Innovating Interprofessional Collaboration in a Primary Care Setting

CHI Health and Creighton University – academic health partners

Presenters: Kristy Brandon, PT, DPT; Joy Doll, OTD, OTR/L, FNAP; Thomas Guck, PhD; Amy McGaha, MD; Thomas Strawmier, APRN

Please note – we represent a much broader team!

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Kristy Brandon, Joy Doll, Thomas Guck, Amy McGaha

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Overview of Session

Workshop agenda

- 10 minutes – Welcome/Introductions
- 10 minutes – Ice Breaker
- 10 minutes – Facility design and team culture
- 10 minutes – Patient-centered team-based collaboration and care
- 10 minutes – Team building activity
- 10 minutes – Patient, program, and cost outcomes
- 20 minutes – Participant analysis and report
- 10 minutes – Question and answer

Let’s get to know one another?

Job	Career	Calling

Session objectives

By the end of this presentation, participants will be able to:

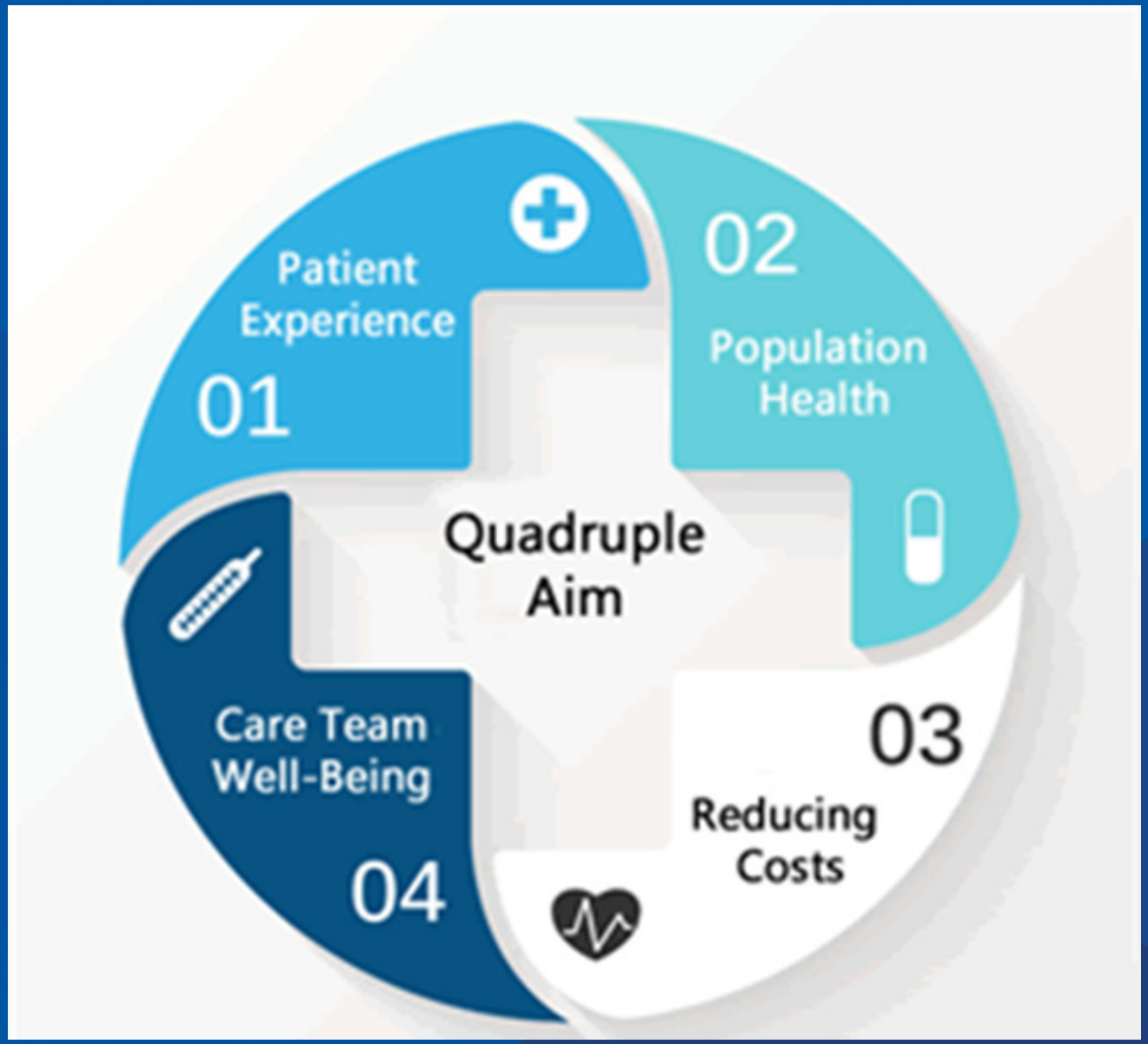
- Describe an exemplar of an IPCLE in primary care.
- Develop an understanding of the importance of culture, patient-centered collaborative care, and outcomes.
- Analyze one's own interprofessionalism within the context of recent advancements in the IPCLE

Icebreaker

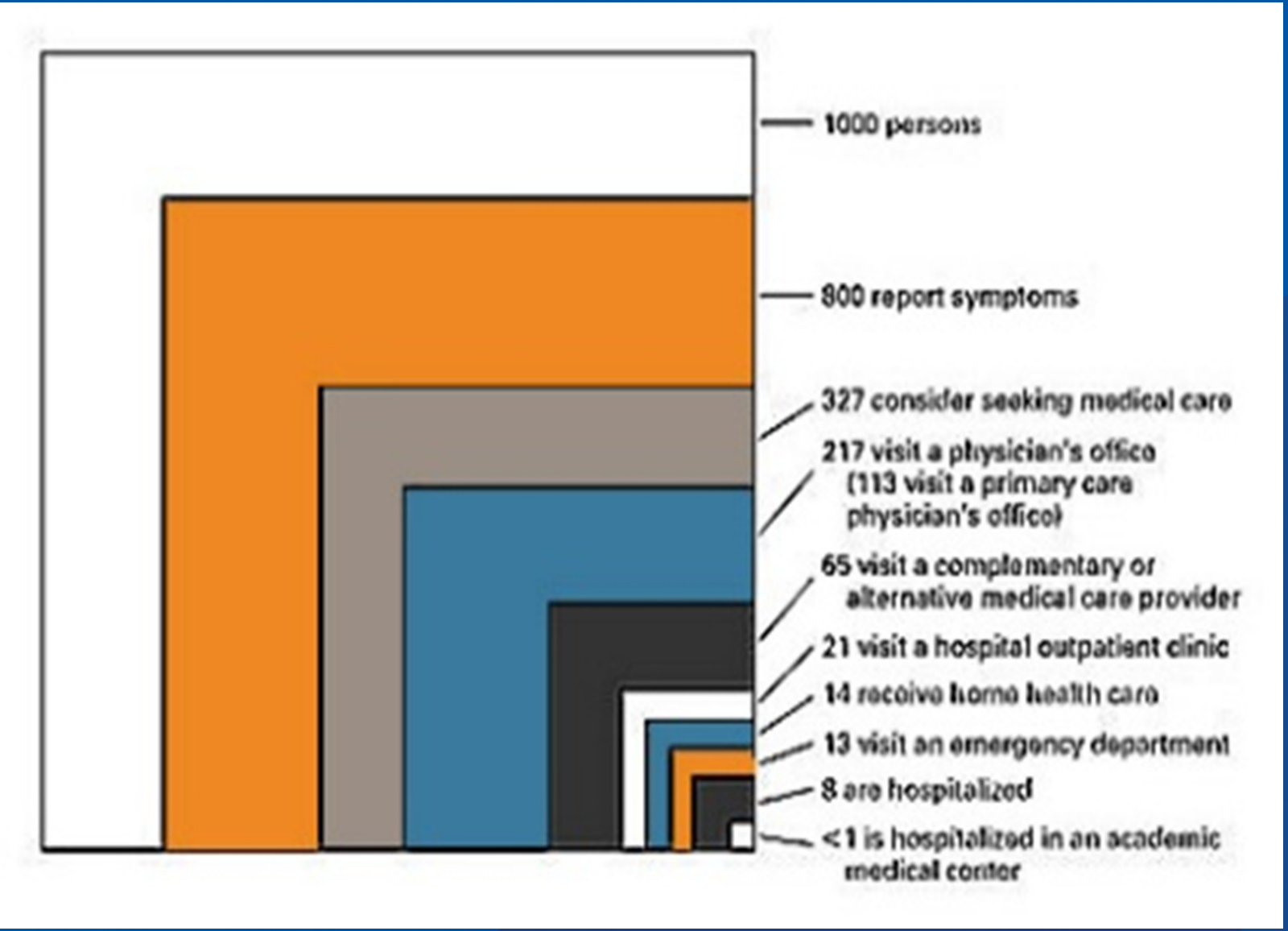
- You are given the opportunity to design a clinic from the ground up that will be an interprofessional learning laboratory.
- What do you do?

