Disclosure
Barbara Brandt, PhD, University of Minnesota

Financial disclosure:

• Received honorarium and expenses covered by ASHA for her presentation
• A salaried employee of the University of Minnesota
• Receives grant funding from US Dept. of Health and Human Services, Josiah Macy Jr. Foundation, Robert Wood Johnson Foundation, Gordon and Betty Moore Foundation and The John A. Hartford Foundation for the National Center for Interprofessional Practice and Education

Nonfinancial disclosure:

Founding board chair: the American Interprofessional Health Collaborative
AIHC Board member
The National Center: A New Model for Public-Private Partnership

The National Center for Interprofessional Practice and Education is supported by a Health Resources and Services Administration $4M, five year Cooperative Agreement Award No. UE5HP25067.

In addition, the Josiah Macy Jr. Foundation, the Robert Wood Johnson Foundation (RWJF), the Gordon and Betty Moore Foundation, and the John A. Hartford Foundation have collectively committed up to $8.1 million in grants over five years to support and guide the center, which provides leadership, scholarship, evidence, coordination and national visibility to advance interprofessional education and practice as a viable and efficient health care delivery model.
HRSA Principles
June 1, 2012 Funding Opportunity Announcement

A coordinating center for interprofessional education and collaborative practice will provide leadership, scholarship, evidence, coordination and national visibility to advance interprofessional education and practice as a viable and efficient health care delivery model.
Topics

• IPE 101: Welcome to the New 50-Year Old Field

• The Current Health Care Drivers: It’s not all about the website.

• What does this mean for the interface between academia and practice?

• What you should be doing – or at least thinking about now.
Pop Quiz / Points to ponder

What is “interprofessional practice and education (IPE)”?

Why should we care about IPE?
Interprofessional Education and Collaborative Practice

Interprofessional education “occurs when two or more professions learn about, from, and with each other to enable effective collaboration and improve health outcomes.”

Interprofessional (or collaborative) care/practice “occurs when multiple health workers from different professional backgrounds provide comprehensive health services by working with patients, their families, carers (caregivers), and communities to deliver the highest quality of care across settings.”

Interprofessional education is a necessary step in preparing a “collaborative practice-ready” health workforce that is better prepared to respond to local health needs.

A collaborative practice-ready health worker is someone who has learned how to work in an interprofessional team and is competent to do so.

It allows health workers to engage any individual whose skills can help achieve local public health goals.
It’s about practice and health outcomes.

Interprofessional education +
Interprofessional, collaborative practice =

The new IPE: Interprofessional practice and education
What is *not* IPE: Shared Learning

Pharmacy

Nursing

Medicine

SLP
IPE Pedagogy / Andragogy

- Strategies focused on how adults learn
- Interactive and learning in interprofessional groups
- Collaborative learning
- Facilitated learning – roles for mentors
- Reflective learning
- Ideally, problem focused and related to collaborative practice
- Role of simulations
- Cognitive science and learning theory
It’s not a new field. . . .

“Discussions with students disclosed the desire to see far more emphasis on the “team” approach to providing health care. Students assert that if future health care delivery systems require a team approach to provide the necessary services, today’s health student must be exposed to the approach in his educational experience.

Students recognize the impossibility of training all professionals in the same courses and program, emphasize the necessity of integrated training when practical.”

Report of the External Committee on Governance of University Health Sciences, University of Minnesota, February 1970
“The Long and Winding Road” of IPE (Hall & Weaver, 2001)

National & International

1970s “Birkenstock” IPE
1972 IOM Report - Teams
Area Health Education Centers
Geriatric Education Centers
Health Professions Schools in Service to the Nation
Pew Health Commission Reports
Kellogg Community-Campus Partnerships
Quentin Burdick grants
Hartford Geriatrics Interdisciplinary Team Training
National Health Service Corps
Community Health Center movement
Various Academic Health Centers
Association of Academic Health Centers
World Health Organization Declaration, 1988
United Kingdom, Canada, Australia, New Zealand
Centre for the Advancement of Interprofessional Education (CAIPE), 1987

Journal of Interprofessional Care
Canadian Interprofessional Health Collaborative
All Together Better Health Conferences
Many more. . . .

