West Michigan Interprofessional Education Initiative
Creating Teams for Patient Centered Care

Conference Summary

Meeting the Goals of Better Health, Better Care, Decreased Costs: Role of IPE & Collaborative Practice

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Fifth Annual Interprofessional Education Conference Summary

Introduction & Community IPE Initiative

Meeting the Goals of Better Health, Better Care, Decreased Costs: The Role of IPE and Collaborative Practice. As healthcare continues to be more complex, a new model to deliver safe, accessible, patient centered care is essential. This new model should move from a silo learning and practice environment to a collaborative ***team*** delivery system. A team approach makes optimal use of the knowledge and skills of each discipline. The essentials of team dynamics are awareness of individual professional competencies, the overlap of common competencies, and the interprofessional collaborative competencies.

According to the World Health Organization (WHO), the definition of interprofessional care is when two or more disciplines learn from, about, and with each other. The **mission** of the West Michigan Interprofessional Education Initiative (WMIPEI) is to identify ways that Grand Valley State University (GVSU); Grand Rapids Medical Education (GRMEP), Michigan State University College of Human Medicine (MSU-CHM) and regional partners can develop collaborative, innovative, and interprofessional initiatives across disciplines, learning institutions, and health care systems. Our **goals** are to:

1. Integrate interprofessional learning throughout the curricula
2. Identify, develop, implement, and assess interprofessional clinical experiences for teams of students to practice and learn about, from, and with each other
3. Implement interprofessional scholarship across disciplines and institutions

Community partners include learners from GVSU in the disciplines of physician assistant, physical therapy, occupational therapy, occupational and safety health, radiology and imaging, recreational therapy, medical lab science, nursing, social work, bioengineering, bio-statistician; medical residents from GRMEP; medical students from MSU-CHM; and pharmacy and optometry students from Ferris State University. Collaborative community partners include community healthcare agencies, hospital systems, rehabilitative and long term care systems as well as community members. Our focus is on education, scholarship, and service.

This transformation of health professions' education with students engaging with students, faculty, and staff outside of their own profession will become a routine expectation. As part of their professional development, all health professions students will learn about their own discipline's unique competencies and competencies common across professions, and will practice and develop skills in team care. More importantly each health care professional will provide care to the fullest extent of their licensure and education.

The emphasis on interprofessional education and practice is a team approach involving the relevant disciplines to secure the best outcomes for each patient. To ensure that students will be able to work effectively in teams, we need to educate them in practice environments where the staff model is interprofessional team care. Thus, this partnership among Grand Rapids regional educational and health care organizations will produce not only excellent students but will also foster excellence in health care.

Day 1	WMIPEI Update	Jean Nagelkerk, Ph.D., FNP, Vice Provost for Health, Grand Valley State University

Dr. Nagelkerk reiterated the need expressed in the Institute of Medicine's (IOM's) report *Crossing the Quality Chasm: A New Health System for the 21st Century* for the quality of care to improve that has resulted in the persistent under-performance, high cost, and safety problems that currently plague American care provision. This year's conference theme includes the triple aim of better health, better care, and decreased costs which highlight the role of IPE in collaborative practice.

The purpose of the West Michigan Interprofessional Education Initiative (WMIPEI) is to address quality, safety, and cost issues faced in West Michigan. Dr. Nagelkerk emphasized the importance of healthcare worker education to provide an interprofessional team approach that moves away from the traditional "silo practice model." Key challenges in providing interprofessional education (IPE) facing practitioners, administrators, and citizens in the American healthcare system include: mounting complexity of care, rising costs, and variable quality coupled with mal-distribution of care based on geography, income, race, and ethnicity.

New model(s) of safe, accessible, and affordable care are needed that move away from a silo learning and practice environment toward a collaborative team delivery system. These new models must make optimal use of the knowledge and skills of each discipline while providing the opportunity for each health professional to work to the full extent of their scope of practice. Synergy of teamwork provides care that leads to better health outcomes, improved efficiencies, and improved satisfaction for the care experience.

New models of collaborative practice are emerging, including: patient-centered homes, integrated healthcare practices, and interprofessional team care. Also, traditional care practices are adapting the following strategies to integrate IPC into the clinical setting: huddles, integrated care planning, daily rounds including patients and families, and interprofessional care presentations. Academic settings are incorporating the following strategies: team-based service learning projects, encouraging participation in interprofessional student organizations, and simulation and skill based IP learning experiences.