Our story!

Collaborative Care Model


Patient Experience
01
02
Population Health
Quadruple Aim
Care Team Well-Being
04
03
Reducing Costs

The why



Providing the right care, at the right time, in the right place

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What should you know about primary care?

Delivery model	Influenced by
Traditional care delivery	Reimbursement model Payer mix Health system policy Revenue models
Integrated care delivery	
Patient-centered medical home	
Combination	

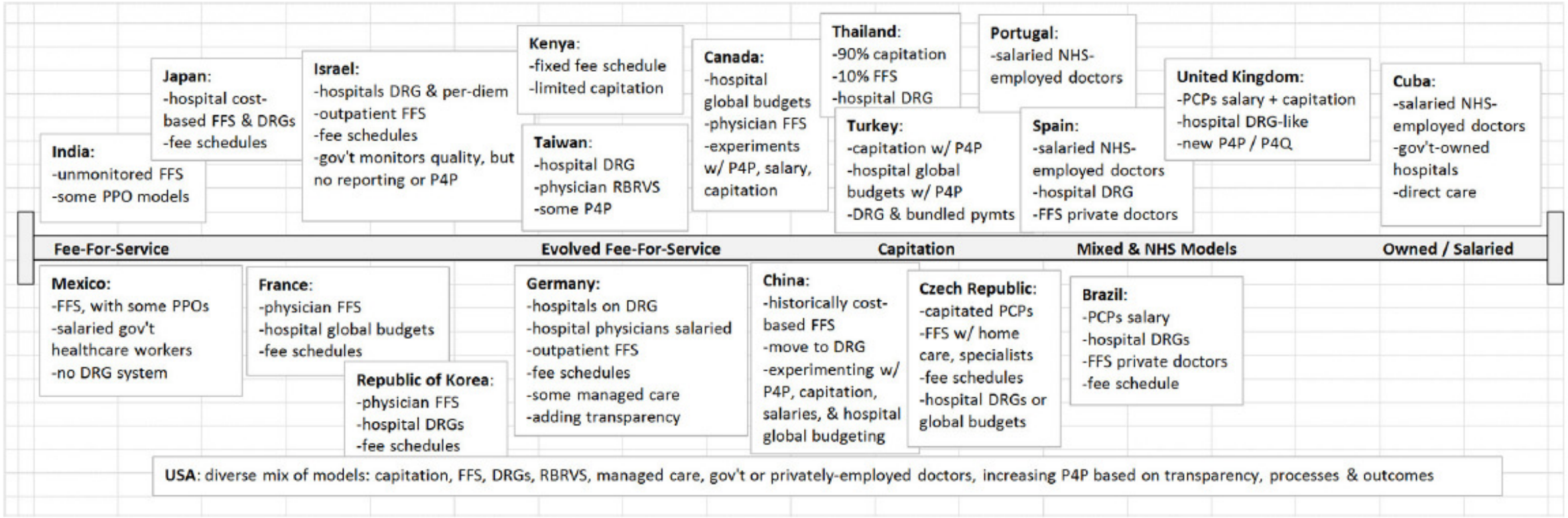
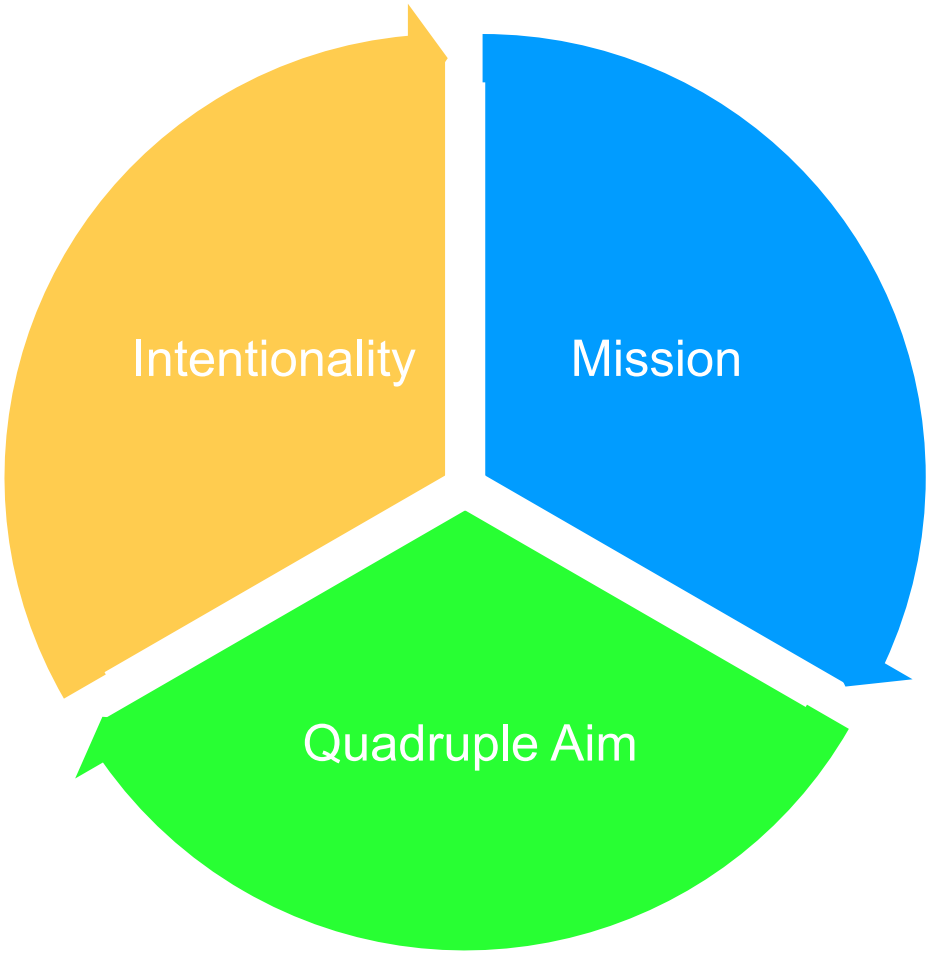


FIGURE 1 | Healthcare Payment Models in 20 Countries. Adapted from Fried and Gaydos (2). FFS, Fee for Service; DRG, Diagnosis-Related Groups; PPO, Preferred Provider Organization; RBRVS, Resource-Based Relative Value Scale; P4P, Pay for Performance; P4Q, Pay for Quality; NHS, National Health Service; PCP, Primary Care Provider.

