Training Healthcare Heroes in the Trenches:
Resilience and Team-based Care for Vulnerable Populations

NCIPE Conference, July 30 2018
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A collaboration between the ASU Center for Advancing Interprofessional Practice, Education & Research, A.T. Still University and El Rio Health
Funded by the Josiah Macy Jr. Foundation
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Lise McCoy, Gerri Lamb, and Kristen Will

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• Scan your badge barcode or sign in to each workshop
• Complete workshop evaluations (paper) and end-of-Summit evaluation (electronic)

Those who purchase CE credit:
• MUST sign in to receive credit
• Will be sent a certificate after the Summit

****If you would like CE credit but have not purchased it, see Registration
5-MINUTE ICE BREAKER

Introduce yourself to each person at the table; and if you already know each other. Work together to fill out the wheel grid on the table with each person’s basic profile:

- Name
- Institution
- Academic Role
- Clinical Role
- Why attending this session? – this part can be verbal only.
WORKSHOP OBJECTIVES

- Identify opportunities and challenges for practice-based IPE
- Share 8-Step process for program development
- Practice strategies for prioritizing learning content and formats
PART 1: THE VISION

- Meet and greet your colleagues.
- Explore the rationale, steps and methods associated with launching a training program for special population healthcare teams.
- Share rewards and challenges associated with caring for vulnerable patients.

Presenter: Gerri Lamb, PhD RN Arizona State University
The problem

- FQHC healthcare teams serve patients with complex needs.
- Do FQCH healthcare teams need intermediate training?
- What issues and training needs do they express?

Goal: Learn how to create an effective model for academic-clinical co-creation and collaboration
Caring for the very vulnerable in ways that recognize the demands for optimizing team performance and for managing and innovating in the complex context in which primary care teams function. Thus a comprehensive, team-centered approach.

**Essential characteristics**
- Team-centered
- Comprehensive
- Evidence and theory-based
- Authentic
STEP 2: FORM RESEARCH AND ADVISORY TEAMS

- **Collaborators:** Arizona State University; ATSU-SOMA; El Rio Community Health Center

- **Advisory Team:** Barbara Brandt, Director of the Center for Interprofessional Practice and Education; Nancy Johnson, CEO, El Rio Community Health Center, Kathy McNamara, Associate VP, Clinical Affairs, NACHC
STEP 3: SEEK FUNDING

- 1 year: January 1 – December 31 2018;

- $35,000 Macy President’s Award

- Prototype development and testing

- Goal: Learn how to create an effective model for academic-clinical co-creation and collaboration

- Funding to expand program and dissemination
METHODS– HOW WE BEGAN THE PROCESS

Interviews with 3 El Rio healthcare teams:
1. Children with complex care needs,
2. Homeless,
3. Transgender children.
INTERVIEWS OF 3 TEAMS CARING FOR VULNERABLE POPULATIONS

EXAMPLES OF INTERVIEW QUESTIONS

Caring for children with complex care needs

- What is it like to care for children with complex care needs?
- What do you think your team does particularly well in caring for these children?
- What are some of the major challenges you face as a team in caring for this population?
- What would you like to change about you work together as a team?

Educational needs & preferences

- What kinds of educational/practice materials would help you make these changes?
- What format would work best for you?
# HOW WE LEARNED THROUGH ACTION RESEARCH CYCLES

<table>
<thead>
<tr>
<th>Spring 2018</th>
<th>Summer 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 Focus Groups</td>
<td>Prototype Development</td>
</tr>
<tr>
<td>Cross Team Discussion 1</td>
<td>Cross Team Discussion 3</td>
</tr>
<tr>
<td>Cross Team Discussion 2</td>
<td>Cross Team Discussion 4</td>
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</tbody>
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**Cycle 1**
- Study and Plan
- Take Action
- Collect and Analyze Evidence
- Reflect

**Cycle 2**
- Study and Plan
- Take Action
- Collect and Analyze Evidence
- Reflect

**Cycle 3**
- Study and Plan
- Take Action
- Collect and Analyze Evidence
- Reflect

Team Centered Care for Vulnerable Populations

Progressive Problem Solving with Action Research

Image Credit
Team Centered Care for Vulnerable Populations

PRIORITY TRAINING CONTENT FOCUS AREAS – AS IDENTIFIED BY HEALTHCARE TEAMS

- Vulnerable Populations
- Patient & Family Engagement and Activation
- Team Engagement and Resilience
- Empower teams through formation of cross-discipline Communities of Practice
WHAT IS A COMMUNITY OF PRACTICE?