Dr. Nagelkerk concluded her introduction by discussing the West Michigan Interprofessional Education Initiatives from the past year:

- Developing online student foundational, IPE, patient safety, and team building modules
- Securing a nursing education practice quality research grant to implement the WMIPEI model in practice and evaluate its effectiveness on patient outcomes, staff satisfaction, and student learning
- Belonging to an Innovations Incubator for the national coordinating Center for IPE and Collaborative Practice at the University of Minnesota

Day 1	**Integrating IP Core Competencies**	**Sharon Decker, PhD, RN, ANEF, FAAN Professor Anita Thigpen Perry School of Nursing at Texas Tech University Health Sciences Center Director of The F. Marie Hall Sim*Life* Center Director of the Health Sciences Center's Quality Enhancement Program**

Dr. Sharon Decker presented a brief history of the development of IPE and how Texas Tech University integrated simulation into that journey. Dr. Decker's objectives for the IPE Conference presentation included discovering strategies that are currently leading an institution toward IPE and exploring opportunities for integrating core interprofessional competencies into educational curricula.

Dr. Decker expressed the need to transform the education of healthcare workers by changing how we teach, what we teach, and where we teach. Dr. Decker stated that the World Health Organization's development of an agreed upon definition of IPE as students from two or more professions learning about, from, and with each other to enable effective collaboration and improve health outcomes, was critical to the foundation of IPE.

After providing a brief history of IPE, Dr. Decker presented two main drivers of IPE including patient safety and the cost of training healthcare workers. Dr. Decker emphasized the importance of communication and the need for healthcare workers to come together and move past the term interdisciplinary and into interprofessional collaboration. Effective teamwork is linked to positive patient outcomes and increased staff satisfaction.

Dr. Decker discussed how Canada, Australia, and Israel are ahead of the United States in terms of adapting IPE concepts; however, the U.S. is quickly building upon the framework that others have provided. Accreditation standards can drive the IPE culture change. Dr. Decker cited a review of accreditation documents for ten different professions that yielded 205 statements referencing IPE; however, of those, 77% were related to the professions of pharmacy and nursing. Other disciplines need to have increased accountability to IPE too. When healthcare workers are evaluated based on accreditation standards, it makes the job of creating buy-in to the concept of IPE easier.

The importance of creating buy-in to the concept of IPE cannot be underestimated. Dr. Decker discussed numerous challenges to implementing IPE within an organization, including: unprepared and unenthusiastic faculty, philosophical and academic policy differences, lack of reward and recognition structure, turfism, financial structure, overcrowded curricula, various geographic instruction locations, variations in learner age, educational levels, and clinical experiences, communication barriers, varying professional practice acts and regulatory boards, and various accreditation standards. An effective way to promote IPE is to empower and recognize others through seed money/grants, awards (CLARION; interprofessional student teams), and publicity.

Dr. Decker emphasized that IPE must be integrated into the curriculum and it must be done early and throughout undergraduate and graduate education; one IPE experience is not enough. IPE needs to encompass active and engaged learning, such as through the use of simulation. Dr. Decker also indicated the importance of distinguishing between collaborative work groups and IPE. IPE is no longer the "nice thing to do" it is a cost effective approach to managing the complexity of care for today's patients.

Day 1	The Role of IPE & Practice in Healthcare Reform	John Gilbert, CM, PhD, FCAHS

Dr. Gilbert's presentation began with a discussion of why healthcare reform is so difficult in that healthcare professional education is a tale of many silos. Dr. Gilbert pointed out the physical separation created by different buildings on a traditional university campus for each of the various health professions (medical schools, colleges of nursing, lab sciences, etc.). Dr. Gilbert referred to the healthcare workforce as a variegated mob; in Canada there are 68 healthcare-related jobs identified; in the United States there are 240 healthcare-related occupations. With so many healthcare occupations, they each want to protect their own turf and tend to use acronyms that only their own profession can identify with. Silos are a reality and can be very difficult to tear down.

Dr. Gilbert pointed out the importance to test and make sure that all three parts of the definition of IPE are met with any given IPE experience. Reminder of the IPE definition: "Learning with, from and about, for the purpose of collaboration, to improve the quality of care." It is important to frame the problem for teaching and learning, to look at the variables of competency, scope of practice, patient population, and setting/environment. Commonly used learning mechanisms to incorporate IPE include: paper case scenarios, videos, simulations, and live patients.

With any IPE endeavor there are a number of approaches to consider: learning (tell me and I forget; passive learning), show me and I remember (problem based teaching), involve me and I really understand (problem based learning which is best for IPE). Dr. Gilbert emphasized the need to prepare individuals for interprofessional collaborative practices by establishing knowledge bases, acquiring new skills, modifying attitudes, changing behaviors, and developing perceptions that pave the way for collaborative practice (between professions, within and between organizations, and with clients, their caregivers and communities). Healthcare professionals have to learn by doing things in practice. Dr. Gilbert likened this need to a grandmother who is the embodiment of teaching virtues to her grandchildren; learning with them before they can do things for themselves. Dr. Gilbert emphasized the need to model IP collaborative practice in primary care, tertiary care, and community settings (chronic disease management, mental health, etc.). IP Collaborative practice is a complex process; classroom learning does not equal workplace practice. Competencies are the bottom line; however, competencies are of little value if interpersonal and communication skills are poor.