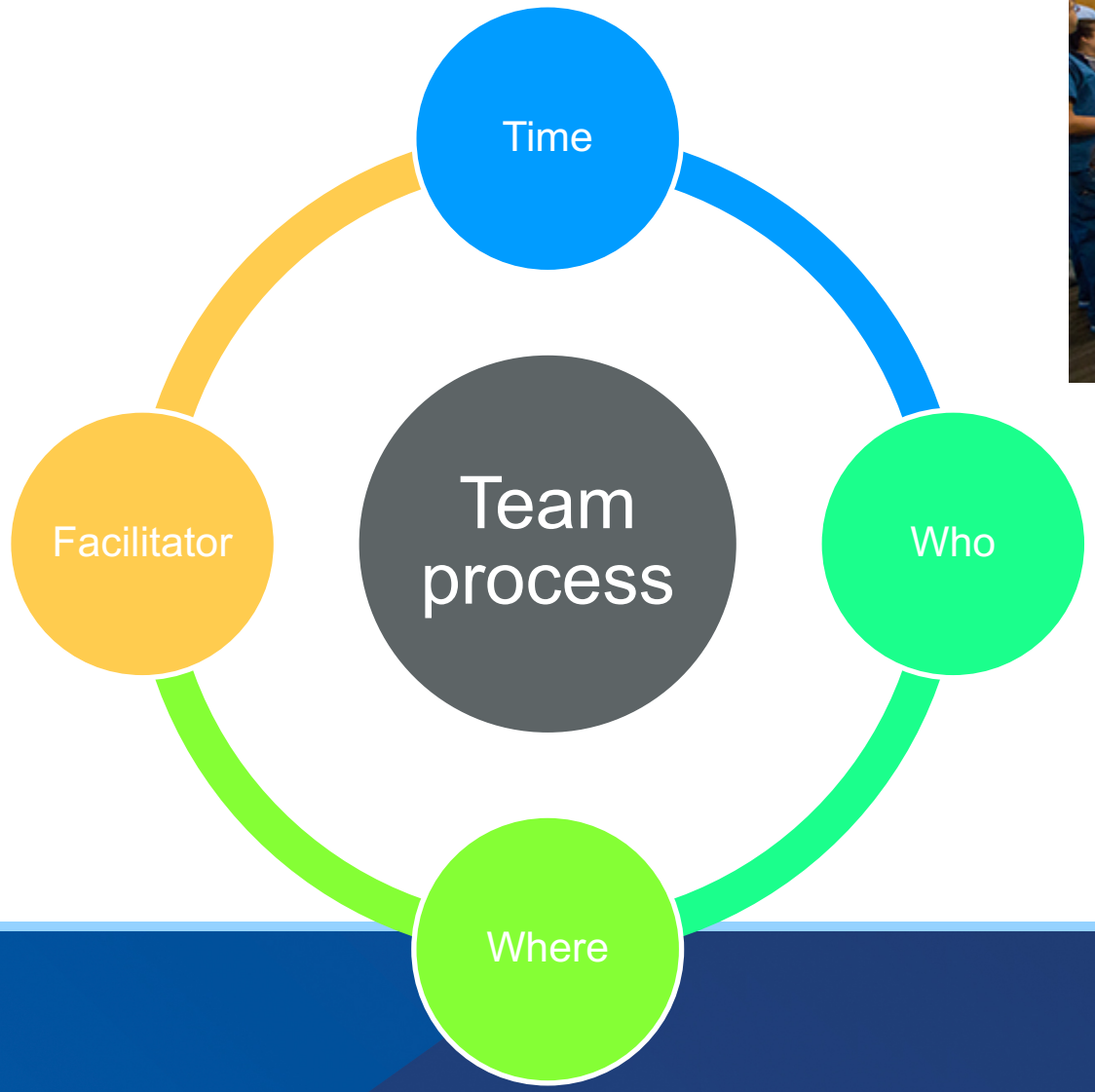
Counte MA, Howard SW, Chang L and Aaronson W (2019) Global Advances in Value-Based Payment and Their Implications for Global Health Management Education, Development, and Practice. Front. Public Health 6:379. doi: 0.3389/fpubh.2018.00379

Overall Themes



Facility Design

Clinical Workflow



Innovating Interprofessional Collaboration

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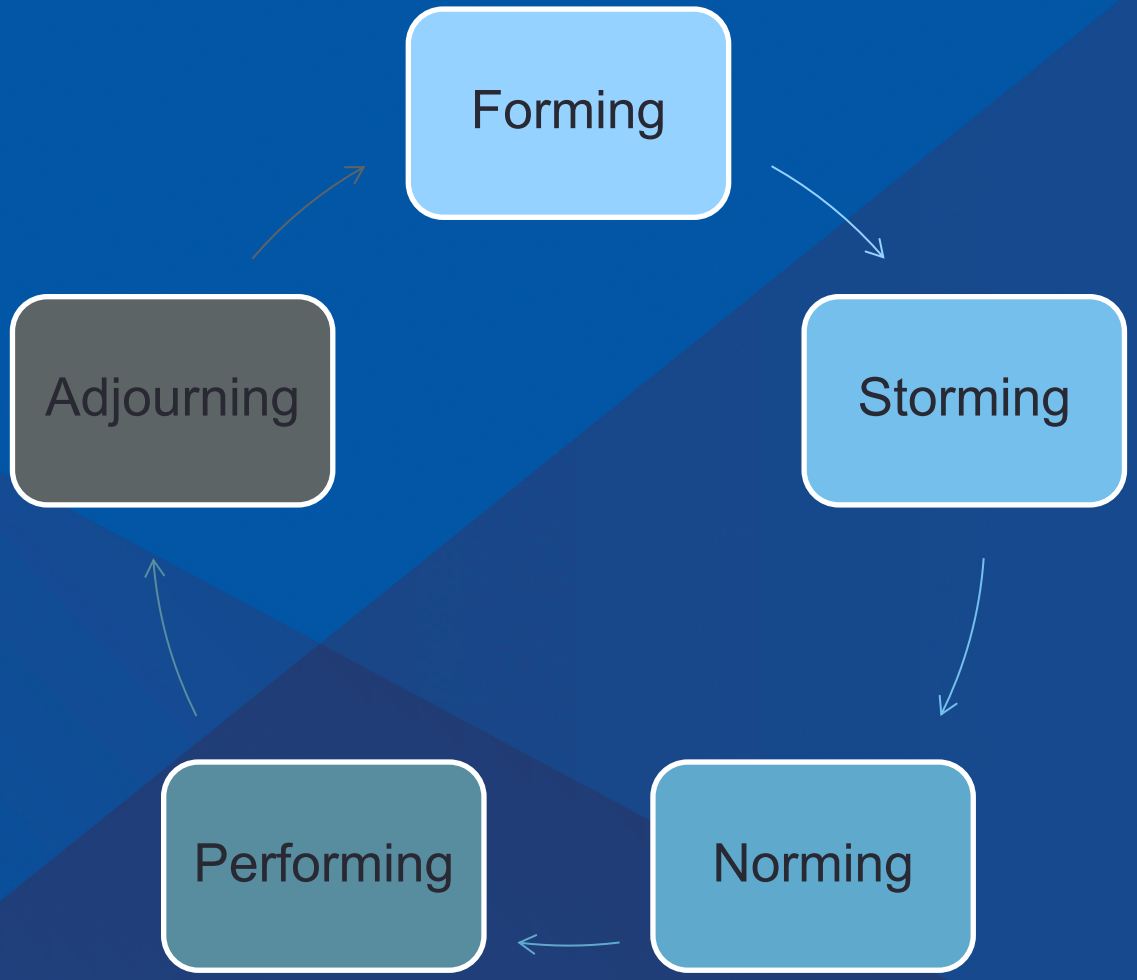
Traditional Care vs. Collaborative Care

Traditional Care	Collaborative Care
Physicians direct	Physicians participate
Disciplines report	Professions confer
Patient and family informed	Patient and family actively engaged
Care progress updated	Care progress mutually assessed
Orders given through hierarchy	Care plan jointly developed in real time
Come "knowing everything"	Come "prepared but incomplete"
→ Patients talked "about"	Patients talked "with"
→ Begins with synopsis, physiologic update	Begins with introductions, goals, questions, concerns
Focus on disease/treatment/problems	Focus on people/needs/goals/suggestions
Third person ("he" "she" "they")	First or second person ("you" "we" "I")
Medical language/acronyms	Ordinary language or immediate translation
Bullet points	Conversational
Frequent side/silo conversations	Inclusive conversation together
"Who will do what" unspoken/assumed	"Who will do what" clarified/agreed upon
→ Uniprofessional teaching and learning	Collaborative teaching and learning
Patients and families as recipients of knowledge	Patients and families as co-teachers and co-learners
Care and education "delivered/provided"	Care and education "co-created"—generative

