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

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Lise McCoy, Gerri Lamb, and Kristen Will

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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

STEP 1: IDENTIFY A PROBLEM OF PRACTICE

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

THE GAP AND THE VISION

- 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.

Team Centered Care for Vulnerable Populations

INTERVIEWS OF 3 TEAMS CARING FOR VULNERABLE POPULATIONS

EXAMPLES OF INTERVIEW QUESTIONS

Caring for children with complex care needs

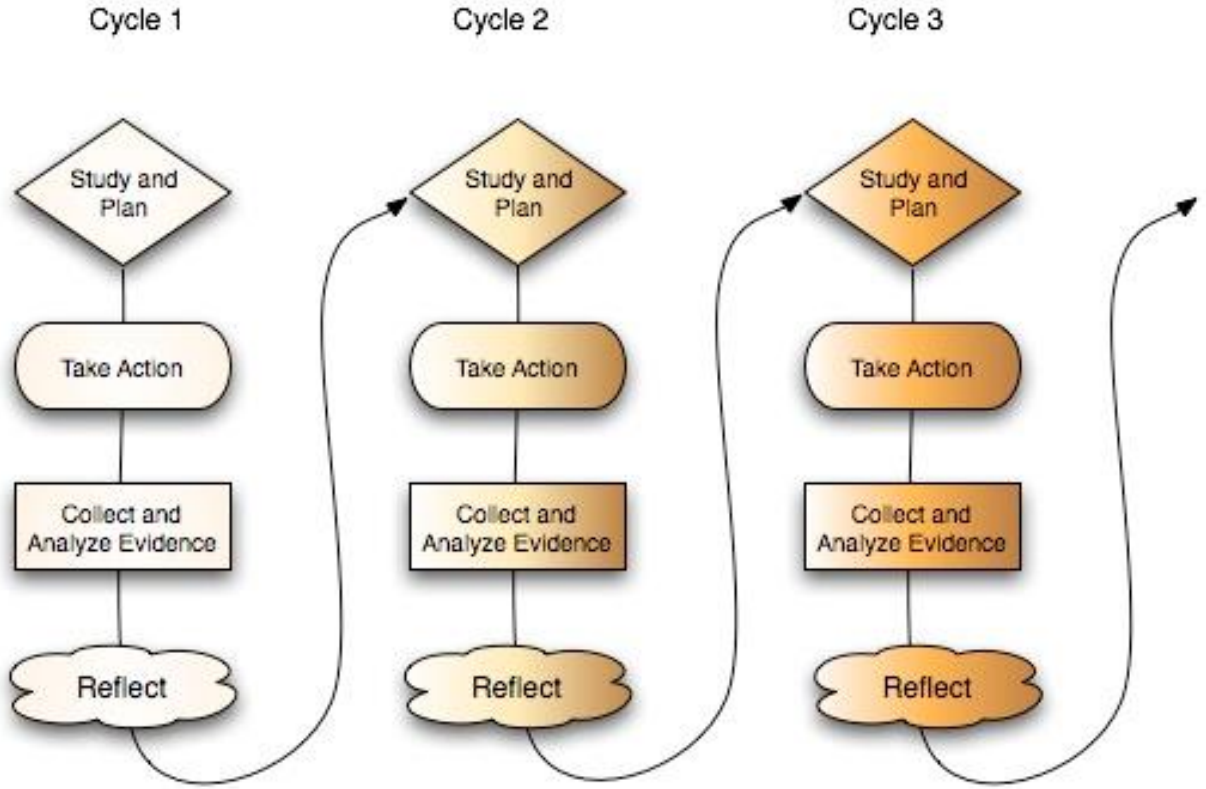
- What is it like to care for children with complex care needs?
- What do you think your team does particularly well in caring for these children?
- What are some of the major challenges you face as a team in caring for this population?
- What would you like to change about you work together as a team?

