



Robert Wood Johnson Foundation

# Charting Nursing's Future

Reports on Policies That Can Transform Patient Care

## Implementing the IOM *Future of Nursing* Report—Part II: **The Potential of Interprofessional Collaborative Care to Improve Safety and Quality**

2011

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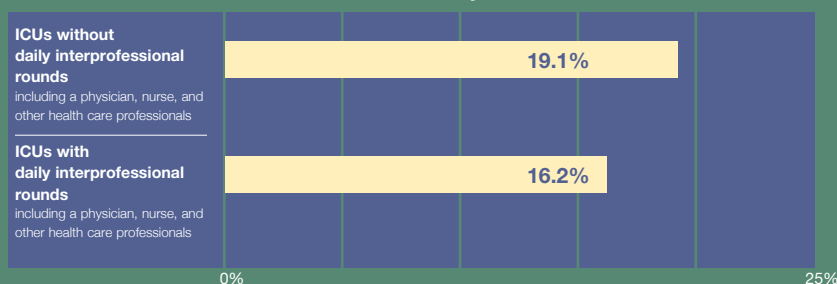
**F**or more than a decade, health professionals have strived to build safer, more efficient, and less costly systems of care, with the goals of reducing medical error, improving health outcomes, providing more preventive care, and increasing patient engagement in care decisions. In the process, a consensus has emerged among those in the vanguard that these safety and quality goals can best be met by replacing conventional siloed care delivery with a collab-

orative, coordinated approach that capitalizes on the unique expertise of each profession.

Although the system as a whole struggles to implement this vision, significant strides have been made in every health care arena. This brief showcases interprofessional practice, discusses the educational transformation needed to prepare health professionals to provide collaborative care, and looks at policies that support its delivery.

Figure 1 **The Effect of Interprofessional Care Teams on Intensive Care Unit (ICU) Mortality**

Likelihood of Death within 30 Days of ICU Admission



A study of critically ill patients admitted to 169 Pennsylvania hospitals over the course of two years found that daily rounds by an interprofessional ICU team were associated with a significantly reduced risk of death.

Source: Adapted from data and conclusions presented in Kim MM, Barnato AE, Angus DC, Fleisher LF, Kahn JM. The Effect of Multidisciplinary Care Teams on Intensive Care Unit Mortality. *Arch Intern Med.* 2010;170(4):369-376. Figures above courtesy of Dr. Jeremy M. Kahn, University of Pittsburgh.

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## The Value of Interprofessional Practice

At Phoenix Baptist Hospital, a respiratory therapist, dietician, critical care nurse, intensivist physician, and clinical pharmacist conduct rounds on each patient in an ICU. The introduction of interprofessional team care in Abrazo Health Care's Phoenix, Arizona, ICUs reduced the number of days that patients spent on ventilators by a dramatic 60 percent.

Initially team members discovered a need for greater understanding of overlapping clinical areas. For example, dieticians needed to appreciate fluid management, and respiratory therapists needed more knowledge of pharmacology to work with nurses on sedation issues and patients' ventilator needs. Team-taught didactic education sessions and regular meetings to share observations led to the creation of well-functioning teams and a culture of respect for each profession's expertise. Paramount to the teams' success is shared leadership by critical care nurse and physician managers.

Abrazo Health Care is part of Nashville-based Vanguard Health Systems, which is rolling out interprofessional rounds in its ICUs nationwide.



Photo: Jim Burk, courtesy of Phoenix Baptist Hospital

# Teamwork and Collaborative Decision-Making: Keys to Improving Care

Just over a decade ago, a landmark report from the Institute of Medicine (IOM) pointed out that, “In its current form, habits, and environment, American health care is incapable of providing the public with the quality health care it expects and deserves.” Two years earlier, another influential IOM report estimated that as many as 98,000 people were dying in American hospitals each year as a result of medical error, at a staggering cost of roughly \$38 billion.

In response to these revelations, a vibrant safety and quality movement emerged. It has produced impressive reductions in hospital-acquired infections and saved lives, but the majority of health systems remain wedded to traditional ways of operating. Newer measurement tools suggest that the number of adverse medical events is much higher than originally estimated, likely affecting one-third of all hospitalized patients, and that a pervasive hospital culture that undervalues collaborative decision-making continues to compromise patient care. A 2010 study of nurses working



“As the health care community is looking for new strategies, and new ways of organizing to optimize our efforts—teamwork is fundamental to the conversation.”