Uhlig, et al, 2018, p. 1442

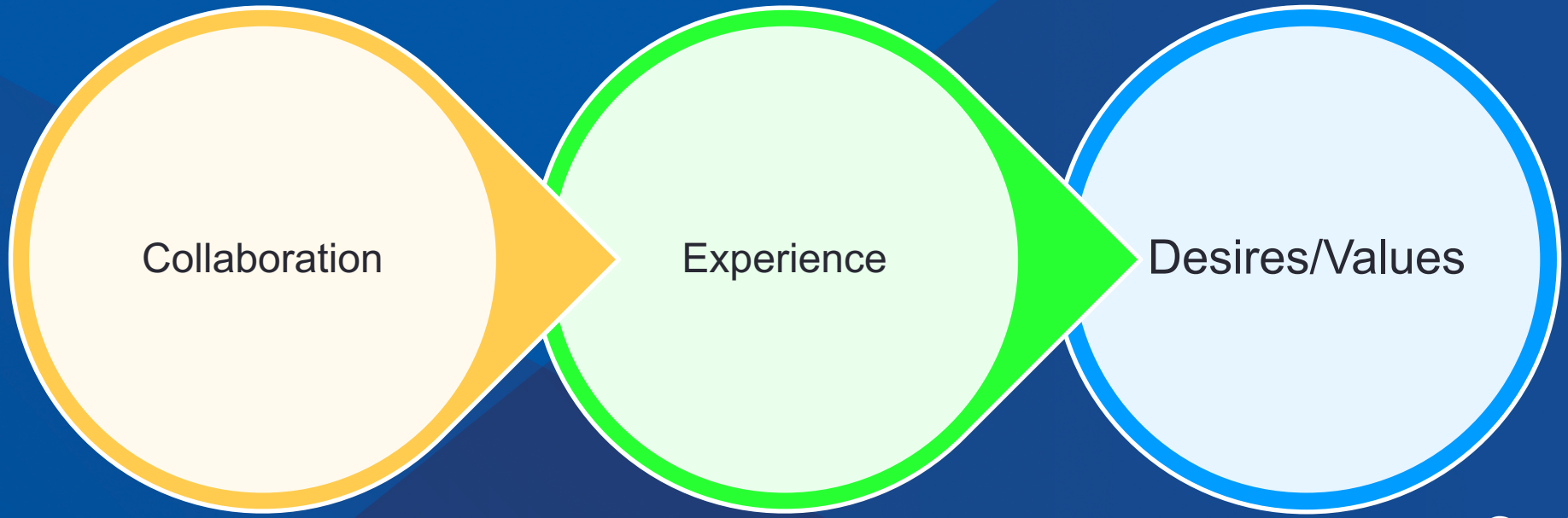
TEAM DEVELOPMENT



Source: Tuckman & Jensen, 1977

Team Composition

- When choosing a team, consider:



TEAM EVALUATION

Questions to ask.

What's going well?

Then consider…

What's not going well?

Develop solutions…

What adjustments need to be made?

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Team Processes

Huddles

Briefs

Debriefs

TeamSTEPPS definition of huddle—an ad hoc meeting to regain situation awareness, discuss critical issues, and emerging events

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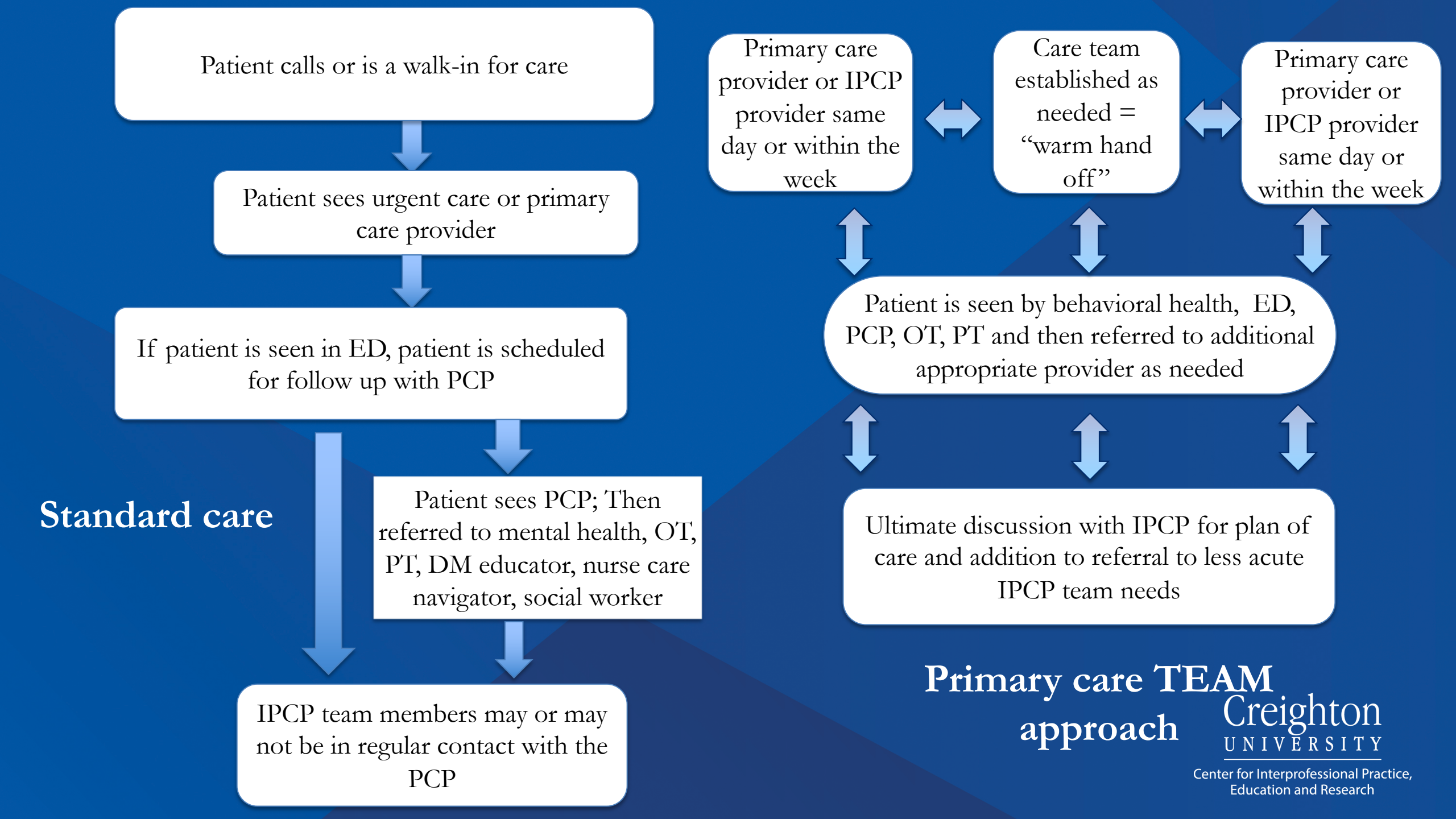
Patient calls or is a walk-in for care
Patient sees urgent care or primary care provider
If patient is seen in ED, patient is scheduled for follow up with PCP
Patient sees PCP; Then referred to mental health, OT, PT, DM educator, nurse care navigator, social worker
IPCP team members may or may not be in regular contact with the PCP
Standard care
Primary care provider or IPCP provider same day or within the week
Care team established as needed = "warm hand off"
Primary care provider or IPCP provider same day or within the week
Patient is seen by behavioral health, ED, PCP, OT, PT and then referred to additional appropriate provider as needed
Ultimate discussion with IPCP for plan of care and addition to referral to less acute IPCP team needs
Primary care TEAM approach
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Example of Team Discussion Processes

Huddles

- Twice per day
- All clinicians and learners

Pre-visit planning

- Twice per day- post huddle
- MA and provider proactive in patient care
- IPE team members circulate/present

Care Coordination Meeting

- Once per week
- Highest utilizers
- Collaborative care plan
- Document in collaborative care note

Team Strategies

- Rounding
- Collaborative care planning
- Warm Handoffs
- Teamlets
- Shared decision making

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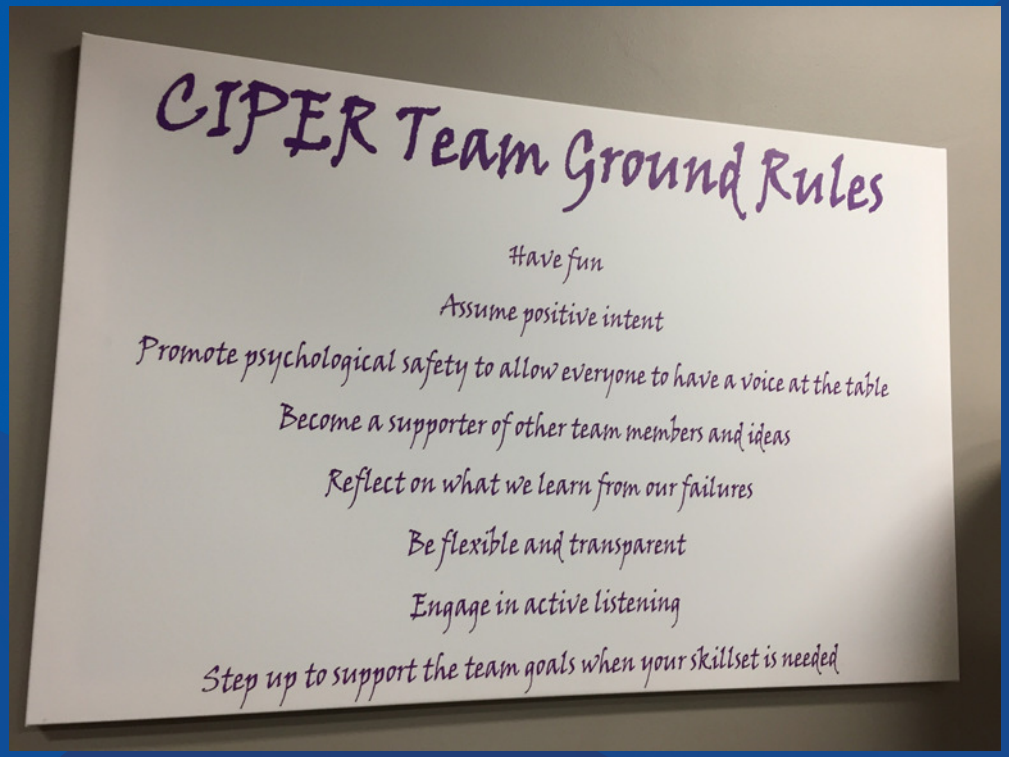
Team Culture

Activity

- What can you impact in your clinical workflow?
- What can you do to support team culture?