Minnesota

Center for Health Interprofessional programs
ACT II
Minnesota Area Health Education Center
Minnesota Area Geriatric Education Centers
End-of-life Patient-Centered Teamwork
Physician & Society courses
Community-University Partnership for Health
Walker-Methodist Transitional Care Unit
Burdick geriatrics fellowship in Moose Lake
Institute for Healthcare Improvement Collaborative
Immunization Tour
Duluth strategic initiatives
Health Careers Center multiple activities
CLARION retreats and national case competition
Fourteen AHEC rural interprofessional sites
Hartford GITT
IERC faculty development activities
Tufts Institute on Systems
Systems-based Practice
Center for Bioethics courses
Center for Spirituality and Healing
Many more. . . .
Dr. Dewitt “Bud” Baldwin’s ACGME Office

briefs

Health care team competition is March 25

Three teams made up of students in good academic standing from UT-Houston’s six schools and The University of Houston’s Graduate School of Social Work, College of Pharmacy, and Health Law and Policy Institute will participate in a competition designed to illustrate an interdisciplinary approach to health care.
Interdisciplinary Education: First National Visibility

- Introduced in US in mid-late 1960's
- First IOM report: “Educating for Health Teams”- 1972
- Committee: allied health, dentistry, medicine, nursing, pharmacy
- Significant federal funding throughout 1970s

Why wasn’t “IDE” been mainstreamed?
At the administrative level...

...academic health centers must recognize an obligation to engage in interdisciplinary education and patient care, and regional consortia of health professional schools not otherwise associated with academic health centers should be formed to foster educational teamwork;

...methods must be developed within institutions to relate interdisciplinary education to the practical requirements of health care.
At the teaching level...

...clinical care, and particularly ambulatory care, offers a setting with the most immediate promise for successful inter-disciplinary education, while classroom instruction appears initially more feasible in the humanities and the social and behavioral sciences associated with health care;

...interdisciplinary instruction will require that faculties develop new skills, present new role models, and work to understand the impediments that have accumulated to hamper cooperation among health professions.
At the national level...

...a clearinghouse should be established to collect and distribute information on programs of interdisciplinary education and models of health care teams;

...government agencies should support innovative interdisciplinary health education, new health care models associated with educational programs, and research on the obstacles to interprofessional cooperation;

...the Institute of Medicine should further the lines of investigation opened by this conference and advance the concepts of interdisciplinary education in the health professions.
Early Lack of Broad Support

- Primary care not a locus of power in medicine
- Era of specialization in medicine
- Little interest in care delivery processes
- Other health care occupations early in professionalization, new roles and controversies
- Lack of evidence for outcomes of “IDE” or team-based care
- No alignment between education and practice
- Considerable independent work in “IDE”

What is the same? What is different?
Cycles of interest over time

Rehabilitation,
Mental health,
Comprehensive care in chronic illness,
Primary care,
Rural care,
Geriatrics,
Intensive care,
Transplantation Teams
Hospice and palliative care
Abraham Flexner & His Legacy
100 Years Later
The “Rational” Competency Model

Health Professional Education in Academic Institutions: The Rational Competency Model, based upon national consensus of competencies

Community Practice and Training Partners

Competency Assessment

Capability Assessment

Clinical & Practice in Community

The National Center for Interprofessional Practice and Education is supported by a Health Resources and Services Administration Cooperative Agreement Award No. U5P25067. © 2013 Regents of the University of Minnesota, All Rights Reserved.
Why now?  What’s different?
Current interest in interprofessional practice and education

• Institute for Healthcare Improvement “Triple Aim”
  o Improving the patient experience of care;
  o Improving the health of populations; and
  o Reducing the per capita cost of health care.