Mary Wakefield, PhD, RN, HRSA Administrator

in critical care and surgical settings, *The Silent Treatment: Why Safety Tools and Checklists Aren't Enough to Save Lives*, found that even when safety tools indicated a patient care problem, fewer than one-third of nurses felt comfortable speaking up and were able to get coworkers to listen to their concerns.

Equally daunting challenges vex the primary care arena. Nearly one in two Americans had one or more chronic conditions in 2005, and that number is expected to rise as the population ages and obesity becomes more prevalent. Chronic conditions account for three-quarters of today's medical care expenditures, yet the primary care delivery system is poorly structured to provide the preventive services, coordinated care, and patient education and support needed to effectively treat a chronically ill population.

Many experts believe that teamwork and collaborative decision-making are essential to remedying these systemic ills.

**“Regardless of the context in which policy-makers choose to introduce collaborative practice, research evidence and experience have demonstrated that a team-based approach to health-care delivery maximizes the strengths and skills of each contributing health worker.”**

World Health Organization. *Framework for Action on Interprofessional Education & Collaborative Practice*. 2010.

The 2010 IOM report *The Future of Nursing: Leading Change, Advancing Health* created in partnership with the Robert Wood Johnson Foundation, articulates a vision for a transformed health care system in which “interprofessional collaboration and coordination are the norm.” The report urges providers to use all health professionals “to the full extent of their license and education” and calls on health professions schools to prepare students for interprofessional collaboration through joint classroom and clinical training opportunities.

A coalition of educational associations echoed this call with the 2011 release of a set of core competencies (see p. 5) to guide educational programs in preparing health professions students for collaborative practice. Many in academia believe that all future health professionals will need to participate in collaborative care delivery. Although teams per se will not be appropriate for every health care situation, proponents view teamwork, respectful communication, and an understanding of each professional's role as essential skills for the safe and effective delivery of patient care. These developments in academia are welcomed by those in the practice community who believe that teamwork has a vital role to play in improving quality throughout the health care system.

Table 1

## Conventional vs. Collaborative Care

Conventional	Collaborative
Authoritarian	Collaborative
Autonomous practice culture	Team culture
Physician driven, with physicians accountable for care outcomes	Patient centered, with team members sharing responsibility for care outcomes
Episodic, fragmented	Continuous, coordinated
Primary care delivered in one-size-fits-all, 15-minute visits	Primary care delivered via individualized visits, phone calls, and online communication
Payment based on quantity (fee for service)	Payment based on value (considers both quality and cost)
Reactive, focused on illness	Preventive, focused on health
Communication is inconsistent	Communication is imperative

### Interprofessional Care for Medically Complex Patients

#### *Harvard Vanguard*

In 1997, a nonprofit, multispecialty medical group, known today as Harvard Vanguard Medical Associates, developed a congestive heart failure (CHF) program run by nurse practitioners (NPs). The program significantly reduced hospital admissions for enrollees and cut their emergency room visits by 92 percent in one year. Yet despite these initial results, over time, all-causes readmissions for the group's CHF patients began to rise. "We found that managing one disease really well in isolation did not lead to a total improvement in care," says Diane Gilworth, RN, MPH, NP, vice president of nursing, who designed and managed the program.

As Gilworth's team investigated, they discovered that patients frequently received conflicting advice from the specialists who treated their related conditions. For example, some patients were trying to follow several dietary plans at once. This lack of coordination among care providers appeared to be stymieing their best efforts.

As a result, Gilworth decided to refocus the CHF program on managing CHF's causes: heart disease, hypertension, and diabetes. Under the newly named Complex Chronic Care (CCC) program, care has become interprofessional, collaborative, and noticeably more efficient. Each CCC patient is assigned an NP who consults with all the patient's subspecialists and incorporates their guidance in a single plan of care. The NP then manages and coordinates that care, connecting patients to nutritionists, social workers, and other professionals as needed. An RN works with each NP to monitor the patient's condition and facilitate care between visits. In the case of a diabetic patient, for instance, this might involve tracking hemoglobin levels and adjusting insulin doses according to prescribed

guidelines. The model is dynamic, allowing patients to meet more or less frequently with the NPs and their primary care physicians, who remain responsible for the patients' overall care.