Plan the continuum of IPE (with, from, about): ***Expose*** - allow students to develop a sense of their profession, allow students to understand areas of collaboration, ***Immerse*** students the year prior to graduation with team based practice, ***Master*** - train IP practice educators in practice settings (train the trainers/sustainability), understand external forces affecting IPE (institutional supports, working culture, physical environment). Build incentives for IP teaching/learning & practice; train trainers, develop IP planning groups.

Lastly, in relating IPE to IPP, Dr. Gilbert asks, where is the patient's voice? Patients need to push practice demands. Positive impacts that can be directly linked to IPE/IPP include: development of healthy workplaces, Health Human Resources planning linked to population health, improved safety (example: development of checklists in the operating room), and better chronic disease management. Dr. Gilbert cautioned everyone about the tendency of healthcare workers to focus on an object; not a subject; we need to be careful to build IPP and care that keeps the focus clearly aimed on the patient and not just their disease.

Day 2	The Role of IPE in Graduate Education	Peter G. Coggan, MD, MSEd

Dr. Coggan provided a brief history of graduate medical education (GME), specifically discussing the significance of the Flexner Report (1910) to address the serious public concern about the quality of students graduating from medical schools. The Flexner Report was influential in shaping how medical school training would be structured based on the European model of medical school training (two years of basic science and two years of basic medical training); this model still governs what is taught today.

In 1940 the American Medical Association (AMA) commissioned another report on GME which abolished apprenticeship training programs and put in place structured residency training programs similar to today. In 1981 a commission on GME formed the Accreditation Council for Graduate Medical Education (ACGME) which set national standards for all residency training programs including: general competencies, milestone projects (resident performance), and educational outcomes. Overall, the ACGME has high-level support for the concept of IPE; however, no concrete recommendations were provided on how the GME should accomplish the goal of IPE.

Since the 1940s, there have been numerous reports of reform in medical education; however, these reports have not had a great impact on the training provided in medical schools. In 2007 the AMA published the Initiative to Transform Medical Education (ITME) Report and began an initiative to transform medical education. Dr. Coggan pointed out that of the ten recommendations listed in the ITME Report for medical school training, none specifically mention IPE. This speaks to the rigidity of the various healthcare professions and the rigidity of the cultures in which we operate professionally. Dr. Coggan indicated that today's physicians graduating from medical school are unprepared to be team players with other healthcare workers because the necessary skills are not included in their training.

Dr. Coggan pointed out sources of resistance to IPE, including: professional silos that allow us to develop within our own profession but make interaction difficult, professional specialties have their own view of how things should be done and the language that they use, and the fact that GME funding flows through hospitals, therefore training programs are very hospital-centric and thus more difficult to change. Yet, Dr. Coggan was able to provide several specific examples of how current practitioners are able to provide IPC in vascular surgery, pediatrics, and rounding that involved the IPP of attending physicians, nurses, residents, pharmacists, physician assistants, physical therapists, social workers, discharge planners, and nutritionists. Dr. Coggan indicated that teams function more effectively if the team members are educated together. IPE allows students to appreciate the skills and abilities that each of them brings to the table, talk comfortably about what they are learning, and build/establish relationships that produce better care.

Dr. Coggan discussed the necessary items (authority, responsibility, accountability, and budget) that are needed to introduce IPE into the education of health professions. Dr. Coggan also emphasized the need for a national IPE consensus conference that would result in regulatory change in each professional licensing/accreditation body, changes in licensure that requires IPE, change in hospital privileges, and changes in reimbursement that recognizes IPE to create change. IPE has the ability to affect change in two of the reasons for enormous waste in health spending: patients being over treated and not enough coordination of care. GME programs cannot exist without clinical programs as a base. Dr. Coggan argued that to change healthcare delivery to an increasingly IPP model, we first have to change the way in which healthcare is delivered and the educational model will follow.

Day 2	**Interprofessional Education Low Hanging Fruit: A Panel Discussion** **Facilitated by: Gayla Jewell, PhD, RNC, NP**	**Cindy Beel-Bates, PhD, RN, FGSA** **Michael Bouthillier, BS Pharm, PharmD** **Linda Goosen, PhD, MT(ASCP)** **John B. O'Donnell, MD**

Dr. Gayla Jewel facilitated this panel of practitioners/educators and asked the panel leading questions regarding what their individual professional disciplines (nursing, physicians, pharmacy, and laboratory science) each thought about their frustrations with implementing an IPE endeavor, their concerns regarding curriculum fullness, and lastly to provide examples of IPE successes.