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

Spring 2018	Summer 2018
3 Focus Groups	Prototype Development
Cross Team Discussion 1	Cross Team Discussion 3
Cross Team Discussion 2	Cross Team Discussion 4



Progressive Problem Solving with Action Research

Image Credit

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

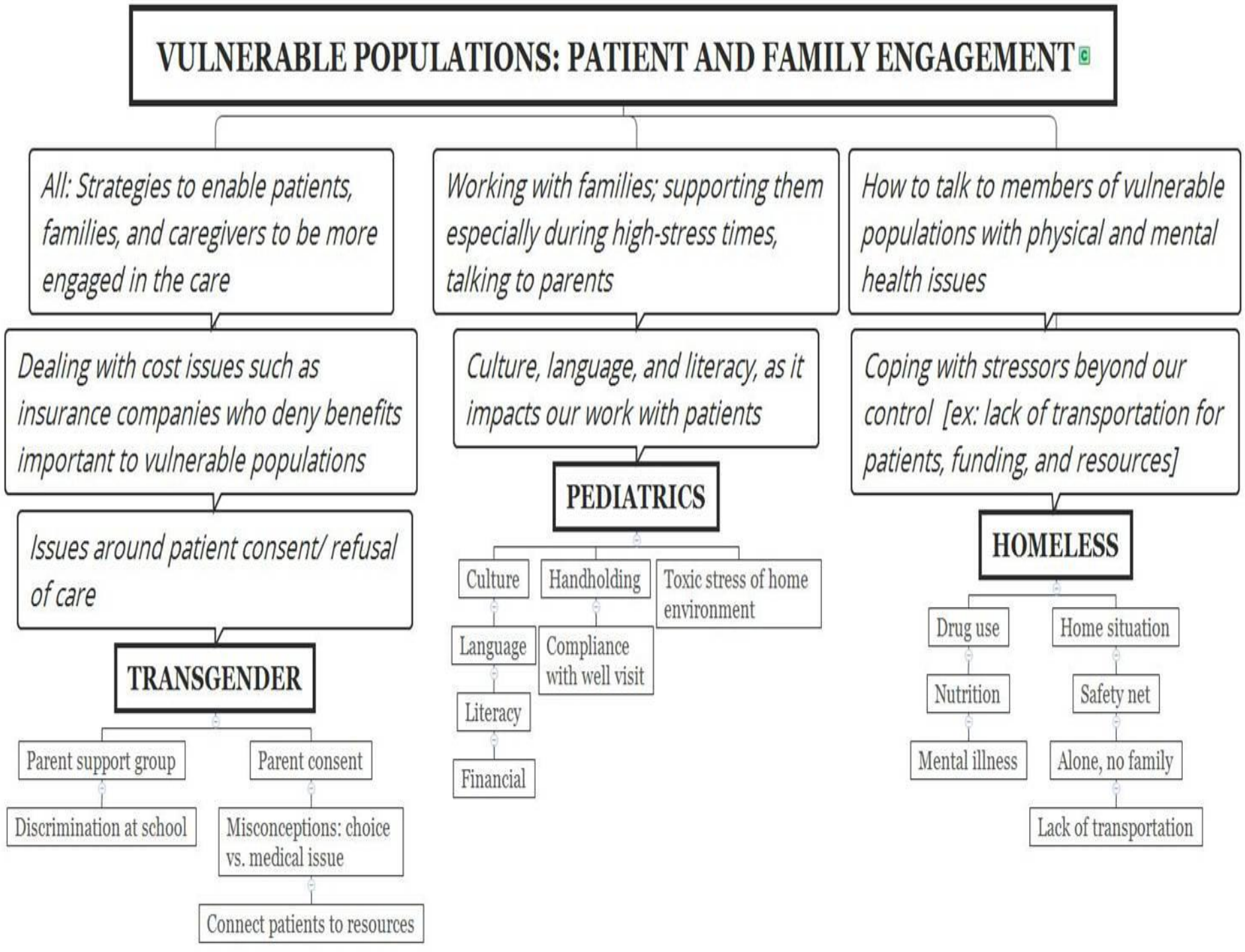
- Divide into three groups: circulate through three stations: 3 minutes per station.
  - Mark a star next to the challenges you have encountered serving medically underserved populations; feel free to write in a new item.
  - Mark a star next to rewarding aspects of serving your medically underserved 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