CCC addresses the needs of some of Harvard Vanguard's sickest patients. To be admitted into the program, patients must have three or more poorly managed chronic conditions and have been admitted to the hospital within the last six months.

Now the group is preparing to expand its chronic care model by developing an accountable care organization (ACO), which will allow Harvard Vanguard to influence the way its patients receive care in other settings. An ACO takes responsibility for managing care across the continuum, whether patients are in the hospital, in long-term care facilities, or at home. Once again, RNs and NPs will play central roles, working across all settings to monitor patients' conditions, coordinate the efforts of health care providers, educate and support family caregivers, promote patient self-management, and facilitate access to community resources.

### Interprofessional Initiative Ensures Efficacy of Safety Program

#### *Legacy Health*

Eliminate needless deaths and eliminate preventable harm. These two ambitious goals set the stage for a major safety and quality campaign that harnessed the power of interprofessional teams to transform Legacy Health, a nonprofit corporation that operates six hospitals in the Portland, Oregon, metropolitan area.

In the spring of 2008, Legacy launched its Big Aims initiative with three related efforts to improve safety and quality: develop and implement evidence-based best-practice "bundles," review 50 consecutive deaths at each hospital and develop an action plan based on the findings, and

develop a process to support daily interprofessional rounds in all patient care areas.

The first project enlisted interprofessional teams to develop best-practice bundles of five to seven evidence-based interventions aimed at eliminating the most common health care-associated infections. Then Legacy trained all staff, from clinicians to transportation aides to housekeepers, about their roles and the importance of implementing each step within a bundle for every patient, every time. To reinforce the training, leaders joined daily interprofessional rounds to engage staff and resolve barriers to implementation.

The second project focused on identifying opportunities for improvement within each individual hospital. Local teams analyzed each hospital's most recent 50 deaths to ascertain whether failures to recognize a problem, to communicate well, or to respond contributed to the patient's death. Then each team used its findings to develop hospital-specific interventions. For example, the discovery at one hospital that sepsis was a contributing factor in 40 percent of the deaths reviewed led to the introduction of a best-practice bundle to specifically address this complication.

Concurrent with the first two projects, Legacy expanded the interprofessional rounds program already in use in its intensive care units to all units of the hospital. Legacy created a script to ensure that each member of the care team was introduced to the patient and his or her family, that the patient's medications were reviewed, and that safety concerns were discussed. The script also directed the team to engage the family regarding social challenges and other issues that might affect patient care.

To assess the impact of its Big Aims initiative, Legacy tracked infection and mortality rates across its six hospitals over a 24-month period. Legacy reported that its monthly aver-



age combined infection count dropped from 74.4 to 41.2 over that period, an improvement of 44.6 percent. Legacy's inpatient mortality rate also decreased by 13.5 percent despite a simultaneous increase in the clinical complexity of its patient population. (Details are discussed in the April 2011 issue of *Health Affairs*.)

Results of the Big Aims initiative were shared with all Legacy employees and with the board of directors and were posted in public areas for patients and their families to see. Legacy believes this transparency not only raised awareness but increased engagement in safety and quality improvement among these stakeholders.

### **Interprofessional Team Targets Community's Costliest Patients**

#### *The Camden Coalition*

The Camden Coalition of Health Care Providers is an interprofessional, community-based initiative that is revolutionizing health care delivery for Camden, New Jersey's costliest patients. These individuals, sometimes called super utilizers, typically rely on hospital emergency rooms (ERs) for care because they have no primary care services available to them or do not know how to access those that exist. Many have medically complex conditions compounded by mental illness, addiction, and/or the cumulative toll of homelessness.

A study of Camden's hospital use by the coalition's founder, Jeffrey Brenner, MD, revealed that 80 percent of Camden's health care costs, most of which are paid with public funds, were attributable to 13 percent of its patients, many of whom were using the ER for nonemergencies. The most common diagnoses for ER visits were head colds, viral infections, ear infections, and sore throats.

In response, Brenner began meeting with an interprofessional group of Camden's primary care providers. This group of physicians, nurse practitioners, physician assistants, school nurses, podiatrists, and a midwife

## **The Value of Interprofessional Teams**



A Spanish-speaking patient describes her symptoms to her health coach while an advanced practice nurse, who specializes in the management of chronic conditions, examines her foot. AtlantiCare Regional Medical Center, part of the AtlantiCare integrated health system in southeastern New Jersey, developed its Special Care Center to address the needs of patients with high blood pressure, diabetes, congestive heart failure, and other chronic conditions. The team provides each patient with a personal

health coach, who often shares cultural roots and speaks the same native language. Coaches help patients manage their chronic conditions, meet wellness goals, and communicate better with clinicians.