Opening Remarks. Dr. Linda Goosen explained how medical lab science is not typically involved in IPE and she wants to know how educators can get involved. Dr. Cindy Beel-Bates explained how Kirkhof College of Nursing (KCON) has participated in IPE experiences since 2007 working with the disciplines of pharmacy, physical therapy, occupational therapy, and physician assistant studies. Dr. John O'Donnell indicated that Michigan State University's internal medical residency program focused on the early, "low-hanging fruit." Authority on high is needed to proceed, but there are some quick things that can be done to implement IPE. Dr. Michael Bouthillier expressed that while pharmacy is the most commonly used downstream intervention in chronic disease management, pharmacy is often not involved upfront, but is rather thought of as downstream.

Frustrations with Implementing IPE. Dr. Goosen voiced an often quoted statement that while medical laboratory sciences is *behind the scenes*, 70% of medical decisions are made based on laboratory test results, but they are often not consulted or included on IPP teams. Likewise, pharmacy representative, Dr. Bouthillier expressed that pharmacy which is often a co-basement dweller with medical lab sciences, is left out of the IPC team. Dr. Bouthillier expressed the need for an open/inclusive environment on the IPP team so that people do not feel intimidated; physician arrogance needs to be removed so that all IPP team members can participate fully. The entire panel expressed the need to clearly identify IPE/IPP team roles, enhance communication skills, and require accountability. Additionally, mutual understanding of trust and commitment is needed as well as the self-awareness and a desire to participate on IPE/IPP teams and to seek out IPE encounters.

Curriculum Fullness. The panel expressed mutual concern that fitting IPE into an already jam-packed curriculum would force each discipline to have to give up content. The panel agreed that they would need to be nudged by accreditation standards to fit IPE into their curricula. Pharmacy and nursing already have the "heavy hand" of accreditation standards to include IPE into their curricula. Dr. Bouthillier explained that Ferris State University is already teaching to PA and NP students the same content that is taught to third year pharmacy students. There is no reason why courses taught to individual disciplines could not be taught interprofessionally to pharmacy, NPs, physicians, and PAs which might result in cost savings for the university. Additionally, team-based problems could be solved by the classroom participants who represent various professions. The panel also thought that smaller incremental successes or classroom learning experiences might be a good way to "test the waters" of an IPE idea first before moving ahead with a proposal to change something that would involve approval from various individuals and/or committees. Incremental success builds groundwork for later success.

Concrete Examples of IPE and Associated Concerns.

- Dr. Goosen suggested that medical laboratory science students could join in morning rounds so that they can participate in IPE; explaining how much a given lab test costs, inquiring why physicians ordered a particular test and suggesting alternatives to achieve the desired purpose of testing.
- Both Dr. O'Donnell and Dr. Bouthillier stressed the important of having upper management support and to have clearly defined expectations of what is expected of IPE students, otherwise they stand silently and do not participate in the IPE experience; they are afraid to speak. Dr. O'Donnell explained how the MSU internal medicine clinic uses pharmacy students in the in-patient clinic; he suggested the development of statements of what you can expect from pharmacy students in experiential clinical settings. Make the implicit more explicit. Prepare statements of what you can expect from each student at IPE learning experiences so that nobody stands silently afraid to say something.
- Dr. Beel-Bates expressed concern that very little of IPE is an easy sell; the quality of the "low-hanging fruit" (or the easy stuff to implement) may not be as good as the other fruit on the tree. You might make short-term gains, but the easy stuff may not sustain long-term value. You need to make sure the IPE objectives are meeting IPE accreditation standards.
- Dr. Beel-Bates discussed a new IPE nursing course that will begin winter 2013 (Integrated Team-based Care) where students will be in a team with students of other professions for the entire semester. First thing they plan to focus on is building trust and mutual understanding of scope of practice. Next, they will use case studies and standard patients to solve problems. The students will be videotaped and will analyze team process. The focal point of the course is not necessarily the clinical outcome or the decisions that are made; it's how did they function as a team, how are teams built, what are team dynamics and allowing them to practice as a team with team-based problem solving. The culmination of the course will be meeting together four Fridays in a row for three hours to put this into practice in the community with real patients. Research shows that if students can impact and see IPE working with a real patient they will internalize IPC. Participating patients will be long-term care based (community-based; long-term care, primary care, hospice, and pediatric).
- Dr. Bouthillier emphasized how Pharmacy programs are so content heavy that it can be difficult to figure out where reflection can be imbedded. Students need to have a strong self-identity of what their role and responsibility is and then need to find their authentic voice and not shrink from responsibilities, but grow into them. Those who are leaders on the IPC team need to hold each other accountable to fulfill their scope of practice.
- Lastly, the panel concurred that patient satisfaction surveys may also be a driver of IPE/IPC.

