Executive Summary

Developing a Model for Interprofessional Education

January 9, 2009
Grand Valley State University
Pew Campus
Loosemore Auditorium
Grand Rapids, Michigan

Sponsored by

Grand Valley State University

Grand Rapids Medical Education & Research for Health Professionals

Michigan State University College of Human Medicine

First Annual Interprofessional Education Conference Executive Summary: A Blueprint for Action

Introduction

The Institute of Medicine (IOM) reports have become the center of the current restructuring of the health care education curriculums. The movement toward interprofessional work and the initiatives for interprofessional education is a result of the need for patients to receive safe quality care. Interprofessional education (IPE) and practice is a team approach involving the appropriate disciplines to secure the best patient outcomes. The purpose of this conference is to develop a national model for IPE and to infuse interdisciplinary learning experiences into and across the curriculums of the health professions programs.

Multiple factors are influencing changes in the culture of health professional education and care delivery, including not only safety issues, but also fragmentation of healthcare delivery, rising health care costs, inadequate technological infrastructure for sharing information electronically, and health professionals often working in silos. Data as reported in the Institute of Medicine publication, "To Err is Human: Building a Safer Health System", clearly shows that the United State Health Care System "is not as safe as it should be and could be". Tens of thousands of people die needlessly in hospitals each year as a result of medical errors that could be prevented. Beyond the cost of precious human lives, there are significant other tolls including patient disability, loss of patient trust, and decreased morale, frustrated health care providers, and financial costs estimated as high as $29 billion per year nationwide. At times, "the delivery of care" has been overly complex and uncoordinated, requiring multiple steps and patient "handoffs" that slow down care and decrease rather than improve safety" (Corrigan, Donaldson 2000).

Community IPE Initiative

Grand Valley State University, in conjunction with community partners, has launched an innovative health care community initiative, the West Michigan Model of Interprofessional Education. This partnership of Grand Valley State University (GVSU), Michigan State University College of Human Medicine (MSU-CHM) and Grand Rapids Medical Education and Research Center for Health Professionals (GRMERC) has begin the development of a culture of synergy, innovation, and quality improvement with interdisciplinary teams working together to improve the health care and education available to our patients and students. Collectively partners are exploring alternative approaches to providing curricula that integrate core competencies across health care disciplines into education and practice. The initiative is led by an Interprofessional Education (IPE) Steering Committee which meets monthly at the GVSU Cook DeVos Center for Health Sciences. The objective is to identify ways that GVSU, GRMERC, MSU-CHM and regional partners could develop collaborative, innovative, and interprofessional initiatives across disciplines, learning institutions and health care systems. The IPE Steering Committee explored and is facilitating the development of the West Michigan Model of Interprofessional Education. The core of the model is the strong vibrant partnerships among our academic institutions, practice partners and community organizations. Appendix A contains a model of the West Michigan Model of Interprofessional Education depicting three core elements of: 1) Education, Scholarship and Service; 2) IOM Core Competencies (patient centered care, evidence-based practice, quality improvement, the use of informatics and interdisciplinary teams (Greiner, Krebel 2003); and 3) Outcomes for Education and Practice. Central to

implementation of the model are the six champion areas work groups of clinical setting, curriculum, interdisciplinary cross cultural competence, scholarship, service and simulation.

IPE Conference

The Steering Committee members hosted a conference to kick off the implementation of the West Michigan Model of Interprofessional Education to our faculty (academic institutions) and community (practice partners). The first interprofessional education conference titled, "Developing a Model for Interprofessional Education" was held on Friday, January 9, 2009 in Grand Rapids (Please refer to Appendix B for a conference brochure). Speakers included Linda Cronenwett PhD, Dean and Professor of the School of Nursing University of North Carolina at Chapel Hill; David Garr MD, Medical University of South Carolina Professor of Family Medicine and Executive Director of South Carolina AHEC; and Anthony Errichetti PhD, New York College of Osteopathic Medicine at St. Barnabas Hospital of New York City.