AtlantiCare's Special Care Center replaced fee-for-service payments with monthly per-patient fees, opening the door for a redesign of primary care. The team meets every morning to make sure that patients receive appropriate tests and follow-up care. The team also incorporates behavioral health specialists to address familial and other stresses that can affect health.

decided to form an independent non-profit organization to provide coordinated care to Camden's most marginalized patients. The coalition currently operates several initiatives designed to demonstrate that a collaborative approach to care delivery can improve patient care and reduce costs.

One of these initiatives, the Care Management Project (CMP), specifically aims to reduce unnecessary ER utilization. CMP employs an outreach team consisting of a social worker, a bilingual medical assistant, and a nurse practitioner to help patients apply for government assistance benefits, secure temporary shelter, enroll in medical day programs, and coordinate primary and specialty care. The coalition does not maintain a clinic. Instead, the interprofessional team visits CMP's enrolled patients where they reside: in homeless shelters, abandoned homes, hospital rooms, and street corners. Enrollment in CMP also means these patients now have an advocate and care coordinator when they visit the ER because the city's hospital social workers alert

the CMP team when enrollees arrive. Over time, the coalition hopes to help the individuals it serves stabilize their living environments and find long-term medical homes.

According to coalition data, many of its enrollees have significantly decreased their hospital utilization after only a few months of outreach visits to manage their chronic conditions, aggressively treat any coexisting depression, and assist them in securing public benefits. Although their work has been largely underwritten by Camden's Cooper University Hospital and philanthropies, including the Robert Wood Johnson Foundation, the dollars saved from decreased hospital utilization should provide a means of sustaining community-based programs of this type over the long haul. The coalition is prepared to participate in New Jersey's recently approved Medicaid ACO Demonstration Project, which will use "gainsharing" payments to reward providers of high-quality care whose patients use fewer high-cost health services.

## Interprofessional Education

In its *Framework for Action on Interprofessional Education and Collaborative Practice*, the World Health Organization defines interprofessional education (IPE) as a process in which “students from two or more professions learn about, from and with each other to enable effective collaboration and improve health outcomes.”

For more than a century, U.S. health professionals have received their training independently of one another, graduating with a limited ability to work collaboratively to care for the increasingly complex needs of today’s patients. Recognizing the urgent need to remedy this failing, six national educational associations representing schools of nursing, allopathic and osteopathic medicine, pharmacy, dentistry, and public health came together in 2009 to form the Interprofessional Education Collaborative (IPEC). This year IPEC released a set of competencies (see *Core Competencies for Interprofessional Collaborative Practice*, below) designed to enable health professions schools to reshape their curricula to better prepare future clinicians for both collaborative and team-based care.

“These competencies are essential to changing the university and practice cultures,” says Frank Cerra, MD, professor of surgery and former senior vice president of health sciences and dean of the medical school at the University of Minnesota. The goal is “to reconnect education and practice so we actually teach what we want students to do in practice.”

Many of the health professions have already laid a foundation for these changes. In 2008, the American Association of Colleges of Nursing revised its curricular frameworks for baccalaureate- and master’s-level nursing education, better known as *The Essentials*, to include interprofessional communication and collaboration. Both accrediting bodies for nursing programs, the Commission on Collegiate Nursing Education and the National League for Nursing Accrediting Commission, have added interprofessional collaboration to their standards in recent years. So have the accrediting bodies for pharmacy and dental schools. The 2003 IOM report, *Health Professions Education: A Bridge to Quality*, provided an impetus for some of these changes.

### Core Competencies for Interprofessional Collaborative Practice

#### The Interprofessional Education Collaborative’s Interprofessional Competency Domains

- **Values/Ethics for Interprofessional Practice.** Work with individuals of other professions to maintain a climate of mutual respect and shared values.
- **Roles/Responsibilities for Collaborative Practice.** Use the knowledge of one’s own role and those of other professions to appropriately assess and address the health care needs of the patients and populations served.
- **Interprofessional Communication.** Communicate with patients, families, communities, and other health professionals in a responsive and responsible manner that supports a team approach to the maintenance of health and the treatment of disease.
- **Interprofessional Teamwork and Team-Based Care.** Apply relationship-building values and the principles of team dynamics to perform effectively in different team roles to plan and deliver patient-/population-centered care that is safe, timely, efficient, effective, and equitable.

