Interprofessional Team Structure and Collaboration in a Rural Nursing-Led Clinic

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Take Home Messages

• Interprofessional collaboration can promote a more engaged, dynamic and fulfilling workplace.
• Diverse professionals can provide critical insight into many aspects of patient care.
• Transformation takes time, effort and empowerment.
Definitions

“Interprofessional education occurs when two or more professions learn about, from and with each other to improve collaboration and the quality of care.” (WHO 2010)

“Interprofessional practice happens when multiple health workers from different professional backgrounds work together with patients, families and communities to deliver the highest quality of care.” (WHO 2010)
Terminology (has evolved)

“Interdisciplinary”
Internist, cardiologist, cardiovascular surgeon, etc.

VS

“Interprofessional”
Cardiologist, pharmacist, physician assistant, occupational therapist, etc.
IPE Is Not New

**IOM 1972 Report: Educating for the Health Team**

“How should we educate students of health professions in order that they might work in teams.”
<table>
<thead>
<tr>
<th>Competency Domain 1:</th>
<th>Values/Ethics for Interprofessional Practice</th>
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<tbody>
<tr>
<td>Competency Domain 2:</td>
<td>Roles/Responsibilities</td>
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<td>Competency Domain 3:</td>
<td>Interprofessional Communication</td>
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<tr>
<td>Competency Domain 4:</td>
<td>Teams and Teamwork</td>
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Many Professions Involved.....

<table>
<thead>
<tr>
<th>Allied Health</th>
<th>Nurse Anesthesia</th>
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<tbody>
<tr>
<td>Architecture</td>
<td>Nursing and Law</td>
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<tr>
<td>Athletic Training, Sports Studies, and Exercise Science</td>
<td>Nutrition and Dietetics</td>
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<td>Basic Science, Genetics, Microbiology</td>
<td>Occupational Therapy</td>
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<td>Behavioral and Community Health</td>
<td>Optometry</td>
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<td>Chiropractic Care</td>
<td>Palliative Care</td>
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<tr>
<td>Communication Science and Disorders</td>
<td>Physical Therapy</td>
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<td>Curriculum Evaluation and Education Research</td>
<td>Physician Assistant</td>
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<td>Dental Hygiene</td>
<td>Psychology</td>
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<td>Education Administration and Leadership</td>
<td>Radiologic Sciences</td>
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<td>Global Health</td>
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<td>Health and Environmental Sciences</td>
<td>Respiratory Therapy</td>
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<td>Health Services Administration and Research</td>
<td>Social Work</td>
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<td>Law</td>
<td>Speech-Language Pathology</td>
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<td>Library Science</td>
<td>Veterinary Medicine</td>
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IPE in Accreditation Standards

- Accreditation Council for Pharmacy Education
- Accreditation Council for Occupational Therapy Education
- Accreditation Review Commission on Education for the Physician Assistant
- Commission on Collegiate Nursing Education
- Council on Dental Accreditation
- Liaison Committee on Medical Education
- Others.....
Evolution in Thinking about Health, Healthcare and Health Professionals
(Adult) Learning Theory

- Need to know reason for learning and should have relevance.
- Learn best when based on experience (including errors).
- Learn through practice, application, problem-solving.
- Learning is a socio-cognitive process.
- We can’t know everything.
Learning can be Transformative

• Learning changes how we see ourselves, others and the world
• Learning from experience, critical reflection, and personal development
• New roles and ways of acting
  • Disorienting dilemmas
  • Long-held beliefs are challenged and re-examined
  • Integrate new thoughts
Iterative Processes

Building Team Work Competencies

- **ACT** as team member
- **PRACTICE** as team member
- **THINK** as team member
- **PREPARE** self as team member

Creating Collaborative Care

Transforming Ways of Knowing

- **CONTEXTUAL** knowing
- **INDEPENDENT** knowing
- **TRANSITIONAL** knowing
- **ABSOLUTE** knowing

Acquisition → Demonstration → Application
Rural PHCM: adult, pediatrics, psychology, and women’s healthcare since 2001.