Report Out

Best Practice Tips: Set Team Expectations



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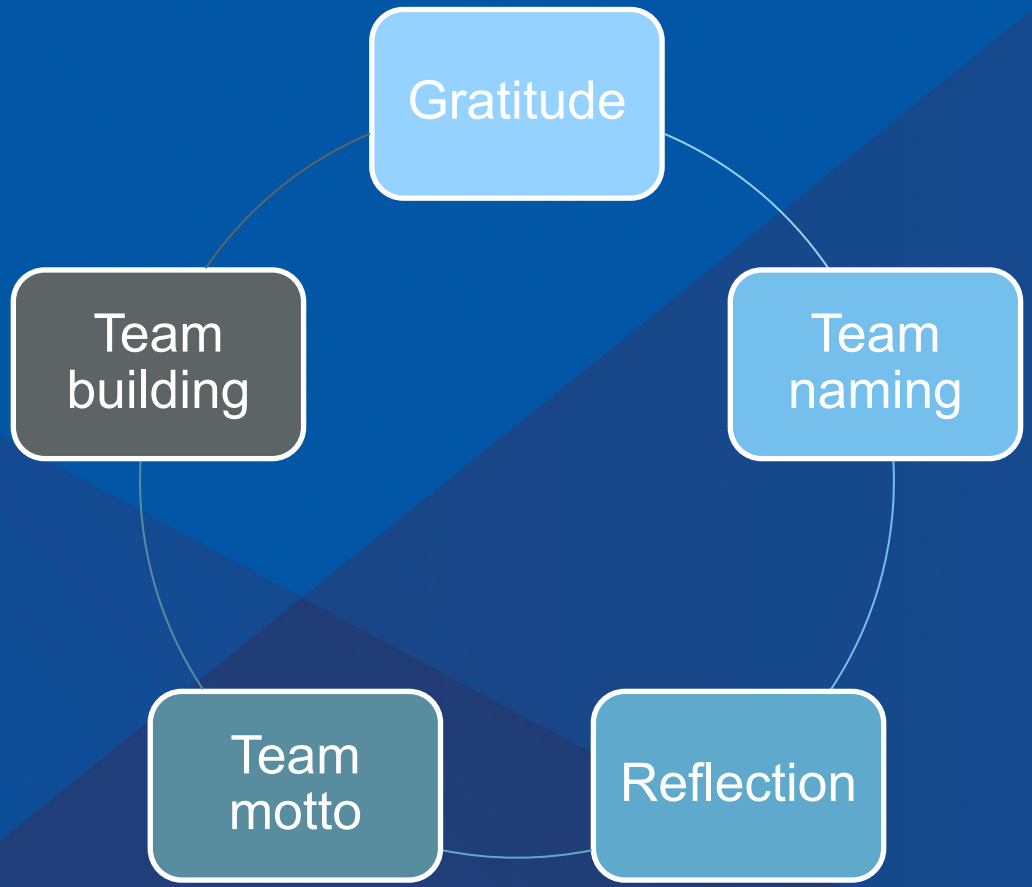
Best practice tips: Know yourself and your team members

- As a leader, you must be aware of your strengths and weaknesses to help lead
- Some examples include (Clark, 2009):
  - Meyers Brigg
  - Strength Finders
  - Kolb Learning System Inventory
  - DISC
  - Thomas-Kilmann Conflict Mode Inventory
  - Bolman and Deal Leadership Orientation Instrument

Best Practice Tips: Team Building and maintaining



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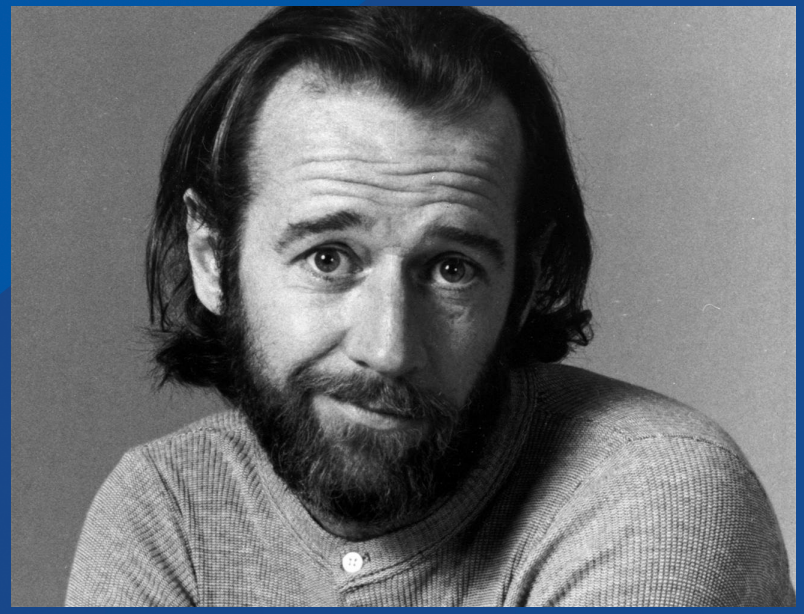
Best Practice Tips: Be aware of landmines

Seven Dirty Words That Undermine Interprofessional Collaboration and Team-Based Care and Possible Cleaner Alternatives

Dirty word	Cleaner alternative
Allied	Health professionals
Clinical	Experiential placement
Doctor	Physician[a]
Interdisciplinary	Interprofessional[b]
Medical	Health[c]
My	Our
Patient	Participant

[a]When referring to a medical doctor as an abstract role. For other doctorally prepared members of the care team, use the name of their profession (e.g., nurse).
[b]Just where "interdisciplinary" is serving as a synonym for "interprofessional."
[c]Where it is appropriate to do so (i.e., where the medical model is not the only approach involved).



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Best Practice Tips: Confronting Conflict

Myth	Reality
Health care teams should avoid conflict.	Conflict helps teams grow and become high performing.
Being an effective team member is an inherent skill	Skill development is required especially in complex, health care teams
Conflict should be resolved	Conflict should be embraced
Interprofessional = collaboration	Interprofessional = presents many challenges to collaboration
Major differences lead to conflict	Minor concerns lead to conflict
Power hierarchies are a norm	Democracy helps aid in effective teamwork