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## Persistence and Passion Sustain Interprofessional Vision



**Charting Nursing’s Future *salutes* Madeline H. Schmitt, PhD, RN, FAAN, FNAP, professor emerita, University of Rochester School of Nursing.**

Although interest in interprofessional education and practice has waxed and waned for decades, Mattie Schmitt has persisted in her commitment to collaborative care. She was on the brink of retirement when IPE most recently returned to the national stage, creating new opportunities for her to influence its trajectory.

Dr. Carol Aschenbrener, executive vice president of the American Association of Medical Colleges, asked her to chair the Interprofessional Educational Collaborative panel charged with developing core competencies for collaborative practice (at left).

Why choose a nurse sociologist to lead this endeavor? “Mattie is passionate about quality care in all its dimensions, and I knew that she could move a group to action,” says Aschenbrener. “We wanted to get this done in a year, and she did.”

Schmitt credits her training in sociology for giving her the theoretical lenses to perceive what fosters and obstructs collaboration in health care and the tools to respond. In recent years, Schmitt has crisscrossed the country as an IPE consultant and collaborated internationally on projects such as the World Health Organization’s *Framework for Action on Interprofessional Education and Collaborative Practice*.

Schmitt’s influence in this arena is also visible through the work of her former students, many of whom are furthering interprofessional efforts through their work in academia, practice, foundations, and government.

## Model IPE Initiatives

Despite entrenched curricula and distinct professional cultures, some health professions programs at every level within higher education are making IPE a priority and finding ways to surmount physical, logistical, and cultural barriers to educating health professions students together. Unlike the piecemeal and short-lived attempts of the past, these new IPE initiatives are accompanied by an institutional commitment to integrated learning that has the potential to transform health professions education.

### Acculturating Students at the Undergraduate Level

#### *University of New England (UNE)*

UNE is generating enthusiasm for interprofessional practice with a common undergraduate curriculum for several of its health professions programs: nursing, dental hygiene, athletic training, applied exercise science, and health, wellness, and occupational studies. This curriculum includes shared learning throughout

the basic science prerequisites and in four new courses aimed at imparting interprofessional competencies, which align with the *Core Competencies for Interprofessional Collaborative Practice* (see p. 5). Students participate in the common curriculum for two years before moving on to their professional programs. Once engaged in discipline-specific study, students apply their interprofessional skills during clinical site placements as well as through participation in simulations, workshops, and clinical grand rounds.

UNE, based in Biddeford and Portland, Maine, began contemplating IPE a decade ago. In 2010, its Westbrook College of Health Professions invested substantial financial and human resources to develop curriculum and clinical site partnerships. Today, the interprofessional cultural landscape at UNE is evolving and includes participation from other colleges, including Osteopathic Medicine, Pharmacy, Dental Medicine, Arts and Sciences, and Public Health.

### Multischool Collaborative Makes IPE Possible

- *Vanderbilt University Schools of Medicine and Nursing*
- *Belmont University School of Pharmacy*
- *Lipscomb University College of Pharmacy*
- *Mid-Tennessee Collaborative Master of Social Work Program*

Vanderbilt University's nursing and medical schools have established a pilot IPE program that draws in pharmacy and social work students pursuing graduate degrees at nearby universities. The Vanderbilt Program in Interprofessional Learning assigns students from the four professions to interprofessional working-learning teams at ambulatory care facilities. Throughout their professional education, students spend one half day a week in the clinic and engage in team-focused classroom learning biweekly.

Bringing the various academic institutions together required a commitment to align academic calendars,

*Continued on page 7*

## Academic Health Center Built with IPE in Mind: University of Colorado Anschutz Medical Campus

The University of Colorado (CU) designed its new state-of-the-art CU Anschutz Medical Campus with the explicit goal of creating an environment that promotes collaboration. The campus includes shared auditoriums, simulation laboratories, and student lounges, and dedicated spaces where health professions students can collaboratively pursue interests such as geriatrics or rural health.

CU's first foray into IPE was a joint ethics course in the 1990s. According to Mark Earnest, MD, PhD, associate professor of medicine, "Once the first interprofessional program is in place, it changes the conversation from, 'Here are all the reasons we can't do this' to 'Look, we actually did this.' The other byproduct is that faculty relationships develop across disciplines. That's the cultural substrate that led to the vision for our campus."