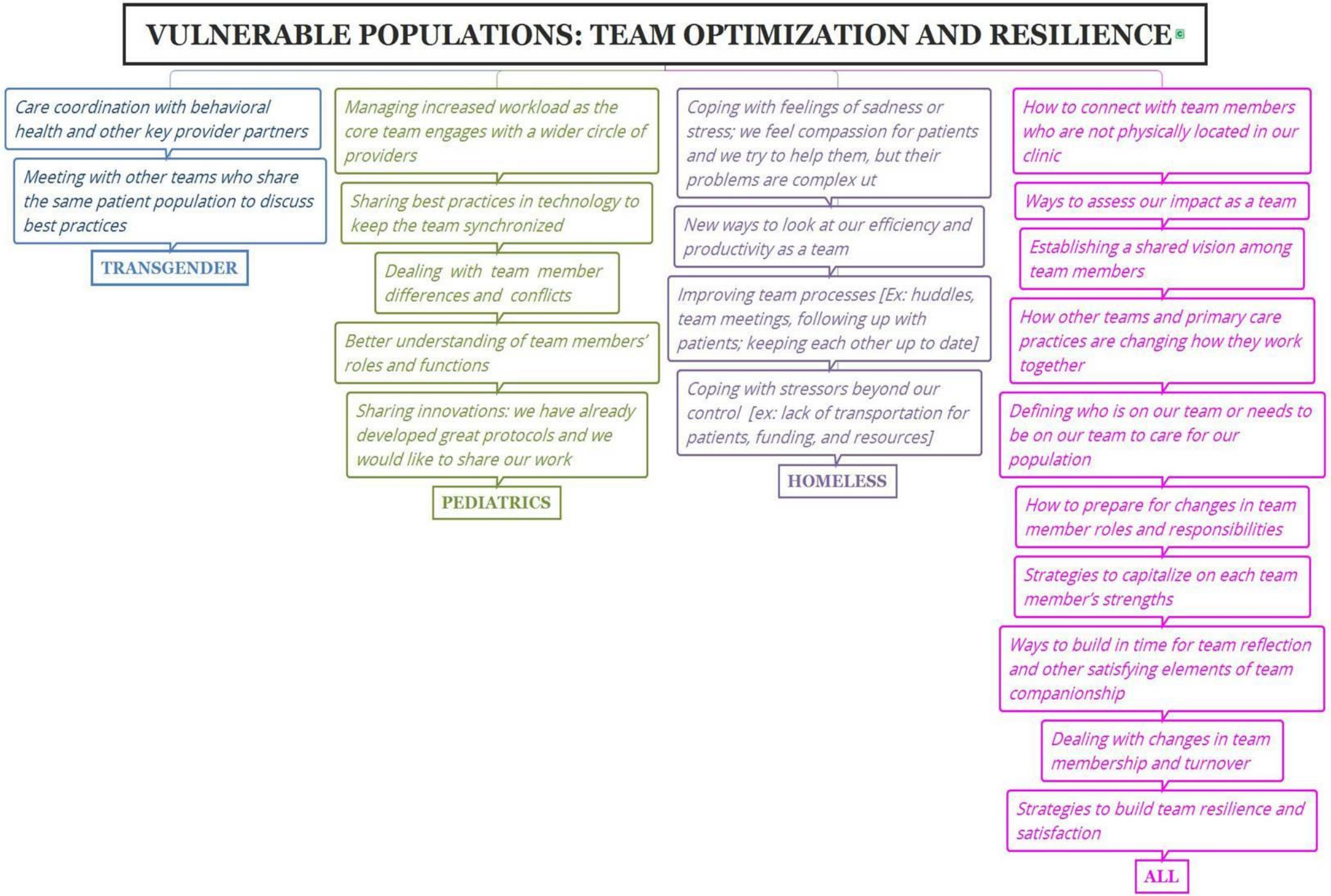
- Step 5: Identify and prioritize training goals
- Step 6: Identify and prioritize training format and theories