Source: Eichbaum, 2018

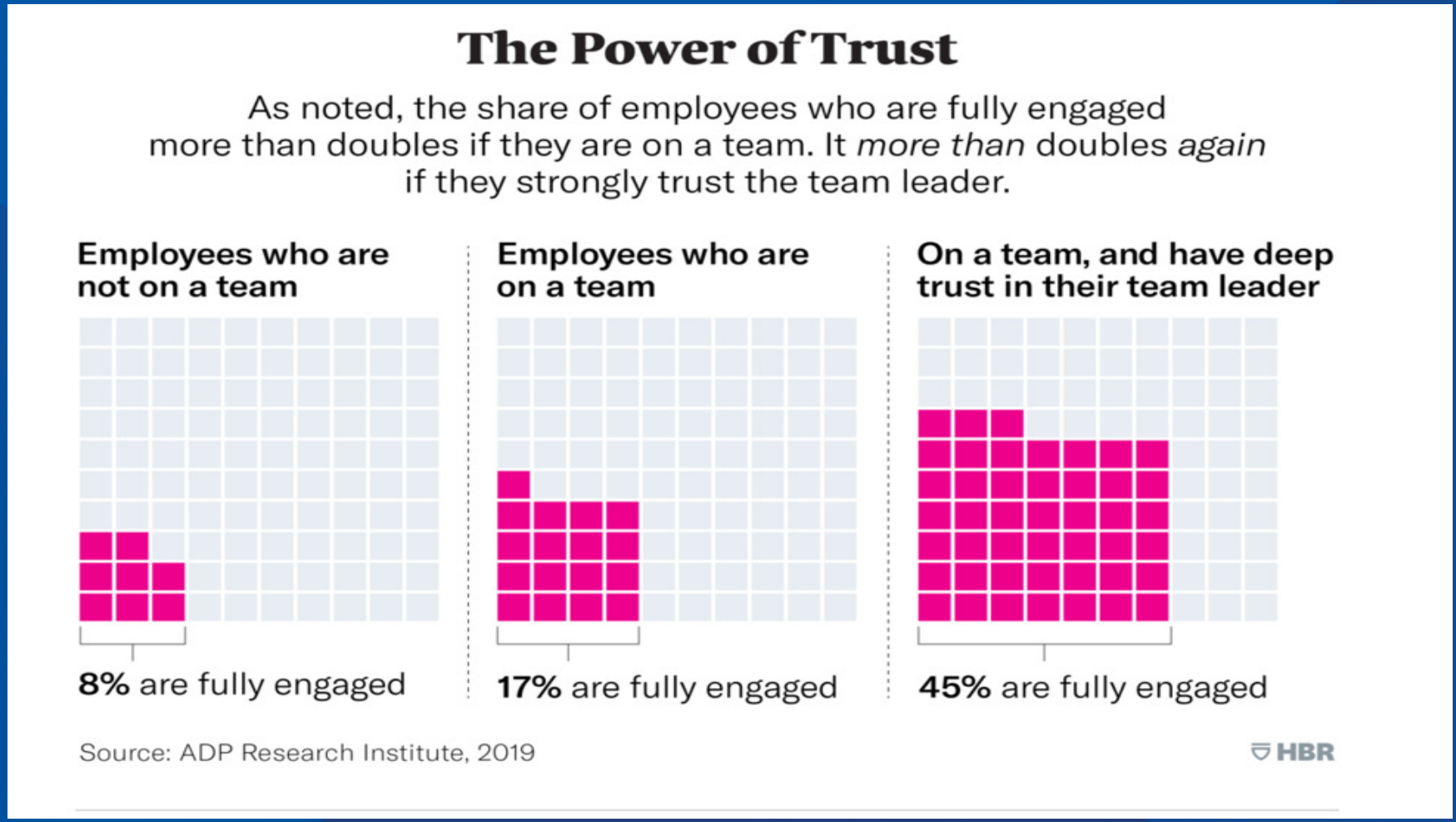
Conflict Engagement

Table 2. Daily Toxic Behaviors[3,4]

Initial Condition	Toxic Behaviors	High-Performing Behaviors
Communication and information sharing	-Own information, are secretive, or share on a "need-to-know" basis -Excessive e-mails, meetings, or phone calls occur without actionable goals -Frequently repeat yourself, or need to ask members of the team for additional information -Team is unclear on your priorities	-Information is shared widely, but is adapted for the audience -Sets clear strategic plans, goals, and vision -Fosters trust through transparency -Communication happens in micro interactions and allows team input -Members of team are clear on your priorities and expectations, and anticipate your needs
Interactions	-Employees avoid interactions with you or seem nervous -Not available to meet/talk -Employees do not speak up -Interactions are strictly work related, and do not acknowledge human side of team -Point out the mistakes of others	-Ongoing employee engagement -Failure is not considered fatal -You're never "too busy" for a team or their ideas/concerns -Interactions embrace the human side of employees—know and value your team on a personal level -Takes ownership of outcomes
Work style	-Expect working nights and weekends to complete workload -Spend the majority of time on fire drills and immediate issues -Leader not present in work environment -Impatient, short tempered, and makes sarcastic remarks about others	-Workload is balanced, and you promote a culture of self-care -Visible at the "front line" regardless if clinical or office setting -Ongoing positive reinforcement and praise occurs in micro interactions -Crisis is the exception, not the norm

(Source: Weberg & Fuller, 2019, p. 25)

Why you need psychological safety



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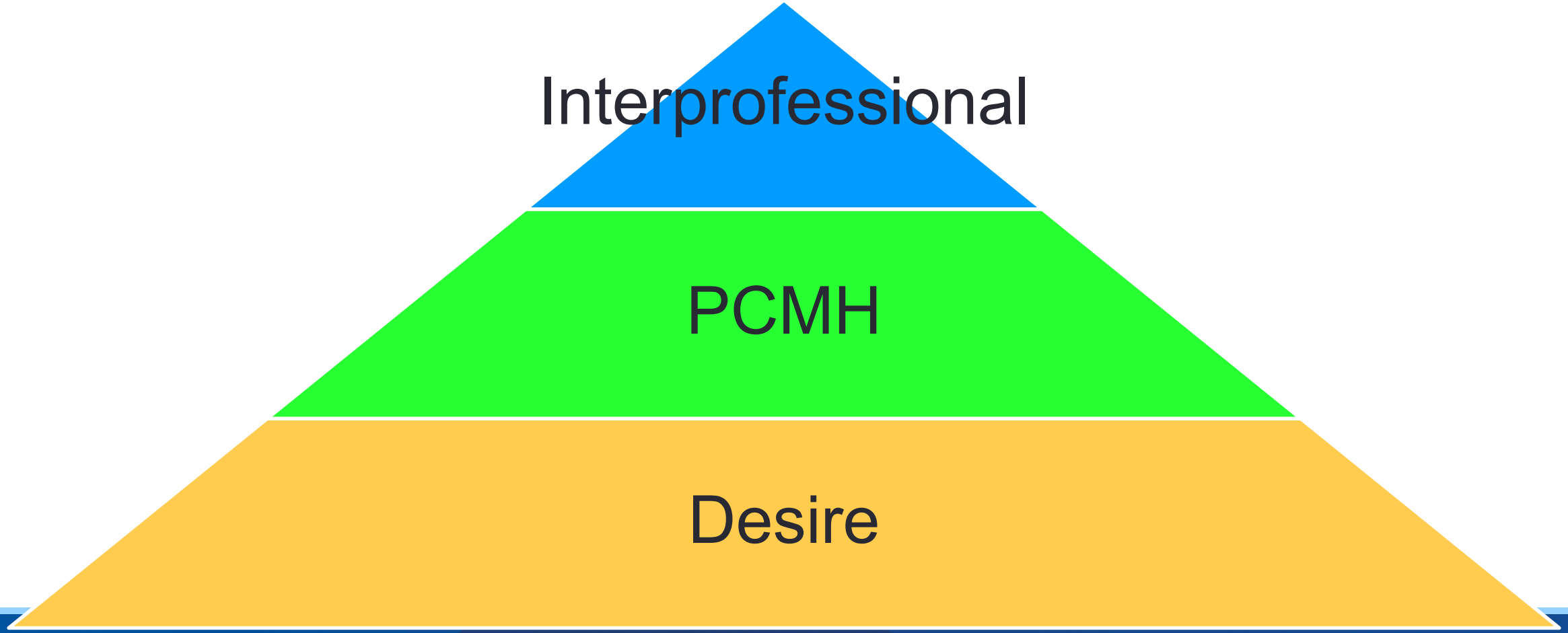
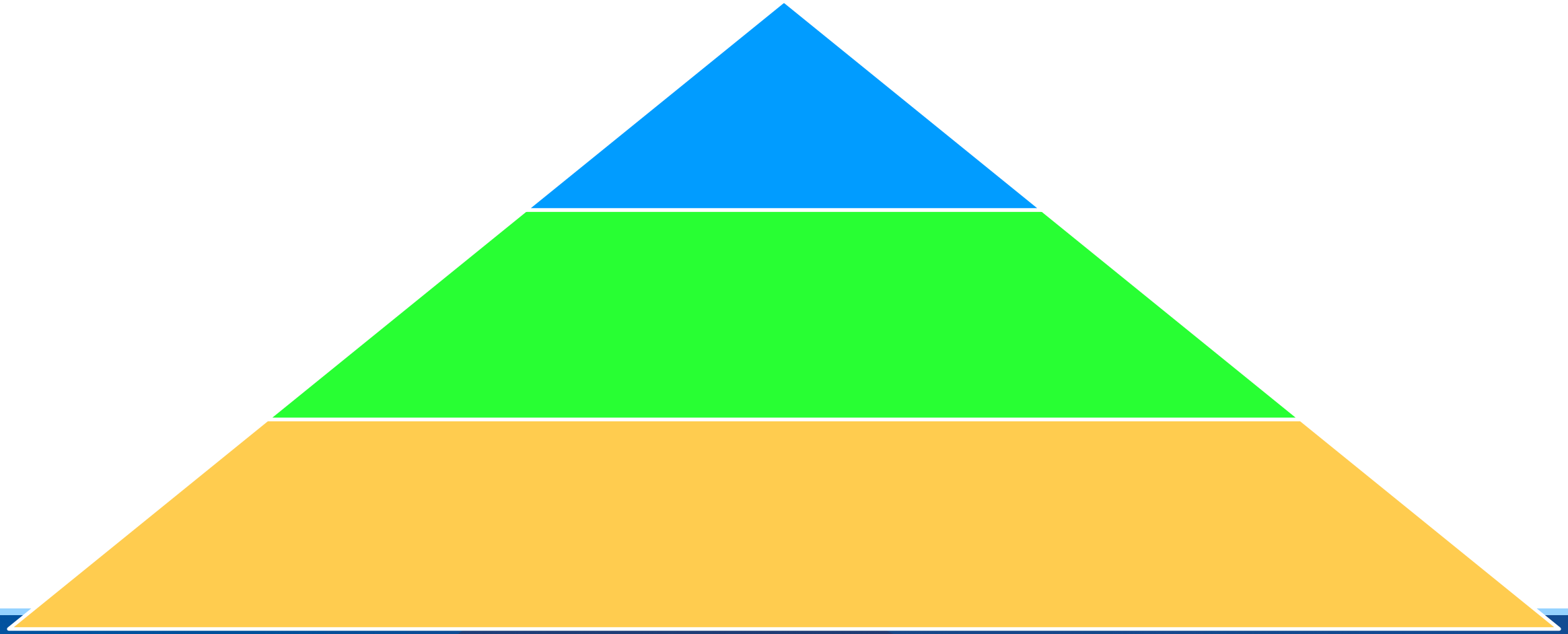
Patient-centered team-based collaboration and care