Like many other academic health centers that have adopted IPE, CU's program has three elements: a campuswide orientation for new students, interprofessional classroom work, and interprofessional clinical experiences. All require a coordinated calendar and integrated curricular elements.

For its preclinical interprofessional training, CU turned to two well-established programs. The first is Health Mentors, developed at Thomas Jefferson University. The program places entering students in interprofessional teams that are mentored by an individual or parent/child pair with chronic health needs. Over two years, students experience the health care system from the patient's perspective and learn about the role each profession plays on the health care team.

The second program pairs interprofessional simulations with Team-

STEPPS (Team Strategies and Tools to Enhance Performance and Patient Safety), a highly regarded curriculum developed by the Department of Defense and the Agency for Healthcare Research and Quality. This evidence-based program uses specific tools and strategies to improve communication and promote safe, high-quality care. CU is using TeamSTEPPS with students, faculty, and clinical staff at CU's partner hospitals so everyone will share a common language.

Startup funds from the Josiah Macy Jr. Foundation and the Colorado Health Foundation supported CU's transition to IPE. The university has committed to creating a permanent funding stream for IPE, either through the assessment of a student fee or through a tuition-sharing agreement among its health professions schools.



designate supervisory faculty, and integrate clinical and classroom experiences into existing programs of study. The Josiah Macy Jr. Foundation provided support for a program coordinator and partial salary for a lead faculty member from each discipline. University administrators anticipate that the program will become self-sustaining as it becomes integrated into each institution's academic program.

### Preparing Graduate and Postdoctoral Students for Collaborative Practice

*Veterans Health Administration (VHA)*  
To support a nationwide transition to a team-based, patient-driven primary care delivery system, the VHA is piloting a graduate/postdoctoral-level training program, Centers of Excellence in Primary Care Education (COE). This year, five VHA facilities in partnership with schools of nursing and medicine were designated Centers of Excellence and received five-year grants. Each center is developing its own approach to acculturating learners to practice patient-centered, team-based primary care. At one center, participants will receive training in teamwork, quality improvement, and research, but most learning will occur as medical residents and nurse practitioner students comanage a panel of patients over the course of two years.

**“When people aren’t educated together, it is extremely challenging to get them to work as a team. This disrupts care and places a huge financial and time burden on health systems.”**

Malcolm Cox, MD, chief academic officer, Veterans Health Administration



## Keys to Successful IPE Initiatives

1. **Obtain commitments from senior administrators.** They can sweep away space use and calendar conflicts, commit necessary financial and human resources, and adjust promotion and tenure policies to support IPE.
2. **Make IPE a central priority.** Institutions with thriving programs have explicitly included IPE in their strategic goals and created a central office or committee authorized to implement programs.
3. **Fully engage faculty.** Schools can motivate faculty to invest in IPE by involving them in planning, providing targeted professional development, and rewarding those who create new curricula or contribute in other ways.
4. **Recognize students as powerful allies.** In 2002 students at the University of Minnesota created the CLARION Interprofessional Team Case Competition, which has engaged students at 16 academic institutions in interprofessional teamwork.
5. **Don't be afraid to start small.** The Medical University of South Carolina began a discrete interprofessional program in the 1990s. It launched a half-day introduction to IPE in 2006. Today its expansive 10-year C3 (Creating Collaborative Care) program strives to integrate IPE throughout the curriculum.
6. **Connect the dots.** Many institutions already have isolated IPE efforts that can be linked, built upon, and expanded.
7. **Look beyond the health professions.** At Arizona State University, students of nursing, medicine, architecture, and engineering are developing teamwork skills by collaborating in the design of healing environments.

Other trainees include students of pharmacy, social work, clinical psychology, and podiatry. Unlike traditional graduate medical education, which is profession specific and designed to serve the host institution's clinical coverage needs, COE is competency based and focuses on the needs of patients and trainees. In addition to preparing graduates to work in and lead patient-centered interprofessional teams, the VHA hopes to improve the primary care delivery experience for both patients and providers through this initiative.