• Collaborative practice and care coordination

• Quality, patient safety and systems improvement

• Patient Protection & Affordable Care Act

• New payment and care delivery models

• New defined interprofessional competencies

• ACGME, LCME and other accreditation expectations

• Patients, families and communities engagement/activation
Mapping the Emerging Landscape in Health Care – Margaret Rogers, PhD, CCC-SLP - ASHA

Outcomes Measurement

Learning Systems

Patient-Centered Care

Transparency
Speech-Language Pathology and the Physician Quality Reporting System (PQRS)

The Centers for Medicare and Medicaid Services' (CMS) Physician Quality Reporting System (PQRS) is a voluntary incentive payment program for eligible health care professionals. It is designed to support improvements in quality of care to Medicare beneficiaries through the tracking of practice patterns. PQRS is separate from the Medicare claims-based reporting initiative and is only for SLPs who directly bill Medicare Part B for the provision of services to stroke patients.

Eight of ASHA's adult NOMS Functional Communication Measures (FCM) have been classified as quality measures, and we are now approved by CMS as a registry through which eligible SLPs can report on these measures. The approved FCMs (PDF) include spoken language comprehension, spoken language expression, motor speech, writing, reading, attention, memory, and swallowing. We are currently seeking new and existing NOMS participants to take part in the Physician Quality Reporting System. As an official registry, ASHA will submit NOMS data on your behalf to CMS. To be eligible for the end of year incentive payment, you must meet the following program requirements:

- Provide speech-language pathology services in a private practice setting to adult stroke patients covered under Medicare Part B.
- Directly bill for services under the Medicare Physician Fee Schedule using your individual National Provider Identifier (NPI).
- Have an individual NPI, as assigned by CMS.
- Have an associated Taxpayer Identification Number (TIN).
- Collect and submit NOMS data on three or more quality measures for at least 80% of all eligible Medicare beneficiaries in the reporting period.

Eligible SLPs who wish to participate in PQRS should register for NOMS data collection.

To find out more about NOMS and the Physician Quality Reporting System, please...
National Outcomes Measurement System (NOMS)

News

ASHA Launches a New and Improved NOMS Data Collection and Reporting Tool

The release of ASHA’s new web-based NOMS data collection instrument now makes the reporting of outcomes easier. Enhancements to the Adult NOMS tool include simplified data collection forms with optional summary reporting, a new goal setting feature with access to real-time national benchmarking data, and a built-in G-code converter to assist with Medicare’s claims-based reporting. This new tool is available to NOMS participants only. If your organization is interested in submitting data to ASHA’s national registry and learning more about NOMS, read additional information below on the heading “What is NOMS?” The new Pre-Kindergarten data collection instrument will be coming soon.

The Adult NOMS Functional Communication Measures (FCM) can be used in two Medicare programs

The NOMS FCMs can be used to assist with Medicare’s claims-based reporting. The CMS measures, known as “G-codes” with accompanying severity/comorbidity modifiers, can easily crosswalk to the NOMS F-point scales. It is important to note that the FCMs are only one component of NOMS. To receive access to all of the components of NOMS—national database of treatment outcomes and customized data reports—your organization must subscribe to NOMS and become a registered NOMS site. To find out more about how NOMS and its FCMs relate to Medicare’s claims-based outcome reporting using G-codes, view frequently asked questions related to NOMS and claims-based outcome reporting.

In 2008, eight of the 15 Functional Communication Measures (FCM) used in the Adult NOMS data collection tool were submitted to the National Quality Forum (NQF) for review. All eight were endorsed and subsequently became available for use in the Centers for Medicare and Medicaid Services Physician Quality Reporting System (PQRS). PQRS is separate from the Medicare
COLLABORATING ACROSS BORDERS IV (CAB IV)

Transformative Change from the Classroom to Practice

Collaborating Across Borders (CAB) IV, June 12-14, 2013
in beautiful Vancouver, British Columbia, Canada

What's New

- "New" Conference presentations are now available for viewing. Presentations available for viewing are posted with speakers' consent. Click here to view the conference presentations.

- We are excited to announce that the peer-reviewed CAB IV abstracts are now posted online! With so many high quality presentations to choose from, we hope that this will help you more easily select the breakout sessions you would like to attend. Click here to review the abstracts.