Evolving


Team process
Collaborative care planning
IP integrated model of care

Activity – Identify Your Foundation



Report Out

Metrics: The Quadruple Aim

Drives Interprofessional Education

Drives Collaborative Practice

Also Drives Metrics

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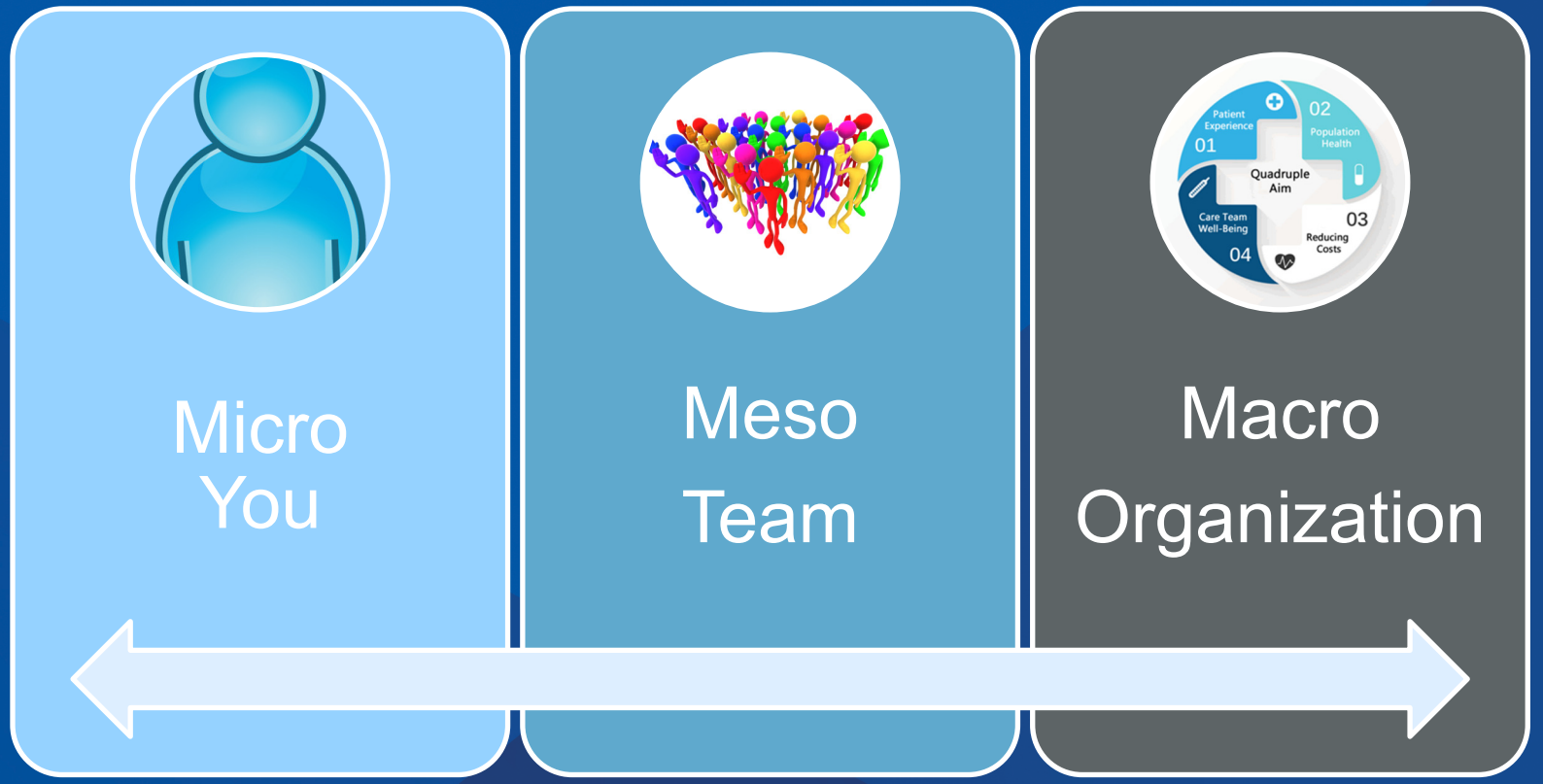
Make and Measure Change at Different Levels of the Organization



Source: Weiss KB, Passiment M, Riordan L, Wagner R for the National Collaborative for Improving the Clinical Learning Environment IP-CLE Report Work Group. Achieving the Optimal Interprofessional Clinical Learning Environment: Proceedings From an NCICLE Symposium. http://ncicle.org. Published January 18, 2019. doi:10.33385/NCICLE.0002

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Metrics Considerations:

- Discuss Twice; Measure Once
- IPE
  - Knowledge, Skills, Abilities, Attitudes, etc
- CP
  - Setting IP vs OP, Primary vs Specialty, One vs Many Locations, Reimbursement Model
- Sources of Data
  - EHR, Learners, Patients, Teams, Insurance Companies, Pharmacies, Data Team?

"If you don't know where you are going, you'll end up someplace else."
— **Yogi Berra**

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Metrics Considerations:

- Process
  - Culture, Engagement, PCMH, CPC+,
  - Continuity, QI, Safety, Wait Times, etc.
- Outcomes
  - Learner, Patient, Cost, etc.; Quadruple Aim
- Research vs Clinical
  - Design and Measurement Considerations
  - IRB