### Teaching Practicing Clinicians to Work As a Team

- *University of Virginia (UVA)*
- *University of Toronto (UT) Centre for Interprofessional Education*

When faculty at UVA's schools of medicine and nursing decided to incorporate an IPE thread throughout their curricula, they realized they would also need to prepare faculty members and clinicians. Enter the university's Interprofessional Education Initiative (IPEI) and continuing medical educa-

tion faculty coordinator John Owen, EdD, MSc, who organized an intensive three-day leadership course called ehpic (educating health professionals for interprofessional collaboration). Developed at UT's internationally recognized Centre for Interprofessional Education, ehpic provides experiential learning opportunities in collaborative practice and teamwork for practicing professionals. The course focuses on understanding professional roles, communicating effectively, and acknowledging the impact of professional attitudes and cultural values in the clinical context.

At UVA, practice and education leaders backed the ehpic training, and 32 clinicians and faculty eagerly took part. “We didn't say, come and learn to communicate with one another,” notes Owen. “We said, come learn how to better care for your patients.” IPEI cochair, V. L. “Tina” Brashers, MD, FACP, FNAP, professor of nursing and attending physician in internal medicine, concurs. “For both students and faculty, making IPE training clinically relevant is absolutely critical.”

## Policies That Support Collaborative Care

Traditional fee-for-service insurance plans have long been criticized for rewarding the quantity of services provided rather than their quality. These plans typically only reimburse face-to-face encounters between patients and individual physicians or specialized providers. Under such plans, providers cannot bill directly for the services of care team members such as nurses who typically provide the preventive and care coordination services that avert acute care episodes. Recent efforts aim to change this equation by identifying and rewarding care models that improve patient outcomes and reduce costs, often through the use of interprofessional teams.

### Federal and State Governments

At the federal level, the Affordable Care Act established the Center for Medicare and Medicaid Innovation to test new ways of delivering and paying for care that reduce costs and improve quality. The Innovation Center's initiatives include primary care payment models that make it easier for physicians and other clinicians to improve care within and across settings. These models supplement traditional fee-for-service payments with a monthly care management fee.

The Innovation Center is also experimenting with bundled payments that cover all the services delivered across an episode of care and with shared savings programs that reward providers with a share of the money they save when they reduce costs by

## The Value of Interprofessional Education



During an exercise at the University of Washington (UW), medical students (center) prepare to perform a rapid sequence induction of anesthesia using a high-fidelity mannequin. One nursing student (at right) stands ready with medication and another (at left) tracks the patient's vital signs for sudden changes. The students must coordinate their activities and function as a team to successfully complete the assignment.

UW's Institute for Simulation and Interprofessional Studies (ISIS) began as a traditional medical simulation laboratory. A 2008 grant from the Josiah Macy Jr. Foundation allowed

ISIS to refocus its efforts on interprofessional training in leadership skills, situational awareness, communication, mutual support, and conflict resolution for students, faculty, and clinicians.

Photo: Daniel Low, courtesy of the University of Washington

improving the quality of the care they provide. The goal is to create financial incentives for hospitals, physician practices, and other care providers to invest in the preventive, care management, and care coordination services that reduce patient use of expensive acute care services.

States are also introducing a range of reforms that directly and indirectly support collaborative care. Forty-one states have committed to promoting collaborative primary care models called medical or health homes for their Medicaid and Children's Health Insurance Program participants, and many have begun implementing programs.

### Private Payers

The need to lower costs has spurred many private payers to experiment with payment methods better suited to collaborative care delivery. These

include bundled payments as well as global payments, which provide a budget for all the care services needed by a single individual. In Rochester, New York, Excellus BlueCross BlueShield is piloting a third approach: a medical home model that relies on nurse care managers and supplements fee-for-service payments with a monthly care management fee tied to performance. The pilot is structured as a learning collaborative to assist practices in moving from a physiciancentric toward a teamcentric model of care. Excellus reports that health outcomes are trending upward, with all participating practices exceeding the 90th percentile nationally in the aggregate on the nine quality measures the insurer is tracking.

### For More Information

- To see interprofessional collaboration in action, visit [www.rwjf.org/pr/product.jsp?id=72984](http://www.rwjf.org/pr/product.jsp?id=72984).



**“Payment models that move us away from fee-for-service toward accountability for population health, the experience of care, and affordability will help us redesign care in a collaborative way to benefit patients, families, and communities.”**

Sanne Magnan, MD, PhD, president and CEO, Institute for Clinical Systems Improvement, and former commissioner, Minnesota Department of Health

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