Day 2	**Interprofessional Collaborate Practices: A Panel Discussion** **Facilitated by: Jean Nagelkerk, PhD, FNP**	**Ramona Benkert, PhD, ANP-BC** **Kristin Spykerman, LMSW, CAADC** **Paul A. Woods, MD, MS** **John E. vanSchagen, MD, FAAFP**

Dr. Jean Nagelkerk facilitated a panel of healthcare professionals to answer the following questions:

- How does your setting implement IPE/IPP?
- Who are the champions for IPE/IPP?
- What are the benefits of IP collaborative practice?
- What advice do you have for settings that are beginning to start IPE/IPP?
- Any practice tips that you might give us?

Dr. Ramona Benkert

In 1971 Congress established Area Health Education Centers (AHECs) with the mission to recruit, train, retain health professionals, particularly diverse health professionals, to serve the underserved populations. One of the avenues to achieve their mission is to collaborate with communities to develop IP education or work with communities to develop collaborative education and practice in settings. To that end, the Michigan AHEC has a HRSA grant with GVSU, WMIPEI, Michigan Department of Community Health, and MI Health Council to implement the WMIPEI model at two practice sites (Wayne State and GVSU) to affect change in obesity.

The HRSA grant will foster IPE clinical education across the state. The implementation of the WMIPEI model champions are Dr. Benkert and her co-program director, Dr. Tom Rowe. They anticipate the benefits of IPC to enhance quality of care for the underserved communities around the state and to improve quality and reduce costs. Dr. Benkert understands the need to know what IPE is first, find out what has worked, link up to experts, and seek advice from other champions. Clinics need to have upper management support and want to be engaged, involved, and actively engaged in training/learning.

Kristin Spykerman

Kristin discussed the development of the Durham Clinic at Cherry Street Health Services which is the implementation of interprofessional care to handle patients with chronic conditions. In an effort to treat people better, The Durham Clinic came out of a merger between the CEOs of:

- Cherry Street Health Services (federally funded qualified health center; primary care silo; 13 centers within community, 68 schools, 6,500 patients, 800 employees)
- Touchstone Innovare (severe and persistent mental illness silo)
- Proaction Behavioral Health Alliance (substance abuse treatment silo)

Merger developed when all three CEOs realized they were serving the same population and that they were not doing a good job of communicating about the same patients with each other. This realization and subsequent merger were key components to the integration of IPC. People with severe and persistent mental illness die 25 years earlier than the general population due to their chronic health problems. Thus, the Durham Clinic evolved as a fully integrated healthcare clinic in one location. Chronic conditions are treated together (example diabetes, hypertension, and depression). One electronic medication administration record and treatment plan is used by all healthcare workers (internist, psychiatrist, social worker, PA, RNs, case managers). Patients are given equal access to all

providers. The main job is to get clients motivate and activated around their chronic health problems (with an average of 7.5 chronic health conditions per patient). The Durham Clinic team is cross-trained and performs daily huddles to review patient's treatment plans.

Kristin discussed the numerous benefits of the integrated model of care that the Durham Clinic offers, including: increased knowledge for staff and patients, development of motivational interviewing skills for a variety of healthcare workers, increased knowledge of how chronic medical conditions interact with mental health issues, better patient care and better patient outcomes, patient activation is up (PAM 13), symptoms are going down, significant decline in psychiatric hospital days (about 1/3 have persistent mental health issues; hospital days are down 50%), stop treating the wrong thing, time savings, less time trying to coordinate care, and patients tell their story once rather than to each different professional.

Kristen advised starting small with any new IPC initiative. There is a massive learning curve between different healthcare professionals; anticipate the cultural shift because resistance will come from both internal and external sources. Kristen stressed the importance of commitment from upper management and a champion who is constantly promoting the process. Kristen felt that not everybody can work in an IPC environment; it requires individuals who are humble, adaptive, and internally motivated. Kristen also cautioned to never leave newly formed IPC teams alone as they could too easily revert back to their old ways.

Dr. John vanSchagen

Dr. vanSchagen described two clinics; one at St. Mary's Peter M. Wege Center for Health and Learning and the other at Spectrum Health where PharmD faculty and students are embedded with medical students and physician faculty. At the Spectrum Health site there is also a social worker and case manager on site. Medical and pharmacy students work on didactics and case based learning, patient care, and medical therapy evaluations. Pharmacy students, residents, and social workers collaborate on prescription coverage and low cost alternatives (over 80% of patients at the clinics are Medicare or Medicaid; only 10% are third party payer insurance; 10% uninsured).