- The Canadian Interprofessional Health Collaborative (CIHC) is posting a series of interviews with patients and clients around their thoughts on team-based health care. The goal is to showcase the realities of team-based care from a variety of different perspectives. Please visit http://incredibly.com often to check for new stories.

- The Social and Local Committee, with the help of the Vancouver Tourism Board, have been working hard to create a list of the 'Top 5' things to see and do in Vancouver. Click here to plan your non-conference related activities.

- Conference program now AVAILABLE. Please visit HERE.

General Conference Information

Conference Overview:

Building upon the highly successful Collaborating Across Borders Conference series (1, 2, and 3), CAB IV is the fourth joint conference that links Canada and the United States around the key themes of interprofessional education (IPE) and interprofessional practice (IPP).

CAB IV will continue the traditions established by previous CAB conferences by focusing on interprofessional education, practice, leadership and policy in a North American context. The conference will feature best practices, showcase evidence-based outcomes and lessons learned, and provide a venue for scholarly dialogue and productive networking.
The Lancet Commissions

THE LANCET

Education of Health Professionals for the 21st Century: A Global Independent Commission

Health professionals for a new century: transforming education to strengthen health systems in an interdependent world

Julio Frenk*, Lincoln Chen*, Zulfiqar A Bhatta, Jordan Cohen, Nigel Crisp, Timothy Evans, Harvey Fineberg, Patricia Garcia, Yang Ke, Patrick Kelley, Barry Kistnasamy, Afaaf Meleis, David Naylor, Ariel Pablos-Mendez, Srinath Reddy, Susan Scrimshaw, Jaime Sepulveda, David Serwadda, Huda Zurayk

Executive summary

Problem statement

Redesign of professional health education is necessary and timely in view of the opportunities for mutual benefit.
The Nexus

Creating the Transformational Nexus for Health

Improved Health and Community Outcomes
National Aims / Triple Aim

The Nexus:
Collaborative linking of academia and the practice of health care.

Team-based Care

Health Professions Education
Orientation and essential skills

Senior Leadership
Faculty, Clinicians, and Practitioners
Operations

Practice Community
Evolving integrated health systems
The current national scene
IPEC Competencies

- Values & ethics for interprofessional practice
- Roles & responsibilities
- Interprofessional communication
- Teams and teamwork

Other Needed Competencies

- Population health, including social determinants
- Patient-center decision-making
- Evidence-based decision-making
- Cost-effective practices
- Quality improvement and safe practice
- Stewardship
- Systems thinking
- Informatics
Global Forum on Innovation in Health Professional Education

Activity Description

Health care is rapidly evolving. No longer does a person receive care from just a single doctor at a single location; information and care are spread among various facilities and health care providers. In order for a patient to receive the best care, health education must reflect the changing health care environment.

Tapping inspiration from the 2010 IOM report, The Future of Nursing, and the 2010 Lancet Commission report on interprofessional health professional education for the 21st century, the IOM Global Forum on Innovation in Health Professional Education aims to apply an ongoing, multi-national, multi-disciplinary approach to exploring promising innovations in health education. The Forum brings together stakeholders from a variety of disciplines and sectors to engage in dialogue and discussion to illuminate contemporary issues in health professional education. Further, the Forum will provide an ongoing, innovative mechanism to cultivate new ideas through global, multi-disciplinary collaboratives, which represent formal partnerships between university-based health institutions that are undertaking recommendations put forward in either the 2010 Lancet Commission report or the Future of Nursing report. The four innovation collaboratives are located in Canada, India, South Africa, and Uganda.