The participants were enthusiastic about the speakers' messages regarding the value of and improvement in care possible through the implementation of interprofessional education and practice. The movement toward interprofessional care assists in creating safe care delivery systems and quality care. Traditionally health professions have looked at the ideal of each profession to meet the expectation of quality care and patient safety. Students were educated with a focus on individual communication skills, little emphasis on team building or group communication skills. Interprofessional education takes a broad view of health care rather than the snapshot each discipline alone provides. David Garr gave an analogy of Charleston's two bridges where two rivers, the James and Elizabeth, converge into the Atlantic Ocean. He describes how while traveling on the older bridge we continue to do what we have always done, but we are watching and anticipating our journey to begin on the new bridge when it is ready. Health care education and the delivery of care are changing and we need to plot the course.

After the national speakers gave us an overview of interprofessional education and practice trends, invited community partners participated in a panel discussion and brought it down to a local grass roots level. The panelists included David Baumgartner MD, Vice President of Medical Affairs, Saint Mary's Health Care; Michael Faas FACHE, President & Chief Executive Officer at Metro Health; Steven Heacock JD, Chief Administrative Officer & General Counsel of Van Andel Institute; Karen VanderLaan PhD, Senior Nurse Researcher at Spectrum Health; and Patti VanDort MSN, RN, Vice President of Nursing & Chief Nursing Officer at Holland Hospital. These community champions supported the need for interprofessional education and practice and noted the benefits of improved patient and community care. David Baumgartner cited the differences of each discipline's culture, tradition, and payment systems as historical barriers to interdisciplinary work. Michael Faas focused on "the glue is communication" and congratulated this conference for taking the lead toward change. Steven Heacock spoke of the workforce history in Michigan. Michigan began as an agrarian economy, then a manufacturing economy, and now the shift is to a knowledge economy. The old paradigm was that one group held the information, now there are 100 million individuals with access to the information. Karen Vander Laan commented on the need for a common language and the synergy that is created with teamwork. Patti Van Dort spoke of the changing landscape and complexity of care and the need for infrastructure to support these practice models. Each of our community partners could give specific

examples of areas in their organizations where interdisciplinary practice was working. These interdisciplinary areas included HIV clinics, medical informatics, an assistive breathing unit, a children's hematology-oncology clinic, a burn unit and critical care units. The perspectives of these leaders reinforced their desire for embracing a new paradigm of patient-centered care.

Champion Work Groups

The West Michigan IPE Model has the identified champion work areas. These are clinical setting, curriculum, interdisciplinary cross cultural competence, scholarship, service and simulation. At the time of registration attendees were given a choice of participation in one of these champion area work group. Each group was facilitated by two or three co-leaders and a recorder. The co-leaders were given guiding questions as a structure for discussion as well as the autonomy to let the workgroup direct the discussion.

Curriculum Champion Group

The Curriculum group co-leaders Maureen Ryan (GVSU, Nursing) and Peggy Thompson (GRMERC) had participants from nursing, physical therapy, radiology/imaging, library science and GRMERC. Proposed IPE course or learning experiences were courses on ethics, legal issues, and death and dying. Another way of integrating IPE into and across the curricula could be introducing a team teaching approach from various disciplines. Other suggestions included a virtual community and an IPE website available to support faculty of GVSU, GRMERC, MSU-CHM and community partners.

Examples of potential inter-professional rich experiences for students could be traveling IPE teams making community visits. Another proposal was the development of partnerships with K-12 education mentoring younger students to this concept of team building and collaboration. Interprofessional Day was suggested to immerse students from different disciplines allowing them to participate in lectures, simulation and other activities across disciplines. There was discussion about the development of a neutral entity for supporting IPE and the need to celebrate success. The curriculum champion group had a focus on interdisciplinary team role and identity in an academic learning environment

Clinical Setting Champion Group

The Clinical Setting group co-leaders Cynthia McCurren (GVSU, Nursing) and Peter Coggan (GRMERC) had participants from nursing, graduate studies, local and international community hospital agencies, a medical residency program, and a member from the educational business community.

Generally all types of clinical settings that lend themselves to IPE clinical practice. Specific examples identified by the group were palliative medicine, free clinics, and wellness and prevention settings. A dedicated education unit for interdisciplinary care would be of value for students to rotate through and learn team-building and collaboration skills.

It is important that IPE begin early in the educational process. The emphasis needs to be an attitudinal change and the willingness to learn each other's roles to develop collaboration skills. Another recommended shift was the focus on the patient as the leader of directing his/her health care. Patient safety, which is the ultimate goal, can be

a financial incentive to institutions to support interdisciplinary team care. The clinical setting champion group focused on interdisciplinary team role development and sustainability with an awareness for patient centered care.