- DNP/ARNPs, RNs, LPNs, LCSW, professional office staff, consulting MD.
- Insured/Sliding scale fees
- 60% patients <2x FPL, 50% uninsured

Archer: ~15 miles from UF-GNV.

- 1200 residents
- 20% of residents < FPL
- Issues of under/unemployment, access to transportation, access to Rx, access to healthy food sources
2015 HRSA Grant to Transform Practice

1. Established a robust care coordination infrastructure for complex patients (T2DM, COPD, MDD).

2. Expanded practice to include additional MBH resources

3. Initiated team training and workplace transformation
   1. QI-based approach
   2. Needs assessment and revision of work roles
   3. TeamSTEPPS as foundation
Critical Insights from External Needs Assessment

1. Role confusion
2. Lack of autonomy (professional staff)
3. Parallel team structures
4. Disparate visions
Interventions

1. 60min bi-weekly collaborative care conference (50% care – 50% team).
   • Each conference explored an aspect of teams, teamwork and transformation.
   • Prioritized by assessment and expressed needs
2. Process mapping and redesign
3. Voluntary changes to workforce (MD, Data Manager)
Evaluative Methods

Patient-Level Assessments:
1. HbA$_{1c}$
2. Patient Health Questionnaire 9 (PHQ-9)
3. COPD Assessment Test
4. Patient Reported Outcomes Measures Information System (PROMIS-29)

Teamwork Assessments:
1. TeamSTEPPS Team Perceptions Questionnaire (T-TPQ)
2. Collaborative Practice Assessment Tool (CPAT)
3. Team Compositive Questionnaire (TC)
Starting Points

1. Breaking the ice...establishing/reinforcing culture of psychological safety

2. Understanding roles and responsibilities: theoretical and actual

3. Define short-term wins: Flu vaccination rates

4. Redefining roles and responsibilities based upon new understandings

5. Working through areas of conflict to discern new approaches to concerns:
   i. Financial counselor as final point of clinical contact
   ii. The art of polite disengagement
   iii. Critical incident response
Collaborative Care Conferences

1. Mandatory attendance for all team members, clinical and non-clinical

2. 50% focus on patients, 50% focus on team

3. Flexible curriculum based upon real-time feedback
   1. Roles/Team structures
   2. Communication
   3. Leadership
   4. Situational monitoring
   5. Mutual support
   6. Flexible curriculum based upon real-time feedback

4. When needs/incidents arose, they were addressed immediately
Patient Discussions

Typical format:
• Two patients per conference, presented by DNP/ARNP.
• DNP/ARNP described priorities and challenges from his/her perspective.
• Team provided insight and information based upon their understandings.

Learnings:
• Non-clinical staff were frequently more knowledgeable about SDOH related information that impacted patient health/welfare.
• Non-clinical staff instrumental in identifying patients with food insecurity, financial issues and transportation issues.
• Non-clinical staff frequently offered unique interventions to address patient-related issues: helped to facilitate home visits, identify community resources.
• Dramatic change in culture.
Outcomes

Teamwork Related

Collaborative Practice Assessment Tool

Team Composite Scale

Team Perceptions Questionnaire
Outcomes

Collaborative Care Cohort (n=60)

• HbA$_{1c}$: 52% (n=26) $\geq$ 1% reduction (pre-post).
• 57.16% of those individuals maintained < 7% for 1+ years.
• 50% of patients with MDD diagnoses experienced reduction in severity.
• COPD: 40% (n=4) $\geq$ 2 point reduction in COPD symptoms
• PROMIS 29: + sleep, social engagement; - fatigue, depression, anxiety
• Preventive services (Flu, routine vaccination, mammography, colonoscopy): documentation of adherence or documented declination of service: 43% $\rightarrow$ 93% (across all active patients).
Lessons Learned

• It takes a village.
• It takes time.
• Conflict happens. It must be addressed.
• Cultural change is challenging, some may not be on board.
• An empowered workplace is a happy workplace.
• Everyone is responsible for the patient.
References