See the Full Committee Roster

Upcoming Meetings

Assessing Health Professional Education: A Workshop
October 9, 2013 - October 10, 2013 (8:00 AM Eastern)
View Agenda - Additional Meeting Resources

Previous Meetings:

Establishing Transdisciplinary Professionalism for Health: A Workshop
May 14, 2013 - May 15, 2013 (8:30 AM Eastern)
View Agenda - Additional Meeting Resources

Workshop 2: Educating for Practice: Learning how to improve health from interprofessional models across the continuum of education to practice
November 29, 2012 - November 30, 2012 (8:30 AM Eastern)
View Agenda - Additional Meeting Resources

Workshop 1: Educating for Practice: Improving Health by Linking Education to Practice using IPE
August 29, 2012 - August 30, 2012 (8:30 AM Eastern)
View Agenda - Additional Meeting Resources

View All Previous Meetings
TeamSTEPPS®: National Implementation

About TeamSTEPPS

TeamSTEPPS is a teamwork system designed for health care professionals that is:

- A powerful solution to improve patient safety within your organization.
- An evidence-based teamwork system to improve communication and teamwork skills among health care professionals.

National Implementation of TeamSTEPPS

About the TeamSTEPPS National Implementation Project

AHRO and the Defense Department have teamed to build a national training and support network called the National Implementation of TeamSTEPPS Project.

More...

Team Strategies and Tools to Enhance Performance and Patient Safety

TeamSTEPPS Training Eligibility

Are You Ready for TeamSTEPPS?

TeamSTEPPS Tools and Materials

Spotlight

- New - TeamSTEPPS® Primary Care Version. This version of TeamSTEPPS adapts the core concepts of the TeamSTEPPS program to reflect the environment of primary care office-based teams.

- New - TeamSTEPPS Long-Term Care Version. A version of TeamSTEPPS adapted to the environment of nursing homes and other other long-term care settings such as assisted living & continuing care retirement communities.

- New - TeamSTEPPS Enhancing Safety for Patients With Limited English Proficiency. A module to help develop a customized plan to train staff in teamwork skills as applied to work with patients who have difficulty communicating in English.
Disruptive trends

- Mismatch between the number of medical school graduates and medical residency “slots” – how will academic integrated health systems respond?
- Right sizing primary care and PCMH: who, what, when and where
- Volume to value movement
- Self-insured employers and innovative cost-cutting strategies
- Destination health care
- Elected officials: Concern for both health care and higher education
- Engaged university boards of trustees/regents representing the citizens
- Health systems – implication of concern for unsustainable cost of retraining
Health Professional Education
Student Learners

- Isolated faculty
- Student ‘tourist’ rotations
- Siloed accreditation
- Two years retraining required
- Focus on individual clinical competence
- Learning in silos
- Unorganized IPE Research
- Unknown IPE Programs
- Focus on individual patient encounters
- Hierarchical care delivery
- Out-of-control costs
- Competing scopes of practice
- Fee-for-service model
- Focus on care, not health
- Undifferentiated IPE Practices
- Health Practice
  Necessary Workforce
- Uncoordinated care
What should you be doing . . . or at least thinking about today?
Revisiting the role of health professions education in the new world

“Can our graduates who do not value interprofessional working, know little about each other, may never have communicated with each other, haven’t been taught collaboration skills, and have no shared clinical experience as students be expected to practice effectively in the emerging health care system?”

Madeline Schmitt, PhD, RN, FAAN, University of Rochester, 2010
The current state of IPE

A great deal of enthusiasm and experimentation
National momentum driving local work
New offices to manage IPE with investments
Little evidence for program development:
  When to start?
  What dose?
Few templates to guide curriculum design
Lack of metrics and standardization in the field
Emerging ideas for You

• Stay abreast of the health care delivery system transformation
• What does this mean specifically for your profession now and as the health system evolves, including new emphasis of health not care?
• Invite transforming health systems, payers and others at the to co-create your educational program
• Be informed about national changes in IPE and implications -- accreditors, competencies, approaches
• Take advantage of the many opportunities for learning
• Read the literature – Journal of Interprofessional Care
• Adopt: the “All collaborate, all learn, and all teach” philosophy
• Value IP research, evaluation and informatics as core in rewards and recognition
AHSA – Very involved

Staying abreast of health care developments – new models

Engagement

• Interprofessional Professionalism Collaborative
• Institute of Medicine Global Forum
• Collaborating Across Borders