“Communities of practice are groups of people who share a concern, a set of problems, or a passion about a topic, and who deepen their knowledge and expertise in this area by interacting on an ongoing basis.”

Etienne Wenger, Richard McDermott and William Snyder in Cultivating Communities of Practice, 2002
STATIONS ACTIVITY: CHALLENGES AND REWARDS

- Divide into three groups: circulate through three stations: 3 minutes per station.
  - Mark a star next to the challenges you have encountered serving medically underserved populations; feel free to write in a new item.
  - Mark a star next to rewarding aspects of serving your medically underserved population(s); feel free to write in a new item.
  - Mark a star next to the training delivery system you prefer. You are welcome to write in a new item.
PART II: EXPERIENCING THE PROCESS

- Step 5: Identify and prioritize training goals
- Step 6: Identify and prioritize training format and theories

Presenter: Lise McCoy, EdD  School of Osteopathic Medicine in Arizona
VULNERABLE POPULATIONS: PATIENT AND FAMILY ENGAGEMENT

TRAINING THEMES ANALYZED

All: Strategies to enable patients, families, and caregivers to be more engaged in the care

Dealing with cost issues such as insurance companies who deny benefits important to vulnerable populations

Issues around patient consent/ refusal of care

Working with families; supporting them especially during high-stress times, talking to parents

Culture, language, and literacy, as it impacts our work with patients

How to talk to members of vulnerable populations with physical and mental health issues

Coping with stressors beyond our control [ex: lack of transportation for patients, funding, and resources]

TRANSGENDER

Parent support group

Parent consent

Discrimination at school

Misconceptions: choice vs. medical issue

Connect patients to resources

PEDIATRICS

Culture

Handholding

Toxic stress of home environment

Language

Compliance with well visit

Financial

HOMELESS

Drug use

Nutrition

Mental illness

Home situation

Safety net

Alone, no family

Lack of transportation
VULNERABLE POPULATIONS: TEAM OPTIMIZATION AND RESILIENCE

TRAINING THEMES ANALYZED

- Care coordination with behavioral health and other key provider partners
- Managing increased workload as the core team engages with a wider circle of providers
- Coping with feelings of sadness or stress; we feel compassion for patients and we try to help them, but their problems are complex
- New ways to look at our efficiency and productivity as a team
- Improving team processes [Ex: huddles, team meetings, following up with patients; keeping each other up to date]
- Coping with stressors beyond our control [Ex: lack of transportation for patients, funding, and resources]

- Meeting with other teams who share the same patient population to discuss best practices
- Sharing best practices in technology to keep the team synchronized
- Dealing with team member differences and conflicts
- Better understanding of team members' roles and functions
- Sharing innovations: we have already developed great protocols and we would like to share our work

TRANSgendEr

PEDIATRICS

HOMELESS

- How to connect with team members who are not physically located in our clinic
- Ways to assess our impact as a team
- Establishing a shared vision among team members
- How other teams and primary care practices are changing how they work together
- Defining who is on our team or needs to be on our team to care for our population
- How to prepare for changes in team member roles and responsibilities
- Strategies to capitalize on each team member's strengths
- Ways to build in time for team reflection and other satisfying elements of team companionship
- Dealing with changes in team membership and turnover
- Strategies to build team resilience and satisfaction
We listed possible training topics on the provided checklist form, and asked the cross-disciplinary team to rank these training concepts. (N=13)

Activity:
- Complete the checklist individually.
- Prioritize goals
Feb '18 Survey: Team Self-Care, Resilience and Satisfaction (8 choices)

n = 13

- Resilience
- Inc workload
- Share Innov
- Refl time
- Coping
- Turnover

High | Med | Low
NEEDS ASSESSMENT
SURVEY RESULTS

Feb ‘18 Survey: Optimizing Teamwork (13 choices) n=13

High  Med  Low

- Imp team
- Shared vision
- Best Tech
- Care Coor
- Eval
- Roles
- Ext comm
- Prep role chg
EXPRESSED PRIORITIES: TRAINING DELIVERY APPROACH

- Engaging, interesting
- Practical; builds on experience
- Opportunity to learn together and from each other
- Blended: short learning segments with face-to-face & online activities
- Includes theory, evidence, best practices, ready-to-use tools and strategies
- Happens during scheduled work hours.
PART III: SAMPLE LESSON PLAN

- Step 7: Implement a draft lesson based on priority topics and seek feedback about its relevance.

- Step 8: Establish a method to stabilize the new Community of Practice and training platform.