Interdisciplinary Cross-Cultural Competence Champion Group
The Interdisciplinary Cross-Cultural Competence champion group co-leaders Gayla Jewell (GVSU, Nursing) and Linda Goossen (GVSU, CLS) had participants from nursing, radiology, physical therapy, local community hospital agencies, and the regional director of school health programs.

This group started with an experiential exercise of drawing a flow chart to illustrate the decision making process among health care professionals. The consensus was that there were "loose linkages" between patients and the agency departments . From the patient perspective the physician gives orders and the orders are carried in departmental silos. The system appears fragmented, disjointed, and confusing. Much information is lost due to an uncoordinated flow. Participants suggested that professional roles are developed from personal characteristics and social cultural characteristics. These characteristics influence the choice of a professional career and may influence inter-professional interactions. The dominant social culture in the U.S. is that of competition which creates a background for a hierarchical and competitive system of health professionals. A horizontal and ecumenical system would be a different choice and a level field to educate and train health care providers to work in a team approach.

The group's consensus is that educators need to buy into interprofessional education or else the paradigm shift will not occur. Maintenance of the IPE shift includes continuous in-service events, support from administration and evidence of sustainability. The group identified discipline biases and how they create barriers to functioning in interdisciplinary teams.

Scholarship Champion Group
The Scholarship group co-leaders Cindy Coviak (GVSU, Nursing) and Alan Davis (GRMERC) had participants from nursing, physician assistant studies, research institute, radiology and imaging, and a physician organization.

There are multiple examples of current inter-professional research. For example, MSU-CHM students are all assigned to do research projects with other disciplines. There is an osteoporosis study with researchers from GVSU KCON and CHP partnering with local rheumatology and orthopedic practices. This study will continue with Van Andel Institute (VAI) looking at genetic markers.

A suggestion was made to consider research projects in primary and ambulatory care. Historically, acute care settings are the first choice. The group also recommended interdisciplinary research with GVSU, MSU-CHM, GRMERC, and VAI integrating students and faculty. Also of benefit to the group would be a research website specifically for networking and collaboration on projects. The focus of this group was on the development of studies for obtaining evidence-based practice, quality improvement, and the use of informatics to compute data findings in interprofessional teams.

Service Champion Group
The Service group co-leaders Karen Ozga (GVSU, CHP) and Wallace Boeve (GVSU, PAS) had participants from nursing, the business community, regional hospitals, and an

ethnic health initiative agency.

Discussions regarding current interdisciplinary service activities included one hospital's effort in providing a health booth at the Whitecap baseball games. The health booth is staffed with a nurse, a physician. and an EMT. Another example is a non-profit organization which focuses on ethnic health disparities as an opportunity for interdisciplinary learning. It was suggested that foundations and philanthropy are places where students can be involved in service to the community. Participants suggested that students educated in an interdisciplinary model, who are placed in a practice setting that does not value interdisciplinary partnerships, will revert to the existing practice in that setting. Educating the student early in an interprofessional curriculum and clinical setting may be the solution to imprinting students to the concept of interdisciplinary teams. The focus of this group was patient centered-care and interdisciplinary teams.

Simulation Champion Group
The Simulation group co-leaders Dianne Wagner (MSU-CHM), Andrew Booth (GVSU, PAS), and Michael Shoemaker (GVSU, CHP) had participants from nursing, occupational therapy, physical therapy, GRMERC, and regional hospitals.

Interprofessional simulation experiences need to start at the beginning of professional training and continue throughout the life of the professional to maintain competencies. Participating in a simulation reinforces the expectation of students to learn to be a part of a team. The collective members of a team create system-wide safety. Safety cannot be maintained by a single individual.

There are several ways that simulation can best serve the needs of the health care community. Simulation can be used for delivering "bad news", advance directives, a sentinel event re-enactment, and demonstrating competencies. Simulation can be keyed to a CME activity or root cause analysis. The same learning methods experienced in simulation can have a carry-over effect to actual patient care. The possibilities for simulation are only limited by the imagination of the developer. The focus of the Simulation champion workgroup was on the cohesiveness of interdisciplinary teams and maintaining good communication.