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Metrics

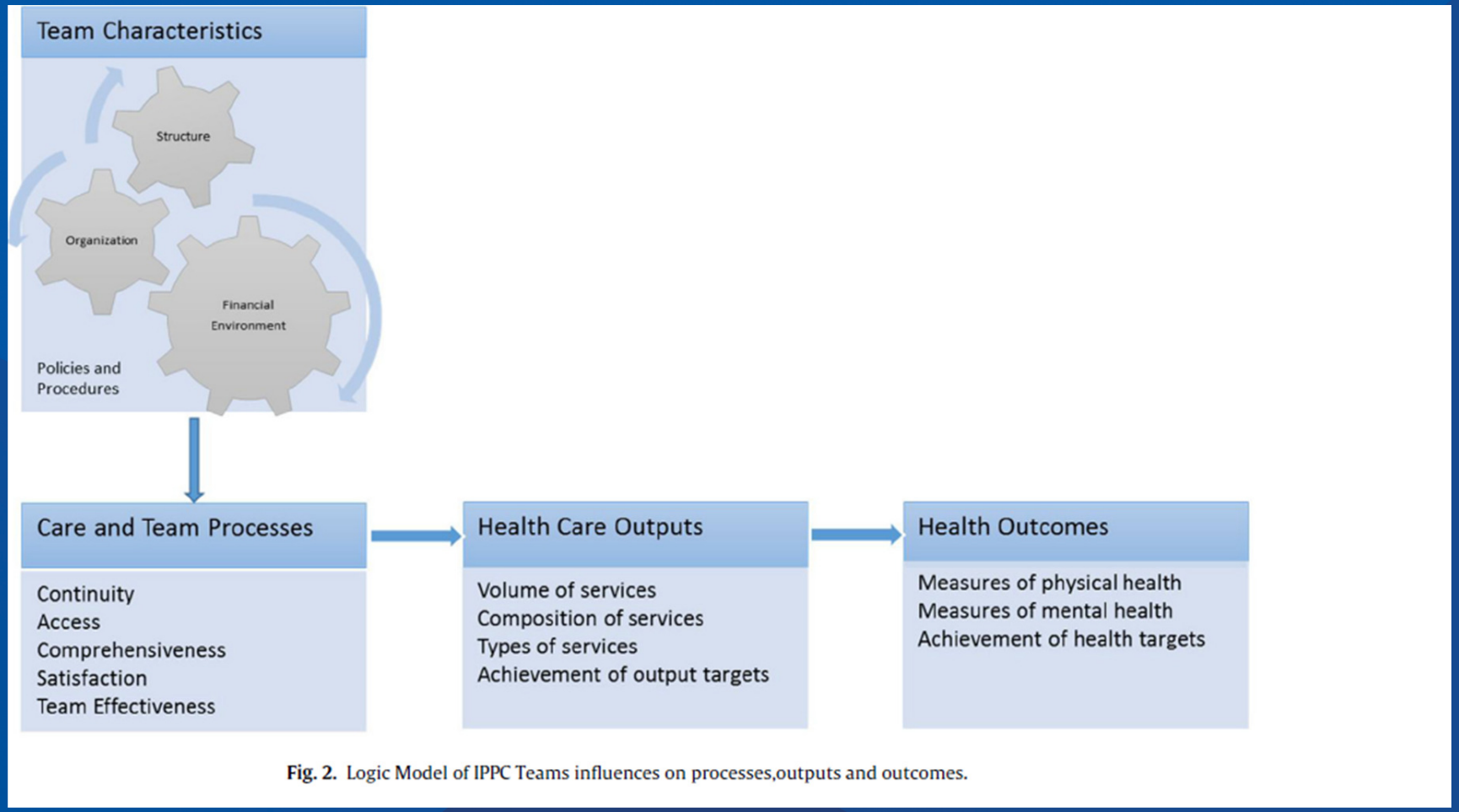

Fig. 2. Logic Model of IPPC Teams influences on processes,outputs and outcomes.

Wranik WD, et al. Implications of interprofessional primary care team characteristics for health services and patient health outcomes: A systematic review with narrative synthesis. Health Policy (2019), https://doi.org/10.1016/j.healthpol.2019.03.015

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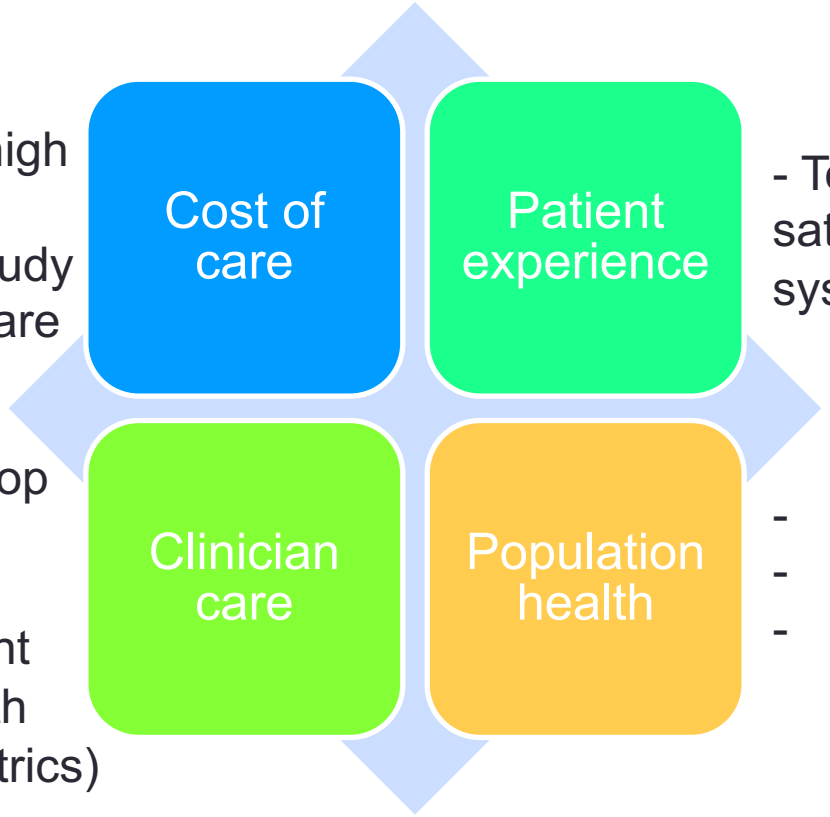
Our Metrics – Quadruple Aim as Our Framework

- Studied high utilizers
- Cohort study
- Cost of care



- Top 5 in patient satisfaction (used health system metrics)

- Become top clinic for employee engagement (used health system metrics)

- ED visit
- Hospitalization
- Hemoglobin A1C

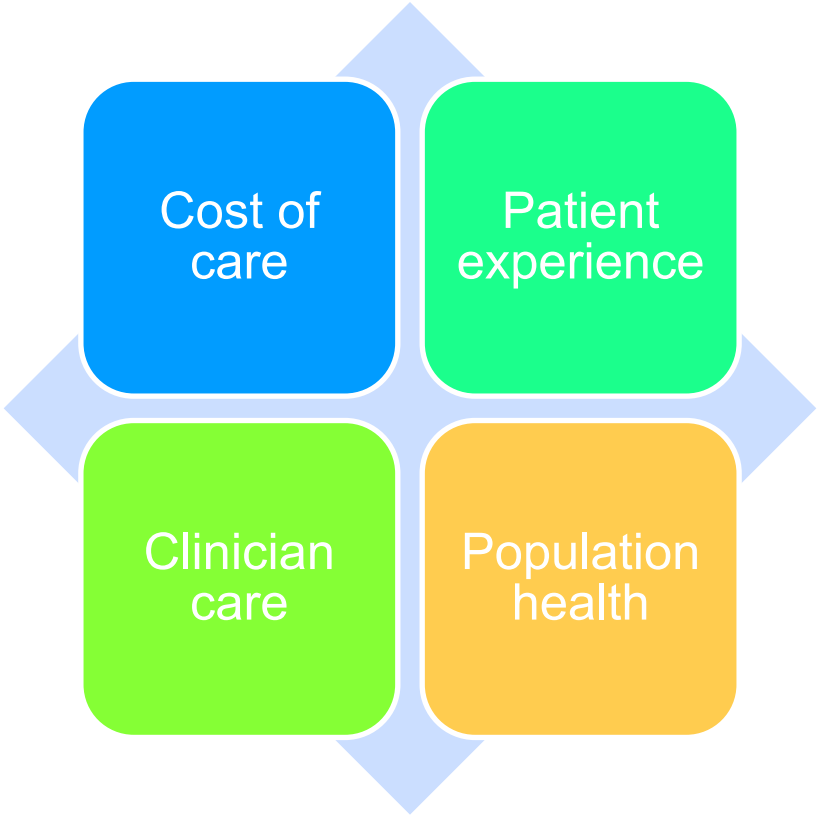
Supplemental Table 2.

Statistical Comparisons of All Outcomes

	2016	2017	
	[95% CI]	**[95% CI]**	**p**
1 ED Visit, %	89.7 [82.6-94.1	73.0 [63.2-81.0]	<.001
1 Hospital Visit, %	37.8 [31.8-44.2	20.1 [15.6-25.6]	<.001
A1c, %	10.3 [9.9-10.	9.5 [9.1-9.9]	0.001
Total Patient Charges, $	$ 18,491 [15,274-22,386]	9,572 [7,907-11,58]	<.001

Note. All statistical tests accounted for the nesting of patients within year. Due to skewed data distributions, total patient charges and their respective 95% CIs were estimated using a log-linear mode

Your present/hoped for outcomes?



Report Out

Closing and Reflection

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