Dr. vanSchagen cites the benefits of these two clinics as creating improved interprofessional respect, lowering the cost of care for patients, improving safety of prescribing and monitoring, improving adherence to medications, decreasing patient waiting times, reducing complications of chronic disease, and reducing the frequency of hospitalizations. Dr. vanSchagen advises to work on team building, camaraderie, and communication skills when starting an IPE/IPC initiative. Also, find ways for healthcare professionals to work to the full extent of their training, get team members to take ownership of each patient, and share in the success of improving outcomes. Lastly, Dr. vanSchagen advised to allow for increased physical space to accommodate multiple learners in one space and to transform patient flow and office processes to allow for multi-step care.

Dr. Paul Woods

Representing Spectrum Health, Dr. Woods discussed how they are doing IPE/IPC in single specialties and small groups, but overall IPE/IPC is not happening that much in the primary care arena. Dr. Woods also discussed how Spectrum Health's 32-35 primary care facilities will most likely be consolidating due to the fact that they are not viewed as an asset to quality patient care.

Dr. Woods discussed how the old model of care in which the physicians do everything is based on an antiquated hierarchical model that is further enhanced by a compensation model that pays for doing

"stuff" rather than outcomes achieved. A new model of care is to provide the right care, to the right patient, at the right time, by the right provider which is necessary because there is estimated to be a 40,000 primary care physician shortage by 2020. It is too expensive to educate more physicians when other healthcare workers can do things less expensively.

Dr. Woods also described the Transformational Model of Care that is STEEEP (safe, timely, effective, efficient, equitable, and patient centered). The Transformational Model of Care is a mechanism to achieve the triple aim (better health, better care, and decreased costs) through the use of lean process improvement, episodes of care and advanced care models (DIAMOND, COMPASS), interprofessional team-based care, and seamless integrated care experiences for every patient across the continuum. Dr. Woods indicated that there is currently more development in IPE than IPP/IPC because it is costly to implement new approaches. Dr. Woods advises to demonstrate benefits with early wins and to tell stories about how IPE/IPC will make people's live better.

Day 2	**IPE & Healthcare Transformation: A Virtuous Cycle**	**Joshua Tepper, MD, MBA Vice President of Education Sunnybrook Health Sciences Centre**

Dr. Tepper discussed how interprofessional education (IPE) and interprofessional care (IPC) are increasingly transformational tools in the delivery of health care. From his initial rural Canadian family practice experience to his current position as Vice President of Education at Sunnybrook Health Science Centre, Dr. Tepper reviewed the progress and challenges faced in the move to IPE and IPC.

The Canadian government understood that both the lack of access to primary care and the massive healthcare worker shortage were major concerns to implementing IPE/IPC. They also understood that opening new medical schools/training facilities was not the answer and nor was simply paying healthcare workers more. The Canadian government decided to put IPE/IPC on the agenda by providing patient driven comprehensive health services by caregivers who work collaboratively to deliver quality of care within and across settings. They realized that if they were successful in implementing IPE/IPC the result would: improve quality of care, decrease error rates, improve employee retention, decrease employee burnout, and improve employee satisfaction and engagement. Thus, the Canadian national government created an IPE and IPC Task Force to: redesign curriculums to incorporate IPE/IPC, provide seed money for pilot programs, restructure primary care to be team based, collect data better, and create momentum. The Task Force emphasized the importance of having IPE taught to students in the classroom carry over into the professional work environment.

Dr. Tepper also expressed concern that the healthcare buzz words have changed over the last decade resulting in IPE/IPC no longer being a hot topic, but that they should be because IPE/IPC is not "solved." Dr. Tepper presented two solutions for continuing IPE/IPC work. First, coupling; IPE needs to be linked into the current healthcare discussion items (electronic health records, chronic disease management, health outcomes, quality, sustainability, safety, etc.) Second, we need to measure IPE placements and hold IPE/IPC initiatives accountable by measuring outcomes using a Balanced Scorecard approach (for example use simulations to measure how teams work together vs. individuals).

IPE/IPC is incredibly hard to implement, requiring infrastructure change, financial change, and culture change. It is important to have visionary leadership that can look for positive deviants and hold them up as an example of change leadership. Dr. Tepper expressed the importance of raising the profile of people who are doing good things related to IPE by providing awards, holding conferences, conducting academic research. Organizations can achieve IPE/IPC through habit; choose to be a leader. IPE/IPC leadership creates a virtuous, positively reinforcing, cycle:

IPE/IPC → increases knowledge and skills → improved care → improved outcomes/decreased costs → motivated patients, families, community, staff, and physicians → more IPE/IPC

IPE/IPC takes investment and time to build highly successful IPE/IPC teams. Also, it is very important to measure outcomes and plan for how your organization will sustain change once you make it. Healthcare workers may be reluctant to change at first; however, when they see the impact on health outcomes they are asking to participate on IPE/IPC teams. IPE/IPC is transformative in terms of how it can change the delivery of care.