Awareness promotion

• Internal
• External

Ad Hoc Committee Recommendations
Low hanging fruit

- Learn about the curriculum and roles of other professions
- Explore opportunities to collaborate
- Examine your curriculum and courses for contemporary realities
- Interprofessional learning and education
- Reflect on naturally occurring interprofessional settings
- New modes of E- and I- interaction and learning
- The weave
- Interprofessional learning facilitator

- Rigorous assessment and evaluation: Value-added?
Next discussion

The National Center for Interprofessional Practice and Education
2013 Joint Researcher-Academic Town Meeting / ASHA Approved CE Provider Workshop
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Founding board chair: the American Interprofessional Health Collaborative
AIHC Board member
Disclosure

Kenn Apel, PhD, University of South Carolina

Financial disclosure:
Received a waiver of his registration fee from ASHA for participating in this presentation

Nonfinancial disclosure:
• Serves on ASHA’s Interprofessional Education ad hoc committee
• Represents the Council of Academic Programs in Communication Sciences and Disorders on the Global Forum on Innovations Health Professional Education (Institute of Medicine)
• Serves as a member of the University of South Carolina’s Committee on Interprofessional Education
Disclosure

Robert Moore, PhD, University of South Alabama

Financial disclosure:
Received a waiver of his registration fee from ASHA for participating in this presentation

Nonfinancial disclosure:
• Serves on ASHA’s Interprofessional Education ad hoc committee
• Serves as the coordinator of Special Interest Group 6, Hearing and Hearing Disorders: Research and Diagnostics
• Member of the American Academy of Audiology’s Research Committee, ASA and AAS
Disclosure

Nancy Scherer, PhD, Arizona State University

Financial disclosure:
Received a waiver of her registration fee from ASHA for participating in this presentation.

Nonfinancial disclosure:
Nothing to disclose
The National Center for Interprofessional Practice and Education and You

Barbara F. Brandt, Director
Associate Vice President for Education

American Speech-Hearing-Language Association
November 13, 2013
Important Earlier Points

A 50 year old field that is experiencing a resurgence

What IPE and CP is and isn’t

Many new and different drivers renewing interest in interprofessional education and collaborative practice

Evidence that teamwork contributes to health outcomes

Very little evidence to guide educational development
Topics

The work of the National Center

How the University of Minnesota’s experience informed the National Center

Examples of innovative models
The National Center: A New Model for Public-Private Partnership

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Nine interdependent goals

1. Provide unbiased, expert guidance
2. Provide supporting evidence
3. Identify exemplary IPECP environments
4. Prepare academic and practice faculty and preceptors
5. Collect, analyze, and disseminate data metrics
6. Coordinate IPECP scholarly, evaluation and dissemination efforts
7. Evaluate the impact of team-based care
8. Develop new, and support and/or enhance existing team-based IPECP programs across the U.S.; and
9. Convene and engage IPECP thought leaders, educators, practitioners, and policy-makers
The University of Minnesota’s Approach
IPE: Opportunities for Community-University Partnerships Linked to Health

Integrated Health Care & Higher Ed System Transformation

- Driving Costs Out of Systems
- Community Health Outcomes
- Workforce Development
- Access to Care
- Patient Safety/Quality
- Teamwork
- Getting to Know Each Other

Improved Health and Learning Outcomes

Health reform in Minnesota: Navigating partisan environments
Three Phase Structure

Phase I
- Orientation to IPE
- All students together
- Day 1
- Small groups for blended module

Phase II
- Establishes Toolbox
- Current IPE Experiences/Courses
- Development of new IPE

Phase III
- Authentic Experiences
- All students involved in delivery of care/community health services
- Most complex
- Use of outreach/AHEC sites

AHC Support
- Office of Education/Center for Interprofessional Education
The Nexus

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National Aims / Triple Aim

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Team-based Care

Health Professions Education
Orientation and essential skills

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Faculty, Clinicians, and Practitioners
Operations

Practice Community
Evolving integrated health systems
Institute for Healthcare Improvement

Triple Aim

- Improving the patient experience of care;
- Improving the health of populations; and
- Reducing the per capita cost of health care.
Our vision for a transformed health system

