving a common goal.

First Author, **Stuart Gilman, MD, MPH**, Director, CoEPCE Coordinating Center  CoEPCE Professor of Clinical Health Science, University of California Irvine, School of Medicine

*Connecting the dots: Interprofessional health education and delivery system redesign at the Veterans Health Administration.*
The core principles of teamwork and appreciation for the contribution of all health professionals must be effectively taught, sufficiently valued and continuously practiced to have lasting effect among trainees into practice.

First Author, **John Thomas, MD** Former CoEPCE Resident
Yale University School of Medicine

Moving from silos to teamwork: integration of interprofessional trainees into a medical home model (in the Department of Veterans Affairs)
Two thirds of the health care providers joining the US workforce by 2030 will be nurse practitioners or physician assistants. The large influx will have the greatest effect in primary care where fewer physicians are choosing primary care.
Health professions trainees participating in a novel population panel management curriculum report that it increased their confidence in using tools to improve patient care, increased their knowledge about managing their panel, and enhanced their ability to identify patients who would benefit from interprofessional care.

First Author, Catherine Kaminetzky, MD, MPH
Chief of Staff VA Puget Healthcare System
Associate Professor of Medicine, University of Washington

Implementation of a novel population management curriculum among interprofessional health care trainees.
The National Center is charged to provide the leadership, evidence and resources needed to guide the nation on interprofessional education and collaborative practice. In that pursuit, we aim to challenge tradition and create a deeply connected, integrated learning system that will transform education and care together.
EXECUTIVE SUMMARY ACADEMIC LEARNING ENVIRONMENT – 7 Recommendations

- Develop ... ideal learning environments fully capable of addressing the inseparable mission of delivering quality patient care and educating the next generation of health practitioners.

- Expand the definition and support of ...teaching faculty

- Prioritize continuity of patient care and learning

- Prioritize proactive, patient-centered population-based team care delivery as the organizing principle

- Develop and implement metrics that support education as well as quality patient care and system performance

- Educate trainees from different professions together

- Develop collaborative leadership models for care delivery and educational programs.

Co-Authors Judith Bowen, MD, FACP (Pictured/ Past CoEPCE Physician Consultant), Professor of Medicine, OHSU and Gordon Schectman, MD

Executive Summary Recommendations - VA Whitepaper – Academic PACT: A Blueprint for primary care redesign in academic practice settings.
PACT ICU provides a forum to invite perspectives beyond the primary care provider’s. This feature results in a more robust treatment plan than might be developed by individual providers, who might not have time to consider options that are outside their scope of practice. Formulating an enriched care plan, informed by multiple professions has the potential (and is showing evidence of) improving utilization and providing better care.

Case Study #1 VA Boise - PACT ICU Model-Interprofessional Case Conferences for High Risk/High Need Patients - CoEPCE: Compendium of Five Case Studies: Lessons for Interprofessional Teamwork in Education and Workplace Learning Environments.
The dyad serves as a setting to develop a more robust picture of the patient informed by different perspectives, such as integrating the medical model with the psychosocial aspects that are strengths of nurse practitioner training.
The huddle may contribute to efficiencies in a busy clinic setting. For example, the RN Care Manager can have upwards of 1,200 patients on his/her panel and, between staff and trainees, as many as 12 providers with whom to communicate. The huddle strengthens the communications with providers and is an opportunity to touch base on the patients, coordinate care, and keep track of high-risk patients who might fall off the radar otherwise.
Clinicians are increasingly being required to proactively optimize the health of an assigned population of patients, in addition to assessing and managing the health of individual patients presenting for care. This is an emerging competency that makes use of population data, team based care, evidence-based chronic care based on clinical data in electronic health records, and PI tools to effect improvements in care metrics.

Realign existing resources to establish and sustain the linkage between interprofessional education and collaborative practice.
Physician and nurse practitioner trainees work together with trainees in pharmacy and health psychology in the complex approach to polypharmacy. The model has not only strengthened CoEPCE partnerships with other VA departments and specialties, but has also revealed opportunities for collaboration with academic affiliates as a means to break down traditional silos among medicine, nursing, pharmacy, geriatrics, and psychology.
Why interprofessional team care for Polypharmacy issues? It is such a complex multifaceted issue, there are many things contributing to polypharmacy.