Presenter: Kristen Will, PA-C, Arizona State University
PATIENT ENGAGEMENT & PATIENT ACTIVATION

- **Patient Engagement:**
  - Actions individuals take to obtain the greatest benefit from the healthcare services available to them
  - Includes patient activation, interventions designed to improve activation
  - Differs from compliance as patients make their own decisions regarding care

- **Patient Activation:**
  - Patients willingness and ability to take independent actions to manage their own health and care
  - Knowledge, skills and confidence to manage one’s health and healthcare
LEVELS OF PATIENT ACTIVATION

**Level 1**
Disengaged and overwhelmed
Individuals are passive and lack confidence. Knowledge is low, goal-orientation is weak, and adherence is poor. Their perspective: “My doctor is in charge of my health.”

**Level 2**
Becoming aware, but still struggling
Individuals have some knowledge, but large gaps remain. They believe health is largely out of their control, but can set simple goals. Their perspective: “I could be doing more.”

**Level 3**
Taking action
Individuals have the key facts and are building self-management skills. They strive for best practice behaviors, and are goal-oriented. Their perspective: “I’m part of my health care team.”

**Level 4**
Maintaining behaviors and pushing further
Individuals have adopted new behaviors, but may struggle in times of stress or change. Maintaining a healthy lifestyle is a key focus. Their perspective: “I’m my own advocate.”

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A goal of the lesson is to also introduce practical tools that teams can use and obtain their feedback.

**Patient Activation Measure (PAM)**

1. When all is said and done, I am the person who is responsible for managing my health condition.
2. Taking an active role in my own health care is the most important factor in determining my health and ability to function.
3. I am confident that I can take actions that will help prevent or minimize some symptoms or problems associated with my health condition.
4. I know what each of my prescribed medications does.
5. I am confident that I can tell when I need to go get medical care and when I can handle a health problem myself.
6. I am confident I can tell my health care provider concerns I have even when he or she does not ask.
7. I am confident that I can follow through on medical treatments I need to do at home.
8. I understand the nature and causes of my health condition.
9. I know the different medical treatment options available for my health condition.
10. I have been able to maintain the lifestyle changes for my health that I have made.
11. I know how to prevent further problems with my health condition.
12. I am confident I can figure out solutions when new situations or problems arise with my health condition.
13. I am confident that I can maintain lifestyle changes, like diet and exercise, even during times of stress.
PAM SCORE & RELATIONSHIP TO ACTIVATION

- Stage 4
- Stage 3
- Stage 2
- Stage 1

PAM Score
EVIDENCE-BASED INTERVENTIONS

- **Fairview Clinic** in Minnesota, primary care practice
- PAM scores integrated into the medical record
- Treatment plans and protocols developed for managing patients with low to high PAM scores
- Utilize PAM scores to target high risk patients for readmission or high utilization of healthcare system

In the co-creation model, we utilized other real-world examples to relate to our community partner.
The **Courage Center** in Minnesota, winner of CMS innovation grant
- PCMH/FQHC model
- High level of patients with complex chronic disease; high utilization of healthcare services
  - Average 10.8 hospital days per year per person
- Utilizing PAM scores to create specific treatment plan pathways and protocols
  - Increased PAM scores by average of 7 points
  - Reduced hospital admissions by 71% (to 3.1 days per year per person)
Could utilizing the PAM in your practice be helpful and feasible?

How would you utilize the PAM tool?

Licensing required for use

After discussion of the topic and tools, we elicited discussion about the relevancy of the material and got “real-time” feedback.
Along with feedback on the content, we wanted to ensure the “level” of content was appropriate.
TAKE HOME: CREATION CHALLENGE #1

- Utilize the levels of engagement in clinical practice and beyond
- Which level would you focus on for your practice?
- How could you use this framework?

We also created take-home challenges based on pre-assigned reading materials to tie into community of practice theme.
1. Form the problem
2. Create the steering committee
3. Establish funding
4. Co-creation with community partner
5. Prioritize goals
6. Prioritize training and content format
7. Co-create content

8 Step Process
STEP 8: ESTABLISH A METHOD TO STABILIZE THE NEW COMMUNITY OF PRACTICE AND TRAINING PLATFORM.
STEP 8: OUR NEXT STEPS

- Co-create Prototype: Develop launch pad for virtual meeting place of CoP
- Test Prototype with community partner
- Establish further funding to continue research and development
- Become a model to support healthcare teams caring for vulnerable populations
• At your tables, please use the provider handout to review the 8 steps. While discussing the steps, discuss at your table the following questions:
  • What tactics would you adopt?
  • What would you do differently?
Thank you for your attention & participation!

Questions?

Please contact: lmccoy@atsu.edu or gerri.lamb@asu.edu
REFERENCES