Presenter: Lise McCoy, EdD School of Osteopathic Medicine in Arizona

TRAINING THEMES ANALYZED



TRAINING THEMES ANALYZED



ACTIVITY: PRIORITIZE GOALS

We listed possible training topics on the provided checklist form, and asked the cross-disciplinary team to rank these training concepts. (N=13)

Activity:

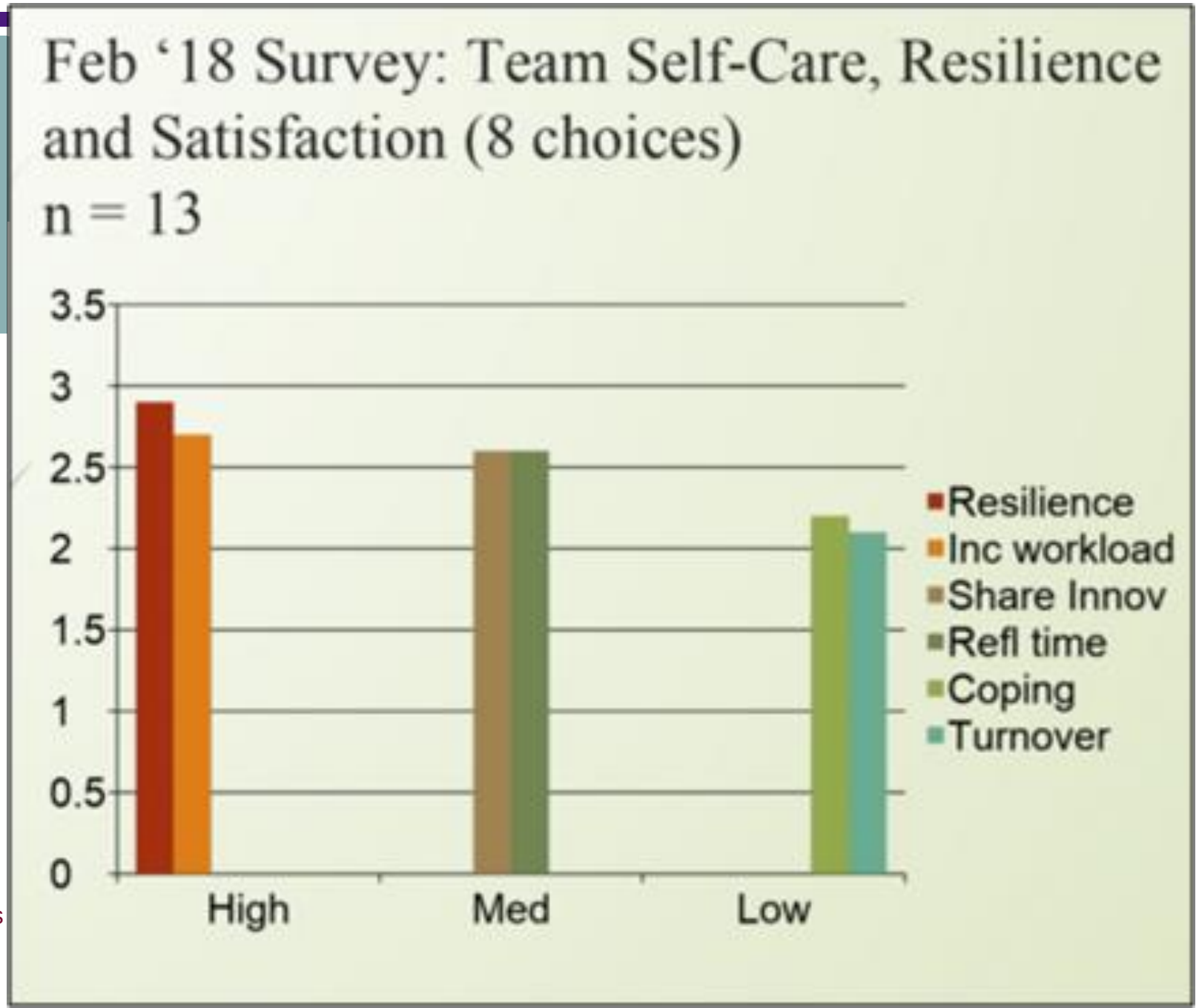
- Complete the checklist individually.
- Prioritize goals