CoEPCE Polypharmacy clinic: A shared medical appointment approach
Seven “Centers of Excellence” and facilities around the country (Boise, Cleveland, Houston, Los Angeles, San Francisco, Seattle and West Haven) have worked for many years to create improved interprofessional environments and purposefully developed curriculum where VA’s trainees, residents and interns from many areas and levels of expertise learn and work together with their interprofessional faculty teams.
Only by building a future workforce of competent health care professionals can we leverage the concept of panel management to reach its fullest potential to efficiently and effectively improve population health outcomes.

First Author, Maya Dulay, MD, San Francisco CoEPCE
Associate Professor of Medicine, University of California San Francisco

Interprofessional population health advocacy: Developing and implementing a panel management curriculum in five Veterans Administration Primary Care Practices
Shared Decision-Making (SDM): Care is aligned with the values, preferences and cultural perspectives of the patient. Curricula focus is on communication skills necessary to promote patient’s self-efficacy.

Sustained Relationships (SR): Care should be patient-centered, continuous, comprehensive and coordinated. Care is designated to promote continuity of care; curricula focus on longitudinal learning relationships.

Interprofessional Collaboration (IPC): Care should be team based, efficient and coordinated, curricula focus is on developing trustful, collaborative relationships.

Performance Improvement (PI): Care is designed to optimize the health of populations; curricula focus on using the methodology of continuous improvement in redesigning care to achieve quality outcomes.
We learned that interprofessional leadership is vital to the development and delivery of effective interprofessional curricula, as well as for role modeling of leadership behaviors to trainees across professions.

Interprofessional transformation of clinical education: The first six years of the Veterans Affairs Centers of Excellence in Primary Care Education
We’re building the structure in which it will be hard to do the wrong thing!

Mamta (Mimi) Singh, MD
CoEPCE Coordinating Center Physician Consultant and Past Director, Cleveland CoEPCE
Assistant Dean of Health Systems Science
Case Western Reserve University
In many respects, health professions education remains isolated from practice realities, and profession-specific learning does not prepare future and current health professionals for working together.

We must transcend boundaries to connect “traditional” health professions, educators, new and emerging health and care providers, care coordinators, administrators of health care delivery and payment systems, and policy-makers in partnership with patients, communities, and populations.
It appears that including multiple professions may improve not only self-reported teaching skills and confidence, but also subsequent interprofessional collaboration, co-presentation, and feedback.

Taking SGIM's Teaching Educators Across the Continuum of Health Care on the Road—A Local, Interprofessional Faculty Development Innovation
Large-scale systems transformation of education and clinical care is a complex undertaking that requires dedicated work of national leadership and policymakers, clinical and academic leadership, faculty, clinical staff and the trainees themselves.

Interprofessional transformation of clinical education: The first six years of the Veterans Affairs Centers of Excellence in Primary Care Education
Ordinarily, this patient might have slipped through the cracks of ... But after he left, our team health tech coordinated future appointments with a nutritionist, a weight-loss specialist and an optometrist. A week later, the patient came to see our team nurse, who explained how to control diabetes and how to use a finger-stick glucometer to monitor blood sugars. Without the help of my team, I’d be alone and overwhelmed in coordinating all of this vital care.

In Memory
Yogesh Khanal, MD
1985-2016
Yale School of Medicine Chief Resident
Past Resident CoEPCE West Haven VA
Residency programs will focus more on the importance of teamwork training and interprofessional collaboration. All physicians will work in teams throughout their career, and more time in residency must be spent with learners and practitioners from other disciplines and professions with an explicit goal of developing team competencies.
A collaborative practice-ready workforce is a specific way of describing health workers who have received effective training in interprofessional education. 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.
Who should lead the interprofessional collaborative team?”
Our answer is that no single person or profession should lead. Across our care environments, formal and informal leaders have included physicians, nurses, physical therapists, occupational therapists, chaplains, nurse practitioners, pharmacists, social workers, patient–family advisors, and patients and families during their care.