Poster Presentations

The following poster presentations were offered at the conference:

Interprofessional Education in Michigan Physician Assistant Curricula – A Pilot Study **Purpose: Explore IPE in Michigan Physician Assistant (PA) Curricula.**	**Stephanie Cole, PA-S** **Megan Micallef, PA-S** **Grand Valley State University**
Outcomes of Wounded Warriors with TBI: Standard of Care Versus Enhanced Care **Purpose: Demonstrate that educating an interprofessional team on the unique health care needs of polytraumatically-injuried wounded warriors will enhance the delivery of a rehabilitation model of care for improving the physical and psychological functioning of wounded warriors and their return to work, social, and family roles.**	**Jean Nagelkerk, PhD, FNP** **Jacobus Donders, PhD** **Lorraine Pearl-Kraus, PhD, FNP-BC** **Jeff Trytko, MS** **Lawrence Baer, PhD** **Theresa Bacon-Baguley, PhD, RN** **Susan Jensen, PhD, RN, CCM** **Jared Skillings, PhD**
Interprofessional Faculty Training Series: Collaborative Practice **Purpose: IPE has been reported to enhance the quality of interprofessional collaboration (IPC), improving patient care and health outcomes. Despite the fact that healthcare professional students complete robust training programs, they frequently are not "work-ready" unless they have developed interpersonal and team-working capabilities. Irrespective of the established benefits of IPE and IPC, many training institutions have not yet embraced thee models or added them to their curricula.**	**Donald Sefcik, DO, MBA** **Deborah L. Virant-Young, PharmD, BCPS** **Michigan State University** **College of Osteopathic Medicine**
Quality Improvement Project Using Tailored Interventions with an Interdisciplinary Approach to Decrease Blood Culture Contaminants **Purpose: This project is the third cycle of Plan-Do-Study-Act (PDSA) within an ongoing quality improvement (QI) initiative. The purpose of this project is to 1) evaluate the rates of blood culture contamination and 2) determine knowledge level and current practice issues of those responsible for blood culture (BC) collection after initiation of the use of blood culture collection kits and improved education/training of staff responsible for BC culture collection procedures.**	**Tracey Haener, MSN, ANP-BC** **Cheryl Yonke, MS, SM(ASP)** **Nancy A. O'Connor, PhD, ANP-BC** **Deborah Dunn, EdD, MSN, GNP-BC, ACNS-BC** **Gail Lis, DNP, ACNP-BC**
R2-Rounding for Results: An Innovative Approach to Family Centered Rounds **Purpose: To improve rounding effectiveness, a team designed an innovative approach to clinical rounding. The team desired to increase the engagement of families with providers in order to enhance safety, quality, and satisfaction.**	**Martina Keeler, MD, FAAP** **Jodi Meinke, MSN, RN, CPN-PC/AC** **Jennifer Liedke, BSN, RN, CPN** **Helen DeVos Children's Hospital**
Partnering with the Media to Promote Standard Patient Methodology **Purpose: To increase awareness and promote the significant role standard patient methodology plays in the education of health care professionals, support and enhance recruiting efforts to continually increase Standard Patient pool, partner with local media to spotlight Grand Valley State University as a leader in healthcare and IPE.**	**Cindy Bartman, BSN, RN**

Safety Culture Transformation Study **Purpose: Address the need for health professionals to communicate effectively in the provision of safe, quality, patient-centered care. The safety program research was designed to provide interprofessional education learning experience to health professions students and staff.**	**Jean Nagelkerk, PhD, FNP** **Tom Peterson, MD** **Brenda Pawl, MSN, FNP-BC** **Susan Terman, BSN, RN** **Amy Anyangu, BS, CRN** **Susan Mlynarczyk, PhD, RN, PNP** **Lawrence Baer, PhD**

Paper Presentations

The following paper presentations were offered at the conference:

R2 – Rounding for Results: An Innovative Approach to Family Centered Rounds **With improved collaboration and engagement in daily assessment and plans of care, families feel as if they are part of the team, their input is valued, and they are more prepared for discharge. All members of the team, including families and patients, add a unique perspective that contributes and enhances the plan of care.**	**Martina Keeler, MD, FAAP** **Jodi Meinke, MSN, RN, CPN-PC/AC** **Jennifer Liedke, BSN, RN, CPN** **Helen DeVos Children's Hospital**
Development and Implementation of an Interprofessional Standardized Indwelling Urinary Catheter Insertion Checklist **This initiative is unique in that greater standardization of training and assessment was achieved across a variety of disciplines, as well as bringing clinical services and academic institutions together. This quality specific campaign to improve patient care will help bridge academic-service gaps in practice competencies.**	**Sylvia Baird, MM, BSN, RN** **Tina M. Barnikow, BSN, RN** **Peter Coggan, MD, MSEd** **Luann Huizinga, BSN, RN** **Pam Jager, BSN, RNytko, MS** **Regina Manczak, BSN, RN** **Carlos H. Rodriguez, MD, FACS** **Nancy Schoofs, PhD, RN** **Vickie Slot, MSN, RN** **Margaret E. Thompson, MD**
Exposure of GVSU Physician Assistant (PA) Students to Different Helath Professions During the Didactic Phase Increases the Awareness of Students to Interprofessional Collaborations **After only two semesters, the Hospital Community Experience course sequence has been successful in increasing PA students' awareness of interprofessional collaborations.**	**Martina Reinhold, PhD** **Karlin Sevensma, DO** **Andrew Booth, PA-C** **Grand Valley State University**
Panel Discussion: **Key Elements of Designing an Interprofessional Simulation: The Who, The What, The How** **Expectation is that participants will leave with ideas and resources to help implement interprofessional simulation in their setting.**	**Michael Shoemaker, PT, DPT, PhD, GCS** **Dianne Wagner, MD, FACP** **Pam Jager, BSN, RN** **JoAn Beckman, MSN, RN, CCRN, CEN** **Ron Perkins, BSN, RN** **Vickie Slot, MSN, RN**
A Cost-Effective Patient Centered Medical Home (PCMH) Care Delivery Innovation that Improves Outcomes **Study demonstrates that there are opportunities to improve clinical outcomes/capture revenue that supports this role and adds to financial viability. This doctoral work led to entrepreneurial opportunities for the Doctor of Nursing Practice (DNP) to impact healthcare/health systems.**	**Rosanne Burson, DNP, ACNS-BC, CDE** **Kathy Moran, DNP, RN, CDE** **University of Detroit Mercy**
Creating & Leading in an Environmental Collaborative **Successful IPE programs seeking to accomplish the triple aim require leaders with a specific skill set. This presentation identifies specific competencies and gives tools to determine their effective implementation.**	**Linda S. White, MPA, RMA, CBSP** **Grand Rapids Community College**

Panel Discussion: **Key Elements of Debriefing an Interprofessional Simulation: The Who, The What, The How** **Expectation is that participants will leave with ideas and resources to help implement interprofessional simulation in their setting.**	**Andrew Booth, MS, PA-C** **Peggy deVoest, PharmD** **Linda Foster,** **Pam Jager, BSN, RN** **Vickie Slot, MSN, RN**
Modification of Battery-Operated Toy Car to Enhance a Child's Functional Mobility and Participation **Although the PT recognized the child's needs and had a vague vision of how to potentially address these needs, it was only through interprofessional collaboration with engineering that the PT's idea became a reality.**	**Lisa Kenyon, PT, PhD, PCS** **John Farris, PhD** **Phil DeJonge** **Jake Hall**
Statewide Partnerships to Promote Interprofessional Education & Practice **The Michigan Health Council's clinical education and recruitment programs provide examples of ways to formalize partnerships that provide measurable value to users. One challenge for the IPE movement in Michigan is to gain a statewide understanding of each interprofessional stakeholder's expertise and find ways to work together to maximize impact.**	**Anne Rosewarne, CEO** **Michigan Health Council**

Conclusion

The theme of this year's conference was to explore the role of interprofessional education (IPE) and interprofessional practice (IPP) in meeting the triple aim goal of better health, better care, and decreased costs. Conference presenters shared specific challenges and successes that their own organizations faced while implementing IPE/IPP. These examples, plus the invaluable tips offered by presenters, allowed conference attendees to visualize how they could implement IPE/IPP within their own organizations.

The West Michigan Interprofessional Education Initiative (WMIPEI) has accomplished many initiatives this past year, including the development of online student foundational, IPE, patient safety, and team building modules and completion of the interprofessional education initiative preceptor manual.

In looking ahead to the coming year, the WMIPEI model will be implemented and assessed through funding from a Nurse Education, Practice, Quality and Retention (NEPQR) grant awarded to the Michigan Department of Community Health (MDCH) by the Health Resources and Services Administration (HRSA). The WMIPEI model will also be part of the inaugural group in the Innovations Incubator for the national Coordinating Center for IPE and Collaborative Practice at the University of Minnesota.

Together we are developing the interprofessional infrastructure for faculty, students, preceptors, and practice partners while co-creating new practice approaches to collaborative team-based care in our health care delivery systems. We look forward to your continued participation in the year ahead.