The Nexus

Leading to partnerships

Producing positive impact on Triple Aim outcomes

Education

Practice
New Nexus

Working together to transform education to keep pace with the rapidly transforming processes of care

Creating a closed loop model for continuous improvement of the delivery of health care

Working collaboratively to achieve the Triple Aim in both health care and higher education: cost, quality and the user experience
What we are learning about the “Nexus” in “courageous conversations”

- Functional, symbiotic relationship to fulfill missions
- Transparency
- Integrated and coordinated education and practice
- Patient-, family- & community-engaged and centered health
- Longitudinal & continuous learning experiences
- Policy & regulatory alignment
- “Competence” demonstrated through performance
- Documentation of value-added and business case for IPE to CP
- Metrics and data-driven design and feedback
National Center for Interprofessional Practice and Education
What we’re doing now

Our strategic priorities

- Engaging people
- Creating and sharing knowledge
- Building a network of living laboratories
- Developing resources and services
What we are learning

✓ Hunger for leadership and engagement

✓ Extremely uncoordinated growth of health professions education system in many places

✓ Absence of a common language and understanding

✓ A lot of “Just tell me what to do” and make it simple

✓ Perception of unsustainable re-training costs

✓ Immediate need for evidence for the early adopters

✓ People, families and communities – a strong, important and growing movement
Canadian Return on Investment Model: Interprofessional Education and Collaborative Practice

**Logic Model of IPC/IPE Process**
- **Input**
  - (funding, financing, HR, interprofessional education, etc.)
- **Process**
  - (culture, interprofessional team, communication, etc.)
- **Output**
  - (access to care, quality of care, etc.)
- **Secondary Outputs**
  - (policy changes, professional guidance, etc.)
- **Outcome**
  - (health improvements, well-being, etc.)

**Benefits**
- Impact metrics fill the matrix below.

**Costs**
- Metrics/Measures of cost fill the matrix above.

**Logic Model**
- Use of the logic model of IPE/IPC process allows tracing input costs through to impact benefits.

**Current assumptions:** Fixed physical capital; extant legislative frameworks; negotiated contracts
Implementing the Canadian ROI Model in the United States

1. Core team: epidemiologist, informaticist, nurse leader, physician, educators, evaluators, economist, and other experts as needed

2. Logic model development to guide the implementation while staying focused on improving Triple Aim outcomes

3. Informatics expertise of the U of M and its skills in developing and managing data exchanges and national databases

4. Data: An integral part of the incubator performance sites participation and performance

5. Qualitative and quantitative assessment tools

6. Building both a value proposition database at National Center level as well as incubator site initiative database that becomes incorporated into the value proposition database
Why Gather Data

1. The National Center vision is to reconnect education with clinical care, creating a Nexus that is focused on improving health outcomes as in the Triple Aim

2. The National Center working principle is that Nexi focused on health outcomes will improve that outcome

3. A National Center core outcome is to demonstrate to stakeholders the value added of the IPE and CP approach

4. To demonstrate this value, we must produce convincing data and information, both qualitative and quantitative
Critical Queries of the Database

Does interprofessional education and collaborative practice…

• improve the Triple Aim outcomes on an individual and population level

• result in improvement in educational outcomes?

• identify environmental factors essential for achieving Triple Aim outcomes?

• identify factors essential for sustainability of the transformation of the process of care?

• identify changes needed in policy, accreditation, credentialing and licensing?
Research – Coming Soon

1. Searchable data base on the National Center’s website with information of the over 600 articles that present and analyze empirical data, to be updated regularly

2. Descriptive review of the current literature that highlights key findings for further research and program development

3. Framing paper that outlines a research agenda in interprofessional practice and education mapped to the outcomes of the Triple Aim

4. Collection of validated instruments for measuring various aspects of interprofessional practice and education

5. Brief framing paper about the challenges and powerful potential of meaningful evaluation in the Nexus

6. Interprofessional criteria for clinical and teaching sites
http://nexsusipe.org
Three examples

Grand Valley State University

Medical University of South Carolina

University of Kentucky
Thank you to our
Official Event Contributing Partner

ASHA Corporate Partner