Team Affiliation:

Prioritizing Training Topics for Team-Centered Care for Vulnerable Populations

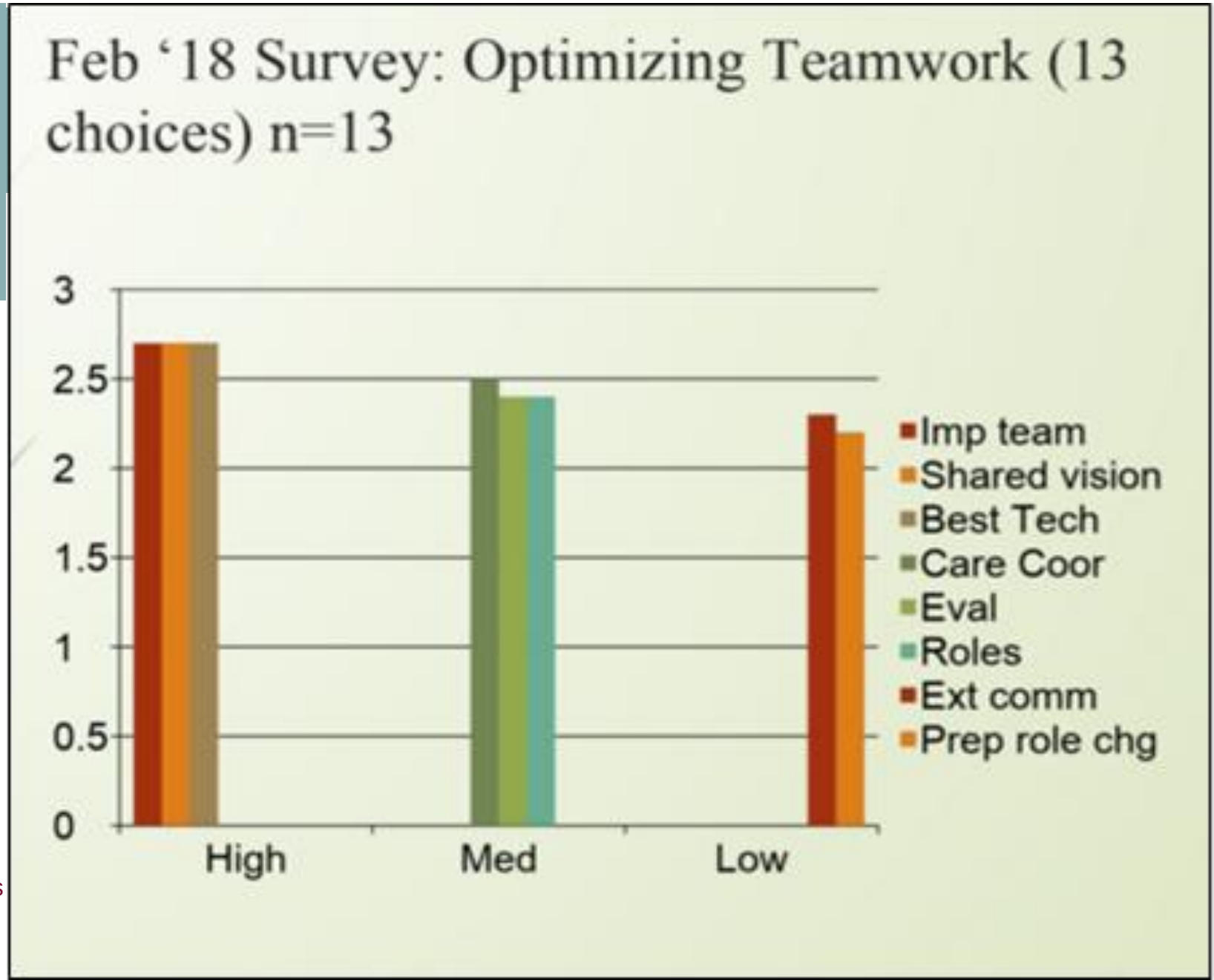
	Topic	Priority			Notes: Reason for your prioritization
		Important	Somewhat Important	Not Important	
	1. Working with Vulnerable Populations				
H	Gaining deeper understanding about social determinants affecting a sub-group of vulnerable patients [Ex: why homeless individuals are homeless]				
P	Working with families; supporting them especially during high-stress times, talking to parents				
A	Strategies to enable patients, families, and caregivers to be more engaged in their care				
T	Raising community awareness and acceptance of vulnerable populations				
P	Defining standards of care for vulnerable populations				
T	Dealing with cost issues such as insurance companies who deny benefits important to vulnerable populations				
A	Best practices for vulnerable populations				
H	How to talk to members of vulnerable populations with physical and mental health issues				
T	Issues around patient consent/ refusal of care				
P	Culture, language, and literacy, as it impacts our work with patients				