IPE Blueprint for Action
In this executive summary, interprofessional education has been promoted as a method for health care reform in education. The IPE Steering Committee ***objective*** to develop a national model for interprofessional education and to infuse interdisciplinary learning experience into and across the curriculums of the health professions programs was re-affirmed by conference participants. The ***definition of interprofessional education*** that emerged from the Steering Committee discussions is: two or more professions with different educational backgrounds, learning with, from, and about each other during their professional education to improve collaboration and the quality of care (Barr 2006, Curran 2005).

Our blueprint is organized around the six champion workgroup's long term and short term goals. Champion group co-leaders, participants, and recorders will be queried about their interest in continuing work through monthly work group meetings at the Cook-DeVos Center for Health Sciences. Individuals interested in continued participation will be notified of future meetings and a blackboard site will be activated to share information from each of the champion groups.

To maintain sustainability of the West Michigan Model for Interprofessional Education; the champion groups, comprised of academic, practice and community partners, will continue their work. Brenda Pawl will continue to provide project coordination and leadership for the IPE initiative and the recorders will provide documentation support. Brenda is the contact person for questions, suggestions or concerns. Her phone contact information is 331-5960 and her e-mail address is pawlb@gvsu.edu. Brenda will be attending the IPE Steering Committee and the champion work group sessions to provide information and continuity for the IPE initiative.

Long term (LTG) and short term (STG) goals for each of the champion groups include:

1. Clinical Setting:
   - LTG: Implement the placement of "teams" into clinical settings
   - STG: Identify clinical setting locations to place interprofessional teams

2. Curriculum:
   - LTG: Implement the integration of IPE teams throughout curricula
   - STG: Host an Interprofessional Education Day for students

3. Interdisciplinary Cross-Cultural Competency:
   - LTG: Implement cross-cultural competencies into the curricula and educational programming of students, faculty, practice partners and community
   - STG: Develop an in-service for faculty and collaborating partners

4. Scholarship:
   - LTG: Implement interprofessional scholarship across disciplines and institutions
   - STG: Develop a web site for networking scholarly activities.

5. Service:
   - LTG: Implement community based initiatives for service interprofessional teams
   - STG: Identify a service project to place interprofessional teams

6. Simulation:
   - LTG: Implement the process of sharing simulation resources with community partners
   - STG: Develop interprofessional opportunities for simulation scenarios

An important strategy for interprofessional education is the provision of clinical site placements for students in interprofessional teams for quality experiences, provide opportunities for research in developing evidence-based practice, and implementing quality improvement to achieve the common goal of safe quality patient-centered care. The infrastructure being established will support the educational initiative as well as be a resource for the community.

The Institute of Medicine Reports have provided the core competencies of health care. The core competencies are patient-centered care, evidence- based practice, informatics, quality improvement, and interdisciplinary teams. Patient-centered care is respectful

and safe, with shared decision making. To support best outcomes, evidence-based practices is needed as well as quality improvement studies to guide care and to monitor outcomes Evidence-based care is accomplished by integrating best research with clinical expertise, identifying root causes of errors and designing system-wide efficiencies. The use of computerized order entry systems is an additional safeguard for clarity and flagging errors. To be able to work effectively in teams, we need to educate in teams so that there is cooperation, collaboration and communication. Team work promotes seamless, safe care.

The geographical location of Grand Rapids and this community's commitment to health care and life sciences centers GVSU and its partners in an area of concentrated growth in medical research, healthcare education, and state-of-the-art patient facilities. The region has an impressive array of buildings under construction, reflecting a commitment of nearly $1 billion dollars to health care in West Michigan. Exceptional primary, acute, and tertiary care centers and practices, a world-class research center, and strong educational institutions support growth. Grand Valley State University (GVSU), Grand Rapids' home town University, is the foremost provider of nursing and health professional education in the region, and more than 5,000 of our total 24,000 students are enrolled in one of the health sciences. The breadth and depth of health professions programs combined with Michigan State University's College of Human Medicine's (MSU-CHM) expansion in Grand Rapids and Grand Rapids Medical Education and Research Center for Health Professionals (GRMERC) provide a fertile environment for interprofessional learning experiences. We will continue to identify ways that all of our education and regional partners can participate. We believe an excellent base has been established for the development of the innovative West Michigan Model of Interprofessional Education. We look forward to your continued leadership, participation and support.

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