NEEDS ASSESSMENT SURVEY RESULTS



Team Centered Care for Vulnerable Populations

NEEDS ASSESSMENT SURVEY RESULTS



Team Centered Care for Vulnerable Populations

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

Topic of Lesson is Introduced & Feedback from teams is elicited

LEVELS OF PATIENT ACTIVATION

Team Centered

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

Patient Activation Measure (PAM)

13-Item 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.

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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.

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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.

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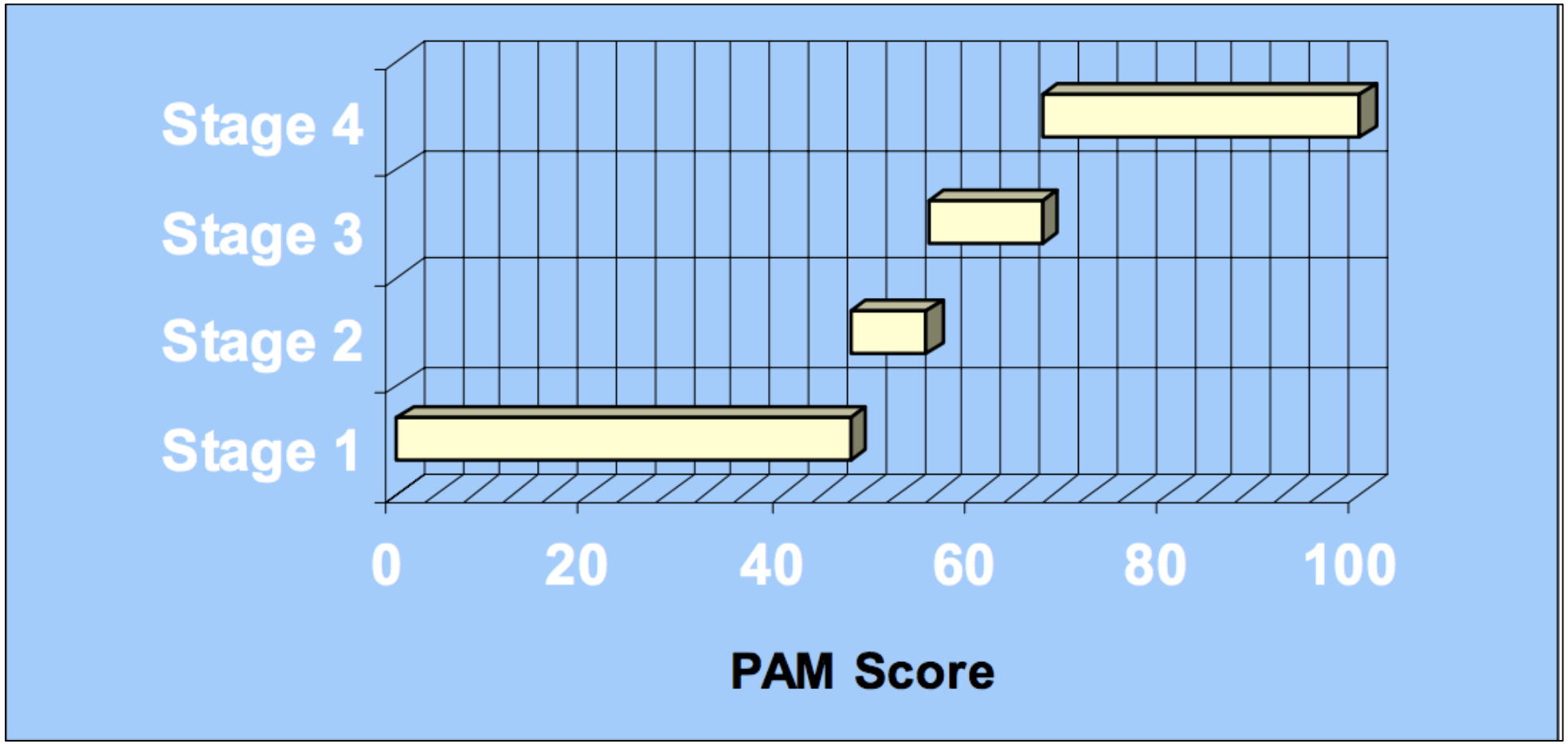
12. I am confident I can figure out solutions when new situations or problems arise with my health condition.
13. I am confident that I can maintain lifestyle changes, like diet and exercise, even during times of stress.

PAM SCORE & RELATIONSHIP TO ACTIVATION



Team Centered

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.

EVIDENCE-BASED INTERVENTIONS

- 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)

TABLETOP DISCUSSION

- 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.

FEEDBACK

- Content and format useful?
- Content and format at right level?

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?

Team Centered

We also created take-home challenges based on pre-assigned reading materials to tie into community of practice theme.

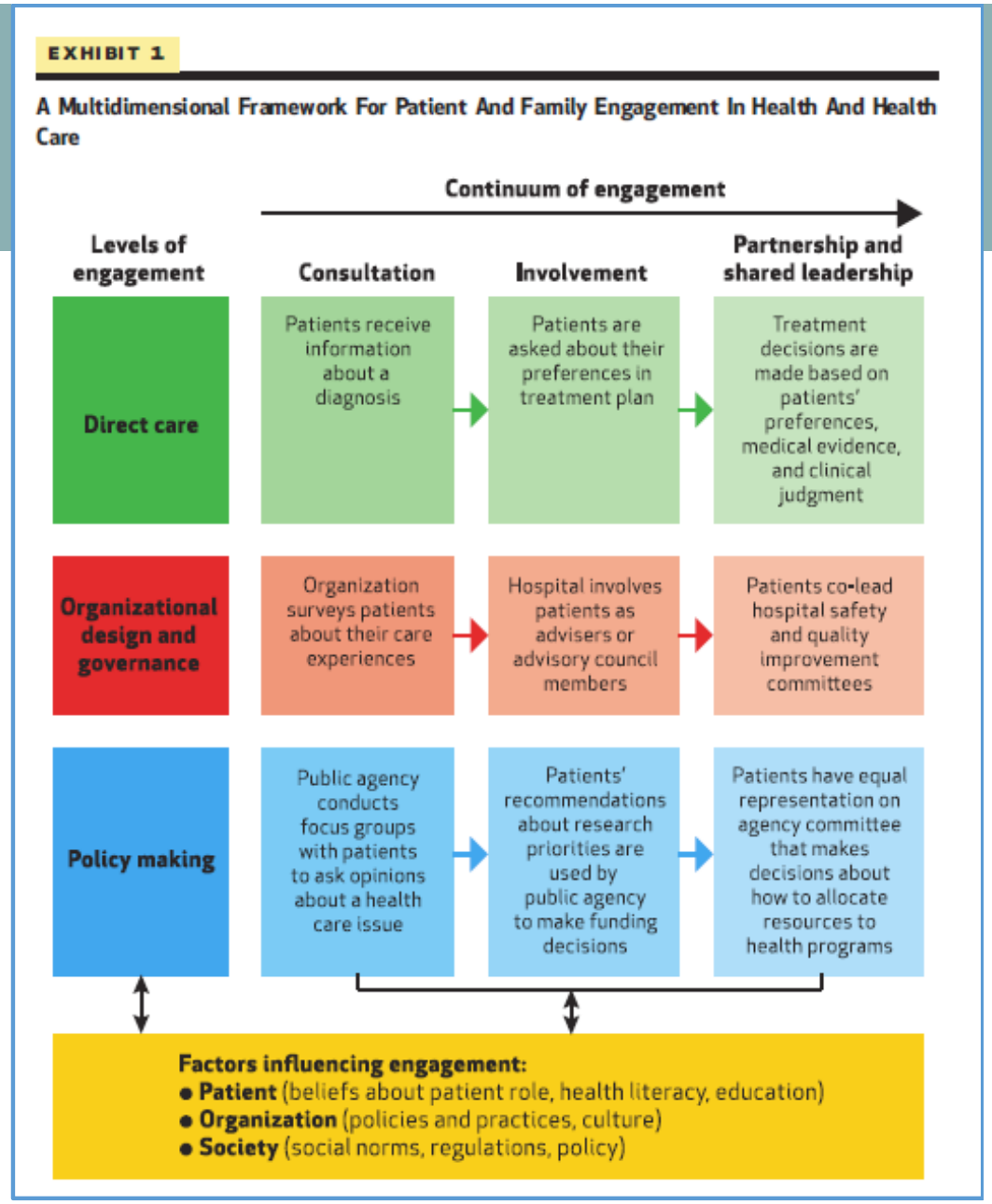


EXHIBIT 1

A Multidimensional Framework For Patient And Family Engagement In Health And Health Care

Levels of engagement	Continuum of engagement: Consultation	Involvement	Partnership and shared leadership
Direct care	Patients receive information about a diagnosis	Patients are asked about their preferences in treatment plan	Treatment decisions are made based on patients' preferences, medical evidence, and clinical judgment
Organizational design and governance	Organization surveys patients about their care experiences	Hospital involves patients as advisers or advisory council members	Patients co-lead hospital safety and quality improvement committees
Policy making	Public agency conducts focus groups with patients to ask opinions about a health care issue	Patients' recommendations about research priorities are used by public agency to make funding decisions	Patients have equal representation on agency committee that makes decisions about how to allocate resources to health programs

Factors influencing engagement:
- **Patient** (beliefs about patient role, health literacy, education)
- **Organization** (policies and practices, culture)
- **Society** (social norms, regulations, policy)

8 Step Process

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

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

REFLECTION & APPLICATION

- 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?

SESSION WRAP-UP & CLOSING

Thank you for your attention & participation!

Questions?

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

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